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Is whistleblowing now mandatory? The impact of mandatory reporting law on trust relationships in health care

Jayne Hewitt*

Trust is vital for promoting positive health care relationships aimed at achieving positive patient outcomes. Patients, as well as the broader society, trust that health care practitioners who have been granted authority by the state to provide safe and beneficial health care are competent to do so. Recent instances where patients have been harmed as the result of treatment that fell below the accepted standard of competence have negatively impacted on trust. As the state has a responsibility to protect the public from this type of harm, legislation that mandates reporting of certain instances where the behaviour of health care professionals has fallen below the acceptable standard has been introduced. While this may have been designed to restore public trust, this article argues that it has the potential to diminish trust on the basis that mandatory reporting may be equivalent to mandatory whistleblowing.

INTRODUCTION

The provision of almost any form of health care necessary to maintain health and wellbeing is not without risk.1 Consequently, when seeking health care from a registered health care practitioner, an individual trusts that the practitioner will competently assess their needs and provide the treatment they require, minimising potential risks. As competence is seen as paramount, state-sanctioned mechanisms designed to ensure that health care practitioners are appropriately educated and credentialled provide a foundation upon which the public can base their trust. It is also imperative that the public can trust that these mechanisms are implemented effectively. In recent times, significant patient harms resulting from treatment by practitioners whose clinical practice fell below recognised standards have been well publicised.2 While this may negatively impact on trust in individual health care professionals, trust in state-sanctioned systems may also be affected. If the public perceives that these mechanisms do not adequately protect them from incompetent practitioners, this may culminate in a loss of trust in the state. Typically, when public trust in the state appears to be on the decline, policy-makers take measures to try to restore it.3 It is within this context that legislative obligations requiring colleagues or employers to report the conduct of health care practitioners that may place the public at risk of harm have been created in Australia.4

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2 For example, the adverse outcomes suffered by patients of Dr Jayant Patel at Bundaberg Base Hospital in Queensland, and Dr Graeme Reeves in New South Wales.


4 Health Practitioner Regulation National Law Act 2009 (Qld), s 140.
The expectation that the state will protect the public from harm requires that it must be well informed about risks to public safety. Mandating notification of certain conduct has been suggested as one strategy that may be implemented to ensure that such information reaches an appropriate regulatory body. This allows for appropriate intervention to ensure those risks do not materialise. It is possible, however, that these obligations will have unintended consequences that undermine its ability to achieve this aim.

Trust is an important feature of the relationship between a health care practitioner and their patient; additionally, as a relational notion, it is also important for developing beneficial interpersonal working relationships that are essential for positive patient outcomes. Therefore the implementation of any legislative policy that has a detrimental effect upon these relationships should be scrutinised. There is a strong perception that whistleblowing is an act that typically impacts negatively on working relationships. By comparing aspects of the legislative requirement with published literature on whistleblowing, this article argues that mandatory reporting obligations are akin to mandated whistleblowing. It then demonstrates the negative effect that this may have on trust relationships that are vital for developing beneficial interpersonal working relationships and positive patient outcomes.

DEFINING TRUST

Having introduced the notion that trust is pivotal in health care, it is imperative that the concept be clearly defined. It is indisputable that health care fundamentally involves people caring for, and about, people; beneficial interpersonal relationships are therefore pivotal. In this context, trust surfaces as a relational notion that exists between people, and people and institutions, supporting the “primacy of these interpersonal relationships”. However, the definition of trust extends beyond a mere relational notion. Where it extends to will depend upon the specific context in which it becomes relevant as well as the particular philosophical perspective through which it is viewed.

When exploring the impact that mandatory reporting requirements have on trust, it must be acknowledged that the decision to legislate this obligation reflected the social and political climate that existed at the time. This suggests that the use of a sociological approach to define trust within this context is appropriate. The benefit of assuming this perspective is that it not only provides a bird’s-eye view of the interactions between key stakeholders, it also allows those individual interactions to be placed within the context of the wider society. In this way it becomes possible to anticipate how particular groups may respond to new health care policies that challenge previously held positions, and how broadly these responses may extend.

Having described the rationale for defining trust from a sociological perspective, a review of the literature uncovers several recurrent themes. For example, Hall et al describe trust as the “optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor’s health. This is clearly defined. It is indisputable that health care fundamentally involves people caring for, and about, people; beneficial interpersonal relationships are therefore pivotal. In this context, trust surfaces as a relational notion that exists between people, and people and institutions, supporting the “primacy of these interpersonal relationships”.


*Australian Health Ministers Advisory Council Governance Committee, n 5.


(2013) 21 JLM 82
interests”.  Implicit in this definition is the view that trust is characterised by a degree of vulnerability, and consequently an element of risk. If the person investing trust believes that another person is sufficiently competent and motivated by concern for their best interests, then trust forms the basis upon which such risks may be accepted. Similarly Calnan and Rowe acknowledge that trust is necessary in situations where there is uncertainty. It is this uncertainty that creates a corresponding level of risk; whether a risk is assessed as high or low can be influenced by how the trustor perceives the motives and intentions of the person on whom they are dependent. Davies and Randall argue that any definition of trust must embody an expectation that vulnerabilities will be protected rather than exploited; this, too, implies that the trustor needs to believe that their best interests form the basis of the trustee’s actions. The common thread implicit in these definitions is that, in circumstances where an individual may be exploited due to a particular vulnerability, trust requires that the motivations and behaviour of another promote the best interests of those at risk.

One of the characteristics of the sociological discipline is its capacity to take an individual situation and place it within the context of the wider society. It is possible therefore to utilise this definition of trust not only in the context of those relationships between health care providers and patients, where the vulnerabilities associated with illness require trust, but also more broadly so that it encompasses those relationships between health care providers, institutions and the state. While these are explored in greater detail below, it is pertinent to note that the concept of trust can also be aligned with other relational notions such as mistrust and distrust.

The need for trust arises in those situations where one party is exposed through a degree of vulnerability, and an expectation that another party will act to promote their best interests. However, it may be that a previous negative experience gives rise to mistrust instead of trust. Consider, eg, a situation where a patient has been treated by a health care professional in a way that failed to promote their best interest, perhaps by ordering an excessive number of expensive diagnostic tests of limited utility. In subsequent interactions where tests are ordered, instead of trusting the judgment of the health professional, mistrust is the dominant emotion, causing the competence and judgment of the health care professional to be questioned.

Alternatively, in certain situations it may be prudent for a vulnerable person to withhold any expectation if trust has not yet been proven. This state represents “distrust” and it arises when appearances, declarations or behaviours cannot be taken at face value, perhaps having recognised that another party’s interests conflict with one’s own interests. In an increasingly individualistic and commercialised society, one does not have to look far to find examples where this may be so. For instance, consider a situation where a doctor holds a financial interest in a particular pharmaceutical company and only prescribes medications manufactured by this company. It is possible that in these circumstances the doctor is motivated primarily by the financial reward, as opposed to the best interest of the patient.

