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Senate Inquiry into the Australian Health Practitioner Regulation Agency

AMA submission to the Senate Inquiry into the Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law

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Thank you for inviting the AMA to provide feedback on the administration of registration and notifications by the Australian Health Practitioner Regulation Agency (Ahpra) and related entities under the Health Practitioner Regulation National Law.

Registration and notifications affect every doctor around Australia. The AMA has worked hard to ensure the National Registration and Accreditation Scheme (the National Scheme) is transparent, efficient and fair. We continue to work with all Governments, with Ahpra and the Medical Board of Australia (MBA) to improve the scheme so that it supports good practice without having an impact on doctors who practice according to acceptable professional standards, and does not impact on the mental health of any doctor.

It is vitally important that the profession retains the confidence of the public, and we understand that a transparent, easy-to-access complaints and disciplinary system is essential to achieve this goal. But this system needs to be fair and uphold the principles of natural justice for all stakeholders.

The system must show a commitment to impartiality and due process. It is also vital that the wellbeing and state of mind of the practitioner be at the forefront of considerations – particularly in investigations that can be long running and have significant negative health outcomes for the practitioners themselves.

Medical practitioners often state that they perceive a lack of balance in the system. The process can be extremely stressful and onerous for doctors. It involves a large time commitment from time-poor medical professionals, and it can have significant reputational and professional consequences, regardless of whether the practitioner in question is at fault.

With strong AMA advocacy there have been some positive changes made to the administration of the notification scheme in the last few years. The AMA has supported the introduction of the:

- Vexatious complaints framework[1],
- Clinical Input team (medical practitioners now screen every notification to identify and stratify clinical risk),
- Changes to the risk analysis in the notification process (by including the setting and context of the practitioner's and workplace's contribution to risk mitigation).

The AMA understands the need to ensure that all regulatory schemes and legislation are reviewed and tested regularly. However, we continue to be disappointed at the lack of rigour and evidence applied to the assessment of the effectiveness and efficiency of the National Scheme. In particular, the lack of evidence or appropriate business cases to support major changes to the National Law which are being developed under the auspices of the Health Council.

The AMA believes that these changes are liable to have major impacts on the lives and work of medical practitioners without necessarily improving standards of care for patients. The AMA believes that there needs to be an appropriate balance maintained between increasing regulatory scrutiny and power to protect against situations that occur extremely rarely. We do not believe that all the proposed changes deliver this balance.

Terms of Reference

1. **The current standards for registration of health practitioners by the Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards under the Health Practitioner Regulation National Law (National Law).**

The AMA believes that most of the current standards for the registration of medical practitioners in Australia are reasonable. The AMA supports the level of consultation undertaken by all the National Boards and Ahpra when revising any of their standards.

The Medical Board's Professional Performance Framework

The AMA lobbied against the MBA's proposed revalidation proposal in 2016[2]. The AMA recognised the value of introducing extra measures to improve patient safety, but urged instead for the adoption of an approach that builds on the many systems already in place that support doctors in delivering high quality care. Australian doctors already practise in a highly regulated environment. The AMA was therefore generally supportive of the improved Professional Performance Framework announced by the MBA as it enhanced the current processes already in place.

[1] https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Vexatious-notifications.aspx
[2] https://ama.com.au/sites/default/files/documents/AMA_submission_to_the_Medical_Board_of_Australia_Revalidation_in_Australia.pdf

Continuing Professional Development

The AMA understands that the MBA's proposed revised Continuing Professional Development Registration standard is a strong part of that framework. We recognise and have supported the efforts that the MBA has undertaken to date to utilise and build on existing Continuing Professional Development (CPD) arrangements, as well as the MBA's stated desire to ensure that the final standard does not require practitioners to undertake more CPD than they already do now.

But the AMA did have some concerns about the proposed Revised Registration standard for Continuing Professional Development released by the MBA in 2019.

Despite the MBA's commitment to not increasing practitioner workloads, there is significant concern among members of the medical profession that the proposed changes will result in exactly that, along with increased costs.

In progressing work on this standard, the AMA has called on the MBA to be open to adjusting its approach and ensuring that changes only occur where they are supported by evidence, there is demonstrable benefit and they do not increase workloads and costs.

