The Royal Australasian
College of Physicians

Australian Health Practitioner Regulation Agency

Public consultation paper on the definition of 'practice'

Submission by The Royal Australasian College of Physicians

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Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the definition of *'practice'* (practice) used by the Medical Board of Australia. The RACP has received considerable feedback from its Fellows on this issue over the last 12 months.

The RACP considers that the definition of practice should advance the purpose of the *Health Practitioner Regulation National Law Act 2009* and accordingly a careful balance needs to be struck between the objectives and principles of that Act.

It is important to note that the definition of 'practice' extends well beyond the provision of direct clinical care. In situations where a medical practitioner undertakes a non-clinical role there may be a potential risk to the public should the medical practitioner not have the appropriate registration for that role. However, the breadth of the current definition of *'practice'* means that in some cases there is an unnecessary restriction on the activities of medical practitioners with non-practicing registration, without a corresponding benefit to the public in terms of risk reduction.

Relevant factors to consider when determining if a non-clinical role presents a risk to the public include whether the medical practitioner uses the title "doctor"; whether the role in question is supervised by a medical practitioner with a practicing registration and the scope of professional knowledge involved. Some non-clinical roles are examined in more detail in Appendix 1 to this submission.

Taking the above into account, the RACP proposes the following definition of practice:

Practice means carrying out roles in which individuals use their skills and knowledge as health practitioners:

a. in the exercise of that profession; or

b. in non-clinical settings in any way that impacts on the safe, effective delivery of health services where:

   (i) the role is combined with a role mentioned in paragraph (a); or

   (ii) the individual represents, or allows him or herself to be represented as, a member of the health care;

   but does not include roles where the use of the individual's skills and knowledge is:

   (iii) constrained by statutory or other legal responsibilities; or

   (iv) otherwise only incidental to their primary role.

Should the Medical Board of Australia decide to retain the current definition (option 1), the definition would benefit from some clarification to ensure that the meaning is unambiguous. Option 2 is more strongly focused on the "safe, effective delivery of health services" but is apparently unlimited in extent.

Introduction

The RACP welcomes the opportunity to comment on the definition of practice used by the Medical Board of Australia.

This submission comprises the following:

- Part 1 General observations
- Part 2 Answers to specific questions asked in the consultation document
- Part 3 Comments on the options provided
- Appendix 1 Non-clinical activities and
- Appendix 2 Extracts of comments received from RACP Fellows on this consultation.

Part 1 General observations

The term "practice" relates to a number of key obligations under the *Health Practitioner Regulation National Law Act 2009* (Act). Three examples of these are the requirement for a registered health practitioner to have "appropriate professional indemnity insurance arrangements ... in force in relation to the practitioner's practice" (s 129), the misconduct provisions (see eg Pt 8 Div 2) and the prohibition on practice by those with a non-practicing registration (s 75). The scope of these provisions, and many others, turns on the meaning of "practice", however the Act does not define that term.

Section 3 of the Act sets out the objectives and general principles of national registration. The objectives include:

> *(a) [T]he protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered*
>
> *...*
>
> *(c) to facilitate the provision of high quality education and training of health practitioners*
>
> *...*
>
> *(e) to facilitate access to services provided by health practitioners in accordance with the public interest*
>
> *(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.*

The guiding principles of the national registration and accreditation scheme include that:

> *(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.*

The above objectives and guiding principle are especially relevant to the definition of "practice".

Common definition not necessary

The National Boards, including the Medical Board of Australia, have the power to develop or approve standards, codes and guidelines for their respective health professions (s 35(c)). The discussion paper notes that in order to provide an efficient and effective scheme for all health professions regulated under the National Law, the National Boards have endeavoured to align standards, codes and guidelines that are common to each profession. One aspect of this is that the National Boards have agreed on a common definition of "practice".

The definition of practice as set out in a number of registration standards is very broad:

> *Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.*

It is open to the Medical Board of Australia to adopt a different definition of practice if it required a change to the existing definition that the other National Boards did not accept. While it is useful to keep the forms and processes of professional registration, including disciplinary mechanisms, consistent between the National Boards, each profession remains different and needs to be considered separately. This is both as a matter of fact and implicit in the structure of the Act, which contemplates different requirements for different health professions.

Some issues to consider

The RACP agrees that the definition of practice cannot be confined to activities involving direct clinical care. It is clear that there are situations where, if a medical practitioner undertakes a non-clinical role, there is a potential risk to the public if that medical practitioner does not have an appropriate registration. However, the current definition is very broad and potentially covers many roles that can be lawfully carried out by individuals who are not members of a health care profession. This includes health administration, policy development and regulatory roles. The definition of practice should recognise that there are situations where a medical practitioner with a non-practicing registration can also carry out those roles without risk to the public. This is more fully described below.

The following issues that are relevant to defining "practice" under the Act are included for consideration.:

- **Use of the title "doctor"**

Whether individuals use the title "doctor" may have a bearing whether they are practicing as a medical practitioner. Many of the roles outlined in the final sentence of the definition could be, and often are, carried out by people who are not medical practitioners. Potentially, however, there may be an implication that a person who is holding a position as "Dr X" is bringing clinical skills to bear on that role. There may also be an implication that that person is keeping up to date with medical education.

In some circumstances that may pose a risk to the public if there is reliance on that person as a medical practitioner.

However, this issue is complicated by the fact that a person may be entitled to use the title "doctor" through:

- having earned a higher degree;[1] or
- being a member of another health care profession. While non-medical health care professions under the Act are advised to make it clear that they are not medical professionals (usually by indicating their profession in brackets after their name) this may not be completely effective, especially if the representation is verbal.

In addition, the consultation paper notes that:

> *The courtesy title "Dr" is not a protected title and unregistered health practitioners may use the title, as long as in doing so, they do not induce a belief that they are a registered health practitioner.*

These people may carry out a variety of roles, including roles that have some connection with clinical care, without apparently triggering s 116 of the Act (claims by persons as to registration as health practitioner).

Thus a definition of practice needs to strike a balance between:

- protecting members of the public who may be misled by the use of the title "doctor"
- allowing medical practitioners to carry out roles that others, including those entitled to use the title "doctor" may carry out.

