Division 4 - Disciplinary powers of Committees and Tribunal

MEDICAL PRACTICE ACT 1992 - SECT 60

Powers may be exercised if complaint proved or admitted

60 Powers may be exercised if complaint proved or admitted

A Committee or the Tribunal may exercise any power or combination of powers conferred on it by this Division if it finds the subject-matter of a complaint against a person to have been proved or the registered medical practitioner who is the subject of the complaint admits to it in writing to the Committee or Tribunal

MEDICAL PRACTICE ACT 1992 - SECT 61

General powers to caution, reprimand, counsel etc

61 General powers to caution, reprimand, counsel etc

(1) A Committee or the Tribunal may do any one or more of the following

(a) caution or reprimand the person,

(b) order that the person seek and undergo medical or psychiatric treatment or counselling,

(c) direct that such conditions, relating to the person's practising medicine, as it considers appropriate be imposed on the person's registration,

(d) order that the person complete such educational courses as are specified by the Committee or Tribunal,

(e) order that the person report on his or her medical practice at the times, in the manner and to the persons specified by the Committee or Tribunal,

(f) order that the person seek and take advice, in relation to the management of his or her medical practice, from such persons as are specified by the Committee or Tribunal

(2) If the person is not registered, an order or direction can still be given under this section but has effect only so as to prevent the person being registered unless the order is complied with or to require the conditions concerned to be imposed when the person is registered, as appropriate

MEDICAL PRACTICE ACT 1992 - SECT 62

Power to fine in certain cases

62 Power to fine in certain cases

(1) A Committee or the Tribunal may by order impose a fine on the person of an amount of up to 50 penalty units in the case of a Committee or 250 penalty units in the case of the Tribunal

(2) A fine is not to be imposed unless the Committee or the Tribunal finds the person to have been guilty of unsatisfactory professional conduct or professional misconduct A fine is not to be imposed if a fine or other penalty has already been imposed by a court in respect of the conduct

(3) A fine must be paid within the time specified in the order imposing the fine and is to be paid to the Board

MEDICAL PRACTICE ACT 1992 - SECT 63

Committee can recommend suspension or deregistration on grounds of lack of physical or mental capacity

63 Committee can recommend suspension or deregistration on grounds of lack of physical or mental capacity

(1) A Committee may recommend that a person be suspended from practising medicine for a specified period or that a person be deregistered if the Committee is satisfied (when it finds on a complaint about the person) that the person does not have sufficient physical and mental capacity to practise medicine

(1A) If the person is not registered, a recommendation can be made under this section that the person not be re-registered

(2) The Committee makes its recommendation by referring the matter with its recommendation to the Chairperson of the Tribunal or to a Deputy Chairperson nominated by the Chairperson

(3) The Chairperson or Deputy Chairperson may then make an order in the terms recommended or may make such other order as to the suspension or registration of the person as the Chairperson or Deputy Chairperson thinks proper based on the findings of the Committee

(4) An order that a person be deregistered is an order that the person's name be removed from the Register or (if the person has already ceased to be registered) that the person not be re-registered

(5) An order may also provide that an application for review of the order under Division 3 of Part 6 may not be made until after a specified time

(6) Instead of making an order under this section, the Chairperson or Deputy Chairperson may exercise any power or combination of powers of a Committee under this Division

MEDICAL PRACTICE ACT 1992 - SECT 64

Tribunal can suspend or deregister in certain cases

64 Tribunal can suspend or deregister in certain cases

(1) The Tribunal may by order suspend a person from practising medicine for a specified period or direct that a person be deregistered if the Tribunal is satisfied (when it finds on a complaint about the person)

(a) that the person is not competent to practise medicine, or

(b) that the person is guilty of professional misconduct, or

(c) that the person has been convicted of or made the subject of a criminal finding for an offence, either in or outside New South Wales, and the circumstances of the offence render the person unfit in the public interest to practise medicine, or

