

## **CPMEC Response to the AHPRA Consultation Paper on Definition of Practice**

The Confederation of Postgraduate Medical Education Councils (CPMEC), the peak body for prevocational medical education and training in Australasia, has considered the Public Consultation paper on the definition of practice released on 3 October 2011 by AHPRA and wishes to make the following comments on the proposals and options outlined. CPMEC considers a response is warranted as the proposed definition of practice has particular relevance to the teaching, supervision and mentoring of prevocational trainees.

### *1. Challenge of an acceptable inter-professional definition*

As has been noted in some of the other submissions, there are significant challenges in seeking a mutually acceptable definition of practice that would cover all circumstances in the ten health professions. We would submit that there needs to be some discussion around the evidence base associated with the practice requirements of each of the health professional roles. As there are more stringent requirements for the practice of medicine to minimise risks to the patient and the community at large, this needs to be factored into discussions.

CPMEC is of the view that the current definition which states that '**Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession**' is far too encompassing. We contend that the definition of practice should revolve around the clinician's relationship to the patient i.e. when the clinician is in a role where they have direct responsibility for medical service provision, and that the roles of teaching and supervision should be considered under this overarching principle.

Teaching of doctors may occur in settings where there is no implication of associated responsibility for patient care e.g. when a retired clinician takes a medical student group in a hospital based tutorial. Clearly there is need to balance recognition of the contribution of semi-retirees and overall standards to ensure patient safety even though we are not aware that this group of teachers have caused any concerns. There is the additional challenge of separating those non-practising clinicians who will supervise, teach and mentor colleagues from others who will want the recognition but will not contribute.

### *2. Maximise investment in medical workforce training*

The community needs to derive maximum benefits from its significant investments in the training of the medical workforce. Given the rigour and duration of medical training, it is imperative that the community should seek to fully utilise the tacit knowledge of its experienced medical practitioners who are in twilight stages of their careers by not creating unnecessary hurdles through excessive registration fees,

continuing professional development and other barriers. In an environment where there has been a substantial increase in graduate numbers, having access to experienced supervisors and trainers will continue to be important for junior doctors in training.

*3. Comments on questions:*

In relation the questions posed we note as follows:

- Teaching does have the potential to alter patient management but this is unlikely in situations where the clinician does not have direct responsibility for patients. The situation is similar to the use of non-medical professionals in areas such as management, leadership training, and law. The latter also contribute indirectly to the improved patient care and health service delivery.
- If medical practitioners who are teachers, administrators or researchers go back to clinical care they will need evidence of being up to date in their clinical discipline.
- Those doing simulation or non-patient contact may not need to be registered, but registration does acknowledge their legitimacy in clinical medicine and may still add value. Teaching on another clinician's patients may not need registration but they will still be at the bedside and may be seen as registered by the patient.

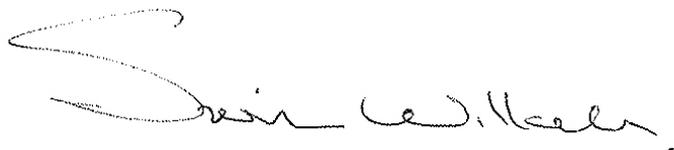
Of the definitions proposed, as per the discussions at the Forum of 22 November 2011, we are inclined to go with Option 2. However, there needs to be a clear expansion of the definition to include responsibility for individual patient care as well as delivery of health services.

*4. Consultation time*

Following the public forum on the definition of practice organised by the Medical Board and AHPRA on 22 November 2011, it would have been advisable to give stakeholders a bit more time to consult internally before making their submissions.

For any queries in relation to this submission please contact Dr Jag Singh, CPMEC General Manager at [jsingh@cpmec.org.au](mailto:jsingh@cpmec.org.au)

Yours sincerely

A handwritten signature in black ink, appearing to read 'Simon Willcock', with a large, stylized initial 'S' at the beginning.

Prof Simon Willcock  
Chair

9 December 2011