CSIRO PUBLISHING

WORKFORCE

Australian Health Review, 2020, 44, 784–790
https://doi.org/10.1071/AH19293

Characteristics and predictors of regulatory immediate action imposed on registered health practitioners in Australia: a retrospective cohort study

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Abstract.

Objective. Immediate action is an emergency power available to Australian health practitioner regulatory boards to protect the public. The aim of this study was to better understand the frequency, determinants and characteristics of immediate action use in Australia.

Methods. This was a retrospective cohort study of 11 200 health practitioners named in notifications to the Australian Health Practitioner Regulation Agency (AHPRA) between January 2011 and December 2013. All cases were followed until December 2016 to determine their final outcome.

Results. Of 13 939 finalised notifications, 3.7% involved immediate action and 9.7% resulted in restrictive final action. Among notifications where restrictive final action was taken, 79% did not involve prior immediate action. Among notifications where immediate action was taken, 48% did not result in restrictive final action. Compared with notifications from the public, the odds of immediate action were higher for notifications lodged by employers (mandatory notifications OR = 21.3, 95% CI 13.7–33.2; non-mandatory notifications OR = 10.9, 95% CI 6.7–17.8) and by other health practitioners (mandatory notifications OR = 11.6, 95% CI 7.6–17.8). Odds of immediate action were also higher if the notification was regulator-initiated (OR = 11.6, 95% CI 7.6–17.8), lodged by an external agency such as the police (OR = 11.8, 95% CI 7.7–18.1) or was a self-notification by the health practitioner themselves (OR = 9.4, 95% CI 5.5–16.0). The odds of immediate action were higher for notifications about substance abuse (OR = 9.9, 95% CI 6.9–14.2) and sexual misconduct (OR = 5.3, 95% CI 3.5–8.3) than for notifications about communication and clinical care.

Conclusions. Health practitioner regulatory boards in Australia rarely used immediate action as a regulatory tool, but were more likely to do so in response to mandatory notifications or notifications pertaining to substance abuse or sexual misconduct.

What is known about this topic Health practitioner regulatory boards protect the public from harm and maintain quality and standards of health care. Where the perceived risk to public safety is high, boards may suspend or restrict the practice of health practitioners before an investigation has concluded.

What does this paper add? This paper is the first study in Australia, and the largest internationally, to examine the frequency, characteristics and predictors of the use of immediate action by health regulatory boards. Although immediate action is rarely used, it is most commonly employed in response to mandatory notifications or notifications pertaining to substance abuse or sexual misconduct.

What are the implications for practitioners? Immediate action is a vital regulatory tool. Failing to immediately sanction a health practitioner may expose the public to preventable harm, whereas imposing immediate action where allegations are unfounded can irreparably damage a health practitioner's career. We hope that this study will assist boards to balance the interests of the public with those of health practitioners.

Received 20 January 2020, accepted 17 April 2020, published online 28 August 2020

Introduction

Health practitioner regulatory boards in Australia ('National Boards') play a crucial role in maintaining standards of health care by sanctioning unsafe health practitioners. Immediate action is one of the most coercive powers at a board's disposal because it authorises suspension or restriction of a health practitioner's registration before a notification about their health, conduct or performance has been fully investigated and prosecuted.[1]

Allegations of serious misconduct can result in intense media scrutiny and pressure on National Boards to react swiftly. Failing to promptly take immediate action in response to serious allegations may erode public confidence in the profession and expose patients to preventable harm. This has occurred in Australia,[2] the UK,[3,4] Singapore[5,6] and New Zealand.[7,8] Conversely, taking immediate action in response to unfounded allegations can damage a health practitioner's reputation and derail their career, even if they are ultimately absolved. For many, the process is often the punishment[9] and, as such, immediate action has been colourfully described as 'regulatory capital punishment before trial'.[10]

