ASOS

Australian Society of Orthopaedic Surgeons

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ASOS response to Consultation Draft Guidelines for the provision of relevant services (health and related services)

Reference material

ASOS has examined the following documents related to the above.

- Consultation Draft Guidelines for the Provision of Relevant Services (Health and Related Services) [The Guidelines]
- Clinical Framework For the Delivery of Health Services – Work Safe Victoria [CFDHS]
- Value-based Healthcare Outcomes Framework For the NSW Workers Compensation and Motor Accident Injury/Compulsory Third Party Schemes, 28 July 2021 [VBHOF]
- State Insurance and Care Governance Regulation 2021 (under the State Insurance and Care Governance Act 2015)
- State Insurance and Care Governance Act 2015 No 19

Executive summary

ASOS supports effective and efficient administration of compensable injury schemes and will make recommendations to that effect where it believes current proposals are unworkable and contrary to public safety.

In this submission ASOS outlines substantial reasons why the Guidelines should not be implemented in their current form. In summary, they will lead to a deterioration in the delivery of patient care, not an improvement.

ASOS' objections to the Guidelines

ASOS cannot support the guidelines in their current form for the following reasons.

1. The use of the term "guidelines", although consistent with the originating legislation, implies to the reader policy guidance, rather than legal directives. "The guidelines" do not indicate that they are in fact legal, enforceable, and in effect mandatory directives yet the word "must" is used 28 times in "The Guidelines". This raises confusion in comparison with other clinical guidelines, which are provided for guidance and consideration only.

Clinical Framework For the Delivery of Health Services (CFDHS)

2. 26. (a) of the guidelines requires that relevant services must be delivered in accordance with the *Clinical Framework For the Delivery of Health Services* (CFDHS).
3. The CFDHS is a publication of Work Safe Victoria and contains the following clauses within its disclaimer. *"Whilst every effort has been made to ensure the accuracy and completeness of the Clinical Framework, the advice contained herein may not apply in every circumstance. Accordingly, the TAC and WorkSafe Victoria cannot be held responsible, and extends no warranties as to:*
    - *the suitability of the information for any particular purpose; and*

- *actions taken by third parties as a result of information contained in the Clinical Framework for the Delivery of Health Services".*

4. The CFDHS contains no endorsements by any medical college, and it is not known where this framework sits in the current raft of legislative obligations covering medical practice.
5. One of the principles of CFDHS, which is primarily designed as a tool to assist claims managers to determine if a treatment was reasonable and necessary, is the instruction (under these guidelines, a direction) to medical practitioners to adopt a "biopsychosocial approach".
6. However, according to one of the parties to the CFDHS framework, such a principle must be exercised with caution. *"The intent of the biopsychosocial approach is to combine the biological and psychosocial factors into a holistic consideration. Claims managers should exercise caution in applying this principle to the question of whether treatment is reasonable to obtain in the circumstances. The idea of reasonableness involves objectivity.* ***A reference to the circumstances raises subjective factors but these are intended to be related to the nature of the injury, and not to details of the personal life of an applicant*** *(Re Jorgensen and The Commonwealth [1990] AATA 129)."*[1]
7. The above judgement shows the complexity of applying concepts such as a "biopsychosocial approach". It is beyond comprehension that a medical practitioner will be mandated by the guidelines/regulations to adopt an approach for which the Commonwealth government is urging caution. Clearly such approaches are designed for consideration by claims managers and are not designed to be legal directives or mandatory guidelines for medical practitioners.
8. This CFDHS framework states that *"This publication is current as at June 2012 and replaces and supersedes all previous versions of this publication."*
9. Hence this CFDHS framework is now 11 years old and can hardly claim to be current practice.

Value-based Healthcare Outcomes Framework (VBHOF)

10. The legal directives demand at 26. (c) that services must be delivered in accordance Value-based healthcare. This is defined at footnote 2 as the *Value-based Healthcare Outcomes Framework for the NSW Workers Compensation and Motor Accident Insurance Schemes* (VBHOF).
11. The VBHOF, as acknowledged by SIRA, has no legal or clinical status. It represents a theoretical and aspirational concept designed to raise issues of cost and efficiency in the consciousness of relevant service providers, including medical practitioners. SIRA describes the VBHOF as follows [bolding added]:
    - *SIRA* ***considers this framework to be aspirational*** *and that the supporting data collection, monitoring and evaluation capabilities will* ***need to be built over time****. This document is therefore published as a* ***statement of intent*** *to guide* ***further co-design and implementation****. SIRA's intention is that the framework* ***continues to evolve*** *in partnership with scheme participants.* (1.)