(d) that the person is not of good character

(2) An order that a person be deregistered is an order that the person's name be removed from the Register or (if the person has already ceased to be registered) that the person not be re-registered

(3) An order may also provide that an application for review of the order under Division 3 of Part 6 may not be made until after a specified time

MEDICAL PRACTICE ACT 1992 - SECT 65

Board may refer breach of disciplinary order to the Tribunal

65 Board may refer breach of disciplinary order to the Tribunal

(1) If the Board has reason to believe that a person has failed to comply with any order (or conditions imposed pursuant to an order) made by a Committee or the Tribunal under this Division, it may refer the matter to the Tribunal

(2) If the Tribunal finds the failure proved, it may exercise any power or combination of powers conferred on it by this Division

The New South Wales Medical Board

PERFORMANCE ASSESSMENT PROGRAM

Background and Overview

The Performance Assessment Program, introduced in October 2000, represents the culmination of intensive research, consultation and development The program is designed to complement the existing conduct and health streams by providing a pathway for dealing with practitioners who are neither impaired or guilty of professional misconduct, but for whom the Board has concerns about the standard of their clinical performance

The program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is properly protected It is designed to address patterns of practice rather than one-off incidents unless the single incident is demonstrative of a broader problem

The professional performance of a registered medical practitioner is defined to be unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience

Leading up to the commencement of the Performance Assessment Program, the Board, through the President, Registrar and Medical Director undertook an extensive program of presentations to stakeholders and interested parties

The Act supports the steps of the Performance Assessment program as follows

1 Notification

Any person may notify the Board of a matter that may indicate that the professional performance of a registered medical practitioner is unsatisfactory However, anonymous referral are not accepted

2 Assessment

The Board, through the Performance Committee, may decide to have the

professional performance of a practitioner assessed if any matter comes to its attention that indicates that the practitioner's performance, or an aspect of their performance is unsatisfactory

Serious matters that raise a significant issue of public health or safety, or which indicate professional misconduct or unsatisfactory professional conduct, are not dealt with under the Performance Assessment provisions of the Act Such matters are dealt with as complaints

Advice to Practitioner

Having decided that a matter is to be dealt with in the Performance Assessment pathway, the Board must advise the practitioner in writing that their professional performance is to be assessed The practitioner must be informed of the details of the matters giving rise to the assessment, and is given an outline of how the process is to work and the opportunity to provide information to assist in the assessment process

The Role of Assessors

Performance Assessment is undertaken by one or more assessors appointed by the Board to conduct an assessment of the practitioner's professional performance, or any particular aspect of their performance Assessors are selected from panels nominated by the relevant College, whether or not the doctor is a Fellow

If in the course of conducting an assessment, the assessor or assessors form the opinion that aspects of the practitioner's professional performance in addition to those that were the subject of notification should be assessed, then these aspects may be incorporated in the assessment

The Assessment Exercise

Assessors may visit any premises reasonably believed to be connected with the practitioner's professional practice This includes any location at which medical records are kept

Central to the exercise is an assessment if the practitioner's knowledge and skill A

variety of tools have been developed with which to conduct the assessment Discussion of clinical scenarios is an important component of the assessment Where practicable, assessors observe and assess the professional performance of the practitioner using simulated clinical situations With the consent of patients, actual clinical situations may be observed, particularly in the assessment of procedural competence

Record review provides an indication of the quality of a practitioner's record keeping and day to day decision making Assessors have the authority to copy records

In addition, assessors are able to question any person on the premises, including patients, examine equipment, take photographs and inspect stocks including drugs

Practitioners are expected to facilitate and cooperate with an assessment exercise Failure to do so is considered to be evidence of unsatisfactory professional performance

Assessment Report

Assessors report in writing to the Board, through the Performance Committee The report may not be admitted or used in any civil proceedings before a court, except with the consent of the person giving the report and the practitioner concerned

The report includes any recommendations that the assessor considers appropriate The Board, through the Performance Committee may then decide that,