We predict this process may be difficult for some, although not all doctors. The ability of some medical practitioners to measure their outcomes is relatively straightforward, for others it is far more problematic. For GPs, engagement with the new Practice Incentive Program Quality Incentive arrangements will need to be explicitly recognised for CPD purposes. It is also important that the proposed CPD activities have clear definition, scope for easy completion by doctors working in any setting, and preferably relate to a clear evidence base.

We are also concerned at the potential one size fits all approach that the MBA proposed, particularly with respect to arbitrary rules around the mix of CPD and the number of CPD hours prescribed. The proposed mix of CPD may not be appropriate for the needs of some doctors, particularly when they are in prevocational and vocational training and are undertaking training that is designed to fit with their training program.

The AMA welcomed the decision to open up CPD arrangements, through the introduction of CPD Homes, in order to give doctors more choice as well as better supporting those doctors who do not hold a recognised College qualification or are not currently part of a recognised training program. The AMA supports standards that are evidence based and demonstrated to show improved performance.

The AMA understands that the MBA has considered all the input provided from stakeholders and have taken their revised standard to Health Ministers for approval. The AMA has always indicated that we are ready to work collaboratively with the MBA in the development of any aspect of this registration standard.

2. The role of AHPRA, the National Boards, and other relevant organisations, in addressing concerns about the practice and conduct of registered health practitioners.

Ahpra, the National Boards and other relevant organisations all have a part to play in delivering a system that shows a commitment to impartiality and due process. It is also vital that the wellbeing and state of mind of the practitioner be at the forefront of considerations for any agency considering issues related to the practice and conduct of registered health practitioners.

Whilst there have been a range of positive improvements implemented under the National Scheme the AMA still thinks we have further to go in the following areas:

- Improved management of vexatious complaints,
- Adoption of the WA model for mandatory reporting,
- Removal of links to the register for minor issues, and
- The potential impact of the revised guiding principles.

We have provided further details on each of these issues through the rest of our submission.

3. The adequacy and suitability of arrangements for health practitioners subject to supervised practice as part of the registration process or due to a notification.

While a number of pre-vocational doctors in training work as resident, house or principal medical officers (RMO/HMO/PHO), significant numbers also work in ‘unaccredited’ or ‘service registrar’ positions to get additional clinical experience to improve their chance of gaining entry into a specialist training program.

Unaccredited positions are typically built around service delivery requirements and in this way, make an important contribution to the delivery of care across Australia’s public health system. They also provide relevant clinical and procedural experience for many trainees in preparation for vocational training.

However, in contrast to trainees in accredited vocational training positions, trainees in unaccredited positions lack access to structured education and training opportunities, clinical oversight, professional development and professional support. Concerns have been expressed about the health and wellbeing of this cohort, who may be more vulnerable to exploitation, work-related stress, and workplace harassment and bullying.

The AMA has called on the Commonwealth Government to show national leadership by committing to fund and resource the appropriate agencies to undertake the accreditation of all prevocational training positions to improve supervision and address issues of poor-quality training for prevocational doctors not in a College training program.

4. The application of additional requirements for overseas-qualified health practitioners seeking to become registered in their profession in Australia.

The AMA supports the role of the MBA and the Australian Medical Council (AMC) in assessing the knowledge and clinical skills of overseas trained doctors or international medical graduates (IMGs) seeking to qualify for medical registration in Australia.

The AMA recognises that IMGs are required to meet rigorous standards of practice, noting these can differ from the requirements for Australian graduates. This is to ensure that standards of medical education and training are maintained and that the community has confidence in the care being provided by all doctors, including IMGs. It is important that assessment processes for IMGs:

- have appropriate regard to overseas qualifications including, where appropriate, mutual or unilateral recognition,
- are nationally consistent, transparent, evidence-based and robust,
- are conducted in a timely fashion and do not impose unnecessary red tape or duplication,
- provide for fair and accessible appeals processes that are based on principles of natural justice, and
- do not impose unjustified cost barriers on IMGs.

