Policy Document

Medical Student Registration and Mandatory Reporting (2022)

Position Statement

AMSA believes that:

1. Mandatory reporting legislation forms an important mechanism in protecting patient safety and ensuring high standards of care.
2. Current mandatory reporting legislation jeopardises practitioner and student health by increasing barriers to help seeking behaviours regarding mental health conditions in an already vulnerable population.
3. Patient safety and health practitioner and student wellbeing are complementary rather than competing interests.
4. The existing Western Australian model of exempting treating practitioners from mandatory reporting reduces barriers to health seeking behaviours in practitioners and students without compromising patient safety.
5. The Australian Health Practitioner Registration Agency's current processes of investigating reported students and practitioners need to be changed to minimise the harms inflicted upon the registrant.
6. Medical defence and doctor's health organisations play a crucial role in supporting practitioners through reporting and investigation processes, and require further resourcing.
7. The value of medical student registration lies within its ability to allow for workforce mobility across Australia, and ensure a consistently high professional standards for medical students.
8. The information collected about medical students for the purposes of registration should be minimal, kept confidential and not transferred without explicit consent.

Policy Points

AMSA calls upon:

1. The Medical Board of Australia (MBA) and Australian Health Practitioner Regulation Agency (AHPRA) to;
    1. Ensure there is no monetary cost to the medical student associated with registration, or for any investigation, counselling or appeal that arises as a result of a report;
    2. Ensure only the following information about students is required to be provided to the Board for the purposes of registration:
        1. Name,
        2. Address,

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A Level 1,
39 Brisbane Avenue,
Barton, ACT 2600

Postal Address
PO Box 6099,
Kingston, ACT 2604

ABN:
67079 544 513

Email:
info@amsa.org.au

Website:
www.amsa.org.au

3. Date of birth,
4. University and year level,
5. Dates of undertaking.

3. Ensure students are not required to provide health status, medical reports nor academic progress as a condition of registration;
4. Maintain the absolute confidentiality of all information provided in the process of registration, with any necessary transfer of information only occurring with explicit consent of the registrant.

2. Australian State Governments to;
    1. Amend the National Registration and Accreditation Scheme in section 141(4) to exempt treating practitioners from mandatory reporting obligations if the reasonable belief as to the notifiable conduct or impairment is formed in the course of providing health services to a health practitioner or student under their care, in line with current legislation in Western Australia;
    2. Amend the National Registration and Accreditation Scheme to exempt practitioners who form a reasonable belief on the impairment of a medical student during the course of providing an educational or pastoral care service whilst employed by the university;
    3. Amend the National Registration and Accreditation Scheme to state that Ahpra has a legally binding duty of care to the registrant which extends to the proceedings of a report;
    4. Fund research into the experiences of practitioners and students who undergo investigation by Ahpra to better characterise this process and inform improvements;
    5. Consider the implications on practitioner and student mental health in all decisions pertaining to mandatory reporting legislation;
    6. Ensure that registrant privacy and confidentiality is maintained throughout the investigation process.
    7. Implement the recommendations of the Every Doctor Every Setting national framework;
    8. Provide funding for peer support networks between health practitioners such as Drs4Drs and Hand-In-Hand services to:
        1. Develop a network between medical practitioners for support around mandatory reporting issues;
        2. Encourage an environment of de-briefing between colleagues; and
        3. Reduce the stigma surrounding help-seeking behaviours through normalisation and fostering stronger understanding of mandatory reporting legislation.
3. AHPRA to:
    a. Acknowledge their responsibility to protect the mental health of the reported practitioner or student throughout the course of any investigation;

b. Offer and fund confidential support by an independent mental health professional to any health practitioner or student under investigation;
c. Ensure that all investigations are completed within 6 months excluding exceptional circumstances;
d. Maintain the absolute confidentiality of all information provided in the process of an investigation in line with the Privacy Act 1988 (Cwlth);
e. Provide training in addiction medicine and toxicology to all regulators and consult experts when managing the registration of practitioners with substance dependence;
f. Educate practitioners and students on the threshold required to make a report in a targeted manner to reduce common misconceptions;
g. Develop an appropriate appeals process by which a student or practitioner can appeal a decision with no additional monetary cost;
h. Ensure appropriate support is provided to students wishing to make an appeal, including independent legal support;
i. Audit internal structures that have been shown to cause additional distress to registrants;
j. Investigate the experiences of practitioners and patients who have been reported to inform procedural changes;
k. Respond to advocacy from stakeholders and representative groups including but not limited to the AMA, AMSA and the Medical Colleges noting their knowledge of practitioner experiences; and
l. Ensure transparency surrounding the processes that occur following a mandatory report as much as possible.