- No further action is to be taken
- The practitioner should be counselled
- A Performance Review Panel should be convened
- If there appears to be a significant issue of public health or safety, or indications of a case of professional misconduct or unsatisfactory professional conduct, a complaint against the practitioner should be made
- A referral should be made to an Impaired Registrants Panel
- The matters should be dealt with urgently under the provisions of Section 66 of the Act

3 Performance Review Panel

Following consideration of an assessment report, the Board may refer the matter to a Performance Review Panel consisting of two medical and one lay member The Board will ensure that the medical membership is appropriate for the case before it, drawing from panels of College members

Conduct of a Performance Review Panel

Performance reviews are to be conducted in the absence of the public and with as little formality and technicality as possible The panel is not bound by the rules of evidence, and may be informed on any matter and in any way it believes to be appropriate As with all Board processes, the rules of natural justice must be followed Assessors may be directed by the Panel to provide further assistance in conducting the performance review

As with a Professional Standards Committee, the practitioner is entitled to be accompanied by a legal representative or other advisor, but may not be represented

Action by Performance Review Panel

If the Panel finds that the practitioner's professional performance is unsatisfactory, it may

- Direct that conditions be placed on the practitioner's registration
- Order that the practitioner completes a specified educational course
- Order that the practitioner reports on their medical practice
- Order that the practitioner seeks and takes advice from specified persons
- Recommend that a complaint be made if there appears to be a significant issue of public health or safety, or indications of a case of professional misconduct or unsatisfactory professional conduct

The exact nature of retraining programs specified in conditions will depend on the needs of the individual, whose responsibility it will be to undertake and pay for requisite retraining programs

4 Reassessment

A Performance Review panel may recommend that a practitioner's professional performance is reassessed by one or more assessors at a future date

5 Monitoring

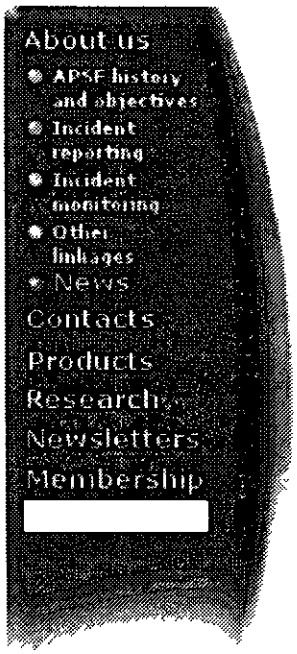
Following a performance review by a Performance Review Panel, the Board monitors compliance with any orders made by the panel, and evaluates the effectiveness of the orders in improving the practitioner's performance

6 Appeal

A practitioner who is the subject of a performance review may appeal to the Tribunal against a decision or any order or direction of a Performance Review Panel The appeal will be dealt with by rehearing and may include fresh evidence

The touchstones of the Performance Assessment Program are protection of the public, concern with the totality of a practitioner's performance, an educative focus and a consistency of process and outcome

The Board believes that the new provisions of the Medical Practice Act provide a coherent and positive framework to address these important issues in a way that is both protective of the public, and in the interests of the profession and its members



About the APSF

The **Australian Patient Safety Foundation Inc. (APSF)** is a non-profit independent organisation dedicated to the advancement of patient safety. The APSF provides leadership in the reduction of harm to patients in all health care environments The APSF through its subsidiary **Patient Safety International (PSI)**, provides a software tool, the Advanced Incident Management System (AIMS∃) to capture information from a wide variety of sources to enable 電e-construction･and classification of incidents from 渡ear misses･to 都entinel events･in a consistent way, so that subsequent, detailed analysis is possible

As the commercial arm of the APSF, PSI is responsible for the marketing, technical development and support of AIMS The APSF is the research basis of PSI and is responsible for on-going development of the classification schema The AIMS software enhances efficiency and quality by providing a single point of data entry to capture, classify, manage and analyse safety and quality information Unlike other systems, AIMS provides detail on why and how problems occur ･powerful knowledge in the development of interventions For more information please visit･ **www.patientsafetyint.com**