[1] https://www.comcare.gov.au/scheme-legislation/src-act/guidance/applying-clinical-framework#300-4

- *The framework defines a set of outcomes to be delivered for healthcare that is provided within the personal injury schemes regulated by SIRA, and a series of* ***aspirational metrics*** *by which progress towards these outcomes can be measured and assessed.* (1.1)
- *As SIRA is in the early stages of co-designing its value-based healthcare transformation, not all aspects of the framework are readily quantifiable. Accordingly, this document contains* ***a list of aspirational metrics****. SIRA plans to partner with the sector to* ***validate and further co-design the proposed metrics*** *to support the framework.* (2.3)
- *The proposed priority metrics across the Horizons 2 and 3 are included in Table 6 below. These* ***metrics are largely aspirational*** *and have been included to illustrate the types of information SIRA intends to utilise to support the health outcomes framework in the future state.* (4.4)

12. **It is contrary to the principles of administrative law and natural justice to create a legal obligation for an individual to comply with a theoretical concept, open to wide and changing interpretation. A document that must be complied with should have ascertainable obligations and the framework is so vague and so subject to change that it is not possible to know what the obligations are.**
13. Furthermore, the VBHOF contains a disclaimer, advising that the publication "*does not represent a comprehensive statement of the law as it applies to particular problems or to individuals, or as a substitute for legal advice. You should seek independent legal advice if you need assistance on the application of the law to your situation.*"
14. ASOS has concluded that the CFDHS and VBHOF frameworks are instruments designed for claims managers to determine what is reasonable treatment and are not appropriate instruments to guide the clinical decision-making of fully qualified appropriately registered medical specialists with full legal duty of care to patients they treat.
15. Medical practitioners are required to have all treatment of compensable patients approved unless treatment is undertaken in emergency situations. Hence, scheme agents are legislated to determine whether treatment should be approved. ASOS believes their role as gate-keepers should not be undermined.
16. The role of agents could be supported by SIRA issuing a clear statement as to what treatments it considers to be "low value" and hence not covered under the scheme by insurers. In doing so, SIRA will rightfully take full responsibility for any adverse events arising from its decisions, leaving clinicians to treat patients in accordance with their diagnosed clinical needs and the clinician's legal duty of care.

Non-compliance with guidelines

17. Non-compliance with the Guidelines creates a "*circumstance in which SIRA can issue a direction*". There is no explanation as to how SIRA will determine that a PSR is non-compliant. The broad delegation of powers and the re-definition of "authorised persons" lead to the logical conclusion that this will be a subjective individual decision on the part of a public service employee so delegated. Given the implications, including irreversible reputational damage, and penalties that will flow from a directive being issued by SIRA, it is

incomprehensible that this power could be exercised without due process prior to action being taken. (See Recommendation 2 to overcome this problem.)

18. The Guidelines state at point 21. (a) that services cannot be provided by an RSP who has "*had their registration or licence under any relevant law, their accreditation or registration by, or membership of, a self-regulating professional organisation, limited or subject to any condition as a result of a disciplinary process or been suspended or disqualified from practice".*
19. Unfortunately, in reality, many disciplinary processes against medical practitioners are not black and white, or speedily resolved. It is possible for a medical practitioner to have a chaperone appointed whilst a complaint is being investigated, for which the medical practitioner may in time be exonerated. i.e., conditions on registration can be part of the investigation process and not indicative of the guilt or innocence of the medical practitioner.
20. Furthermore, in point 21. (b), a PSR cannot provide services if they have "*had a complaint upheld about them or action taken by insurance, compensation or health authorities, government agencies or statutory bodies regarding their conduct"*. This directive makes no distinction between serious complaints impacting on clinical safety and minor complaints arising from allegations that have no clinical consequences.
21. Under point 21. (c), a PSR cannot provide services if they have "*been convicted of any criminal offence or have any pending criminal charges".* According to Sydney Criminal Lawyer Ugur Nedim, "*There are thousands-upon-thousands of types of criminal offences in NSW, and it is unlikely that there are many of us that haven't committed a crime at some point in our lives*" (*Which offences can give me a criminal record?* nswcourts.com.au). Again, the Guidelines make no distinctions between serious criminal offences and those that are unlikely to have any impact on the ability of a medical practitioner to provide safe and effective medical care. The recent dismissal of thousands of criminal offences created during Covid by the NSW courts is a word of caution about an unjust application of what should be an accepted safeguard.
22. Under point 21. (c) a PSR cannot provide services if they have had *"any civil proceedings lodged against them or their practice".* This means that a medical practitioner who is in a legal dispute over a divorce property settlement or a legal dispute with a neighbour over a boundary fence must cease treating compensable patients. Again, the Guidelines have not allowed for severity of the civil proceedings and their likely impact on medical practice.
23. Where such broad-brush powers are assumed by the regulator, the potential for abuse of process and unjustified denial to patients of qualified, quality medical services escalate.
24. Natural justice requires the prevention of abuse of process through appropriately targeted regulations rather than reliance on appeals processes after the fact. Appeals processes, whilst necessary, are costly and lengthy and in many cases incapable of fully redressing injustice for any party involved.
25. It is not clear in point 22. of the Guidelines whether registrars would be precluded from assisting surgeons under this regulation. Registrars and fellows are valuable members of a surgical team and should not be precluded from participating in this capacity.
26. The 7-day notification principle in point 23. of the Guidelines is unrealistic and unfair. The issues referred to are serious and would require any medical practitioner to consult with legal advisers to obtain relevant facts for an appropriate response.