13 Hall M, Dugan E, Zheng B and Mishra AK “Trust in Physicians and Medical Institutions; What is It, Can It be Measured and Does It Matter?” (2001) 79 Milbank Quarterly 613 at 615.
16 Calnan and Rowe, n 10, p 62.
17 Calnan and Rowe, n 10, p 62.
18 Davies HTO and Randall TG, “Managing Public Trust in Managed Care” (2000) 78 Milbank Quarterly 609 at 614.
21 MacDuffie, n 20 at 39.
While trust is typically construed as a positive notion and distrust or mistrust as the opposite, it has been suggested that distrust or mistrust may represent important means of protecting particular vulnerabilities against an abuse of power. In these circumstances, mistrust and distrust hold positive instead of negative connotations. For instance, where excessive diagnostic tests have been requested or a perceived conflict of interest arises, distrust or mistrust ensures that vulnerable interests are protected. However, concepts of trust are dynamic and this means that complex relationships, such as those in health care, can simultaneously involve trust and distrust.

**TRUST RELATIONSHIPS IN THE HEALTH CARE SYSTEM**

The provision of health care services in Australia occurs within a system that is increasingly complex and multifaceted. Consequently, it encompasses a number of key stakeholder relationships, each of which may be influenced by varying levels of trust.

Calnan and Rowe, referring to the National Health Service in the United Kingdom, recognise that trust has traditionally played an important role in relationships and interactions between the state, health care practitioners and the public. These three stakeholders are also relevant in the Australian context. Additionally, organisational trust should be acknowledged since it too has been described as influencing health outcomes. While the salience of trust in any of these relationships will vary from context to context, it assumes particular importance in the relationship between a health care professional and their patient. The vulnerability associated with illness is a primary consideration in this regard. However, the information asymmetries and unequal relationships that arise due to the special nature of scientific knowledge also combine to compel trust. Having identified the characteristics of the relationship between a health care provider and patient that create the need for trust, benefits that may be attained by nurturing trust-based relationships are now examined.

Mechanic observes that trust is typically associated with a high quality of communication and interaction. Good communication increases the likelihood that patients will reveal intimate information, cooperate in treatment and adhere to medical advice. He suggests that trusting relationships will encourage those behavioural changes necessary to prevent health problems and promote health. Trust therefore becomes important for its potential therapeutic effects. Although this is intuitively probable, Calnan and Rowe note that a lack of interventional studies examining the effect of trust in these circumstances makes the assertion difficult to support empirically. Despite this lack

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24 Gilson, n 14 at 370.
25 MacDuffie, n 20 at 40.
29 Calnan and Rowe, n 27 at 349.
30 Calnan and Rowe, n 7, p 3.
32 Mechanic, n 31 at 177.
33 Calnan and Rowe, n 10, p 64.
of empirical evidence, trust has been demonstrated to promote positive interactions between health care practitioners and patients,\textsuperscript{34} ensuring that an imbalanced power relationship need not necessarily hinder positive health outcomes.\textsuperscript{35}

Although the importance of the interpersonal relationships between health care practitioners and patients is readily apparent, other stakeholder relationships should not be understated. It was previously noted that health care services in Australia are becoming increasing complex. They not only encompass technically sophisticated acute care services, but also primary care, residential aged care, mental health care, rural and rehabilitation services. The provision of such a large array of health care services requires the knowledge, skills and support of a correspondingly diverse health care workforce.\textsuperscript{36} In order to accommodate these varied needs, Australia’s current health workforce is disparate, being characterised by a large number of separate professions, each with a different course of preparation, a different emphasis in practice and, to some extent, a different ideological foundation in terms of the way in which the profession interacts with other professions and patients.\textsuperscript{37} Despite these complexities, provided stakeholders work cooperatively to provide a high standard of care, positive health outcomes are attainable.\textsuperscript{38} However, cooperation and effective collaboration cannot be achieved unless constructive working relationships are established and maintained. It is within this context that, once again, the notion of trust becomes essential. By helping to secure open communication and dialogue between disparate health professionals working across a variety of services, trust enables these vital relations to be nurtured and sustained.\textsuperscript{39}

The importance of trust in relationships between health care providers and their patients, as well as health care providers and their colleagues, has now been demonstrated, but it is also relevant to consider its influence in relationships between health care providers and the organisations in which those services are provided. As the provision of high-quality, efficient and safe care is essential for achieving positive patient outcomes,\textsuperscript{40} it is imperative that these values are inherent in health care organisations in Australia. As health care organisations are customarily hierarchical, managers typically assume responsibility for implementing key institutional decisions designed to reflect organisational values. These decisions, and the values they incorporate, must be supported by those who work within a health care institution if positive patient outcomes are to be achieved. The types of decisions that may be implemented by managers include the allocation and performance of work, rewards such as promotion, and in the case of unsatisfactory performance, discipline. While there are often processes designed to assist in implementing these decisions, in workplaces where relationships between managers and health care providers are characterised by inclusive open communication, where people feel valued and respected, then trust is more easily established.\textsuperscript{41} In the absence of trust, institutional values are unlikely to be incorporated into health care provider behaviour,\textsuperscript{42} compromising the performance of health care practitioners. As this performance is essential for promoting positive patient outcomes, trust again can be seen as pivotal.

It can now be seen that providing support for the values and goals of any health care organisation is an important function of trust; however, the benefits may extend even further. Calnan and Rowe suggest that trust has intrinsic importance in health care, similar to other collective goods like social

\textsuperscript{34} Calnan and Rowe, n 7, p 9.


\textsuperscript{37} Duckett, n 36, p 62.

\textsuperscript{38} Calnan and Rowe, n 27 at 350.


\textsuperscript{40} Australian Commission on Safety and Quality in Health Care, n 26, p 1.

\textsuperscript{41} Firth-Cozens, n 28 at 58.

\textsuperscript{42} Gilson, n 14 at 368.
The impact of mandatory reporting law on trust relationships in health care

capital,\textsuperscript{43} enabling stakeholders to access to resources and opportunities for mutual benefit.\textsuperscript{44} For instance, an organisation that fosters trusting relationships will reduce its need to scrutinise and monitor staff. This allows for greater operational efficiency by reducing costs associated with the provision or coordination of care.\textsuperscript{45} It concurrently provides health care practitioners with greater clinical autonomy, enhanced satisfaction with their work and improved collaborative practice.\textsuperscript{46} Cumulatively, the benefits to the organisation as well as health care practitioners strongly support fostering trust in these stakeholder relationships.