MBA registration and other relevant standards for IMGs must:

- mandate requisite English language skills for IMGs, with appropriate exemptions for IMGs from English-speaking countries,
- ensure robust verification of international qualifications;
- for non-specialist IMGs, utilise screening and assessment tools accredited by the AMC including screening exams, pre-employment structured clinical interviews and workplace-based assessment,
- ensure that IMGs are appropriately supervised, taking into account their qualifications and experience and recency of practice,
- rely on the advice of specialist medical colleges in relation to the assessment, registration and supervision of specialist IMGs,
- where appropriate, provide a pathway to the achievement of the requisite Australian standards within a reasonable timeframe, and
- specify mandatory orientation requirements that cover:
    - the Australian health system and processes,
    - local acronyms and colloquialisms,
    - the local community,
    - cultural competency,
    - their rights and obligations, and
    - medical ethics and patient rights.

Compliance against these standards should be monitored routinely, including through regular reporting to the MBA by the appointed supervisor and audit processes.[3]

5. The role of universities and other education providers in the registration of students undertaking an approved program of study or clinical training in a health profession.

The AMA supports the role of the:

- AMC in assessing and accrediting medical education providers and their primary medical programs; that is, programs that lead to a qualification that permits the holder to seek general registration as a medical practitioner.
- MBA in assessing provisional registration requirements for Australian medical graduates who have been awarded a primary degree in medicine and surgery, after completing an approved program of study from a medical school accredited by the AMC.

6. Access, availability and adequacy of supports available to health practitioners subject to Ahpra notifications or other related professional investigations.

Medical professionals find Ahpra highly bureaucratic in the way that it applies its processes across all complaints in a similar manner and how, until recently, there has been no real mechanism to filter and screen out vexatious, malicious or frivolous complaints before the investigator commences their work. This process was taking from 6-9 months in many instances and leaves the doctor in mental and medico-legal limbo.

Notifications can also trigger a change in the doctor's professional practice with adoption of more defensive medicine, a loss of trust in people and patients, and over investigation. It can trigger premature departure from that doctor's practice which can be a disaster in a rural area. The ripple effects are real and the longer the delay in processing the complaint, the more entrenched this becomes.

Accordingly, the AMA strongly supports the recent work of Aphra and MBA to reduce this impact through a range of mechanisms. The best possible support for doctors going through this process is to ensure that it is appropriate and timely. In particular we acknowledge and support the work that Ahpra has done in introducing:

- A vexatious complaints framework (see Section 12 for detailed input on this),
- The establishment of the MBA's National Assessment Committee which meets up to six times a week (Members from all states and territories are rostered to this committee and they consider all notifications soon after they arrive. Where it is evident that no regulatory action will be necessary, notifications are closed without further investigation and the first time that the medical practitioner about whom a notification has been made learns about the notification is after it has been closed),
- Clinical input on all medical notifications from a team of medical clinical advisors (A medical practitioner screens every notification to identify and stratify clinical risk. The

[3] Source: AMA Position Statement on International Medical Graduates 2015 https://ama.com.au/position-statement/international-medical-graduates-2015

clinical advisors provide clinical context and assist other Ahpra staff to formulate recommendations to the MBA. The AMA understands that this early clinical input has resulted in higher quality recommendations being made more quickly, and

- A new risk assessment approach to all notifications (including existing investigations) which takes into account the practitioner's setting and context.

We would like to see such mechanisms maintained and enhanced. But we would also like these processes appropriately evaluated to ensure they are working to the best of their ability.

Doctors mostly take complaints very personally and can adopt a catastrophic view of the outcome. Many can regard a complaint as a career ending event. This is a common trigger for suicidal ideation, and they have the knowledge and means to act on their ideation.

The AMA believes that all doctors should be able to access medical support from their GP or a trusted colleague to help manage the impact of the complaint and to help put the complaint into perspective. They often suffer alone. The AMA acknowledges the work that Ahpra and the MBA have done in this space – but like many areas of support, more is required.

Mandatory reporting

The AMA has long called for changes to the Mandatory Reporting law. Australia's medical practitioners desperately need legislation that does not actively discourage them from seeking medical treatment when they need it. Practitioners are also patients and should have equal rights to access confidential high-quality medical treatment as their own patients and all other Australians.