The legal requirements for immediate action in Australia are expounded in the *Health Practitioner Regulation National Law Act* 2009 (Qld) ('National Law') (Table 1). However, little is known about how frequently or why immediate action is utilised. We therefore analysed a comprehensive national cohort of notifications received shortly after the National Registration and Accreditation Scheme ('the National Scheme') commenced. After these notifications were collected, legislative reforms in March 2018 expanded the grounds upon which immediate action may be taken to include protection of the 'public interest'. These reforms were considered necessary to maintain public confidence in the regulated health professions in Australia, following concerns that existing thresholds for immediate action constrained National Boards from taking swift action to protect public health, public safety or the public interest. Our data provide a baseline for evaluating the effect of these reforms on the use of immediate action in Australia. Our aims were to: (1) understand how often immediate actions were imposed on health practitioners; (2) identify the factors associated with immediate action being taken against a health practitioner; and (3) characterise the concordance between the imposition of immediate actions and any disciplinary action ultimately taken against a health

Table 1. Legal framework for immediate actions in Australia during the study period

What is immediate action?[36]	'Immediate action' was defined as: • suspension or imposition of conditions on a health practitioner's registration; or • accepting an undertaking from the health practitioner; or • accepting the surrender of the health practitioner's registration.
When and by whom can immediate action be taken?[37]	A National Board has the power to take immediate action if it reasonably believes that: • the practitioner poses a serious risk to persons because of the health practitioner's conduct, performance or health; and • it is necessary to take immediate action to protect public health or safety; or • the practitioner's registration was improperly obtained, or has been cancelled or suspended in another jurisdiction that does not participate in the National Scheme.
What is the process for taking immediate action?[38]	Before taking immediate action, a National Board must: • notify the health practitioner of the proposed immediate action; and • invite the health practitioner to make a written or verbal submission about the proposed immediate action; and • consider any submissions made by the health practitioner.
Guiding principles[39]	The objectives and guiding principles of the National Scheme guide National Boards in taking immediate action: • to protect the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and • to operate in a transparent, accountable, efficient, effective and fair way; • to place restrictions on the practice of a health profession only if it is necessary to ensure health services are provided safely and of an appropriate quality.
Judicial consideration of immediate action[40]	• Immediate action: – Requires urgency, rather than a detailed enquiry; – May be based on a serious allegation and a reasonable belief; – May be taken on incomplete information. – Public safety is the primary concern. – Public safety should be secured with as little damage as possible to the health practitioner.
Period of immediate action[41]	Immediate action continues until it is revoked or superseded by a final outcome by a National Board. There is no statutory requirement for a National Board to regularly review it.
Right of appeal[42]	The decision of a National Board to suspend or impose conditions on a health practitioner's registration can be appealed to the responsible tribunal in each participating jurisdiction.

practitioner. We did not seek to compare the use of immediate action between jurisdictions within Australia.

Methods

Setting

In Australia, 16 health professions are regulated under uniform standards within the National Scheme.[11] Established on 1 July 2010, each profession has a National Board that is supported by the Australian Health Practitioner Regulation Agency (AHPRA) and are empowered to investigate notifications about a health practitioner's health, conduct or performance.[12] Notifications in New South Wales and Queensland are managed through co-regulatory regimes in conjunction with the Health Complaints Commission and the Office of the Health Ombudsman, respectively.

Study design, study period and population

This is a retrospective cohort study. AHPRA provided non-identifiable data relating to all notifications about registered health practitioners lodged between 1 January 2011 and 31 December 2013 (study period). These data included the date and source of the notification and the primary issue raised. We followed those notifications through to 31 December 2016 to determine interim and final outcomes. AHPRA also provided us with non-identifiable 'practitioner data' taken from the official registration database of health practitioners in Australia. These data included the age, sex and profession of health practitioners registered between 1 January 2011 and 31 December 2013. Unique identifiers were used to link the notification data with the practitioner data.