Organisational values designed to support positive patient outcomes are undoubtedly subject to various constraints. While an organisation may strive to provide as many treatment options as possible to ensure the most advantageous outcome for an individual patient, access to infinite resources needed to achieve this is just not possible. As a “steward” of the nation’s health,\textsuperscript{47} the state assumes responsibility for ensuring that health care services are adequately resourced. A vital component of this obligation requires the system to be supplied with an appropriately educated and credentialled health workforce. There are a myriad of health care professions involved in the provision of holistic health care services; however, the medical profession has historically wielded significant influence and control within this realm.\textsuperscript{48} While a predominant biomedical discourse has been acknowledged as enabling this,\textsuperscript{49} it is concurrently based upon one of the characteristics of a profession that distinguishes it from other occupations: an implicit social contract with the state.\textsuperscript{50}

The notion of a social contract was first developed during the 17th and 18th centuries to explain the nature of the relationship between the state and its citizens, including fundamental reciprocal rights and duties. As most countries were ruled by hereditary monarchs during this time, an explicit understanding of these obligations was particularly important.\textsuperscript{51} In respect of health care, the social contract has granted the medical profession an ability to practise autonomously, protected by the privilege of self-regulation.\textsuperscript{52} The ability to maintain professional autonomy is significant because it not only ensures that the profession has control over the diagnosis and treatment of individual patients, but also control over the nature and volume of medical tasks and evaluation of care.\textsuperscript{53} Self-regulation has in the past guaranteed the profession control over the criteria for entry, the content of educational training and the standards of practice and conduct expected of its members.\textsuperscript{54} Since the knowledge and skills utilised by the medical profession are specialised and highly valued, it is claimed that others would not be equipped to evaluate or regulate it, and the social contract is therefore warranted.\textsuperscript{55} While these protections provide significant financial and non-financial rewards, there are correspond-

\textsuperscript{43} Calnan and Rowe, n 10, p 64.
\textsuperscript{44} Germov J, “Class, Health Inequality, and Social Justice” in Germov, n 11, p 86.
\textsuperscript{45} Calnan and Rowe, n 10, p 64.
\textsuperscript{46} Calnan and Rowe, n 10, p 64.
\textsuperscript{49} Addicott and Ferli, n 48 at 402.
\textsuperscript{50} Timmermans and Oh, n 12 at 95.
\textsuperscript{52} Cruess and Cruess, n 51 at 580.
\textsuperscript{55} Timmermans and Oh, n 12 at 95.
ing obligations that require the profession to place the patient’s interests above their own, to use
self-regulation to ensure the competence of its members, and demonstrate morality and integrity.66

Self-regulation with regard to professional competence supposed that if a medical practitioner was
discovered falling short of the required standard of practice, they would be assessed by a disciplinary
body such as a medical board.57 This statutory body, comprised predominately of registered medical
practitioners,58 was empowered to consider the individual circumstances of the case and take the
disciplinary action it deemed appropriate. It was considered self-regulating because the task was
exercised independently of any outside body, including the state.59

Trust is a central tenet of the social contract. For it to be effective, it requires the state and its
citizens to have high levels of trust not only in the expertise of doctors but also the effectiveness of
self-regulation as a mechanism for ensuring high standards of care.60 When the public are exposed to
significant risk of harm that self-regulation fails to negate, trust becomes displaced in favour of
mistrust and distrust. This has been demonstrated in recent events in Australia.

Precipitated by allegations of significant patient harms, at least five commissions of inquiry into
health care and/or health care services have been conducted across three States and one Territory in
Australia since 1990. Each of these inquiries was charged with investigating the poor clinical
performance of health care professionals.61 Evidence submitted repeatedly highlighted the inability of
the profession to adequately identify, monitor, support or reprimand poorly performing practitioners
within a self-regulatory scheme. While the inquiries into health services may have been initiated in
response to isolated incidents of poor performance, their frequency and the seriousness of patient
harm they investigated implied a broad failure by the medical profession to satisfactorily maintain
their end of the social contract. Despite evidence of the failure of self-regulation, the culture
supporting professional autonomy and accountability was so entrenched that attempts by institutions
to address issues of patient safety through managerial efforts or changes to policy encountered
considerable resistance.62 However, as a party to the social contract, the state also has a central interest
in optimising health outcomes and minimising harm. As the relationship that had previously been
based on trust became one of mistrust, the legitimacy of the power wielded by the medical profession,
enshrined in their right to professional autonomy and self-regulation, was challenged.63

Based on the perception that the profession could no longer ensure competence and patient safety
through self-regulation, alternative mechanisms were sought. Naturally, as a party to the social
contract, and steward of the nation’s health, the state was expected to address this issue. The costs of
failing to meet this expectation are not insignificant. Trust in the health care system dissolves and is
replaced with mistrust, eventually extending beyond the health care system to become a general
mistrust of the state.64 While it has been recognised that in certain situations, mistrust and trust can be
deployed simultaneously, typically when public trust in the state appears to be on the decline,

66 Cruess and Cruess, n 51 at 580.
67 Queensland Government, Medical Board of Queensland Agency Details (Queensland State Archives, 1 July 2010),
68 Medical Practitioners Registration Act 2001 (Qld), s 15(4).
69 Thomas D, “Peer Review as an Outmoded Model for Health Practitioner Regulation” (2005) 23 Law in Context 52 at 55.
70 Rowe and Calnan, n 53 at 382.
71 Douglas N, The King Edward Memorial Hospital Douglas Inquiry Report (2000); Walker B, Special Commission of Inquiry
into Campbelltown and Camden Hospitals Investigation Report (2003); Australian Capital Territory, Investigation into Adverse
Patient Outcomes of Neurosurgical Services Provided by the Canberra Hospital Final Report (2003); Davies G, Queensland
Public Hospitals Commission of Inquiry, Report (2005); Garling P, New South Wales, Acute Care Services in New South Wales
Health Rev 10 at 11.
73 Rowe and Calnan, n 53 at 379.
74 Abelson, Mill and Giacomini, n 3 at 63.
policy-makers take measures to try to restore it. Consequently responsibility for regulation that would support the abatement of risk and harms moved from the medical profession to the domain of the state in the form of a new regulatory system.

Any public policy measure aimed at minimizing mistrust and restoring trust must first acknowledge that differing attitudes toward trust will affect the policy position that will be taken. First, the existence of trust may be assumed as a factual premise, allowing for the imposition of a particular obligation; because trust exists, health care providers should behave in a certain manner. For instance, because patients trust health professionals, health professionals are required to put their patient’s interests ahead of their own. In this way trust becomes the prima facie source of the obligation, not its object. Alternatively, public policy can proactively seek to promote trust by constructing rules intended to maintain or increase trust where it exists, or to restore trust where it is threatened or diminished. For example, the recent sequence of scandals and egregiously bad instances of professional misconduct have detracted from the status of, and trust in, health practitioners in Australia. Policy decisions designed to restore this lost trust could include external regulatory mechanisms instead of continued self-regulation to promote the maintenance of appropriate professional standards. Included within such a mechanism are rules designed to ensure that the trust reposed in health professionals can be confidently justified. It is also relevant to note, however, that contrary to this view, regulatory mechanisms designed to increase trust may have the effect of promoting a culture of mistrust. O’Neill argues that the imposition of regulatory control mechanisms may distort the proper aims of professional practice by reducing them to measurable targets. While this manifests in the rhetoric of improvement and rising standards, the effect may be to damage professional pride, integrity and subsequently trust. Consequently, cognisant of the desired aims of external regulatory mechanisms as well as their potential costs, the implementation of any policy decision should be carefully assessed and monitored.

In order to undertake such an assessment comprehensively and implement a stance designed to support trust, empirical assumptions about what conditions and measures actually improve or diminish trust must be made. For example, if the state is unable to protect patients adequately from being harmed by incompetent practitioners, then it may be assumed that this will impact negatively on public trust of the state. A stance designed to promote trust therefore will increase regulatory control and mandate that the conduct of these practitioners be notified to a statutory authority representing the state. While this is contrary to the view espoused by O’Neill, this stance reflects the position taken by governments within Australia when they introduced a mandatory reporting obligation within the health care professionals’ national regulatory scheme. However, before being able to ascertain whether this stance will improve trust in the state, as well as trust between other stakeholders, it is beneficial to consider the impetus for the national scheme that included mandatory reporting.