4. Australian Medical Schools to;
    a. Support students through the process of reporting another practitioner or being under report by Ahpra through providing access to mental health practitioners and referring to medico-legal experts;
    b. Integrate education on legislative requirements for mandatory reporting into the medical curriculum vertically and horizontally, noting differences between states with a particular focus on educating students on:
        i. Personal information provided to APHRA;
        ii. How to make a mandatory report under the legislation;
        iii. How to respond to a mandatory report;
    c. Communicate changes to legislation rapidly and adapt curriculum accordingly; and
    d. Implement preventative measures for medical student mental health as outlined in AMSA's policy *Mental Health and Wellbeing*.

5. The Australian Medical Council (AMC) to:
    a. Include educational content on mandatory reporting as part of the medical school accreditation requirements;
6. Medical defence organisations to;
    a. Foster greater understanding of mandatory reporting legislation within students and practitioners by:
        2. Educating medical students on the thresholds of mandatory reporting by providing medico-legal jargon-free information;
        3. Advertising their capacity to help when a mandatory reporting notification has been made to a client;
    b. Support their members through the investigation process by providing medico-legal advice and access to mental health support.

Background

Medical Student Registration

The National Registration and Accreditation Scheme (NRAS), established in 2010 by the Council of Australian Governments (COAG) was introduced to provide consistent legislation on health professionals registration across all jurisdictions. The scheme itself is administered by the Australian Health Practitioner Regulation Agency (Ahpra) and covers 16 health professions, each regulated by their own national board, which registers practitioners and students and develops codes, standards and guidelines (2).

The value of the NRAS is twofold:

1. To ensure the continued consistent high quality professional standards of health practitioners across the board;
2. To allow for workforce mobility across Australia.

Ahpra also works to manage complaints and concerns surrounding individual health practitioners on behalf of the national boards across most states in Australia, (aside from Queensland and New South Wales). In Queensland, mandatory reports are dealt with under co-regulatory arrangements with the Queensland Health Ombudsman. In New South Wales, mandatory reports are made to Ahpra, which then refers them to the Health Care Complaints Commission and the relevant health professional council in New South Wales (3).

Currently, medical students enrolled in an approved program of study leading to registration as a medical practitioner must be registered under the Medical Board of Australia (MBA). Students need not apply for this registration, as their information will be passed on by their relevant medical school. This registration is of no charge to students. Under national law, an approved program of study must be:

a. Approved under section 49(1) by the national board established for the health profession; and
b. Included in the list published by the national agency under section 49(5)(1).

The information concerning individual students is collected by Ahpra, and updated twice a year (March and August). The specific information required is provided in Appendix 1.

It is important to note that unlike the registration of healthcare practitioners, the information and details regarding registered students is not publicly available.There is a profound requirement for confidentiality in personal data, both ethically and legally. Ahpra's use and storage of personal information is regulated under the Australian Privacy Act 1988 under National Law, and thus underlies the principle that the information surrounding registered students has no need to be publicly available.

This registration database presents the possibility for misuse, and thus regulation and registration should be used only for its intended purpose: to minimise risk to patients, to develop an impartial mechanism of notification and investigation of complaints against students independent of university scope and to allow recognition of medical students by any public hospital in that state (4).

Although some of this information is clearly necessary, the requirement for provision of reasoning behind a student's ceasement of study appears to lack a sufficient cause. The storage of this information has the potential to disrupt or compromise future study or registration, particularly if that challenge is ongoing or related to mental health.
Currently, students are not required to prove their capacity to undertake clinical studies as this is assumed. This should remain assumed as otherwise, this would present both an unnecessary burden and an invasion of privacy to the student.

Although Ahpra plays no role in the academic progress of students outside of offences punishable by over 12 months imprisonment, this body has access to student's academic results (5).

Finally, medical student registration should also not incur any financial cost to the student, including initial registration, counselling, or investigation of students (4). Costs relating to investigation of students and student support during this process are potentially burdensome, particularly for those not earning a full time wage. As students are inherently not independent in their medical practice and operate only under the scope of a registered medical practitioner, a fee attached to registration is inaccessible and unnecessary.