Variables

We coded health practitioners into six categories: (1) medical practitioners; (2) nurses and midwives; (3) psychologists; (4) pharmacists; (5) dentists; and (6) other health practitioners (dental hygienists, dental prosthetists, dental therapists, oral health therapists, chiropractors, optometrists, osteopaths, physiotherapists and podiatrists). Nurses and midwives were grouped together because many have dual registration and have similar training pathways. Dentists were separated from other dental practitioners because of differences in the nature and frequency of notifications,[13] whereas 'other health practitioners' were combined because of low numbers and similarity in the nature and frequency of complaints. Health practitioners' ages were grouped by allocating them to 5-year bands based on year of birth (e.g. 1970–74). We recoded this variable to reflect each health practitioner's age group in 2015 to ensure that the privacy of individual health practitioners was protected.

We coded the nature of each notification according to whether it was primarily related to health, conduct or performance because this is consistent with existing legal and research taxonomy.[14] We further analysed the primary notification issue according to the codes assigned by AHPRA.

Health practitioners[15] and employers[16] have a legal obligation to notify AHPRA if a health practitioner engages in 'notifiable conduct', which includes: practising while intoxicated; engaging in sexual misconduct; placing the public at risk of substantial harm due to an impairment; or placing the public at risk of harm by practising below accepted professional standards.[17] These notifications are defined as 'mandatory notifications' and coded as such in the data. Following recent legislative changes, not applicable during the study period, the level of risk required for a mandatory notification to be made differs between treating health practitioners and non-treating health practitioners and employers.[18]

For the purpose of this study, we use the term 'restrictive final action' to describe where a board or tribunal makes a final determination that restricts a health practitioner's practice via enforceable undertakings, conditions (such as education or drug testing), suspension or cancellation of a health practitioner's registration.[19]

Exclusion criteria

We excluded health practitioners registered to an address outside Australia. Data on outcomes of NSW notifications were unavailable in our dataset and hence excluded from our analysis. In addition, data relating to Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners, occupational therapists and paramedics were unavailable because these five professions joined the National Scheme after the data collection commenced.

Analyses

We used counts and percentages to describe notifications. We performed multivariate logistic regression to examine the association between health practitioner characteristics (profession, age, sex and notification history), notification characteristics (issue raised) and the use of immediate action. We calculated cluster-adjusted standard errors to adjust for the lack of independence arising from health practitioners with multiple notifications. Finally, we conducted case-level analyses of the relationship between the use of immediate action and the imposition of restrictive final action. All analyses were conducted using Stata 15.1 (StataCorp, College Station, TX, USA). Ethical approval was granted by the University of Melbourne Medicine and Dentistry Human Ethics Sub-Committee.

Results

Characteristics of health practitioners and notifications

Between 1 January 2011 and 31 December 2013, AHPRA received 14 113 notifications in relation to 11 200 health practitioners (Fig. 1). Over half the notifications were directed at medical practitioners (53%), with nurses and midwives (22%) and dentists (9%) the next most common targets (Table 2). Three-quarters of notifications involved health practitioners aged 36 – 65 years and 60% related to male health practitioners. Some health practitioners accumulated multiple notifications during the study period: 12% had two and 4% had three or more. By the end of the study period (31 December 2016), 13 939 (99%) of the notifications had been finalised. Our results relate to these finalised notifications.