Abelson, Mill and Giacomini, n 3 at 63.
Thomas, n 59 at 53.
Hall, n 67 at 158.
O’Neill, n 70.
Hall, n 67 at 161.
THE CREATION OF A NATIONAL REGULATORY SYSTEM FOR HEALTH PRACTITIONERS

In July 2010, each of the eight separate State and Territory regulatory schemes for health practitioners was integrated into a single national registration and accreditation scheme (the National Scheme).\(^{73}\) One of the main objectives of the National Scheme was to provide for the protection of the public, by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.\(^{74}\)

Prior to implementation of the National Scheme the Australian Health Ministers Advisory Council was charged with exploring its potential regulatory impact. During this process it was acknowledged that practitioners who are unqualified, impaired, incompetent or unethical may cause serious harm to members of the public.\(^{75}\) It was postulated that were these practitioners promptly reported to an appropriate authority, this would help mitigate the damage that they may cause.\(^{76}\) However, as a regulatory system is only as good as the information it has to act on, finding an effective way to ensure that information is brought to the attention of regulators is paramount. Despite the fact that codes of ethics for many of the health professions require practitioners to voluntarily notify a regulatory authority of their concerns,\(^{77}\) in practice this information was either not communicated to an appropriate body or, if it was, the information was not disseminated so that it could be acted upon. Accordingly, one option to address this was the introduction of a mandatory reporting system. This measure would require certain information pertaining to a practitioner’s performance to be reported by practitioners and/or their employers to regulators through the National Agency.\(^{78}\)

To implement the National Scheme host legislation was introduced by Queensland in 2009 and took effect in July 2010.\(^{79}\) With the exception of New South Wales, which continues to use its State legislation for handling complaints about health, conduct or performance matters,\(^{80}\) each State and Territory subsequently implemented a uniform piece of legislation. Specifically, with regard to professional performance, it was mandated that a registered health practitioner report the conduct of another practitioner if they are aware that he or she has practised while intoxicated by drugs or alcohol, has engaged in sexual misconduct, has placed the public at substantial risk of harm because of an impairment or placed the public at risk of harm because they have practised in a way that significantly departs from accepted professional standards.\(^{81}\) This obligation also extends to the employers of registered health practitioners if they form the reasonable belief that a practitioner has engaged in notifiable conduct.\(^{82}\) It is reasonable to expect that under certain circumstances, complaints made by one health practitioner about the conduct of another would enable an employer to hold this belief. By imposing the obligation on individuals as well as employers, the possibility of notifiable conduct eluding the regulatory authority was minimised.

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\(^{74}\) Council of Australian Governments, n 73, p 3.

\(^{75}\) Australian Health Ministers Advisory Council Governance Committee, n 5, p 50.

\(^{76}\) Australian Health Ministers Advisory Council Governance Committee, n 5, p 51.


\(^{78}\) Australian Health Ministers Advisory Council Governance Committee, n 5, p 24.

\(^{79}\) Health Practitioner Regulation National Law Act 2009 (Qld).

\(^{80}\) Health Practitioner Regulation National Law Bill 2009 (Qld), Explanatory Notes, Pt 8, p 82. Except in New South Wales, the National Agency is authorised to manage investigations into the professional conduct, performance or health of registered health practitioners on behalf of the Health Practitioner Boards.

\(^{81}\) Health Practitioner Regulation National Law Act 2009 (Qld), ss 140, 141.

\(^{82}\) Health Practitioner Regulation National Law Act 2009 (Qld), s 142.
The impact of mandatory reporting law on trust relationships in health care

While the purpose of mandatory notification within the National Scheme is to increase protection of the public, the threshold to trigger the requirement to report is high, the intention being that practitioners notify the National Agency if they believe that another practitioner has behaved in a way which presents a serious risk to the public. The requirements focus on serious instances of substandard practice or conduct by practitioners; this is behaviour that puts the public at risk of harm, rather than not liking the way someone else does something or feeling that they could do their job better. Designing the measure in this way helps to ensure that only those matters that pose a very real risk of harm to the public must be notified. Other less serious matters may voluntarily be notified to the National Agency or an alternative health complaints entity. While reporting of each or any of these instances of notifiable conduct will affect those reporting and reported in different ways, the focus of this article is on those instances where there has been significant departure from professional standards necessary to ensure competence. It is relevant therefore to consider the connection between professional competence and notification.

THE IMPETUS FOR MANDATORY REPORTING OF PROFESSIONAL INCOMPETENCE

Mandatory reporting legislation was introduced for medical practitioners in New South Wales in 2008 as a response to public and media outcry over the professional performance of Graham Reeves. This doctor was accused, and later found guilty, of mutilating and sexually abusing numerous patients during operations performed while employed in hospitals on the New South Wales South Coast in 2002. Reeves completed his medical training in 1974, and the first complaints relating to his practice were received by 1986. The complaints were made by nursing staff, medical staff and patients and related to allegations of various matters such as bullying, aggressive and inappropriate behaviour to staff and patients, and inappropriately humiliating and condescending behaviour towards junior medical staff and nursing staff in front of patients. Allegations of incompetence included instances where he failed to offer or administer anaesthetic or analgesia during procedures. Over the course of 15 years, 35 complaints about Graeme Reeves were lodged either with the employing hospital or the New South Wales Health Care Complaints Commission.

Despite these not only numerous but also serious complaints, it was not until March 1996 that the Northern Sydney Area Health Service notified the New South Wales Medical Board of these concerns. It then took a further 15 months before the board officially reprimanded Reeves for unsatisfactory professional conduct, ordered him to cease treating obstetric patients and required him to commence a course of clinical supervision. In December 2001, Reeves’ employment at a public hospital in New South Wales was terminated on the basis of continued complaints about his behaviour and not liking the way someone else does something or feeling that they could do their job better.
competence. Despite this, in 2002 he was able to obtain employment with another area health service to provide obstetric and gynaecological services. 93 Ongoing issues with Reeves’ practice continued until eventually in 2004 the Medical Board concluded that he had engaged in gross professional misconduct of the most serious kind and ordered that his name be removed from the register. 94

The actions of Dr Reeves provided an impetus for the establishment of a Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals. 95 Shortly after the establishment of the inquiry, the Commissioner determined that he should investigate the appointment of Dr Reeves by the Southern Area Health Service, as this raised systemic issues apparent within the service. 96 Concurrently, the New South Wales Minister for Health, Reba Meagher, noted that the case of Dr Reeves challenged the public perception of the medical profession and that it was important that the government take steps to restore trust. 97 Subsequently, legislation was passed 98 which required medical practitioners to make a report to the board when the practitioner believes, or ought reasonably to believe, that another medical practitioner has committed sexual misconduct, is practising while intoxicated by drugs or alcohol, or has flagrantly departed from accepted standards of professional practice or competence and risks harm to a patient. 99 Neither the Explanatory Notes 100 nor comments made by the Legislative Review Committee 101 made prior to the passage of the amendments specifically address how this aims to restore trust. However, it clearly demonstrates that trust in the health care system is perceived as very important and empirical assumptions about the efficacy of reporting as a measure that supports trust must have been drawn. Curiously, these assumptions were made despite the fact that the Medical Board in New South Wales had been aware that Dr Reeves’ clinical competence had been complained of over a period of years.