It should also be noted that a person may be the holder of a MBBS or equivalent degree without using the title "doctor". In these cases, the risk to the public from being misled will be less.

- **The scope of professional knowledge**

Professional knowledge includes knowledge and experience of the health care system as a participant, research skills and knowledge of preclinical sciences, and this may be applied in a non-clinical context. To a lesser extent, this may also be true of clinical knowledge. It is unreasonable to restrict use of this knowledge where there is no real risk to patients.

These issues can be examined more fully in the context of the various roles that are listed in the current definition of practice. A table of these is included in Appendix 1 to this submission.

A proposed definition of practice

The RACP proposes the following definition of practice:

Practice means carrying out roles in which individuals use their skills and knowledge as health practitioners:

a. in the exercise of that profession; or

b. in non-clinical settings in any way that impacts on the safe, effective delivery of health services where:

   (i) the role is combined with a role mentioned in paragraph (a); or

[1] Some medical practitioners also have higher degrees.

(ii) the individual represents, or allows him or herself to be represented as, a member of the health care profession;

but does not include roles where the use of the individual's skills and knowledge is:

(iii) constrained by statutory or other legal responsibilities; or

(iv) otherwise only incidental to their primary role.

It would also be helpful, by way of guidance, for the Medical Board of Australia to produce a specific guideline on the definition, given its pivotal role under the Act, including a table such as the one included in Appendix 1 to this submission.

Part 2 Answers to specific questions asked in the consultation document

Question 1

It can be argued that there is minimal risk to the community if practitioners are not registered, or are registered in the non-practising category if:

(1) they do not have direct clinical contact and

(2) their work does not "impact on safe, effective delivery of services in the profession" and

(3) they are not directing or supervising or advising other health practitioners about the health care of an individual(s) and

(4) their employer and their employer's professional indemnity insurer does not require a person in that role to be registered and

(5) the practitioner's professional peers and the community would not expect a person in that role to comply with the relevant Board's registration standards for professional indemnity insurance (PII), continuing professional development (CPD) and recency of practice and

(6) the person does not wish to maintain the title of "registered health practitioner".

Are there any other factors that the National Boards should consider when advising whether or not a person needs to be registered?

Response

No additional factors need be considered. Of the above factors, number 3 is a key consideration.

Question 2

When health practitioners provide advice, health care, treatment or opinion, about the physical or mental health of an individual, including prescribing or referring, it is clear that there is a level of risk to the public. The public and the practitioners' professional peers would expect that this group of health practitioners would have the qualifications and the contemporary knowledge and skills to provide safe and effective health care within their area of practice. It would be expected that these practitioners will meet the standards set by the Board and therefore should be registered.

Do you support this statement? Please explain your views.

Response

Yes, for the reasons provided in the above statement.

Question 3

Health practitioners who are in roles in which they are directing, supervising or advising other health practitioners about the health care of individuals would also be expected to have the qualifications and contemporary knowledge and skills to do so as there is potential to alter the management of the patient/client.

Do you support this statement? Please explain your views.

Response

If this statement encompasses only situations where the direction, supervision or advice is in respect of care of specific individuals then the statement is supported, because these roles are still within the realm of clinical practice as generally understood. There is a potential risk to the public where that practitioner does not have current practicing registration.

Question 4

There are experienced and qualified health practitioners who contribute to the community in a range of roles that do not require direct patient/client contact and whose roles do not "impact on safe, effective delivery of services in the profession". Examples are some management, administrative, research and advisory roles.

Do you believe that health practitioners in non-clinical roles / non-patient-client care roles as described above are "practising" the profession? Please state and explain your views about whether they should be registered and if so for which roles?

Response

Where the role has an "impact on safe, effective delivery of services in the profession", the need for a current practicing registration depends on a number of factors discussed in the first part of this submission, but which include:

- whether the person holds themselves out as a medical practitioner in the context of that role; and
- the scope of professional knowledge likely to be used.

Whether it poses a medico-legal risk is also relevant.

Appendix 1 to this submission includes examples of these kinds of roles and an assessment of whether these would require a current practicing registration.

Question 5

Experienced health professionals are vital to the education and training of health professionals. Their roles in education have an impact on safe and effective delivery of health services both directly and indirectly.

For which of the following roles in education, training and assessment should health professionals be registered?

- *Settings which involve patients/clients in which care is being delivered ie when the education or training role has a direct impact on care, such as when*

students or trainees are providing care under the direction, instruction or supervision of another practitioner

- *Settings which involve patients/ clients to demonstrate examination or consulting technique but not the delivery of care*
- *Settings which involve simulated patients/clients*
- *Settings in which there are no patients/clients present*

Are there any other settings that are relevant and if so, what are your views about whether health practitioners should be registered to work in these settings?

Please explain your views.

Response

Where patient contact is involved, a practicing registration would be required.

Where there is no direct patient contact, the need for a practicing registration will depend on the circumstances of the case. Medical education, training and assessment is accredited by the Australian Medical Council, as the external accreditation entity for the purposes of the Health Practitioner Regulation National Law, and is overseen by universities and colleges such as the RACP. Ultimately, these entities are best placed to determine the appropriateness or otherwise of the involvement of non-practicing medical practitioners in education, training and assessment. Unnecessary restrictions would run counter to the objectives of the Act.

It should be noted that medical education, training and assessment are often provided at no cost by members of the medical profession who are retired or semi retired, to the immense benefit to the community at large.

Part 3 Comments on the options provided

Option 1

Should the Medical Board of Australia decide to retain the current definition there are a few areas that would benefit from clarification. In particular, with respect to the last sentence of the definition:

> *It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.*

If that is the intended meaning, formatting this sentence as a list (as follows) would make that meaning clear.

> *It also includes using professional knowledge:*
>
> - *in a direct non-clinical relationship with clients; and*
> - *working in:*
>   - *management*
>   - *administration*

- *education*
- *research*
- *advisory*
- *regulatory;*
- *policy development roles;*
- *any other roles that impact on safe, effective delivery of services in the profession.*

The following terms would benefit from clarification:

1. 'professional knowledge' when taken out of the clinical context loses some of its meaning. Ensuring that this expression is linked with clinical care would make its meaning clear.
2. 'client' can have different meanings depending on the context. An explanation of this term.
3. 'non-clinical' is simply defined by what it is not. It is not substantially qualified by anything that follows in the definition as currently phrased.