As the AMA has continually stated, the unintended consequences from the operation of the current National Law are far reaching. Doctors are avoiding seeking treatment for their own health concerns, particularly mental health concerns, out of fear of the consequences and they and their families are suffering as a result. Ironically, current mandatory reporting law put in place to protect the public is actually more likely to expose it to untreated, unwell doctors. For the treating practitioner, it has also had a detrimental impact on the confidentiality of the doctor-patient relationship, impairing the ability of the practitioner to deliver an appropriate level of care.

A nationally consistent approach to Mandatory Reporting provisions would provide confidence to health practitioners, enabling them to seek treatment for their own health conditions anywhere in Australia.

The AMA acknowledges that the threshold for reporting a concern about impairment, intoxication and practice outside of professional standards has been raised. Treating practitioners will now be required to report to Ahpra if they deem their doctor–patient is placing the public at "substantial risk of harm" or if they are suspected of having engaged in sexual misconduct.

But the AMA does not believe these reforms went far enough.

In 2014, 74 per cent of respondents to the Independent Review of the National Registration and Accreditation Scheme called for a national exemption for treating doctors[4]. That review recommended national adoption of the Western Australian model.

In 2017, 75 per cent of submissions to the COAG Health Council called for the adoption of the WA model[5], but lawmakers again chose to ignore the advice.

In its consideration of the national law amendments to mandatory reporting in 2019, the dissenting report of the Queensland Committee called for the adoption of a WA-style model to protect Queensland doctors and their patients[6].

With no evidence that the WA model is doing anything other than improving practitioner health, and therefore, improving consumer protection, the AMA believes that Australia should choose to implement the tried and tested WA model. There appears to be no reason not to adopt the WA model as a first choice. It has the benefit of not only being simple, but having been proven to work, with no downsides, and supported by most peak groups. We know how doctors will interpret it, how the other professions will interpret it, how the MBA/Ahpra will interpret it and how legislators interpret it. It remains successful because of this shared understanding.

7. The timeliness of AHPRA's investigation of notifications, including any delays in handling, assessment and decision-making, and responsiveness to notifiers.

The AMA understands how important this issue is to all medical practitioners. The AMA has worked continually with Ahpra and the MBA to improve the notification process and reduce its impact on medical professionals. The AMA, Ahpra and the MBA have held an annual notifications workshop for the last six years (including a virtual workshop in 2020[7]). These workshops focus primarily on complaints to Ahpra and the MBA but also cover other matters of mutual interest.

These annual workshops have covered a wide range of issues including:

- Examination of the data and trends related to the operation of the national scheme as it relates to medical professionals,
- Timeframes for finalising notifications in assessment, investigation, health and performance assessment,
- Timeframes for referral to Tribunal,
- The performance of and actions to improve timeframes and process for registration,
- Establishment and work of the Ahpra/MBA clinical advisors, and
- Vexatious complaints.

However, the AMA still has significant concerns about the length of many notifications processes.

[4] https://www.coaghealthcouncil.gov.au/Projects/Independent-Review-of-NRAS-finalised/ArtMID/524/ArticleID/68/The-Independent-Review-of-the-National-Registration-and-Accreditation-Scheme-for-health-professionals
[5] https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2018/HealthPractRegNLAOLAB18/trns-pb-HealthPract-5Dec2018.pdf
[6] https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2019/5619T6.pdf
[7] https://www.medicalboard.gov.au/News/2020-09-09-communique.aspx

The AMA understands that the COVID-19 pandemic had a significant impact last year on Ahpra and the MBAs processes. However, the AMA believes that the number of notifications taking longer than 3-6 months to close is still of significant concern. As more than 80% of notifications for medical practitioners result in no further action from the MBA, the AMA would expect to see this timeframe falling.

The AMA supports the change by Ahpra several years ago to only notify practitioners after the assessment phase. Many of our members have reported that instead of receiving notice that they were under investigation, they now receive information from Aphra that a notification was received and there will be no further action.