Open-ended obligation to supply information

27. Point 24. grants SIRA unlimited rights to demand an unlimited amount of information, in multiple undefined formats, and is totally contrary to the principles of administrative justice. Medical practitioners do not have the ability of public servants to be constantly engaged in administrative tasks. Any administrative demands must fit within the clinical context.
28. ASOS believes that a significant number of our members would agree with the comments of a senior orthopaedic surgeon who stated:
    "***This proposal [the directive to comply with the Frameworks] from SIRA takes the simple primary aim of taking an injured person and guiding them back towards normality and totally convoluted this aim. The desire to use metrics that are currently not defined will consume money and time …. There is no structure that will create and eventually collate these metrics into meaningful data. It suggests monthly reports from all involved in patient care as well as patient, employer, and agents. Research is great for guidance as long as there is a clear hypothesis to pursue. This is not evident in this proposal. This is …. a value-based model for health care without any clear idea of why and what we are measuring****."*
29. Regarding Point 26. of the Guidelines, as stated previously, the Clinical Framework has no clinical standing and is an incomplete, conceptual document which in no way can guide clinical care. Clinical services must be delivered in accordance with accepted clinical protocols. Loading medical practitioners with additional obligations, which have no direct and immediate benefit to the patient, is an unnecessary complication to the clinical therapeutic process, with no liability to the third party imposing these conditions.

Open-ended obligation to be involved in training

30. Point 27. gives SIRA the right to impose unlimited training obligations on any medical practitioner treating compensable patients at the medical practitioner's own expense. This open-ended obligation has the potential for SIRA to organise training consultants at costs (of time and money) over which the fully qualified medical practitioner has no control. This open-ended approach to spending medical practitioners' money without approval (given that the training is compulsory) is in direct contrast to SIRA's calls for restraint by medical practitioners on treatment costs.

Open-ended obligation to engage in reviews

31. Point 28. allows insurers and SIRA to instigate multiple reviews at any time for any reason at the cost of the medical practitioner without due process. This would mean that a surgeon would have to cancel lists and abandon patients to comply with a review process "*in the form, timeframes and manner required by SIRA from time to time*".

Obligations to engage "support team"

32. Point 29. does not quantify what is a reasonable request from the "support team". Presumably these requests could be made on a weekly basis, meaning that the medical practitioner is continuously involved in briefing third parties at the medical practitioner's expense.

Provision of no charge reports

33. Regarding Point 39. (d). The provision of reports to insurers and GPs at no cost to the insurer was part of the agreement between ASOS and WorkCover for the 150% of AMA fee. That agreement is no longer in place, and it is now reasonable that our members be able to charge for a preliminary report, as per other states. The demand for free services by SIRA represents a further reduction in fees payable for treating compensable patients.

ASOS' recommendations

Under current regulation, medical practitioners who treat compensable patients must have their treatment approved by scheme agents. Therefore, all treatment that takes place has been approved by agents on behalf of the regulator.

In light of this, ASOS makes the following recommendations.