Most notifications (65%) were lodged by members of the public directly or via a complaints entity (Table 3). Employers lodged 10% of notifications, of which three-fifths were mandatory notifications. Fellow health practitioners lodged 12% of notifications, evenly split between mandatory and non-mandatory notifications. Notifications initiated by other agencies (e.g. Coroners, Medicare), health practitioners themselves

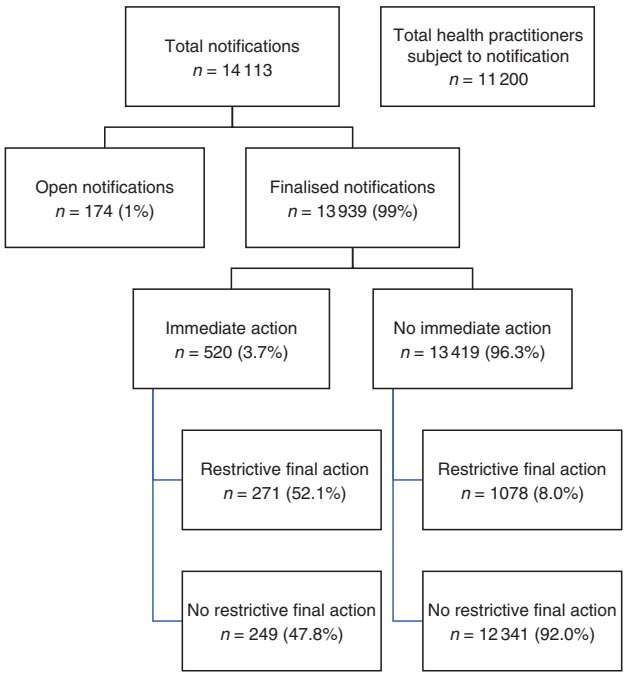

Fig. 1. Derivation of the study sample.

Table 2. Characteristics of health practitioners, subject to notifications (*n* = 11 200)

Characteristic	n	%
Profession		
Medical practitioners	5886	52.6
Nurses and midwives	2494	22.3
Dentists	999	8.9
Pharmacists	640	5.7
Psychologists	585	5.2
Other health practitioners	596	5.3
Age (years)[A]		
≤25	34	0.3
26–35	1346	12.0
36–45	2415	21.6
46–55	3155	28.2
56–65	2779	24.8
≥66	1471	13.1
Sex		
Female	4395	39.2
Male	6805	60.8
Total notifications accumulated		
1	9350	83.5
2	1336	11.9
3	307	2.7
4	111	1.0
≥5	96	0.9

[A]Based on age in 2015.

('self-notification') or AHPRA comprised 8% of notifications. A majority (>45%) of notifications related to health practitioner performance. Approximately one-third alleged poor conduct, with the leading issues in this category relating to interpersonal behaviour (8.5% of all notifications), unlawful use or supply of medications (4%) and sexual misconduct (3%). Concerns about a health practitioner's health accounted for 7% of all notifications. National Boards took immediate action on 520 occasions (3.7% of all notifications) and imposed restrictive final action on 1349 occasions (9.7% of all notifications).

Table 3. Characteristics of finalised notifications during the study period (*n* = 13 939)
APHRA, Australian Health practitioner Regulation Agency

Characteristic	n	%
Source of notification		
Member of the public (directly or via a Health Complaints Entity)	9067	65.0
Employer – non-mandatory	544	3.9
Employer – mandatory	868	6.2
Other registered health practitioner – non-mandatory	898	6.4
Other registered health practitioner – mandatory	709	5.1
Other agency (e.g. Coroner, Medicare)	676	4.8
Self	291	2.1
AHPRA-initiated investigation	204	1.5
Unknown/anonymous	682	4.9
Primary issue raised		
Health	959	6.9
Physical/cognitive illness	222	1.6
Mental illness	347	2.5
Substance use	390	2.8
Conduct	4714	33.9
Unlawful use or supply of medications	553	4.0
Honesty	234	1.7
Interpersonal behaviour	1184	8.5
Sexual boundaries	402	2.9
Non-compliance with conditions	119	0.9
Other conduct issues	2222	15.9
Performance	6489	46.6
Prescribing or dispensing issues	378	2.7
Procedures	608	4.4
Communication and other clinical issues	5503	39.5
Other issues	1777	12.7
Immediate action taken		
Yes	520	3.7
No	13 419	96.3
Final action		
Restrictive final action	1349	9.7
Suspension or cancellation of registration	113	0.8
Conditions on registration	830	6.0
Surrender of registration or voluntary undertakings	406	2.9
No restrictive final action	12 459	90.3
Caution or reprimand	1707	12.2
Referral to another entity	1926	13.8
No regulatory action	8826	63.3
Unknown	131	0.9