Accordingly, if the Medical Board of Australia favours option 1, then it should consider clarifying the definition to resolve the above problems.

Option 2

Practice means any role in which the individual uses their skills and knowledge as a health practitioner in their profession in any way that impacts on safe, effective delivery of health services.

While this definition usefully focuses on the "[impact] on safe, effective delivery of health services", it suffers much of the same problems as the original definition, for example, the term "in any way" is of apparently unlimited extent.

Appendix 1 Non-clinical activities

Scenario	Need for current practicing registration and rationale
Teaching/ examining	This would require a current practicing registration where patient contact is involved. If patient contact is not involved, the need for a current practicing registration will depend on the circumstances of the case. Medical education is ultimately accredited by the Australian Medical Council (AMC) and overseen by the universities and colleges. The issue of whether a current practicing registration is required should be determined by these entities in the specific circumstances of the case.
Research	Need for current practicing registration would depend on the level of clinical contact involved. Research involving clinical contact with patients would require a current practicing registration.
Reviewing/ authoring articles	Do not need a current practicing registration. Final publication of the article depends on the editorial board.
Medical publishing.	Do not need a current practicing registration if there are members on the editorial board with current practicing registration.
Advisory (where role involves giving health related advice such as being a member of a lead clinicians group)	Needs current practicing registration.
Providing medicolegal opinions for use in assessment of liability or damages for court and related purposes, where the current state of medical knowledge is to be used.	Needs current practicing registration. Current clinical knowledge is being used in a way that directly affects a person's legal rights. In some cases, these statements may become part of the public record (ie incorporation of evidence in written reasons for judgment).

Scenario	Need for current practicing registration and rationale
Providing expert evidence on the state of medical knowledge at some point in the past. Examples include: • Patent cases: eg the assessment of common general knowledge applicable at the patent's priority date. • Personal injury cases where the relevant events occurred years or even decades before but the harm (and thus the cause of action) was identified only recently.	Does not need current practicing registration. This work is based on historical standards of knowledge and practice, which by definition may no longer apply.
Medical administration/ management + other health related administrative/ management roles (where the role does not otherwise require a current practicing registration)	Need for current practicing registration would depend on the level of responsibility and medical autonomy held. A person working in medical administration may be constrained by budgetary, legal and higher level policy constraints. A person, whether or not they have a current practicing registration may have to make an administrative decision which is not ideal from a medical point of view, but which is fiscally responsible. Such a person may also be required by legislation to consider or act on the advice of medical practitioners with a current practicing registration.

Scenario	Need for current practicing registration and rationale
Policy development (where the role does not otherwise require a current practicing registration)	Need for current practicing registration would depend on the level of responsibility and medical autonomy held. Where there is oversight by medical practitioners with a current practicing registration, it is not practically relevant whether a person working in policy holds a current practicing registration or not. Where there is no such oversight, it may be potentially misleading for a person with non-practicing registration to hold themselves out as a medical practitioner without making their exact registration status clear (even if only internally within the relevant organisation). In such a case, they should either: • Obtain current practicing registration; or • Not hold themselves out as a medical practitioner without clarifying their registration status.
Regulatory	Need for current practicing registration would depend on the level of responsibility and medical autonomy held. Many of these roles carry statutory obligations requiring consultation and the person carrying out the role would not be free to act autonomously with respect to their role, in so far as it requires clinical judgment.

Appendix 2 Extracts of comments received from RACP Fellows on this consultation

Comment 1.

As usual, what seems simple turns complicated when put through the legal mangle. E.g. 'It all seemed so simple before we attempted to draw up a practice agreement'.

I've got an interest in this because I had to retire from clinical work for health reasons some years ago but maintained a medicolegal practice until just recently. It seemed clear to me that the shift from direct clinical care to providing independent opinions for solicitors pre-supposed continuing exercise of medical experience and knowledge for the benefit of clients (examinees, paying agents, tribunals, courts) so that I haven't had any reservations about the appropriateness of maintaining registration and fulfilling CPD requirements.

However if, some years ago, I'd moved towards administration and policy development, I think that the appropriateness of continuing full registration could have been much less clear. I could foresee a 'private' interest in continued registration, for example for repeating routine scripts. And separately, the possibility that in one's work conflicts of interest might arise between developing some macroadministrative themes and a potential for unwanted effects of same at an individual patient level -which would be beyond one's working frame of reference. In essence, a 'health economics' line of work would potentially have absolutely nothing to do with any 'doctor-patient' relationship.

A question then would be in relation to the attitude of an employer or committees to registration status? Reactions are likely to be mixed. It could come back to what one did privately in terms of registration *not* being included in the job description. With an effect too then that an employing authority would not be under any obligation for medical defence subscriptions in any package.

Members of the PBC often have to make recommendations that can adversely impact individual patients (failure to support a listing). In the UK NICE (National Institute of Clinical Excellence) the medical members of this powerful advisory panel famously disallowed beta-interferon for government subsidy for treatment for MS (because of a perceived inadequate cost-benefit profile).

I thought I would provide this input because it is a very complicated and difficult subject.

Comment 2.

I would not be in favour of narrowing the current definition of medical graduates who can be registered. Such graduates, even if not engaged in clinical practice may find themselves in situations where they have a moral duty to provide care. Two examples come to mind. In remote Australia non-practicing and retired doctors could find themselves the only qualified person to provide acute care to inhabitants of isolated communities, where there may be no other health care worker. Even where health care workers are available a Fellow of the College may have the more expertise in the appropriate circumstance to advise better management of the patient. Secondly, It is not always possible to predict regional or national catastrophes where extra medical help may be urgently needed.

I have no problem with the need for ongoing professional development, but do feel that indemnity insurance should be a personal choice for those of us who rarely if

ever engage in clinical practice and indeed may be prohibited from charging for our services as part of our limited registration.