1. That the draft Guidelines (legally enforceable regulations) as presented be discontinued and that a new set of Regulations be drafted which includes the following:
    a. No compulsion on any medical practitioner to apply the Clinical Framework for the Delivery of Health Services (CFDHS) or the Value-based Healthcare Outcomes Framework (VBHOF).
    b. All reference to these aspirational and theoretical concepts be for consideration only.
    c. Any framework so originating contain a disclaimer stating clearly that this framework does not in any way override any clinical considerations or protocols as accepted by the Royal Australasian College of Surgeons (RACS) and Australian Orthopaedic Association (AOA).
2. That any decision to issue a directive to a medical practitioner can only be taken after due consideration by a medical advisory committee comprising an independent qualified legal practitioner and 4 practising medical practitioners, at least 2 of whom are from the same specialty as the medical practitioner in question. The chair of said committee to be the independent legal practitioner. All members of the committee to be paid for attendance and consideration of the matter.
3. Nothing in this model should prohibit the issuing by SIRA of a notice of concern regarding behaviour considered to be a substantial breach of professional obligations to patients compensable under the scheme, with the appropriate right of response.
4. All directives to be authorised by the CEO of SIRA only. It is essential that the CEO of SIRA takes full professional accountability and responsibility for actions which have the potential to severely damage the reputation of a medical practitioner.
5. That the range of criminal offences that would give rise to a medical practitioner being unable to provide services to the scheme should be clearly defined so as to eliminate process offences and offences which would not impact on patient care.
6. That the range of civil disputes that would give rise to a medical practitioner being unable to provide services to the scheme should be clearly defined so as to eliminate civil disputes that are unlikely to impact on patient care.

7. That a clinical references committee of qualified medical practitioners be established, comprising those specialties which have most participation in the scheme (orthopaedic surgeons treat around 60% of all workplace injuries).
8. That the above committee be appointed to decide what relevant training should be requested of medical practitioners treating patients in the scheme and what the appropriate reimbursement rates for such training should be.
9. That the above committee be appointed to determine what audits requested by insurers of compensable patient records should be approved and what reimbursements should apply for the administrative costs of same.
10. That the above committee be appointed to determine what is a reasonable request by third parties to the doctor-patient transaction and under what circumstances such requests are clinically acceptable, given a patient's enduring right to the confidentiality of the doctor-patient relationship.

Conclusion

The regulator of the NSW Workers Compensation (WC) and Compulsory Third Party (CTP) schemes, the State Insurance Regulatory Authority (SIRA), has determined to change its role from regulating the above schemes to managing the healthcare objectives of the above schemes using formulae labelled "Clinical Framework for the Delivery of Healthcare Services" and "Value-based Healthcare Outcomes Framework".

Under these frameworks, a qualified medical practitioner, including a qualified surgeon who is licensed to treat patients in Australia, would be required to subject all clinical decision-making to a formula (V=O/C, where V=Value, O= Outcomes and C= Cost and resources). This formula is known as "Value-based Care Outcomes Framework".

In addition, medical practitioners would be directed to adhere to the principles of a Clinical Framework developed in 2012 by TAC Vic, which includes 5 principles. No clinical evaluation of the use of these frameworks has been presented and the frameworks carry no endorsement from any medical college.

ASOS maintains that imposing conceptual formulae on clinical decision-making is dangerous. It adds complexity and ambiguity, and places undue pressure on medical practitioners who are legally liable for outcomes and who are already dealing with associated complexities of treating compensable patients.

ASOS' recommendations support the responsibilities of SIRA to remove from the scheme those medical practitioners and other providers who are clearly acting contrary to public safety and acceptable administrative practices.

It should be remembered that AHPRA already has the ability to remove a medical practitioner from active practice if it believes that practitioner represents a danger to the public. The question is why this power is not sufficient for SIRA to rely on. This question has not been answered in the Guidelines.

Currently all medical treatment for compensable patients must be approved by a scheme agent prior to treatment (except in emergency situations). Hence regulators already have strict control over the

type of treatments that can be delivered and have the ability to determine what if any treatments should not be covered in the scheme, including those they consider to be of "low value".

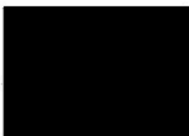
ASOS' recommendations are for the creation of a clinical advisory committee that can act as a guide and reference point to ensure that administrative decisions that impact on the reputation of medical practitioners meet peer review principles and allow for the dynamic environment that medical practitioners operate in.

ASOS believes that no compensable scheme can meet its objectives unless it can maintain the confidence and co-operation of medical practitioners who treat compensable patients. This co-operation is maximised when the scheme is seen to be administering its responsibilities in a just and fair manner and paying reasonable remuneration for the total costs involved in meeting scheme requirements.

Under current legislation, medical practitioners who are engaged in treating compensable patients as private medical specialists are not employees of WorkCover or SIRA. As independent medical practitioners, they supply services to patients who contract with them on the basis that these services will be reimbursed by WorkCover or CPT.

The proposed guidelines aim to turn this relationship on its head and establish an additional, ineffective, and complex layer of regulation. Evidence of this increased control is the fact that the word "must" is used 28 times in the proposed Guidelines. This change in direction would have significant implications in a range of areas, including liability for outcomes and deemed employment status and the application of the *Independent Contractors Act 2006* to any agreement that has significant levels of control by SIRA.

ASOS is committed to working with regulators to achieve world's best practice in the delivery of medical and surgical care and the administration of compensable schemes.



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