The AMA supports the recent reduction in long term investigations – having medical practitioners under such intense scrutiny for 1 to 2 years or even longer is unacceptable. The physical and mental toll on our doctors is immense. The AMA supports the MBA in bringing this number down further. Ideally the AMA would support no investigation taking longer than 2 years other than in exceptional circumstances.

8. Management of conflict of interest and professional differences between Ahpra, National Boards and health practitioners in the investigation and outcomes of notifications.

The AMA supports use of best practice conflict of interest approaches across the National Registration and Accreditation Scheme. The AMA believes that Ahpra and the MBA should always:

- Act in the public interest,
- Be accountable for their actions and decisions,
- Take a risk-based approach.

The AMA notes and supports the work that the National Health Practitioner Ombudsman (the Ombudsman) has been doing on Ahpra and the National Boards conflict of interest procedures[8]. The AMA supports the Ombudsman's continued scrutiny in this area.

9. The role of independent decision-makers, including State and Territory tribunals and courts, in determining the outcomes of certain notifications under the National Law.

The Federal AMA is aware that some jurisdictions have their own processes. The Federal AMA works at the national level with Ahpra and the MBA so has no visibility of how the arrangements are working at the State and Territory level.

10. Mechanisms of appeal available to health practitioners where regulatory decisions are made about their practice as a result of a notification.

AMA thinks this is an area that could be improved. The AMA supports a system which is transparent and accountable but is also fair and upholds the principles of natural justice for all stakeholders. Doctors are one of the most regulated professions in Australia. Their ability to

[8] https://www.nhpo.gov.au/sites/default/files/2020-11/NHPO%20annual%20report%202019-20.pdf

practice can be removed by numerous regulators, including Ahpra and the MBA. These decisions impact irrevocably on a doctor's livelihood and their health - it is imperative that appropriate mechanisms of appeal are always available.

Many of the current proposed amendments of NRAS (the Tranche 2 amendments) have the potential to have significant and possibly catastrophic consequences for medical practitioners, including:

- simplistically amending the guiding principles to provide that the paramount considerations for administering the law are public protection and public confidence in the safety of health services – without giving proper weight to conformance with accepted standards of profession practice,
- requiring health practitioners and students to report offences related to regulated medicines and poisons no matter how trivial the offence may be,
- allowing regulators to issue a public statement if necessary, to protect the public – before a matter has even been considered by the tribunal,
- providing discretion to National Boards to not only notifying former employers and associates of action being taken against a practitioner but also for contract, voluntary and honorary arrangements.

It is imperative that appropriate appeals processes are available for health practitioners considering the far-reaching ability of the regulators. Also imperative is that these appeal processes provide practitioners with an appropriate timeframe to utilise these processes. An example of a proposal that can have catastrophic consequences for a practitioner and where the appeal mechanism being mandated is palpably unfair can be found in the proposed Tranche 2 amendments to the National Law.

The proposed amendments will allow Ahpra and the National Boards to issue statements about practitioners who are the subject of investigations or disciplinary proceedings, and whose conduct they deem poses a serious risk to public health and safety. The argument is that this will allow regulators to warn the public about the risks posed by the practitioner.

The AMA does not support the Medical Board or Ahpra being able to issue a public warning before a tribunal has completed its actions. To do so would imply guilt and is likely to ruin a practitioner's reputation. A public warning is a severe and non-retractable step and should be undertaken only after a health practitioner has been shown to have breached a code of conduct or convicted of a relevant offence.

The AMA has supported the inclusion of a show cause process for a public statement and the ability to appeal a decision to issue a public statement. However, as currently proposed, the provisions for revision or revocation of a public statement do not adequately address the issue that once a statement is made the practitioner's reputation is damaged permanently. The reality is that media organisations that publish the initial statement have no obligation to publish the correction or revocation. The AMA believes that this will lead to significant pain and suffering being inflicted on medical practitioners who undergo this process.

Further, the current amendments are unfair to the practitioner allowing any submissions for a show cause notice to be made "within the stated time" and the regulatory body is only required to give one business days' notice of their decision to proceed with publication. This is a good example of where providing it looks as though there is an appropriate appeals mechanism, but the timeframes make it almost impossible for a practitioner to access appropriately. In this instance the AMA has requested that practitioners should be given at least 7 days in which to lodge a submission and at least three business days' notice of intention to publish (to give them time to lodge an appeal).

