

**Regulation of Medical
Practitioners and Nurses
in Victoria**

A Discussion Paper

August 2001

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Foreword

Medical practitioners and nurses provide services that form the cornerstone of the health care system of Victoria. The Acts of Parliament that register medical practitioners and nurses and regulate their practice in Victoria are the *Medical Practice Act 1994* and the *Nurses Act 1993*. These Acts protect the public by establishing the Medical Practitioners Board of Victoria and the Nurses Board of Victoria. These Boards are responsible for maintaining high standards of education and practice, as well as providing a way for consumers to have complaints of unprofessional conduct by individual practitioners dealt with.

In 1998-99 the Victorian Department of Human Services conducted a review of the *Medical Practice Act* and the *Nurses Act*. The impetus for the review was the requirement that all legislation be assessed against National Competition Policy Principles, and any unnecessary restrictions on competition be removed. The 1998 review also addressed the need to update and modernise this legislation and adopt wherever possible a consistent approach to regulation of all the health professions. As a result of this review, the Victorian Parliament passed the *Health Practitioner Acts (Amendment) Act 2000* that amended the *Medical Practice Act 1994*, and the *Nurses Amendment Act 2000* that amended the *Nurses Act 1993*.

During passage of these amendment acts, the Minister for Health, the Hon John Thwaites MP gave an undertaking that further policy work would be done on outstanding issues of concern to key stakeholders. Issues identified by the medical profession were the need for regulation of corporate medical practices, and the need to strengthen the Medical Practitioners Board's powers to regulate poorly performing doctors. Issues identified by the nursing profession were the need for legislative restrictions on the practice of nursing, the regulation of nursing agencies and the Nurses Board's powers to require of nurses recency of practice.

This discussion paper aims to foster debate about these and a number of other issues, with a view to determining the need, if any, for further regulation of the professions and any extension of the respective registration boards' powers.

If legislative changes are proposed, then these must pass the competition test, that is, the legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

This discussion paper provides an opportunity for practitioners, professional associations and interested consumers to comment on proposals for reform of the powers of the Medical Practitioners Board and the Nurses Board. I encourage you to use this opportunity to contribute to and inform the debate, by making a submission to the Department. I look forward to hearing all views on these issues.



Shane Solomon
Director

Policy and Strategic Projects Division

Consultation Arrangements

Information

Further information on this review is available from:

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Members of the Practitioner Regulation Unit are available to meet with groups to discuss issues. Please contact Ms Abbott on the above number to arrange a meeting.

Copies of Discussion Paper

Further copies of this discussion paper can be obtained by contacting

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The discussion paper is also located on the Internet at the following address:

<http://www.dhs.vic.gov.au/pdpd/> and can be found in What's new.

Submissions:

Those interested in commenting on the above proposals may put in a written or taped submission. Submissions should be forwarded to:

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Submissions should be received by: **Friday 5 October, 2001.**

1. Overview

1.1 Background

The Acts of Parliament that register medical practitioners and nurses and regulate their practice in Victoria are the *Nurses Act 1993* and the *Medical Practice Act 1994*. These acts protect the public by setting up the Nurses Board of Victoria and the Medical Practitioners Board of Victoria. These Boards are responsible for maintaining high standards of education and practice for medical practitioners and nurses, as well as providing a way for consumers to have complaints against individual practitioners dealt with.

The purpose of this discussion paper is:

- To canvas issues in regulation of the practice of medicine and nursing and the need, if any, for further reform of relevant legislation.
- To ensure that any proposals for reform comply with the guiding legislative principles of the National Competition Policy, that is, that the benefits of any proposed legislative restrictions outweigh the costs and that there are no other less restrictive methods of achieving these benefits.

This paper summarises the concerns that have been raised by key stakeholders and the main areas for possible reform. Any views expressed in the paper do not represent a final position. In addition, submissions on matters not directly raised in the paper are welcome.

Those interested in commenting in detail on the legislative regulation of the professions of medicine and nursing are encouraged to obtain copies of the *Medical Practice Act 1994* and the *Nurses Act 1993*. These are available from:

Information Victoria
365 Collins Street
Melbourne 3000
Tel: 1300 366356

Copies of the above legislation can also be downloaded from the following Victorian Government website:

<http://www.dms.dpc.vic.gov.au/>

The following sections of the discussion paper address:

- National Competition Policy considerations.
- Proposals for reform of the regulation of medical practitioners.
- Proposals for reform of the regulation of nurses.
- The process of consultation, including how interested parties can obtain copies of this discussion paper and comment on the proposed reforms.