Finally, I worry that registration procedures for senior physicians who have conscientiously cared for patients for 40 years or more may be too proscriptive, rather than prescriptive.

Comment 3.

Surely it could only be a mixed (bureaucrats and professionals) that could make a simple exercise so impossibly difficult. The system worked very well under the previous State Medical Boards. All we wanted to change was that registration was national rather than state only. This apparent simple task has led us into a dysfunctional abyss.

As I am fully retired, 25 years, whic is long enough to have lived through several systems. The first in 1985, was very straight forward and as far as I can ascertain produced No untoward consequences. The next change, about 2000, was due to a few ill thought out changes in the State Act. This required that for restricted registration, we needed to prove up to a certain standard of continuing professional education. This was relatively simple.

After all restricted registration allowed us to (a) write repeat prescriptions under certain circumstances, (b) refer oneself or close family for a specialist opinion (c) good Samaritan acts.

Then with the advent of APPRHA we were obliged to add some degree of P.I. It would be interesting to know if there has been or is pending any litigation involving the group of senior clinicians. I would like to know how one could even imagine litigation involving this group of practitioners.

Now we are told that this “unnecessary classification” will disappear after 2013.

What is to become of us after that magic date?

I can only speak for myself but I’m sure there are many others who feel the same way, “I have been a medical man for 60 years and no matter what happens to the ‘legal’ classification I will proudly remain a doctor (non-practising of course) until I die.

There is surely still a role for wisdom.

Comment 4.

In reality the only argument is about the cost of registration and whether or not people should be allowed to have a registration category which means they don’t ever use their knowledge/skills/experience (in which case what’s the point of being registered…..??).

All AHPRA really need to do is have a lower level registration cost for doctors who never see a patient (and thus there’s a lesser risk to the community). Write a script and you pay full fee.

If you’re fully retired and no longer registered and you’re asked to be a good Samaritan, then the same rules apply to you as to every other member of the community.

My management, policy and consulting tasks force me to use my medical training continuously. I can’t be a specialist medical manager and somehow pretend I’m not

being a doctor. The experience of the CEO of Bristol should have taught us all that you don't stop being a doctor. I think their definition of practice is fine. if you're not using your knowledge/skills/experience, you don't need to be registered. the professions cant have it both ways on this.

shoot me down but I really don't see what the fuss is about.

Comment 5.

I think that a watering down of the definition to be undesirable. Those practitioners who are using the skills – and qualifications - relevant to that profession should be registered, and meet the requirements and be subject to the disciplinary actions consequential to registration. I don't think we are talking of 'unintended consequences' – only unexpected consequences for certain individuals and employers. I consider the consequences to be intentional and desirable.

Comment 6.

I have already expressed my views. There should be limited registration for referral and prescribing as was the case in S.A without charge to Medicare.

Comment 7.

Thank you for the opportunity to contribute to this consultation. The definition of practice adopted by the MBA was considered by the EAG for CPD and considered appropriate for CPD purposes. It is very similar to and does not conflict with that adopted by the MCNZ. I do not have any other comments to make at this time.

Comment 8.

Retirement and medical registration

At the moment the Medical Board of Australia mandates that a doctor must go from full registration to full retirement – with no intermediate step despite this being unhealthy and a waste of medical resources for the community. I propose a 'senior active' registration category intermediate between full registration and full retirement. This category would have no direct clinical responsibilities, but other paid or voluntary medical-related roles would be possible - and the discretion of writing of repeat scripts only and the ability to refer individuals would be retained, along with a focused CPD requirement, and reduced medical registration and indemnity insurance fees.

Additional comment:

> Dear RACP Colleague,
>
> We have a concerning situation regarding older doctors who wish to give up full time practice but who want to continue to contribute to the profession as 'senior active' doctors. I have written a proposal below that addresses this issue. I would be very grateful for your support for this proposal, or if it is not acceptable in its current form, I would appreciate you suggesting changes that would meet with your approval.
>
> Medical careers, like the human life cycle, have a start, a middle phase, and a finish. Following a prolonged gestation of training, practitioners move on to

their general practice or specialist disciplines and provide clinical care to patients, education and training to junior colleagues, and administrative support to hospitals and other medical organizations over decades of hard work. At some stage the doctor starts to think of slowing down, or contemplates full retirement. These days we know that moving from full time practice to full retirement in one step is not a good thing – for the practitioner's physical health and mental health, and not for the profession either. Government policy is to encourage older workers and professionals to stay in the workforce longer, beyond current retirement age if possible.

Yet, despite this encouragement for older professionals to remain active in their field, in the medical arena we have a situation that is hostile to this happening. The new Medical Board of Australia (MBA) has no registration category that allows older doctors to remain registered after giving up full time general or specialist practice. Older doctors are forced to go straight into full retirement. They are prevented from continuing to practice in a limited capacity as a doctor. This situation denies senior doctors the advantages of a graduated progression to retirement. It also means that these doctors cannot use their accumulated medical knowledge, skills and wisdom for suitable work such as teaching, examining, mentoring, tutoring, assisting with tribunals, and advising government, non-government, voluntary and private/business organizations on medical matters, as well as being a body of registered practitioners available to assist in times of local, state and national disasters. This denies the community a precious medical resource that otherwise would be available.

It is time this gap was filled. A new category of medical registration – termed 'senior active' – needs to be developed by the MBA.

I propose the following model for the 'senior active' category. The description is based on the MBA Limited Registration – Public Interest category (MBA Registration Transitional Plan – Medical Practitioners – Item 17, 30.6.10).

1. Senior active registration would be a limited class of registration, but it would have unlimited duration.

2. The doctor would remain on the register of medical practitioners.

3. The doctor could participate in activities (either remunerated or as a volunteer) that use his or her medical knowledge, skills or wisdom outside the care of individual patients such as teaching, examining, mentoring, tutoring, assisting with tribunals, and advising government, non-government, voluntary and private/business organizations on medical matters, as well as being available to assist in times of local, state and national disasters.