11. How the recommendations of previous Senate inquiries into the administration of notifications under the National Law have been addressed by the relevant parties.

Vexatious complaints framework

The AMA has been concerned about the issue of vexatious complaints for many years. Many health practitioners argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment, including by other health practitioners.

In its submission to the 2017 Senate Inquiry on *Complaints mechanism administered under the Health Practitioner Regulation National Law*, the AMA called for the Ahpra complaints handling mechanisms to be improved by developing a system to triage and remove complaints that are clearly vexatious[9].

This evidence led to the Senate recommending that Ahpra and the national boards develop and publish a framework for identifying and dealing with vexatious complaints.

Having commissioned research on this issue, in 2018 Ahpra published a research report in 2018 *Reducing, identifying and managing vexatious complaints: Summary report of a literature review prepared for the Australian Health Practitioner Regulation Agency*[10].

This research was the first international literature review of vexatious complaints in health practitioner regulation. The report found that the number of vexatious complaints dealt with in Australia and internationally is small, representing less than one per cent but concluded that these complaints have a significant impact on practitioners' lives.

The AMA continued to raise this issue with Ahpra and the MBA, pressing further action be taken to enable vexatious complaints to be identified and managed earlier in the notification process thereby reducing harm to the practitioner.

Following detailed consultation with the AMA in the second half of 2020, Ahpra released its new framework to support the identification and management of vexatious notifications. This framework outlines:

[9] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ComplaintsMechanism/Submissions
[10] https://www.ahpra.gov.au/News/2018-04-16-vexatious-complaints-report.aspx

- principles and features of vexatious notifications,
- the significant impacts of vexatious notifications,
- potential indicators of vexatious notifications,
- how to identify vexatious notifications, and
- what to do where there is a concern that a notification is vexatious.

At the urging of the AMA, the framework also reinforces that health practitioners should not make vexatious complaints about other health practitioners. Vexatious notifications made by a registered health practitioner with the intent of harming another practitioner are taken seriously. A Board can take action against a practitioner who makes a vexatious notification about another health practitioner. This includes investigating the practitioner and, where vexatiousness is apparent, taking action that could affect the practitioner's registration. Vexatious notifications do not have good faith protections under the National Law.

The AMA hopes that that this framework will provide Ahpra staff with a better understanding of what a vexatious complaint might look like and how to manage one when they have identified it. The AMA will be asking Ahpra how the implementation of this framework has worked and looking for Ahpra to be able to demonstrate a decreased practitioner burden from vexatious complaints in their metrics.

12. Any other related matters.

Links to the register

The AMA has been very vocal regarding its concern about the potential for medical practitioners to suffer discrimination as a result of being named in a previous tribunal proceeding[11], particularly where:

- the issue was relatively minor,
- the issue occurred some years ago,
- the medical practitioner or their practice complied with the tribunal's recommendations; and
- other safeguards have been introduced to protect patients.

The AMA finds it difficult to comprehend that medical practitioners, who are named in a tribunal procedure, are offered less protection from discrimination than a person who has served a prison term.

New Paramount Guiding Principle

The AMA agrees that the protection of the public is a critical role of the scheme and believes that current arrangements already deliver on this goal. The proposed amendment to the guiding principles of the National Law to provide that the paramount considerations for administering

[11] https://ama.com.au/sites/default/files/documents/NRAS%20Submission%202%20November%202018_0.pdf

the law are public protection and public confidence in the safety of health services is unnecessary and will not help the operation of the scheme[12]. This is because:

- it is not clear what the new main principle means in practice, and
- the introduction of a "main guiding principle" further complicates the interpretation of an already complex scheme.

The concept of public confidence is not always clear cut and often depends on perspectives. The plethora of online information available on health and wellbeing, including misinformation, is an important consideration in any contemporary discussion of health literacy let alone public perception[13]. We are seeing more people rely on information sources that do not always provide evidence-based information.