Background on Mandatory Reporting Legislation

Medical practitioners and medical students are expected to uphold a high standard of ethical and professional conduct, as specified in the *Good Medical Practice* guide, with the key aim of this being protecting the safety of patients and the integrity of the medical profession (6). For the small minority of doctors who do pose a substantial risk of harm to their patients, Ahpra legally requires a practitioner to make a mandatory notification of their colleague. In Australia, mandatory reporting has the potential to reinforce patient safety whilst simultaneously opening interprofessional dialogue about the profession's response to health and wellbeing of practitioners (7).

For practising medical professionals, section 140 of the Health Practitioner Regulation (National Law) defines 'notifiable conduct' to fall under one of four categories (8):

1. Practised the practitioner's profession while intoxicated by alcohol or drugs
2. Engaged in sexual misconduct in connection with the practice of the practitioner's profession
3. Placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment
4. Placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

By contrast, medical students practice under constant supervision so have a higher threshold for mandatory reporting such that there is only one circumstance whereby notification becomes mandatory (9). This ground is when a medical practitioner has the reasonable belief that the student has an impairment that, when undertaking clinical training, may place the public at substantial risk of harm (9). Student impairments that require mandatory reporting include conditions that are both psychological or physical, as well as some disabilities, conditions or disorders including substance dependence (9). Despite this, intoxication that does not amount to impairment, sexual misconduct or significant departure from professional conduct are not grounds for mandatory reporting of students to Ahpra (9). This can instead be reported to the students' education provider (8). Importantly, having a diagnosed illness does not automatically constitute an impairment in doctors or medical students. If a medical practitioner suspects another practitioner poses a risk to patients or the public, but this risk does not fall under the reasons for mandatory reporting, they can make a voluntary report instead.

Mandatory reporting obligations were first legislated in Australia by the New South Wales parliament in 2008, followed by Queensland in 2009 (8). On 1 July 2010, all states except Western Australia legislated the National Law, which adopted the Queensland act across all jurisdictions, streamlining mandatory reporting obligations. The scheme involved was known as the National

Registration and Accreditation Scheme (8). Western Australia passed an amended national law on 18 October 2010. Their law involved an additional exemption whereby treating practitioners of practitioner-patients were exempt from mandatory reporting requirements, with the aim to avoid discouraging a practitioner who is impaired from seeking treatment. This exemption is listed in section 141(4)(ca) of the National Law (8). Western Australian medical practitioners are not exempt from any other mandatory reporting requirements.

In 2020/2021, 10,147 notifications were made to Ahpra for all health practitioners. Of these, only 42 notifications were made about medical students. Of a total of 1266 mandatory notifications made to Ahpra, approximately 375, or 29.6%, were made about medical practitioners (10). Of these mandatory reports, 31.3% resulted in regulatory action being taken. The number of mandatory notifications pertaining to impairment had increased from the 2019/2020 report (10). While the national Ahpra board has the ability to take immediate action to reports raising serious matters, this immediate action was only taken for 5.9% of notifications received (10). Although these statistics indicate that mandatory reporting may only affect a small minority of health practitioners and medical students, these legislations have wide-ranging implications.

Issues Associated with Mandatory Reporting Legislation

The debate surrounding mandatory legislation has consistently focused on two issues: protecting patient safety, and ensuring the health of practitioners. Amendments were made to the regulations in 2019 in an effort to reduce barriers to help seeking behaviours amongst health practitioners and students, indicating that legislators are aware of these issues. However, these modifications did not fully implement the recommendations of groups including the Royal Australian College of General Practitioners, the Australian College of Emergency Medicine, the Australian College of Rural and Remote Medicine, the Australian Medical Association and AMSA, due to perceived concerns about patient safety from COAG and since 2020, the National Cabinet (11). Effective legislation must achieve the balance between patient safety and protecting the mental health of practitioners, and as such both issues will be explored within this section.

There is a strong consensus that health practitioners are effectively positioned to identify fellow practitioners who jeopardise patient safety (12-16), given their intricate understanding of professional standards. A key impetus for the initial introduction of mandatory reporting laws in 2010 was an investigation by Desroaches et al. which highlighted that individual physicians cannot be relied upon to report colleagues who threaten quality of care purely from ethical obligations (15). Supporters of current mandatory reporting laws highlight the clear messaging that patient safety is paramount through robust identification of dangerous practitioners using all available avenues (17), whereas critics identify the barriers to help seeking behaviours that the treating-practitioner

reporting obligations create (8,18-22). It has also been contested that investigations should be less punitive and that upstream interventions and education around mandatory reporting are required to best support the mental health of practitioners (15). Interests of patient safety and practitioner and student wellbeing are complementary, as a healthy profession leads to healthy patients. As such, these issues are not framed as competing within the ensuing legislation analysis.