During a speech made to the Legislative Assembly commending the passage of the Act, it was noted that “it is precisely because of the rarity of these issues that mandatory reporting is necessary”. 102 However, just three years earlier, a similar Commission of Inquiry had been held in Queensland. The Queensland Public Hospitals Commission of Inquiry (the Davies Inquiry) arose out of complaints relating to Dr Jayant Patel at Bundaberg Base Hospital in 2004 and early 2005. In addition to these complaints, concerns expressed about Dr Patel’s judgment, competence and care, and the failure of both hospital administrators and officers of Queensland Health to address those complaints and concerns, were the focus of the inquiry. 103 The inquiry’s findings concluded that Dr Patel’s conduct as a surgeon was deficient with regard to his assessment of patients, technical ability and post-operative management. It was observed that, as a consequence, the outcomes for Dr Patel’s patients were not “ten times worse than one would expect, they were one hundred times worse”. 104

In the 24 months that Dr Patel was employed at Bundaberg Base Hospital, staff or patients made over 20 complaints about his performance. Those complaints began following a procedure he performed a mere six weeks after commencing at the hospital and continued until he ceased working there. While the complaints varied in their seriousness and the formality with which they were made,

93 Garling, n 89, p 35.
94 Garling, n 89, p 78.
95 Garling, n 89.
96 Garling, n 89, p 2.
98 Medical Practice Amendment Act 2008 (NSW)
99 Medical Practice Amendment Act 2008 (NSW), s 71A.
100 Medical Practice Amendment Bill 2008 (NSW), Explanatory Notes.
101 Parliament of New South Wales, Legislative Review Committee (13 May 2008).
102 New South Wales, Legislative Assembly, Hansard (15 May 2008) pp 7709-7710 (Andrew McDonald).
104 Davies, n 103, p 3.
some of them were extremely grave. Despite this, the inquiry found that senior members of the hospital management team persistently ignored or downplayed their seriousness, in some instances describing the circumstances that gave rise to the complaints merely as “personality conflicts”. On the whole, their actions were unresponsive and discouraged complaint. Regardless of these responses, the complaints continued. What was apparent was that the complaints and the issues they raised were not brought to the attention of the Queensland Medical Board. In fact, the Medical Board of Queensland first learned of concerns relating to the clinical practice of Dr Patel on 15 February 2005. This was not by way of a formal complaint though, rather through a meeting conducted between the Medical Board and the Queensland Nurses Union. However, without specific information regarding Dr Patel’s clinical competence, it was impossible for the regulators to adequately address any concerns.

Despite the evidence and submissions received, Commissioner Davies acknowledged he was not in a position to recommend in any detailed way a better system for dealing with these issues. However, the Australian Health Ministers Advisory Council had previously suggested that one option to deal with the problems associated with getting information to regulators in a timely fashion was to put in place a mandatory reporting measure. This measure would compel particular people to report certain defined matters to a regulatory agency so that they could be investigated in an efficient manner, thereby reducing risks to public safety.

If reporting matters to a regulatory agency ensures protection of the public, the need to mandate this obligation must have been based on a perception that such information was being withheld. It is relevant then to explore the foundation of this perception.

Consider first the practice of Dr Patel in Queensland. Complaints regarding his competence began to emerge shortly after he commenced working at the Bundaberg Base Hospital. Ultimately, in proceedings that came before the Health Practitioners Tribunal in 2007, it was noted that Dr Patel’s case had been before the tribunal “for some time”. However, there is no public record of Dr Patel ever being cautioned, reprimanded or having conditions placed on his registration before this point. Despite numerous complaints relating to his competence, the Davies Inquiry heard that Dr Patel had remained in his position primarily for utilitarian reasons, as the hospital stood to lose substantial amounts of money should he leave or be stood down. In fact, the Commissioner uncovered a litany of poor decision-making processes that led to an inability of the organisation to critically review performance in light of staff and patient complaints.

It appears that significant issues had been recognised by other members of staff and ultimately the local Member of Parliament; however, this information was not communicated to the Medical Board of Queensland with any degree of urgency so that it could be addressed.

Many other jurisdictions have also held inquiries to investigate unsatisfactory patient outcomes, and found that information was poorly communicated to regulatory authorities. For example, in 2001 in the United Kingdom, the Bristol Royal Infirmary Inquiry investigated the outcomes of paediatric heart surgery at that facility. In 1984 the Bristol Royal Infirmary was a designated service for open heart surgery and Bristol Royal Hospital for Sick Children for closed heart surgery for babies under

105 Davies, n 103, p 4
106 Davies, n 103, p 4.
107 Davies, n 103, p 459.
108 Davies, n 103, p 464.
109 Australian Health Ministers Advisory Council Governance Committee, n 5, p 51.
110 Australian Health Ministers Advisory Council Governance Committee, n 5, p 51.
111 Medical Board (Qld) v Patel [2007] QHPT 003, p 3.
113 Casali and Day, n 112.
114 Davies, n 103, p 161.
one year of age. Concerns about the performance of surgeons at Bristol were expressed both internally and externally throughout the 1980s; however, it was not until 1997 that the General Medical Council (GMC) held a disciplinary proceeding on the professional conduct of two cardiac surgeons and the chief executive of the Trust, who was also a doctor. The proceedings included a limited review of the operations conducted at the Bristol Royal Infirmary and found that the three doctors were guilty of serious professional misconduct. Subsequently, the GMC removed one of the surgeons and the chief executive from the medical register, and restricted the other surgeon’s practice for three years. One of the most important systemic issues arising from the Bristol case was that concerns about the safety of the patients were raised by both staff and patients for a period of almost 10 years before a comprehensive review was undertaken. These findings are congruent with similar health care inquiries that revealed organisational cultures where complaints about health care were undervalued and ineffectually addressed.

The findings of these inquiries indicate that complaints about poor care that negatively affect patient outcomes are frequently brought to the attention of line managers and supervisors within health care organisations. In doing so, those raising the concerns trust that they will be dealt with efficiently and effectively so that patient outcomes are not compromised. However, with the exception of the Inquiry into Acute Health Care Services in New South Wales, evidence suggested that not only are many of these issues inadequately addressed at the organisational level, they do not get passed on to regulators. Consequently, the aim of mandating the notification of certain serious instances of poor clinical practice by employers as well as individual health practitioners, is that regulators will be better placed to investigate, assess and intervene where necessary.

MANDATORY REPORTING AND WHISTLEBLOWING

In principle, mandatory reporting obligations appear to provide a solution to the enduring problem of ensuring that regulatory bodies receive relevant information about serious instances of clinical practice that place the public at risk. However, it is possible that unintended consequences flowing from this obligation have the potential to erode the trust that is imperative for beneficial working relationships, and ultimately positive patient outcomes. This assertion is based on the observation that mandatory reporting may be akin to whistleblowing. While whistleblowing can lead to the discovery and rectification of poor clinical practice that poses a risk to the public, exposure of such conduct might be controversial and damaging. Consequently, its disclosure could provoke conflicts that involve negative outcomes for all involved.