Many people have difficulty determining which sources of information are reliable, or they easily absorb misinformation delivered directly to them through advertising and/or social media. The internet has the potential to significantly magnify health misinformation campaigns, such as those associated with the anti-vaccine movement or the use of hydroxychloroquine as a treatment of COVID-19. Such examples show us that public perception of what constitutes a safe health services cannot always be relied upon.

The proposed amendment potentially adds a "gloss" to every provision that:

- gives Aphra or a National Board a discretion, or
- requires Aphra or a National Board to balance competing principles.

In interpreting this provision, the AMA believes that National Boards would need to give paramountcy to:

(a) protection of the public,
(b) public confidence in the safety of services provided by registered health practitioners and students.

This would appear to trump the other guiding principles, including the requirements that:

- the scheme is to operate in a transparent, accountable, efficient, effective and fair way,
- restrictions on the practice of a health professional 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.

In other words, if there is a conflict between protecting the public (or being seen to protect the public) and imposing restrictions on practitioners, protecting the public will win – even if the risk is trivial or the public perception is unfounded.

[12] https://ama.com.au/sites/default/files/documents/AMASubmissionStrengtheningtheNRASHealthPractitionerRegulationNationalLaw.pdf
[13] https://ama.com.au/articles/health-literacy-2021

The proposed new main principles appear to suggest that:

- health services can be provided in a way that is risk free, and
- the procedure that is lower risk is always preferable.

The AMA does not support this view. For example, a doctor must be able to respect the patient's choice to:

- try and have a natural delivery even though the medical professional accepts that a caesarean is a lower risk option, or
- participate in a clinical trial for a new treatment which is untested.

Scope of practice for non-medical health practitioner prescribing

The AMA is concerned with the inconsistent processes for non-medical health practitioners to obtain their endorsement for scheduled medicines (ESM). The AMA supports the national inter-governmental arrangements for the conferring of prescribing authorities on non-medical health practitioners which were endorsed by the Council of Australian Governments in 2016, proscribed under the National Law, described in Guidance for National Boards, and are administered by Ahpra.

Generally, these arrangements ensure nationally consistent approaches to prescribing by non-medical health practitioners that are transparent, robust and informed by evidence. They also ensure common standards across professions for training and clinical practice and support the safe and effective use of prescription medicines. Any expansion of non-medical practitioner prescribing should only occur within this national framework.

However, the AMA understands that the approval process for the ESM varies across non-medical health practitioner Boards. For example, if the Optometry Board of Australia amends their list of scheduled medicines, this does not require Ministerial Council approval. Their ESM registration standards are vague and only mention the different schedules of medicines they can prescribe 'for the purposes of the practice of optometry'[14], while the list of scheduled medicines is included in the *Guidelines for the use of scheduled medicines* appendix[15].

Conversely, the Podiatry Board of Australia's endorsement and list of scheduled medicines is outlined in its ESM registration standards[16], is more detailed, and does require Ministerial Council approval.

The AMA believes that the approval process should be consistent across the non-medical health professions and Ministerial Council approval should be required for any change to the list or endorsement of scheduled medicines, even if the change is to add only one medicine to the list. This is the safest option for non-medical health practitioners wishing to prescribe.

[14] Optometry Board of Australia (2018) *Registration standard: endorsement for scheduled medicines.*
[15] Optometry Board of Australia (2019) *Guidelines for the use of scheduled medicines.*
[16] Podiatry Board of Australia (2018) *Registration standard: endorsement for scheduled medicines.*

It is the AMA's view that only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. Only medical practitioners currently meet the high standards required by the NPS MedicineWise Prescribing Competency Framework in order to safely prescribe independently[17].

The AMA does not support independent prescribing by non-medical health practitioners outside a collaborative arrangement with a medical practitioner. Prescribing by non-medical practitioners should only occur within a medically led and delegated team environment in the interests of patient safety and quality of care. Further, the AMA recommends a system of mandatory referrals to a registered medical practitioner where appropriate clinical criteria and outcomes are not achieved within a specific time frame.

30 APRIL 2021

Contact

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[17] NPS MedicineWise (2012) *Prescribing competencies framework.*