Predictors of immediate action

In multivariate analysis (Table 4), the source of the notification strongly predicted the use of immediate action, when adjusting for the nature of the notification. Compared with notifications lodged by members of the public (the reference category), mandatory notifications by employers (OR = 21.3) and fellow health practitioners (OR = 11.6), non-mandatory notifications by

Table 4. Multivariate predictors of immediate action
CI, confidence interval; APHRA, Australian Health practitioner Regulation Agency

Characteristic	Odds ratio (95% CI)	*P*-value
Source of notification		<0.0001
Member of the public, including via health complaints entity (reference)	1.0	
Employer – non-mandatory	10.9 (6.7–17.8)	
Employer – mandatory	21.3 (13.7–33.2)	
Other registered health practitioner – non-mandatory	4.6 (2.9–7.5)	
Other registered health practitioner – mandatory	11.6 (7.6–17.8)	
Other agency (e.g. Coroner, Medicare)	11.8 (7.7–18.1)	
Self	9.4 (5.5–16.0)	
AHPRA-initiated	12.6 (6.9–23.2)	
Unknown/anonymous	4.1 (2.3–7.1)	
Primary issue raised		<0.0001
Health		
Physical/cognitive illness	3.0 (1.8–5.0)	
Mental illness	4.4 (2.9–6.8)	
Substance use	9.9 (6.9–14.2)	
Conduct		
Unlawful use or supply of medications	2.8 (1.8–4.2)	
Honesty	3.6 (1.8–4.2)	
Interpersonal behaviour	0.9 (0.6–1.6)	
Sexual boundaries	5.3 (3.5–8.3)	
Non-compliance with conditions	1.3 (0.6–2.7)	
Other conduct issues	0.6 (0.4–0.9)	
Performance		
Prescribing or dispensing issues	0.3 (0.1–1.0)	
Procedures	1.6 (0.9–2.9)	
Communication/other clinical issues (reference)	1.0	
Other issues	0.6 (0.3–1.1)	
Prior notification		<0.001
No (reference)	1.0	
Yes	1.8 (1.5–2.3)	
Profession		0.433
Medical practitioner (reference)	1.0	
Nurse/midwife	1.1 (0.8–1.5)	
Psychologist	0.6 (0.3–1.2)	
Pharmacist	1.2 (0.8–1.8)	
Dentist	1.2 (0.6–2.2)	
Other health practitioner	0.7 (0.4–1.4)	
Age (years)[A]		0.261
≤25	0.3 (0.0–3.2)	
26–35	1.1 (0.7–1.5)	
36–45	1.3 (1.0–1.8)	
46–55 (reference)	1.0	
56–65	1.0 (0.7–1.4)	
≥66	1.3 (0.9–1.9)	
Sex		0.006
Female (reference)	1.0	
Male	1.4 (1.1–1.9)	

[A]Based on age in 2015.

employers (OR = 10.9), fellow health practitioners (OR = 4.6) and other agencies (OR = 11.8), self-notifications (OR = 9.4) and notifications initiated by health regulators (OR = 12.6) were all associated with higher odds of immediate action, when adjusting for the primary issues raised in the notification and other confounders. Notifications relating to some issues were also associated with higher odds of immediate action. Compared with notifications about communication and clinical care, the odds of immediate action were highest for notifications about substance abuse (OR = 9.9) and sexual misconduct (OR = 5.4). A history of prior notifications (OR = 1.8) and being male (OR = 1.4) were also associated with higher odds of immediate action being taken. There was no evidence of an association between age or profession and immediate action.