In order to explore this notion further, it is pertinent to examine the concept of whistleblowing and the impact that it may have on working relationships.

The term “whistleblowing” is not a technical term and does not have a common legal definition. However, a whistleblower has been defined as “someone who identifies an incompetent, unethical or illegal situation in the workplace and reports it to someone who has the power to stop the wrong”. This definition provides a sound starting point because it has been widely used in related empirical research and allows for the many forms that whistleblowing can take. When considering the specific provisions of the Health Practitioner Regulation National Law Act 2009 (Qld), (the National Law), it is possible to align the legislative obligations with elements of the whistleblowing
The impact of mandatory reporting law on trust relationships in health care

definition, demonstrating how it mandates whistleblowing in the workplace. For example, the National Law requires that a health practitioner who forms a reasonable belief that another practitioner has behaved in a way that constitutes notifiable conduct, notify the National Agency. Forma
tion of a reasonable belief is congruent with the notion of “identify” contained in the whistleblowing definition. Similarly, notifiable conduct will include behaviour that is “incompetent, unethical or illegal”. Finally, notifying the National Agency satisfies the requirement of reporting to someone with the power to stop the wrong. In this way, mandatory reporting is congruent with the notion of mandated whistleblowing.

The concept of whistleblowing within health care is not a new phenomenon. While medicine is a profession based on scientific principles, it also incorporates high ethical standards and levels of integrity leading to an expectation that medical practitioners would actively seek and promote safe practice. However, it is apparent that those individuals who vigorously pursued these ideals were more often ostracised than lauded. For example, in Vienna during the 1830s Dr Semmelweis demonstrated that death from puerperal fever could be reduced, from more than 20% to less than 2%, by practitioners washing their hands in chlorinated lime. As his ideas were in conflict with his superior, those who thought that the lower mortality rate was due to hospitals’ new ventilation system, they were not implemented. Other physicians also resisted his hypothesis, believing the profession to be “divinely blessed” so it would be unreasonable to think they were the cause of death. For maintaining an outspoken stance on this issue Semmelweis was ultimately hounded back to his native country where he died a broken man. The notion that speaking out can result in serious adverse consequences continues today.

One of the most notable features of whistleblowing that gives rise to its negative connotations is the long-held perception that those who report will be subject to reprisals. Further, even in the absence of reprisals, whistleblowers tend to suffer high levels of stress and adverse outcomes, exacerbated by the perception that those who report are either predisposed to conflict, disgruntled or embittered employees, or driven to report by perverse personal characteristics. This is highly regrettable as the act of whistleblowing serves an essential and valuable function, particularly with regard to health care. Not only does it promote an informed society and expose wrongdoing, it is also crucial if the public are to be protected. Within this context, few individuals are better placed to observe or suspect notifiable conduct of another health practitioner than their professional colleagues. However, it has repeatedly been demonstrated that when this has occurred, the consequences for those reporting have been adverse.

The consequences associated with reporting concerns related to clinical competence were highlighted during the course of the Queensland Public Hospitals Inquiry. For example, the nursing staff reported that, when concerns were raised with Dr Patel, he subsequently refused to speak with them, sometimes for months, and in the face of compelling clinical reasons for communication.


125 Health Practitioner Regulation National Law Act 2009 (Qld), s 141.
128 Brown and Donkin, n 8, p 1.
131 Davies, n 103, p 131.
an operating room nurse gave evidence that Dr Patel was habitually rude to nursing staff and junior medical staff.\textsuperscript{132} One way that nursing staff were able to avoiding these reprisals was to ensure they did not complain about, or challenge, Dr Patel, as his manner then would be one that exuded confidence and charm.\textsuperscript{133} Even when staff brought these issues to the attention of the organisation, they were labelled as “personality conflicts”\textsuperscript{134} and any further complaints were strongly discouraged.

Similarly, during an inquiry into patient outcomes at the Campbelltown and Camden Hospitals, it was submitted that allegations about the competence of surgeons were made by nurses.\textsuperscript{135} The surgeons were later exonerated but felt embittered by the complaints as they had been working at hospitals that were poorly resourced. Following the inquiry, the relationship between the nurses and surgeons was damaged and resulted in less openness, honesty and cooperation in striving for better patient safety.\textsuperscript{136} It was also noted that just two years after the inquiry, the nurses who made the complaints were no longer working as nurses.\textsuperscript{137} While a direct causal link between the complaints by the nurses, the subsequent breakdown in relations and subsequent loss of employment has not been made explicit, it is plausible that challenges made to those in positions of power and influence contributed. Highlighting the impact that whistleblowing may have on the whistleblower helps to explain why, despite the fact that professional codes and organisational guidelines supporting voluntary reporting have been in place for many years, under-reporting of incompetent, unethical or illegal behaviour has been the norm.\textsuperscript{138}

The potential for adverse effects resulting from the mandatory reporting obligation must have been contemplated by those drafting the National Law. Although not explicitly acknowledged as whistleblowing, the Australian Health Ministers Advisory Council recognised that the implementation of mandatory reporting would have some potential costs. For example, the Council acknowledged that some professionals will no longer be willing to engage with one another in a collegiate or open fashion and that this could precipitate the development of a negative working culture.\textsuperscript{139} Conflict associated with perceived breaches of professional codes of ethics and confidentiality, or perceived disloyalty to colleagues,\textsuperscript{140} provides explanations for the development of a negative culture, yet the legislation fails to acknowledge or address these issues. Instead, legislative protection from civil, criminal or administrative liability associated with making a notification was provided.\textsuperscript{141} These provisions can only be relied upon in limited circumstances and do not provide compensation for associated reprisals. Consequently, the other personal and professionals costs that may be associated with complying with the legislative obligations are not addressed and potential negative connotations associated with reporting endure. This could be changed, however, if a safe and supporting environment in which to report is created.\textsuperscript{142} However, certain aspects of the current legislative framework may create barriers to achieving this aim.

\textsuperscript{132}Davies, n 103, p 132.

\textsuperscript{133}Davies, n 103, p 130.

\textsuperscript{134}Davies, n 103, p 142.

\textsuperscript{135}Faunce T and Bolsin SNC, “Three Australian Whistleblowing Sagas; Lessons for Internal and External Regulation” (2004) 181 MJA 44 at 45.


\textsuperscript{137}Faunce and Bolsin, n 135 at 45.

\textsuperscript{138}Firth-Cozens J, Firth R and Booth S, “Attitudes To and Experiences of Reporting Poor Care” (2003) 8 Clinical Governance: An International Journal 331 at 334.

\textsuperscript{139}Australian Health Ministers Advisory Council Governance Committee, n 5, p 50.

\textsuperscript{140}Ahearn and McDonald, n 120 at 14.

\textsuperscript{141}Australian Health Ministers Advisory Council Governance Committee, n 5, p 50.

