1115 Perpetrator Accountability John Sammut

Thank you for the opportunity to talk to you today.

I am here as the immediate past president of the NSW Medical Council, having finished my time as President in July this year.

By way of background who are we when I say I work for the Medical Council?

Whilst the national body AHPRA working with the Medical Board of Australia covers functions like registration and accreditation across the whole country, The NSW Medical Council is the regulatory body responsible for assisting in the protection of the health and safety of the public in their dealings with medical practitioners who primarily practice in NSW. This is a job we have been doing since 1838, and which is supported by legislation.

This is a huge task, given approx. one third of all Australian registered medical practitioners are in NSW (approx. 35000).

We are a standards body, and our aim is to ensure members of the profession keep themselves:

- Safe
- Relevant and
- Up to date

We achieve this in part by dealing with notifications/complaints made against medical practitioners. We assess these complaints against acceptable peer related standards and relevant sections of NSW health law and collaborate closely with our co regulator: the Health Care Complaints Commission. Notifications tend to fall into one of 3 areas of concern: health (dealing with impairment issues), Performance or relevant for today's meeting: Conduct (defined as Reckless, Unethical, Wilful, or criminal behaviour).

So you may say, that is all well and good but what has this to do with "perpetrator accountability" in the profession?

Unfortunately, what we have seen in the MC over very recent years is a significant and persistent rise in the number of notifications relating to medical practitioners who have either failed to respond appropriately to requests for assistance by survivors of FV or who have been perpetrators of FV themselves.

I suspect this rise in notifications is in part due to the efforts of many like you in the audience, to have conversations in society that bring to light the terrible prevalence of this appalling behavior in an attempt to shift cultural expectations and ultimately to save lives and achieve better outcomes for survivors.

These notifications are sometimes made by patients who have disclosed FV to the doctor and believe the practitioner has inadequately managed them by, for example:

encouraging them to return to their abusive partner and 'work it out' or

blame the victim, or

disbelieve the victim and refuse to assist or

fail to complete adequate records (history and examination) of how the patient presented, which of course can affect them down the line particularly in legal processes.

Unfortunately however, we also see notifications where the practitioner themselves has been involved in FV: from so called minor altercations such as pushing your teenage child with a subsequent AVO being issued, through to physical altercations at the lower end of the scale right through to the more serious cases resultant in actual bodily harm.

You might be thinking: but how do these notifications come to the attention of the MC when the conduct occurs outside the practice of medicine/ that is: largely at home?

Well, under the law, there are certain “notifiable events” that, as a medical practitioner, you are obliged to notify the MC of within 7 days. They include but are not restricted to if:

- you have been charged with an offence punishable by 12 months' imprisonment or more
  or if you have been convicted of an offence punishable by imprisonment.

so faced with this increasing number of notifications, in my time as President, we decided we needed to establish a dedicated FV committee to specifically review these matters. In doing so, we were/are looking to develop expertise in helping us to respond in a consistent, nuanced way to this complex and abhorrent conduct issue. The Committee meets weekly if required and has strong community as well as peer representation. It has 4 women and 2 men! We review each case on its particulars and apply some basic principles that help determine how we should we respond in a consistent and effective way within the constraints of the law.

We also reached out to our national partners at the MBA to see what they were doing in this space, to share in the learnings and to ensure a national consistency in our responses as regulators.

For those practitioners who fail in their response/care/ management of survivors who disclose, the way forward is much clearer.

For us in the committee, this is a standards issue and is clearly an (under) performance issue.

When thinking about what is an appropriate response to these disclosures I think the AMA in fact sums it up best in its position statement on F and DV in 2016 when it states:

The AMA Position on Family and Domestic Violence 2016

1. The medical profession has key roles to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of family and domestic violence, whether it be physical, sexual or emotional.

2. Medical practitioners must encourage attitudes and actions necessary to prevent family and domestic violence, identify women, men, families and children 'at risk', prevent further violence and assist patients to receive appropriate help and protection.

Generally, these practitioners are dealt with under the performance stream and encouraged to complete a self-reflection piece looking for their insights into why their behaviour was inappropriate and what they have done to remediate. We might then occasionally call them in for a formal counselling interview to ensure they understand the issues and have remediated effectively. Some other strategies might involve recommending they work with their indemnity insurer on better record keeping or occasionally a request they attend a course, doing a deeper dive and gaining a better understanding of all the issues related to FV.

For those that are themselves charged or convicted of FV matters, the landscape is difficult and far less straightforward. We are mindful that we must fulfil our obligations as a regulator under the law in dealing with these notifications. That is, we must always turn our mind to how this notification intersects with our primary role of ensuring the health and safety of the public. Health law has not in fact turned its mind specifically to this area of egregious behaviour which occurs outside the practice of medicine.