4. The registrant may, without fee or reward, refer an individual to another medical practitioner (in fully registered medical practice) for the purposes of providing health care. The registrant may, without fee or reward, prescribe a therapeutic substance in extenuating or emergency situations under the following conditions: (a) the prescription involves the renewal of a prescription provided by another medical practitioner (in fully registered medical practice) within the previous period of six months and does not relate to a drug of addiction within the meaning of the relevant Poisons act, or (b) the prescription is provided to an individual who requires temporary relief or first-aid pending attendance on that individual by another medical practitioner (in fully registered medical practice), and (c) if the registrant undertakes limited prescribing as outlined in (a) and (b) above, the registrant must, within a 12-

month period preceding the date on which the prescription is prescribed, have undertaken professional education activities relating to the prescribing of therapeutic substances.

5. Maintenance of this category of limited practice would require an annual medical check by a general practitioner for registrants over the age of 80 years.

A category of this nature would allow senior doctors to continue to contribute to the profession after leaving full time general or specialist practice. This would be good for senior doctors, the profession, and the community.

This category allows doctors the limited capacity to refer individuals to other medical practitioners, and a limited capacity to prescribe therapeutic substances. It is possible that the doctor could exercise discretion and use this limited capacity to prescribe for him or herself, or for immediate family. This level of discretion is available to all doctors in fully registered medical practice despite the general advice from the AMA and medical boards that doctors should not treat themselves or their immediate family except in emergency or extenuating circumstances. Given the limited nature of referral and prescribing allowed in the senior active category, and the requirement to undertake relevant professional educational activities in prescribing, I cannot see any reason to deny this discretion to senior active doctors. To do so would raise the question of age discrimination.

In my view the success of the category will depend on how restrictive the practice definition is and how much it will cost doctors to be registered in this category. The three major costs for this category will be the medical board registration fee, the indemnity insurance fee, and professional education expenses. If the total of these can be kept within reason (say well below $1000pa) then the category may be an attractive place for senior doctors to maintain their registration after leaving full registration status in their discipline and before moving to full retirement.

Comment 9.

My understanding about practice in medicine to be specific:

1- Practising the same or relevant job so to carry a registration the person has to have knowledge and experience as well as the right qualification from approved country so in medicine he/she has should be able to practice clinical with direct patients' care to help patients/clients in terms of the right diagnosis and treatment

2-Should be able to contribute to teaching, research, quality assurance and when needed take part in policy and pathways development to help junior colleagues practicing effectively and safely. I am not sure about every practitioner should have knowledge in management but it is good to communicate effectively with the non clinical management as all working towards a very good the patients' care

3- Safe medical practice and safe relevant procedures to help patients with ensuring zero harm

4-Should have documented CMEs up to update and prepare to change wrong/old practice once new development or changes occur in science (no fixation)

Comment 10.

I am one who contacted the college re MOPS points and wrote to the president. I pointed out that I retired entirely from private and hospital consultative and teaching roles and that I only run a bone density machine from which I report the results. I was told that I had to maintain full registration and that with respect to MOPS to contact the relevant government departments. I did so and eventually after months of phone calls and getting to more and more senior persons, I was told that the government relied on the college for their advice and I should contact the college. The proverbial catch 22 situation was therefore achieved.

Whilst full registration seems reasonable (though probably not sensible), I think it is ridiculous that I should need to acquire 100 MOPS points per year. To find a source of 100 points for the maintenance of knowledge of bone density reporting is impossible to find and therefore the vast majority of my MOPS points are totally irrelevant to my practice. Perhaps 10 to 20 but no more would be a sensible compromise, particularly since I have been reporting them for 20 years.

Comment 11.

we faced a similar issue in New Zealand and in the end I think there was acceptance that the definition of “practice” should only include those situations where there might be some risk to the health or safety of individuals or the public. This achieved the purposes of the national registration law without being unreasonably burdensome.

Comment 12.

This has been a big issue [in New Zealand] – the MCNZ simply uses a similar stance that if you are using the knowledge/skills obtained getting your MBChB then you are practicing medicine. Vocational scope is the second test. Eg If a doctor from overseas not registered but in health management they are deemed to be practicing without an APC by MCZN – fine and/ or gaol is the penalty.

Comment 13.

The call for views about what constitutes clinical practice is timely given that the National Health Reform mandates clinician involvement.

If we go back 40 years I hazard that most clinicians had a shared definition of practice. Even today I suspect our patients understand what the practice of clinical care is. I wonder if the confusion crept up on us, almost unawares, as health delivery became more complex and morphed, without cognisant planning, from the sole practitioner into a systems model of supply with many hands touching the system.

I would like to propose that practice is the skill of tailoring the systems to the individual patient's needs. It encompasses both those who touch a patient and those who do not. The discriminating activity is that the practicing clinician tailors or interprets the system for the single patient as opposed to fitting what is possible to the greatest number of patients. I do not mean to exclude the latter considerations from the practice of a clinician but a practicing clinician is one who has carriage of incorporating these imperatives into other sources of knowledge and skills to come up with a health plan tailored to a specific individual.

This concept fits with the reality of indemnity insurance where final accountability for a patient rests with the practicing clinician.

Comment 14.

My feeling is that there needs to be some allowance for doctors at the end of their career working part-time. Experienced practitioners constitute a valuable resource for locums, contract work and teaching but there is no allowance in the present rules. Given the increasing demands and lack of resources to cope (especially in the public system) I feel this is short-sided and lacks vision, or understanding of the roles that "near retirement" doctors in good standing can offer.

The Board burnt much good-will with the poor handling of the original registration process.

Let us hope they show some wisdom this time round.

Comment 15.

[comments also provided to AHPRA]

"My comments relate specifically to the medical registration category “Limited prescribing and referral only”.

Individuals in this category are precluded from any other form of practice so that under the current definition of practice they are unable to teach in any setting, participate in conferences, review scientific articles or publish material related to the practice of medicine.

My whole career was focussed on teaching and examining medical students. Now that I have retired I continue to receive invitations to teach and examine medical students on a pro bono basis. These activities would take place in settings which involve patients to demonstrate techniques but not delivery of care, settings which involve simulated patients or settings in which there are no patients present. The current definition precludes me from doing this.

Since I retired I have reviewed abstracts submitted for presentation at conferences and have chaired conference sessions. I should not have done this.