APSF history and objectives

The APSF was incorporated as an association in July 1989, but the origins of the Foundation derive from an incident monitoring study in anaesthesia (AIMS-Anaesthesia) that began in 1988 This study arose from a symposium on patient safety and monitoring (Adelaide 1987). The symposium found that problems occurring in anaesthetic practice in Australia should be identified and analysed so that cost-effective preventative methods could be developed to minimise their adverse effects

A related study into Hyperbaric Medicine incidents (HIMS) has been operating since 1992, and is coordinated by the Hyperbaric Unit of the Royal Adelaide Hospital, in collaboration with APSF The study receives reports from Australian and international centres and the results have

been presented at international meetings such as the Hyperbaric and Underwater Medicine Society

In 1993, funding was received from the Australian Commonwealth Government to continue AIMS-Anaesthesia, and to set up pilot studies in other specialty areas In 1994 the brief was broadened to develop an incident monitoring model that could be used on an institutional basis, rather than being specialty focused A pilot study was conducted in six tertiary facilities in different Australian States.

The national release of results from the Quality in Australian Health Care Study (QAHCS) in 1995 prompted strong reaction from government, health care professionals, and the public generally The South Australian government took the initiative to look at options for reducing risk in South Australian health care units As a consequence, in November 1996, the APSF was engaged to develop and implement a patient incident reporting and monitoring system for all public health units in SA - the Australian Incident Monitoring System (AIMS).

Since that time AIMS has been implemented in several Australian States, as well as individual health units In 2000 the system was introduced into a health care site in New Zealand There is growing international interest in the APSF's patient safety products as health care professionals and administrators acknowledge the importance of incident data collection, analysis and remedial solutions

Since 1988, the APSF has developed classification systems for coding and reporting of incidents and adverse events Data from the QAHCS was classified into the Generic Occurrence Classification (GOC)TM, and this data compared with the Harvard Medical Practice Study (USA) As part of a process of review and improvement, the GOC is currently being redeveloped to provide simpler entry of data into the classification, and more effective analysis and reporting (See Products)

The APSF is governed by a Council representing medical and other clinical colleges and the Consumers' Health Forum The Foundation has established affiliations with other analogous organisations to enhance patient care and service delivery across the Australian health care system and beyond

Incident reporting

Incident reporting at health unit sites· Incident information is collected throughout the health unit on paper form and is then data entered and coded using the APSF software This data contains confidential information on those involved in the incident and is protected from legal discovery under Australian Commonwealth Quality Assurance legislation

The coding of the information provides the means for understanding the underlying causes of the incident and for analysing the contributing factors This analysis supports the preparation of a range of comprehensive reports to assist management in identifying problems and remedial action

All aspects of incident reporting remain under the control of health unit management

Incident monitoring

Incident monitoring APSF collects data from the health units with all identifying information removed This anonymous data is then keyed into an aggregated database that allows all health units to receive comparative information linking their performance with other 'like' organisations The de-identified data supports the aggregation of low frequency events at international level and is therefore very effective for identifying and coordinating system-based strategies to better detect, manage and prevent problems

Other linkages

Historically, falls and medications have generated significant numbers of incidents

The APSF held a national conference in 1999, "Incidents and Accidents in Australian Health Care", from which some working groups emerged

A task force on Falls is coordinated by the Joanna Briggs Institute for Evidence Based Nursing, based at the Royal Adelaide Hospital.