\textsuperscript{142}Latimer and Brown, n 129 at 3.
The impact of mandatory reporting law on trust relationships in health care

First, recent research suggests that reprisal does not necessarily accompany all forms of whistleblowing; however, the legislative obligation creates a unique situation where it may be more likely. Mandatory reporting applies across the 14 health care professions regulated by the National Law. This means that a practitioner’s obligation to report is not restricted to reporting other practitioners within the same profession. While it may be argued that it is difficult for one professional to assess if there has been a significant departure from accepted professional standards from another profession, there will undoubtedly be conduct that places the public at risk of harm that can be readily identified. A health practitioner’s obligation then applies in respect of all other registered health practitioners. In a system where multidisciplinary health care teams are now the norm, this appears to be appropriate. However, not all members of the health care team will be on an equal footing or status. Consequently, it may be that a junior or less influential member of the team is the first or only member to be aware of notifiable conduct which they are obliged to report, leaving them exposed and subject to reprisals.

Additionally, prior to the introduction of the National Law, a health care practitioner who was aware that another practitioner had engaged in conduct that would now be defined as “notifiable” could weigh the personal risks and benefits before deciding to notify or “blow the whistle”. Choosing to remain silent is no longer an option. Having created this obligation, and recognising some potential costs, the legislation should ensure that practitioners who report notifiable conduct are provided with a safe and protected environment. The National Law requires a health practitioner who becomes aware that another practitioner has practised in a way that constitutes notifiable conduct, to notify the National Agency using the prescribed “notification” form. This form states that upon receipt of a notification, information may be provided about the reporter to the health practitioner the subject of the notification. In research conducted to inform the Australian Parliament, it was argued that one of the most successful ways to protect a whistleblower is by keeping their identity anonymous. This can be achieved by providing disclosure regimes which operate on the basis of anonymously provided information or, at the very least, by imposing a duty upon the recipient of the disclosed information not to reveal the discloser’s identity. Failing to provide this assurance clearly contradicts these findings.

It may be argued that information relating to the identity of a person making a notification forms part of the natural justice afforded to any person subject to a complaint about their professional competence. However, the Victorian Supreme Court of Appeal in Byrne v Marles (2008) 28 VAR 438; [2008] VSC 78 at [82] concluded that, in a general sense, the requirements of natural justice may be satisfied if “the decision-making process, viewed in its entirety, entails procedural fairness”. This suggests that in disciplinary proceedings that might eventuate following a mandatory notification, natural justice relates to the substantive hearing and determination of an inquiry into a person’s conduct. Whether the identity of a person making a notification was relevant to a substantive hearing would be revealed during preliminary investigations. Therefore there is no reason not to withhold this information until such time that this determination is made. This is particularly in light of the fact that doing so may expose that person to exacerbated feelings of conflict, disloyalty and reprisals.

143 Brown and Donkin, n 8, p 2.
144 Brown, n 8, p xxix.
145 There are some circumstances prescribed in the legislation where a health practitioner will not be required to report notifiable conduct. See eg Health Practitioner Regulation National Law 2009 (Qld), s 141(4).
148 John, n 147, p 3.
Although it is not inevitable that a whistleblower will suffer mistreatment from colleagues or management, estimates suggest that up to 30% do. But even for the purported 70% who may not experience mistreatment, reporting is still a difficult and stressful experience. The fact that this is now a legal obligation does not automatically suppose that the ethical conflicts that it poses will disappear. While personal inner conflict associated with perceived breaches of professional codes of ethics, disloyalty to colleagues and organisations and the potential for distressing reprisals all contribute to make voluntary whistleblowing an extremely stressful undertaking, it is impossible to predict precisely the effect that mandating this requirement will have. It is possible, though, to anticipate that it will impact negatively on those trust relationships that are imperative in order to achieve positive patient outcomes.

MANDATORY REPORTING AND ITS IMPACT ON TRUST

The salience of trust in any interpersonal relationship will vary depending on the context. It is evident that the vulnerability associated with illness requires that trust assume particular importance in the relationship between a health care professional and their patient. However, in order to achieve positive patient outcomes, the importance of trust in other health care relationships should not be understated. It has been noted that in Australia the provision of health care services is characterised by a multitude of complex services and procedures, performed by multidisciplinary and disparate health care professionals. Within this setting, effective collaboration, teamwork and communication are essential. Each of these elements, vital for constructive working relationships and positive patient outcomes, can be enhanced if they occur within a trusting environment. However, it is suggested that under the spectre of mandatory reporting, this may be much more difficult to achieve.

To understand how mandatory reporting may negatively influence interpersonal trust between health care practitioners, consider the perspective of the practitioner who is mandated to make a notification because they have become aware of certain conduct.

Up until this point, the practitioner may have been working collaboratively within a multidisciplinary interdependent team. Trust within this team was pivotal, with each member holding certain expectations regarding the clinical competence, reliability and honesty of their colleagues. In order to achieve optimal patient outcomes, each member will be expected to practise competently; if they fail to do this, poor patient outcomes could eventuate. The interdependence of the team therefore creates a level of vulnerability that requires trust. For example, if there is a failure to report accurately and efficiently on a diagnostic test or procedure, this may cause a delay in commencing a beneficial therapy. As a result, the patient’s hospital admission may be prolonged. Additionally, such a delay may be attributed to a practitioner, when in fact another member of the team failed to perform according to expectations. Therefore, effective collaboration requires each member of the health care team to trust that other team members can confidently be relied upon to perform according to expectations.

Trust therefore not only improves the ability of individual health professionals to collaborate effectively, but becomes a self-fulfilling prophesy, ensuring team performance reflects expectations.

Becoming aware that another health care practitioner has departed from accepted professional standards to such an extent that the public are at risk of harm can leave the witnessing practitioner suffering from stress, frustration and anxiety. This can also lead to erosion of trust between the

149 Brown, n 8, p xxvii.
150 Brown, n 8, p xxvii.
151 Calnan and Rowe, n 27 at 349.
152 Firth-Cozens, n 28 at 58.
153 Calnan and Rowe, n 7, p 87.
practitioners. However, this right also carries corresponding obligations, not least of which is the responsibility to an employee as an effective and appropriate point of disclosure will depend on the level of trust uniformly ignored and, at worst, treated with contempt and abuse.

notifications by employees will be made to a line supervisor or manager. Whether this is perceived by organisational values are reflected in practitioner behaviour. is affected instead.

As many health care organisations are hierarchical, it is feasible that in the first instance, notifications by employees will be made to a line supervisor or manager. Whether this is perceived by an employee as an effective and appropriate point of disclosure will depend on the level of trust instilled not only in that person but in the organisation as a whole. Clearly, if organisational trust is high, then this will support notification. Trust will be sustained if the employees’ expectation that a notification will be appropriately handled is fulfilled. However, it is possible for an employer to fail to form a reasonable belief that a practitioner has practised in a way that constitutes notifiable conduct despite an issue being raised by an employee. Whether a practitioner has significantly departed from accepted professional standards will at times require a subjective judgment that could potentially differ from the one made by the reporting practitioner. In those situations where, despite a perception or even finding of wrongdoing, there is inaction within the organisation, this suggests to the employee that the notification was not appropriately handled and their trust has been misplaced. History has demonstrated that in those circumstances where the wrongdoing is very serious, managers have consistently failed to handle complaints made by employees appropriately. For example, a comparative analysis of eight inquiries across six countries revealed that where individual health professionals chose to speak out about issues of serious misconduct, they were, at best, almost uniformly ignored and, at worst, treated with contempt and abuse. As a consequence, this may be not only frustrating for the whistleblower, but damaging to organisational trust necessary for ensuring organisational values are reflected in practitioner behaviour.