I am currently a co-author on a paper analysing the outcome of treatment of a large number of patients about half of whom I treated some years ago. The paper is about to be submitted for publication. Two of the co-authors are not registered medical practitioners. The current definition indicates that I should not participate in this activity

Most of the activities described above are often carried out by biomedical scientists who are not registered as medical practitioners. It seems irrational to preclude medical practitioners who have limited registration from those activities.

I would suggest that activities which do not involve direct patient care should be excluded from conditions of registration."

Comment 16.

... I would be surprised if there would be any dissension about the paramount emphasis on the health and safety of patients. I accept that changes have been made with underlying good intentions. I suspect that AHPRA has been surprised and

embarrassed at the response to the “current” definition of practice but I am reminded of a comment by a U.S. Judge recently paraphrased in the press –“Beware of those in authority with good intentions”.

The matter clearly revolves about the meaning and usage of words. In my opinion the recent attempt to change the long accepted definition of practice to cover a range of eventualities has been arbitrary, unnecessary and divisive. I believe the brief re-statement of Practice in Option2 of AHPRA’s Public Consultation Paper is quite sufficient.

I take issue with some of the terms used in the discussion (while I accept that they may have been used with good intentions).

E.g. :”current” may be technically correct but in my view would be more accurately replaced by the phrase “recently revised and extended” definition of practice…

In my opinion “broad” is an adjective better applied to the traditional (Option 2) definition of practice. In the context it has been used it would have been more accurate to have used “extended and detailed” rather than “broad”.

Comments you receive will inevitably reflect the experience of the Physicians making them and my own case is no exception. My entire professional life as a physician (General/Diabetes) was spent in a public hospital (Modbury Hospital) from 1973 until 2000 and I gradually tailed off my private practice until September 2010. I had joined SAPMEA as part-time Medical Director in 2001 and will leave at the end of this calendar year. My responsibility has been to oversee the introduction of 1-Day Clinical Workshops on specifically requested topics held in country locations throughout South Australia. My main contribution has been to recruit speakers known to be articulate, knowledgeable and up-to-date and build suitable programs around them. I have regularly acted as Facilitator (to keep proceedings to time and if necessary occasionally ask the “dumb” question) but at no time during 10 years have I done any of the teaching. (On most occasions I have been the student).

Wording of the document for re-registration in September 2010 suggested I would need to be fully registered at considerable expense and also to engage in CPD, which in the circumstances seemed quite unnecessary. With the full knowledge of the SAPMEA Board I declined to re-register and have continued as Medical Director until now. I intend to make similar comments to AHPRA in response to the Public Document.

Comment 17.

Since retiring from standard hospital practice well over 10 years ago, I have continued to give medical and organisational and strategic advice to a large Aboriginal-run not-for-profit organisation (The Unity of First People of Australia) that runs chronic disease suppression and control programs and operates health promotion strategies at the individual and community levels in remote parts of the Kimberley and Pilbara Regions in the far north of WA.

This also involves community-based health screening (for chronic diseases and their risk factors) in many remote communities. This is done with collaboration with diabetes specialists and medical scientists from Perth and from regional hospitals and laboratories in Perth and in regional centres. This data collection, collation, analysis and reporting would normally be classified as “research”. That has led to several international publications and to presentation of our findings at local, national and international conferences. Overall, the results of this work are encouraging and are assisting to improve the poor state of health among Indigenous Australians.

I would be discouraged from doing this work if the Medical Board of Australia decided that I could do this type of work only if I were to be fully registered and required to pay full registration fees and medical insurance. This should be evident from my personal circumstances because I am no longer receiving a salary and I am in my 70s. Despite that, I am fortunate to be able to contribute my long experience, knowledge and skills for the benefit of others. I would be bitterly disappointed if this were denied to me, thus depriving the most seriously disadvantaged sub-population in our community, the Indigenous people, opportunities to benefit from what I and my colleagues can offer them.

Comment 18.

[supports comment 8]

Comment 19.

A: The reasoning given the present definition:

"It takes into consideration the evolving nature of health care and the practice of the health professions, allowing for technological innovation and other changes to health care delivery. To limit the definition of "practice" to specified tasks, defined scopes of practice or only direct patient/client care relationships may inadvertently restrict the practice of the health professions and the delivery of health care services, contrary to the interests of the public."

Criticism:

"technological innovation and other changes" are usually, but not exclusively, produced by non---medically qualified personnel, and not having been 'registered medical practitioners' has not, in the past , stopped such developments. Therefore, putting these in as "essential reasons" for the need for such a definition does not seem logical. The publics interest is served by ensuring that these innovations, and other consequences of changes in health care delivery, are provided by medically qualified practitioners in direct patient care.

Proposed Definition:

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non---clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

The above definition appears to be in contradiction to Law as it stands today:

The proposed definition includes practitioners who are, in Law described as posing a minimal risk.

Extract from the Law:

> 75 Registered health practitioner who holds non-practising registration must not practise the profession (1) A registered health practitioner who holds non-practising registration in a health profession must not practise the profession.

(2) A contravention of subsection (1) by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

It can be argued that there is minimal risk to the community if practitioners are not registered, or are registered in the non-practising category if:

(1) they do not have direct clinical contact and

(2) their work does not "impact on safe, effective delivery of services in the profession" and

(3) they are not directing or supervising or advising other health practitioners about the health care of an individual(s) and

(4) their employer and their employer's professional indemnity insurer does not require a person in that role to be registered and

(5) the practitioner's professional peers and the community would not expect a person in that role to comply with the relevant Board's registration standards for professional indemnity insurance (PII), continuing professional development (CPD) and recency of practice and

(6) the person does not wish to maintain the title of "registered health practitioner".

Question 1: Are there any other factors that the National Boards should consider when advising whether or not a person needs to be registered?

> "to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered."

It is relevant to note that the National Law provides for the protection of the public through the protection of titles. Other than a few notable exceptions under Part 7, Division 10, Sub---division 2, the National Law does not define the activities that require registration as a particular health practitioner. That is, it is not a breach of the National Law for a health practitioner to use their knowledge and skills without being registered if the individual does not breach the sections of the National Law related to the protection of title or to the specific practice protections. For example, a retired practitioner teaching anatomy would not need to be registered and would not be breaching specific practice provisions.