Strengths of the current legislation include the high threshold for reporting medical students and the description of safeguards that mitigate the requirement to make a mandatory report (9). This rightly recognises the limited capacity for medical students to do harm due to supervision whilst on clinical placement, as well as the importance of other safeguards such as modified scope of practice, management strategies and compliance with monitoring and supervision. However, this section must be considered in the context of the systemic barriers to help seeking which reduce the likelihood that a medical student or practitioner will be able to implement safeguards. It is noted within the guidelines that a 'substantial risk of harm' is a high threshold for reporting risks of harm, however the threshold for reportable harms has decreased from the previous iteration of the law, for which the law defined a 'risk of substantial harm' (23). This change implies the threshold of reportable harms is lowered. As such, returning the harm threshold to 'substantial harm' whilst maintaining the risk threshold at 'substantial risk' would constitute more robust legislation and removes the capacity for misguided or vexatious reporting (11).

There remains two fundamental issues with the existing legislation. The first is the requirement for treating practitioners to report their health student or practitioner patients. The second is the unmitigated misunderstandings and misguided perceptions of mandatory reporting that cause inappropriate reporting and increased barriers to help seeking behaviours for common mental health conditions (18-21). Despite the high threshold for reporting students, there remains a perception that disclosing mental health issues related to depression and anxiety to a treating practitioner can result in a report being made (24). BeyondBlue's National Mental Health Survey of Doctors and Medical Students found that 36.4% of respondents stated that 'impact on registration and right to practice' was a barrier to seeking help (25). This compounds with many other barriers that medical students face when seeking to access mental healthcare, which are outlined in detail in AMSA's *Mental Health and Wellbeing* policy (26). As such, including treating practitioners in mandatory reporting legislation under the guise of protecting patient safety is paradoxical as the practitioner-patient is deterred from primary prevention and early intervention. Through this, it is clear that the only effective mechanism for ensuring that medical students are able to seek help is to exempt treating practitioners from mandatory reporting.

Not only is there a perceived barrier, but many treating practitioners misunderstand the reporting threshold and make overly cautious notifications

which adversely affects the wellbeing of the reported student (8). There remains a deleterious stigma surrounding mental health conditions in the medical profession (26), indicating that some treating practitioners may overestimate the extent to which having a mental illness such as anxiety or depression confers a substantial risk of harm to the public. Furthermore, treating practitioners are not as appropriately placed as practitioners that observe student conduct in the clinical setting due to the necessity of extrapolation to determine the risk to patients, heightening the variability of reporting. Importantly, the WA model—which has been in place for over a decade—has not recorded any difference in patient safety outcomes (8,20). Taking these points together, it becomes clear that mandatory reporting by treating practitioners is both comparatively unimportant in ensuring patient safety and also greatly detrimental to the mental health of medical students and doctors.

Furthermore, the lack of national consistency in the mandatory reporting legislation creates difficulties in communication and education of practitioners across all States and Territories about their reporting obligations (27). When a practitioner works in more than one State or Territory, the practitioner needs to be aware of and apply the different reporting requirements, creating room for concern and confusion. Thus, despite the increasing threshold of reporting requirements, confusion lowers the perceived threshold for reporting (3). As such, national law should be changed to be consistent with WA legislation. This stance is consistent with findings from the Independent Review of the National Registration and Accreditation Scheme for health professionals (28). To further mitigate the lasting perceptions and misunderstanding of reporting thresholds, robust education programs are required which will be discussed in a later section of this policy.