Finally, mandatory reporting obligations may also impact on those trust relationships between health care professionals, the public and the state. It is recognised that as a party to the social contract, the state may exercise its right to alter the ability of health care professionals to self-regulate. However, this right also carries corresponding obligations, not least of which is the responsibility to

156 Smith and Brown, n 155, p 131.
159 Health Practitioner Regulation National Law 2009 (Qld), s 141(4)(e).
161 Donkin, Smith and Brown, n 160, p 106.
162 Donkin, Smith and Brown, n 160, p 134.
164 Hindle et al, n 115, p 8.
165 Donkin, Smith and Brown, n 160, p 134.
ensure that any legislative obligations that have been created are adequately funded and resourced. Having identified that a regulatory authority is unable to act if there is a dearth of information pertaining to the conduct of health practitioners who place the public at substantial risk of harm, and instituted legislative mechanisms to address this, the protection of the public should be enhanced. This, of course, will only occur if there are sufficient people and processes to efficiently and effectively investigate and action notifications that are made. As the National Scheme is still in its early phase, it is not possible to ascertain whether it has been sufficiently resourced by the state. It is pertinent, though, to revisit the conduct of Dr Reeves and the disciplinary processes addressing it.

The Medical Board in New South Wales was aware of this doctor’s unsatisfactory conduct for several years, and tried several ineffective measures before adequately restraining him from harming patients. For example, despite an order banning Dr Reeves from practising in obstetrics, he was still permitted to practice gynaecology. This limited ban resulted in nursing staff and other colleagues assuming responsibility for monitoring his practice.166 The subsequent failure of the de facto surveillance of Dr Reeves’ practising restrictions provides evidence that inadequate resourcing can limit the efficacy of any mandated reporting obligations. While it was noted by the Health Minister at the time that this was detrimental to trust within the health care system, it could not be related to the Medical Board having a lack of information. The cumulative effect, however, may be the same, with trust in the health care system depleted. Under these circumstances, trust may be replaced by mistrust which consequently leads to delays in the public seeking health care when it is required. Not only does this increase the risks associated with the provision of health care, it also requires greater resources and financial costs.167 Clearly, the consequences of a loss of trust are detrimental to overall patient outcomes and are to be avoided by the state.

CONCLUSION

Australia’s health care system provides some unique challenges to achieving high-quality, efficient health care services for those who require them. This is not only for those health care practitioners working within it, but also other key stakeholders charged with ensuring that unnecessary patient harms are avoided and positive patient outcomes are realised. Many of these challenges can be mediated if the relationships between each of the key stakeholders exhibit a high degree of mutual trust.168 While the need for trust between individual health care practitioners and the patients they care for may be self-evident, it is also imperative for facilitating positive working relationships between individual health care practitioners and health care practitioners and the state. Trust between health care practitioners promotes open communication and collaboration essential for providing safe, holistic health care across diverse settings.169 Trust inherent in the social contract170 between health professionals and the state has previously authorised self-regulation and promoted clinical autonomy.171 However, the ability of health professionals to ensure the satisfactory standards of clinical competence necessary to promote patient safety through self-regulation has in recent years been challenged, and the state has responded.

As stewards of the nation’s health, the state assumes a unique role in the protection of the public.172 It must ensure that health care practitioners whose substandard clinical competence poses a significant risk of harm are appropriately assessed and addressed. Adequate information is undeniably

166 Garling, n 89, p 73.
168 Calnan and Rowe, n 10, p 64.
169 Calnan and Rowe, n 10, p 64.
170 Rowe and Calnan, n 53 at 382.
171 Cruess and Cruess, n 51 at 580.
172 World Health Organisation, n 47, p 119.
paramount to enable the state to fulfil this role.\textsuperscript{173} The recent introduction of mandatory reporting obligations for health care practitioners is designed to support this. However, it can now be seen that, despite its well-intentioned premise, this measure has the potential to reduce, rather than enhance, levels of trust across stakeholder relationships at many levels.

Relationships of trust may be negatively impacted upon when certain expectations are not met. As there is an expectation that health care practitioners will practise in a clinically competent manner, becoming aware that another practitioner has engaged in notifiable conduct causes this expectation to dissipate, eroding trust.\textsuperscript{174} This effect can be magnified with the imposition of mandatory reporting as it aligned with mandatory whistleblowing. Unfortunately, despite the fact that whistleblowing provides an invaluable service to society, those people charged with reporting experience significant levels of stress and increased anxiety related to the conflict that they may experience between maintaining loyalty to the profession and protecting the public.\textsuperscript{175} In addition, the spectre of potentially damaging reprisals can weaken professional collegiality. As trust facilitates open communication and collaborative practice that is essential for achieving positive patient outcomes,\textsuperscript{176} loss of trust will be detrimental to attaining this goal.

This negative impact may also extend to organisational trust, given that employers have an obligation to report notifiable conduct from which they cannot be exempt. Historically, health care institutions have demonstrated poor managerial decision-making when faced with the task of addressing complaints relating to professional competence.\textsuperscript{177} It is difficult to predict with accuracy whether mandatory reporting will impact positively on institutional processes designed to deal with notifications, but unless they do, institutional trust may also dissolve only to be replaced with mistrust or distrust. Under these circumstances, institutional values predicated on safe patient care and positive outcomes are unlikely to be incorporated into practitioner behaviour.

The unique relationship between health care practitioners and the state that is based on a social contract similarly relies on trust. However, when circumstances conspire to weaken this trust, the state may take steps to rectify this.\textsuperscript{178} This requires the state to form empirical assumptions about what measures enhance rather than diminish trust.\textsuperscript{179} While the state appears to have determined that mandating that health care practitioners report notifiable conduct, it has been suggested that these directives actually serve to weaken trust.\textsuperscript{180} Additionally, the effectiveness of any measure will be negated if it is inadequately resourced and supported. As a consequence, trust in the ability of the state to ensure the protection of the public through the implementation of mandatory reporting may be compromised. Ultimately this, too, may impact negatively on positive patient outcomes.

While the introduction of mandatory reporting may appear to address the significant concerns relating to the practice of incompetent health care practitioners, a more critical examination of the requirement demonstrates that the obligation has the potential to damage trust relationships that are essential for achieving positive patient outcomes. It is essential therefore that implementation of the legislative obligation be closely monitored to ensure that these negative consequences are brought to light and addressed.

\textsuperscript{173} Australian Health Ministers Advisory Council Governance Committee, n 5, p 51.
\textsuperscript{174} Calnan and Rowe, n 7, p 115.
\textsuperscript{175} Donkin, Smith and Brown, n 160, p 133.
\textsuperscript{176} Calnan and Rowe, n 7, p 115.
\textsuperscript{177} Hindle et al, n 115, p 8.
\textsuperscript{178} Abelson, Mill and Giacomini, n 3 at 63.
\textsuperscript{179} Hall, n 67 at 161.
\textsuperscript{180} O’Neill, n 70.