B: On the issue of Direct clinical roles / patient or client health care and the case for redefining non-practicing and a new category of limited practice registration:

Extract from the Law:

> *When health practitioners provide advice, health care, treatment or opinion, about the physical or mental health of an individual, including prescribing or referring, it is clear that there is a level of risk to the public. The public and the practitioners' professional peers would expect that this group of health practitioners would have the qualifications and the contemporary knowledge and skills to provide safe and effective health care within their area of practice. It would be expected that these practitioners will meet the standards set by the Board and therefore should be registered.*

Question 2: Do you support this statement? Please explain your views.

Do not entirely agree:

1. Referring implies referring to another practitioner or an investigation. Because yet another person is therefore involved, the risks must be minimal.

2. Prescribing, that is, primary prescribing (as opposed to repeat prescribing) , implies a diagnosis had been made as a the result of normal clinical practice, on a fee for service basis. This can be excluded for practitioners on a non---practicing or on a limited practice registration.

C. 'Advice, Opinion, Consulting:'

These words are frequently used in the discussions and in the present Law

However, these activities clearly do not involve direct clinical practice with primary care / responsibility for the health and well being of a patient. By definition, they are filtered through a third person who has the primary responsibility for the well being of the patient. In this context regard should be given to the influence of the Internet on patient behaviour and choices.

Such activities should therefore NOT need full registration but could be included in a non---practicing or a limited practice registration.

D. Public Indemnity:

The purpose of Registration is to protect the public and to this end public indemnity was introduced, both as a protection for damage done and as a disincentive for practitioners. But it does involve significant cost which cannot be recouped by practitioners who do not have access to remuneration for their activities.

E. Maintenance of Professional Standards:

This evolved from the same needs which lead to the evolution of Public Indemnity.

F. Summary:

I believe that the definitions as had been evolved and used by the NSW Medical Board were more discerning and fine tune3d than the present proposal.

Comment 20.

...

The dilemma – what action should I take when my registration expires in September 2012?

Renew full registration?

As someone whose taxable income is far below the tax-free threshold, I am unable to claim any rebate on the annual registration fee ($670) and the premium for medical defence – unlike my colleagues in clinical practice. Although I easily meet the RACP requirements for CME activities (see footnote), I find that formal documentation of time spent on CME is a pain.

Seek non-practicing registration?

While seemingly appropriate for my situation, the Medical Board of Australia Update (May 2011) stated clearly that those holding this form of registration "must not practice the profession". The only reason for offering non-practicing registration

seems to be for use of the courtesy title of “Dr”. That doesn’t apply to me as I hold a higher doctorate from the University of Melbourne.

Drop all medical registration?

Many of my colleagues have reluctantly done retired, regarding non-practicing registration as being pointless.

Specific questions and comments

(1) The New Zealand Ministry of Health invited me to join several working groups during preparations for the start of the NZ Bowel Screening Pilot. Currently, I am a member of the Evaluation Advisory Group for the NZ Pilot (2011-2015) - one of 15-20 people helping to monitor and evaluate its success. As this activity is conducted outside Australia, does the Board have the authority to insist on full registration while I remain on the EAG?

(2) Earlier this year, the Editor of *Lancet Oncology* asked me to review a manuscript submitted for publication in that journal. He was uncertain whether or not to accept the article despite input from six reviewers. As seventh reviewer I was able to recommend acceptance, the important article being published shortly afterwards. Does reviewing manuscripts constitute medical practice? Where is the boundary with medical research? As with the first point above, does the Board have the authority to insist on full registration when requests come from outside Australia?

(3) This year, I have been a co-author on three publications:
van Vliet CM *et al*. Dependence of colorectal cancer risk on the parent-of-origin of mutations in DNA mismatch repair genes, *Human Mutation* 2011;32:207-212;
Pignone MP *et al* . Costs and cost-effectiveness of full implementation of a biennial faecal occult blood test screening program for bowel cancer in Australia. *Med J Aust* 2011;194:180-185;
Flitcroft KL *et al*. A case study of bowel cancer screening in the UK and Australia: Evidence lost in translation? Journal of Medical Screening: *In Press*.
Do I need full medical registration to be a co-author? Irrespective of the relevance of the study to clinical practice?

(4) Finally, many advisory roles are performed in settings where checks and balances are in place to ensure that standards of advice are high.
To give one example, two years ago, DoHA commissioned Cancer Council Australia to update the NHMRC-approved clinical practice guidelines on colonoscopic surveillance for bowel cancer – after polypectomy, following curative resection of bowel cancer and in inflammatory bowel disease. I was invited to join the Colonoscopic Surveillance Working Party and to be the lead author on a chapter on colonoscopic technique and quality. As events unfolded, my main role proved to be supporting the project officer (a senior PhD) responsible for conducting all literature reviews and the two health economists who assessed cost-effectiveness of surveillance. The project officer had no previous experience in clinical medicine and the health economists had never worked in the cancer area. All three lived in Melbourne. While they were quick learners, this involved me in many meetings face-to-face and by telephone and much e-mail correspondence. I received no remuneration for any of the time spent on the project. Importantly, all outcomes were regularly reviewed by members of the Working Party, the draft document was released for public comment, a revised draft was again

reviewed by the Working Party, then by an independent group of experts selected by CCA, then reviewed internally by NHMRC and by another independent group of experts, this time chosen by NHMRC. The update took 24 months to complete, NHMRC giving its final approval in October 2011. *When such a review system is in place, whether I should have full registration or just non-practicing registration seems to be a minor matter.*

In my view, medical practitioners whose practice is limited to advising about implementation of screening programs, development of health policy etc should be covered by non-practicing registration – similar to the non-practicing cover that medical defence organisations offer to practitioners not involved in patient care. Insisting on full registration is likely to prematurely force many of us into full retirement.