Beyond the letter of the legislation, Ahpra and the MBA's treatment of notified practitioners and students is another factor that impacts both public safety and practitioner health. As described in Ahpra's annual report, only 31.3% of reports result in regulatory action (10). That is to say that the majority of reported practitioners are not posing a threat to patient safety. While many practitioners are not subject to regulatory action, the process of an investigation can have significant personal and professional consequences. Thus, it is vital that the process of reviewing reports takes into account the mental health of the reported practitioner or student. This is currently not the case, as being involved in a report has been linked to psychiatric morbidity, and has been described as major life trauma equivalent to bereavement or marriage breakdown (21, 29). 40% of doctors involved in medico-legal concerns considered leaving the profession (21). This reputation may further increase the stigma and create barriers to help seeking behaviours. There is a current dearth of literature on experiences of practitioners who have faced Ahpra reports, which must improve such that evidence-based changes to harmful processes can be made. In 2022, AMA Victoria called for fundamental changes to Ahpra's processes. Their recommendations included amending the National Registration and Accreditation Scheme to ensure that Ahpra has a binding duty of care to the

registrant, offering confidential support by an independent mental health professional to anyone under investigation, mandating that all investigations be completed within 6 months (currently they can last up to two years) and requiring Ahpra and MBA staff to undertake training in addiction medicine and toxicology (19). These changes would be likely to improve the experiences of practitioners and students under investigation and must be considered.

At time of writing, the QLD Parliament is considering the Health Practitioner Regulation national Law and Other Legislation Amendment Bill 2022 (30). This Bill inserts new division 7B into part 8 of the National Law which allows for the National Agency and Health Ombudsman to issue public statements about registered practitioners who are subject to investigations or disciplinary proceedings when their conduct poses a serious risk to public safety (30). This indicates that some State government's recently proposed changes have failed to adopt the AMA's recommendations, and have introduced further stigma-inducing laws such as this that allows for public naming and shaming of health practitioners under investigation. Doctor's Health in Queensland (DHQ)—a body that supports and advocates for practitioners and medical students—strongly opposes the changes due to the potential for serious harm to the publicly shamed practitioner's mental health, reputation and employment (31). They also note that this legislation would generate an omnipresent fear of being shamed for health system failures, further demoralising and deterring practitioners from seeking help. Furthermore, DHQ argues that being 'tough' on 'bad' doctors doesn't improve patient safety and paradoxically drives a culture of shame and secrecy, harming patients and the healthcare workforce (31).

Mandatory Reporting: Education and Support

The disproportionate fear many students have around mandatory reporting is a manifestation of a lack of awareness of the details of the law and what genuinely constitutes the 'substantial harm' required for a report to be made (32). Thus, it is important to educate medical professionals about both the ethical necessity of mandatory reporting, and the facets that comprise the thresholds of what is considered genuine impairment for reporting (33). Health regulators and practitioner health programmes should educate and explore the barriers for health care workers to access and receive help, as more than 1 in 10 healthcare workers had thoughts of suicide or self-harm with many not seeking professional help (34).

However, where reports are made, questions continue to be raised about the timeliness, appropriateness, and effectiveness of the regulatory response (35). The delayed process of mandatory reporting has the ability to impair a practitioner's career and emotional wellbeing (36). Thus, support networks such as Drs4Drs and Hand-in-Hand could provide a bridge between formalised psychological help and being alone in the mandatory reporting process. Such support networks have the potential to alleviate the fear and stigma around being reported through mandatory reporting procedures.These networks also

play a vital role in supporting practitioners to return to work following an investigation.

Numerous other stakeholders are pivotal in both supporting reported students and practitioners as well as working upstream to improve culture and decrease the stigma surrounding mental health. In 2019, Everymind developed the Every Doctor, Every Setting Framework, which among many models of prevention and mental health promotion also called for treating practitioner exemptions to mandatory reporting obligations (37). This framework also notes the importance of Medical Defence Organisations in providing medico-legal support to individuals and using their platform to educate medical students and doctors on mandatory reporting legislations (37). It is important that all of these actors are empowered to advocate and educate through increased funding and stronger recognition and platforming within the profession.

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Appendix 1: Information collected by AHPRA on Registered Medical Students (37)

1. The name of the education provider
2. Student's name
3. Student ID number
4. Student's date of birth
5. Student's sex
6. Student's mailing address in Australia and email details
7. Name of approved program of study being undertaken
8. The date on which the student started the approved program of study or clinical training
9. The date on which the student is expected to complete the approved program of study
10. For students that have completed or otherwise ceased to be enrolled in the approved program of study or clinical training, the date of completion and cessation and;
11. The reason why the student completed or otherwise ceased to be enrolled in the approved program of study or clinical training

Policy Details:

Name: Medical Student Registration and Mandatory Reporting (2022)

Category: C – Supporting Students

History: **Reviewed Council 3, 2022**

Connor Ryan, Talissa Stojanoski, Jenn Kim, Sophie Rice, Ally Yates with Yufei Xu (National Policy Mentor) and Ashraf Docrat (National Policy Officer

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