Relationship between immediate action and restrictive outcomes

Of the 12 590 notifications where no restrictive final action was taken, no immediate action had been taken in 98% of those cases. Among 520 notifications where immediate action was taken, approximately half (52%) ended in a restrictive final action – a higher rate of restrictive final action than among cases where no immediate action was taken. Among the 1349 notifications that resulted in restrictive final action, the majority did not involve immediate action before the final outcome (79%).

Discussion

Occurrence

This longitudinal study found that during the study period, National Boards in Australia rarely imposed immediate action to restrict or suspend practice. However, the power to take immediate action has since expanded and we hope that future research will explore whether there are any changes in its use. Comparable jurisdictions, such as New Zealand and the United Kingdom (UK), employed immediate regulatory powers more frequently during the same period. It is likely that this was due to the combination of broader powers and more mature regulatory systems. For example, the New Zealand Medical Council may take immediate action pending the outcome of criminal charges[20] or if a health practitioner's performance,[21] health[22] or conduct[23] poses a serious risk to the public. In 2012–13, it did so in 4% of notifications about performance and 10% of notifications about impairment.[24,25] In the UK, the power to impose interim orders extends to the protection of the public interest, where no imminent risk is identified.[26] In 2012–13, interim orders were imposed in >25% of notifications against medical practitioners and in >20% of notifications against nurses or midwives. By contrast, in the USA, state laws treat professional licences as the property of the licensee and courts insist on strict procedural protections that render immediate action more difficult.[27,28]

Factors associated with immediate action

We found that National Boards are more likely to take immediate action when the notification originates from peers or employers than from patients or the public, even when adjusting for the nature of the notification brought by the notifier. Previous investigations[2,29] into egregious breaches of patient rights show that patients and families often attempted unsuccessfully to raise concerns with regulators long before shortcomings in care were finally acknowledged and addressed. However, peers may be better placed to recognise poor performance and public risk

and may only report the most serious cases. This may compel regulators to act on notifications from these sources more frequently.

Notifications relating to substance abuse, impairment and sexual boundary violations had the highest odds of triggering immediate action after adjusting for the source of the notification. This may represent the gravity and risk of harm to the public and the availability of objective evidence (e.g. drug, psychiatric and forensic testing) upon which interim decisions can be based. Conversely, notifications regarding clinical care, communication and behaviour were much less likely to trigger immediate action in our study. This may be because the risks are lower or the evidence is more difficult to elucidate beforehand. That men are more likely to be subject to immediate action is consistent with previous research.[30] Profession was not a predictor of immediate action, which may suggest regulatory consistency across the National Scheme.

Concordance

The use of immediate action requires regulators to delicately balance the interests of the public with those of the health practitioner. Immediate actions may disrupt health practitioners' careers, resulting in potential economic, reputational and emotional harms. Therefore, analysing the concordance between the use of immediate action and restrictive final action can unlock insights into how National Boards consider evidence, balance risks and interpret legal principles.

Most notifications in our study resulted in neither immediate action nor restrictive final action being used. This accords with overseas research.[31] However, in nearly half of all notifications where immediate action was used, no restrictive final action ensued. We consider that such discordance is inevitable; immediate action responds to the gravity and probability of risk, not to its certainty. An *ex post* determination that the risk was small or non-existent does not impugn the initial response *ex ante*.[32] Discordance may also occur when serious allegations cannot be substantiated or when the use of immediate action prompts health practitioners to retire or undertake corrective behaviours (e.g. treatment, education, training, mentoring) that remediate risk and obviate the need for restrictive final action.

In contrast, we found that over 80% of the notifications resulting in restrictive final action were not preceded by immediate action. Conceivably, not all findings of unprofessional conduct give rise to an immediate risk to the public. The threshold for imposing immediate action is high, requiring the risk to be serious. Many notifications may involve risk that is below this threshold. Furthermore, evidence of risk may not be available until an investigation has concluded.