For more information on Medications incidents, contact A/Prof Chris Doecke at the Pharmacy Dept, Royal Adelaide Hospital

Visit our Patient Safety Links page for other related sites

IATROGENIC INJURY IN AUSTRALIA

A report prepared by the Australian Patient Safety Foundation

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October 2001

Iatrogenic Injury: Unintended or unnecessary harm or suffering arising from any aspect of healthcare management

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Executive Summary

> *" the value of history lies in the fact that we learn by it from the mistakes of others - learning from our own is a slow process"*
>
> *W Stanley Sykes (1894-1961)*

It has long been recognised that medical care itself has the potential to cause harm However, general acknowledgement that much iatrogenic injury may be due to preventable human error or system failure appears to have been slow in coming

Factors contributing to this late recognition include difficulties in accessing medical records (compounded by the tort system and fear of litigation), difficulties in attributing problems to healthcare management rather than disease processes, and a general reluctance to openly acknowledge and record system failures and human errors when patients have been harmed Objective information about the relative risks and benefits of diagnostic and therapeutic options is often not available, and, where it is, ways of conveying these to patients, so that they can make properly informed decisions, are not well developed

Healthcare is a risky business Simply being a patient in an acute care hospital in Australia carries, on average, a 40-fold greater risk of dying from the care process than from being in traffic, and a 400-fold greater risk than working in the chemical industry

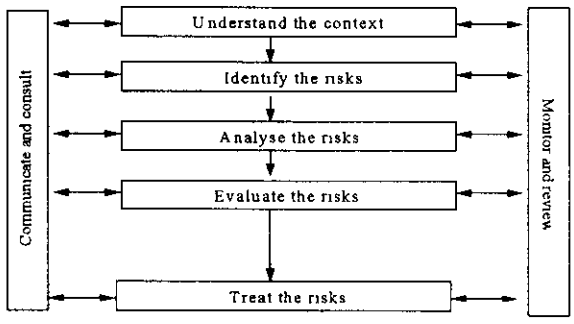
Iatrogenic injury is costly, at least 10% of admissions to acute-care hospitals in Australia are associated with a potentially preventable adverse event It has been estimated that the direct medical costs of these events exceeds $2 billion per year and that the total life-time cost of such preventable injury may be twice that amount, there is also a heavy toll in human costs on both those who are harmed and those who care for them Furthermore, medical misadventure consumes over half the amount spent on compensation and insurance by State Treasury Departments

There are ethical, humanitarian and financial imperatives to find out what is going wrong, collate and analyse the information and devise and implement strategies to better detect, manage and prevent these problems It may be estimated that as much as half of this burden to society may be removed within 5-10 years if the necessary investments are made in a systematic approach to this problem Failure to do this will result in escalating costs, as the factors contributing to iatrogenic injury will become more prevalent, not less, in the coming years

It is also necessary to recognise that healthcare is a complex system, and to apply the approaches to system failure and human error which have been proven effective in other complex human endeavours (eg nuclear power stations, off-shore drilling rigs, aviation) We should avail ourselves of the considerable expertise that has been accumulated in these other disciplines, and apply it to the business of health care

Patient safety is an essential component of risk management, quality improvement and clinical governance The new Risk Management Standard (AS/NZS4360) provides an explicit framework for addressing iatrogenic injury (see Figure) *

Figure A simple representation of the risk management framework in the new Standard AS/NZS4360



First, the context must be understood This involves an understanding of healthcare as a complex system, of human error and system failure, of issues such as privacy,

* ACSQHC has agreed to use this standard as a framework for its activities [d]

consent, litigation, risk-benefit ratios and evidence-based medicine, and of the human and economic costs when things go wrong These issues are addressed in this report

Second, the risks need to be identified There are only three ways in which we can find out what happened when things have gone wrong

A those who are involved either in delivering or receiving health care can report details

B trained reviewers can extract information from medical and other records, and elicit additional information after the event, and

C teams of people can be employed to undertake prospective observations or measurements This last option is too expensive to be used "across the board", especially for rare events, and must be reserved for studying specific problems identified by one of the first two more generally applicable methods