Footnote

CME activities:

My medical reading includes (1) the five journals that I personally receive (*Med J Aust*, *Intern Med J*, *Gastroenterology*, *Clin Gastroenterol Hepatol*, and *J Gastroenterol Hepatol*), (2) a total of 20 journals that I read on-line or in hard copy through the Royal Melbourne Hospital Library, (3) monthly INGENTA updates on colorectal cancer prevention and screening, (4) a customized electronic update on news about GI cancer received five days each week from the American Gastroenterological Association, and (5) Cancer News, a daily update provided by Cancer Council Victoria. This information is supplemented by e-mail discussions with colleagues from within Australia and overseas and occasional attendance at medical conferences.

Comment 21.

Any diminution of the breadth of the definition of "practice" in regard to the profession of Medicine would create more problems than at present. The difficulties are not in the breadth of the all-encompassing definition of practice but in the failure of the legislation to recognize elsewhere that one size does not fit all.

A narrow definition, such as Option 2, disenfranchises a very large number of those who contribute to the profession of Medicine without actually earning an income from direct patient care. Provision of health care requires a complex team and that complexity needs to be recognized by the Board.

While the business of the Medical Board (and other Boards) is primarily concerned with maintaining ethical and safe provision of delivery of health care, it also has a de facto role in ruling those who are, and are not, "medical practitioners". One example of the problem is given by the paper: the "retired" practitioner who teaches anatomy to medical students. The discussion paper suggests that this person would not need to be registered. I assure the Board that, while this is legally true inasmuch as no patient will complain to the Board directly about this teacher, in practice it is extremely important to that teacher's credibility and thus the effectiveness of his/her teaching that he/she should be registered as a "Medical Practitioner". This is NOT about protection of title. It is about credibility as a medical teacher and hence efficacy of teaching. Further, is he/she entitled and enabled to teach surface anatomy in a practical manner if NOT a medical practitioner?

In the Registration fees, the Board recognizes different levels of direct patient care and the medical indemnity organizations recognize different levels of risk associated with different care models. The Board should be able to be more flexible in

recognizing the even wider differences inherent in the breadth of the definition of "practice".

Consider the medical practitioner whose career has been teaching medical students and research underpinning the pathogenesis of disease. Some such research is also carried out effectively by those trained as scientists but the broader training and experience of medical practice gives a different perspective, complementary to that of the narrowly-trained scientist. The teacher/researcher is more effective if a contemporary knowledge of and continuing interest in medical practice is maintained, even without delivery of direct patient care. The paper lists some roles. Another not listed is the interview of selected patients in front of, or by students, to demonstrate aspects of basic medical science or of disease pathogenesis without actual delivery of care. "Paper" cases are much less realistic to students.

While all of these roles should be defined as "Medical practice", not all require significant indemnity insurance, for example. Consider the teacher/researcher who last earned an income from direct patient care over 30 years ago. Is indemnity insurance anything but an imposition? Other examples could be made in a similar vein, for example for medical administrators.

Consider one further example where the national registration regulations create apparent anomalies and certainly create anger. Consider the medical researcher who is qualified as a physician in Australia; drifts into full-time pharmacological research and teaching, taking a large decrease in income but motivated altruistically; teaches pharmacology and therapeutics and internal medicine in leading Australian and overseas medical schools; goes from a salaried to an honorary academic appointment on reaching age 65; continues research actively after reaching age 70; and whose research has become increasingly "basic", using entirely animal models and in vitro situations. If from Queensland, this person enjoys a special registration class that excludes him/her from initiating prescription of scheduled medicines although he/she has been responsible for curriculum development, teaching and examination of medical students in an accredited medical school and is still very competent, conservative in prescribing habits and still doing world-leading pharmacological research of therapeutic value. If from another state, this person cannot prescribe at all without "full" registration. In either case the registration and indemnity fees have a disproportionate and significant cost when compared to his/her superannuation pension, the sole source of income for an honorary appointment at this age. The situation creates frustration and anger. The offer of a non-practising title of "doctor" is merely an embarrassment if this person has earned doctoral degrees such as the MD and PhD, perhaps both. The problem is the one-size-fits-many restrictions of the national registration scheme, not the definition of practice.

The Board needs to consult widely with the large range of persons encompassed by the appropriately-wide definition of practice to identify means to encourage continuing service to the medical profession by altruistically-minded medical practitioners whose practice is rarely in direct patient care and who do not enjoy an income from direct patient care.

Comment 22.

I believe there will be significant advantage in redefining practice as it applies to medical practitioners to restrict it to the provision of direct clinical care. As is acknowledged by the consultation paper, many doctors at various phases of their career may move away from having the provision of clinical care as their primary responsibility to playing roles in management or in education. Examples would include doctors who have been Vice Chancellors of Universities and ministers in both federal and state governments. It would be an inappropriate and unfair expectation to individuals in positions such as this to have to maintain continuing professional development in a way that is vital for those who are involved in direct clinical care. Needless to say if individuals are in positions like this it will be incumbent on them to avoid getting into situations where they are providing clinical care that does require this maintenance of professional development in a way that keeps them up to date with the requirements of clinical practice. The legislation does at present recognize that individuals can have non-practicing registration and identifies processes by why they can, after a period of time when they are not registered, return into clinical practice with appropriate mentoring and supervision.

Having made these general statements I will attempt to answer the questions that are put in the paper.

Question 1. I do not believe that there are any other factors that the National Board should consider when advising whether or not a patient needs to be registered.

Question 2. I support this statement.

Question 3. I do not support the statement that practitioners who are in roles where they are purely supervising or advising other health practitioners in a way that might be undertaken by people who do not have medical training need to have registration that should be focused on clinical care.

Question 4. I do not believe that medical practitioners in non clinical and non patient client care roles as described in the preamble to this question need to be registered to act in those areas.

Question 5. While this is a little bit more difficult, I have been personally aware of a number of highly skilled individuals who have retired from clinical practice who have been prevented from continuing roles in teaching because of rules that are too rigid. I do not believe there should be any expectation over and above that of responsibility by curriculum mangers that would prevent knowledge which individuals in this category can impart in the various settings, to their being allowed to do so.

With regard to the various options proposed I would support Option 2 which involves changing the present definition in practice so that it focuses on delivery of care in the clinical arena.