We began by asking: what is our role in this space? How would the law expect us to act in response to these perpetrator offences? When we started we were often challenged: Why does the medical council concern itself with these events particularly since they are

occurring outside the practice of medicine? If the practitioner is competent in their work and has a previously an unblemished record of performance do we need intervene? Are these issues not already dealt with by the criminal courts? Is this regulatory overreach subject to challenge by appeal?

Of course, in answer I would say we believe strongly as a Council that the NSWMC has a purview for several reasons:

1: our remit is the protection of the health and safety of the public.

We believe this may be put at risk if the practitioner dealing with victims of FV is themselves a perpetrator. We take this very seriously because it is actively promoted in the community that victims of FV are encouraged to seek support from their GPs and other health care providers and it's an added layer of complexity when the professional they are seeking assistance from is themselves charged with FV offences.

One worries about notions of empathy and the provision of appropriate psychological support to the survivor. We know those early interactions after initial disclosure are crucial in determining how the survivor might continue to reach out to the profession to gain the necessary support and interventions.

For example, a survivor who reports to a general surgeon or their family GP that the injuries they have sustained to solid organs in their abdomen or the bruises to their face are in fact not the result of a misstep and fall but rather the result of violence and abuse, who fails to receive a sympathetic, empathetic response and appropriate referral to relevant support services may miss out on lifesaving interventions to break the cycle of abuse. Doctors have a crucial role in this space and it begins with the recognition and abhorrence of the behaviour. All of which may be missing in those that are in fact, themselves perpetrators of this violence. Furthermore,

2: We believe it is the public interest to act.

Our reputation as a profession is crucial to the effective functioning of us as medical practitioners. Our work fundamentally relies on trust from those who seek our care. Ensuring the public maintains trust in the profession is essential for us to be able to do our job: we are a caring profession, trusted with some of the most intimate details of a patient's life. While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice.

Doctors have a duty to make the care of patients their first concern and to practice medicine safely and effectively. They must be ethical and trustworthy.

Patients trust their doctors because they believe that, in addition to being competent, the doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion.

A public that believes we tolerate such behaviours and continues to welcome amongst us those that are perpetrators of these offences risks the undermining of that trust. This is not in the public interest.

So, having determined that the council did have a role in this space, we then had to work through a number of subsequent issues. Issues like:

Can we act if there is a charge but no conviction yet recorded (what of the presumption of innocence)? And again,

Was Health Law intended to extend into the private lives of practitioners or should it confine itself with matters solely pertaining to "in the practice of medicine"?

We dealt with these complex questions by developing a risk matrix to help guide our assessment of the severity of the notification,

mindful that ***all*** such notifications are a cause for grave concern. We look not only at the severity of the offence, but also whether children are involved, whether there has been a past history of similar charges/convictions, the type of practice they are involved in, as well as mitigating factors such as whether they have temporarily been stood down from work (making the public less exposed), whether they have gained any insight eg: by having attended /completed courses of relevance, by seeking treatment/counselling….and so on.

As part of the assessment process, **we also need to assess the impact on their own mental health** - facing charges and going through a court process, and how this might affect how they do their job as well. In addition, some will have issues related to alcohol or drugs or financial pressures that impact on their ability to do their professional job. These will be independently assessed by the Council calling for a psychiatric evaluation where required by a Council Appointed Practitioner.

Ultimately, **the kinds of actions we might take include**

1: **completion of a self-reflection** form that asks them to describe the incident, to talk about how they think the incident made the victim and or their family/carer feel? How the incident has impacted on their practice? Whether they have discussed it with any other organisation or service provider? What input they might have received from managers, peers and colleagues? And looking forward: based on their reflections what areas of practice do they think they could improve? And importantly, since the incident, what have they done to improve their practice (courses? Learning modules…).

2: Conduct a **counselling interview** to further explore the issues and gauge a sense of insight, remorse and motivation for change

3: direct their enrolment in and satisfactory completion of behavioural change program or

4: ensuring they seek and engage with counsellors or psychiatrists on a regular basis that is monitored.

5: and for some, we may refer them to the impaired practitioners program for specific treatment or remediation (esp in relation to D & A issues).

Infrequently, the offence might be of such severity or the nature of the offence together with the nature of the practice means we might take urgent interim action under s 150 of NSW health Law, acting for the protection of the health and safety of the public and in the public interest to suspend a practitioner pending the outcome of criminal proceedings.

And so, I **would finish here** hoping to have successfully illustrated to you how the NSWMC takes these notifications very seriously and believes in the importance of ensuring perpetrator accountability, most importantly for the protection of the health and safety of the public but also to maintain the standards of, and trust in the profession.