One tried and tested way of finding out what happened when things have gone wrong is incident monitoring A standardised reporting system has been developed, the Australian Incident Monitoring System (AIMS), which is suitable for use throughout the Australian healthcare system It is currently in use in all South Australian public hospitals, in four networks in Victoria, and the Northern Territory, plans are underway for its introduction to all of the Australian Capital Territory and Western Australia and to parts of New South Wales, Tasmania and Queensland It is being used, or has been trialed, by twelve medical specialties* A new, simpler, more comprehensive version, with the option of reporting electronically via the web, AIMS+, is currently being trialed and introduced

Another way of finding out what has gone wrong is to extract information from medical and other records The Australian Institute of Health and Welfare collates information about morbidity and mortality from the various State collections of ICD (International Classification of Disease) codes generated at the time of patient separation, and from the Australian Bureau of Statistics Register of Deaths, and may, in the future, be able to link these with PBS and MBS data However, the primary emphasis in these collections has been on the underlying disease rather than complications and co-morbidities, and they are currently not reliable or effective for collecting information about most types of iatrogenic injury It is proposed to progressively improve the capture of iatrogenic injury information using these established processes

Standard methods for extracting information specifically about iatrogenic injury using retrospective medical record review were developed in the Californian medical litigation crisis in the early 1970s, were used for the Harvard Medical Practice study in the 1980s and, in the 1990s, for the Quality in Australian Healthcare Study (QAHCS) and the Utah-Colorado Study By analysing information obtained using these methods it was determined that at least 10% of admissions are associated with a potentially preventable adverse event,

* It is now being introduced across Western Australia and the ACT and in parts of New Zealand and the APSF classification system has been chosen for trial as the basis for the newly formed National Patient Safety Agency's central repository for adverse events and near misses in the United Kingdom

and that such adverse events are associated with as many as 50,000 permanent disabilities and 10,000 deaths each year in Australia

A multi-national collaborative project is being planned to refine the definitions and methodology used and a new streamlined software-based process is being developed - the Australian Medical Record Analysis System (AMRAS) It is proposed that a randomised sample of all hospitals be studied each year and that strata of hospitals in each State be compared between jurisdictions and over time with respect to a "composite indicator", representing a "basket" of adverse events, analogous to the consumer price index

Third, the risks need to be collated and analysed. Up until 1995, none of the available systems had the capacity to do this A Generic Occurrence Classification (GOC) was therefore developed specifically for things that go wrong in healthcare It comprises a multi-axial framework into which all iatrogenic events may be classified and is designed to elicit their salient features, place them in context and record their contributing factors, be these system- or human-based The GOC can be used to classify incidents or events identified by incident reporting, medical record review, complaints, morbidity and mortality studies, medico-legal investigations and coronial recommendations An expanded version of the GOC (GOC+), built from over 50,000 incidents and events from all of these sources, with a new structure designed to facilitate accurate, rapid coding and flexible, comprehensive, cost-efficient reporting and data analysis, is to be trailed and installed at key sites

The mechanisms exist, therefore, to have a single repository for all things which go wrong in healthcare in Australia Data from the QAHCS has already shown why a national database is necessary

- even in large teaching hospitals most types of adverse events occur so infrequently that they cannot be prospectively tracked or sufficiently characterised at a local level to devise remedial strategies

- having data from all available sources in a common repository allows the strengths of each data source to be exploited and for maximum value to be gained from all the available information

AMRAS will provide information about the frequency and, with further work, the costs of adverse events, allowing evidence-based priorities to be set and progress to be tracked AIMS will provide vital complementary information, as it elicits the underlying human-error and system-based causes of incidents which are not provided in the medical record These details are essential to obtain the information necessary for devising effective corrective strategies

AIMS+ is being set up to provide both an easy-to-use tool to manage risk and improve quality and safety at a local level, as well as to capture details about the nature and underlying causes of the majority of events which, individually, occur too infrequently to be characterised at a local level AIMS+ also has built-in quality assurance mechanisms to allow comparisons of patterns over time and between health care units and jurisdictions