To our knowledge, only one other study has examined immediate actions against health practitioners.[31] That study analysed data from the General Medical Council (GMC), which regulates medical practitioners in the UK. There were 294 notifications where interim orders were imposed. In total, 214 of these were finalised over 16 months of follow up. 56% of the notifications resulted in final sanctions that were less restrictive than the interim order. In contrast, of the 66 cases where the GMC suspended a health practitioner's registration, 71% were preceded by immediate action. It is difficult to compare these findings to our results for two reasons. First, our definition of restrictive final action was wider and included undertakings and conditions. Second, the power to impose interim action in the UK was broader than the requirement to impose immediate action in Australia at the time of our data collection. However, in March 2018, the power of National Boards to take immediate action under the National Law was expanded to include cases where it is 'otherwise in the public interest' and 'to maintain public confidence'.[33] These new powers more closely approximate the powers available to the GMC, so the contrast between the UK findings and ours is interesting and potentially relevant for future research.

Strengths and limitations

This is the first study in Australia, and the largest internationally, to examine immediate actions by health practitioner regulators. The key strength is that we analysed a large number of notifications relating to multiple health professions. Our lengthy follow-up period ensured that virtually all notifications in the sample reached a final determination, thus avoiding a common bias where cases with the longest closure periods are excluded.

Our study has several weaknesses. First, we did not differentiate between conditions and suspension in our definition of 'restrictive final action'. We may have overestimated concordance for notifications where the immediate action (e.g. suspension) was more restrictive than the final action (e.g. conditions), or vice versa. Second, reprimands do not restrict a health practitioner's right to practise, so they were not included in our definition of 'restrictive final action'. However, they are serious final outcomes that may be used by National Boards following the imposition of immediate action. Third, important health practitioner variables were unavailable, including the size, location and nature of the health practitioners' practice. Previous studies have correlated these factors with the likelihood and type of regulatory action taken.[14] Fourthly, there is significant heterogeneity of the 'other health practitioner' group. Although we combined health practitioners from different professions into this group to allow for a sufficiently rigorous analysis, this may limit the external validity of our findings. Finally, despite the size of this study, ~40% of Australian registrants are missing from this study because data from NSW was unavailable for analysis. This potentially limits the applicability of our findings to NSW and is one of the reasons why we did not seek to compare the use of immediate action between jurisdictions.

Conclusions

The public and the health professions expect National Boards to uphold professional standards, ensure public safety and maintain public confidence. This sometimes necessitates timely and decisive action in response to urgent or serious risks. Our results show immediate action was seldom used during the early stages of the National Scheme in Australia, but that its use varied according to the source or nature of the notification. After this study concluded, the definition of immediate action under the National Law was expanded because of community concerns that the existing test was too restrictive and prevented National Boards from responding to several high-profile failures, particularly involving Djerriwarrh Health Service in Victoria, where the public would have otherwise expected National Boards to have intervened.[34,35] As a result, AHPRA also implemented new

processes for the assessment and determination of risk in cases where immediate action was proposed. It remains to be seen whether these expanded powers will serve their intended purpose, but our results provide a baseline against which the effect of changes in legislation, policy and societal expectations can be examined. Our findings may also assist regulators in their ongoing efforts to balance the interests of the public and the health practitioner within the framework of the National Scheme.

Competing interests

The authors do not have any competing interests to declare.

Acknowledgements

We thank AHPRA for providing support and assistance with this research. This research was funded by a National Health and Medical Research Council Partnership Grant with AHPRA. A/Prof Matthew Spittal was funded by the Australian Government on an Australian Research Council Future Fellowship. A/Prof Marie Bismark was funded by the Dame Kate Campbell Fellowship. Dr Owen Bradfield was funded by the Australian Government on a Melbourne Research Scholarship and is a 2020 Fulbright Future Scholar.

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