1.2 Process and Timetable

The Practitioner Regulation Unit of the Department of Human Services is responsible for conduct of this review and consultation, with advice and assistance from the Legislation and Legal Services Section of the Department. Contact arrangements for the Unit are set out at the end of this paper.

The legislative program is determined by Cabinet in light of many competing priorities. At this stage it is planned that, subject to Cabinet endorsement, any amendments required to the *Medical Practice Act 1994*, the *Nurses Act 1993* or other acts will be put to Parliament in its Autumn 2002 sittings. The tentative timetable for the review is as follows:

- Discussion paper released August 2001.
- Responses to discussion paper received no later than **Friday 5 October 2001**.
- Discussions with other government departments and bodies affected by the proposed legislation, for example the Department of Justice and the Health Services Commissioner, October – November 2001.
- Amendment Bill/s to Parliament Autumn Sitting March – April 2002.

1.3 National Competition Policy Context

The conduct of this review and any subsequent proposals for reform of legislation are required to comply with National Competition Policy (NCP) Principles. In 1995, the Council of Australian Governments agreed to implement a National Competition Policy based on the recommendations of the National Competition Policy Review Committee chaired by Professor Fred Hilmer (the Hilmer Report). NCP is given effect through three intergovernmental agreements:

- the Conduct Code Agreement;
- the Competition Principles Agreement; and
- the Agreement to implement National Competition Policy and related reforms.

The guiding legislative principle to be applied to these reviews is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

Any proposals for amendment to legislation must consider the following matters:

- the objectives of the legislation;
- the nature of the restriction on competition;
- the likely effect of the restriction on competition and on the economy generally;
- the costs and benefits of the restriction; and

- alternative means for achieving the same result including non-legislative approaches.

2. Corporatisation of Medical Practices and Regulation of Unprofessional Conduct

2.1 Background

Concerns about the impact of increasing 'corporatisation' of medical practices have been raised by a variety of bodies and in a number of forums. These concerns principally relate to the potential for non-medically qualified corporate owners to influence their employee medical practitioners to practice in ways that may compromise clinical independence and patient service. Concerns relate to potential undue influence over a medical practitioner's:

- referral patterns;
- consultation targets;
- ordering of diagnostics; and/or
- prescription of pharmaceutical medicines.

Other concerns raised relate to the potential for financial arrangements to influence clinical practice that are not transparent and understood by patients, and that access by patients to their medical records may be compromised by the sale or closure of a corporate medical practice.

The Medical Practitioners Board of Victoria has also received a number of complaints that stem from the policies of a medical practice rather than the practice of an individual medical practitioner. These complaints relate to supervision of non-medical staff within the medical practice, infection control and the management of medical records. Health complaints bodies such as the Victorian Health Services Commission and the NSW Health Care Complaints Commission have also raised concerns about entrepreneurial promotion of medical treatment in areas such as impotence, anxiety, drug and alcohol dependency, tattoo removal and laser treatment.

There is a range of papers that have discussed some of these issues:

- The Commonwealth Department of Health and Aged Care paper titled *Corporatisation of General Practice. Scoping Paper*. KPMG Consulting. October 2000.
- Royal Australian College of General Practitioners paper on the Corporatisation of General Practice, September 2000. The College has set up a task force to address the issue on behalf of members.
- The Australian Medical Association paper titled *General Practice Corporatisation – Scoping Paper* November 2000.
- The General Practice Division of Victoria (GPDV) newsletter titled *Corporatisation Update* in February 2001.
- The Australian Competition and Consumer Commission's draft *Guide to the Trade Practices Act for General Practitioners*, March 2001.

The section below sets out the views of various bodies on the impact of corporatisation of medical practices and the issues for maintenance of professional standards and regulation of the medical profession.

2.2 Stakeholder views

Australian Competition and Consumer Commission (ACCC)

The ACCC has recently published a *Guide to the Trade Practices Act for General Practitioners*. The paper identifies some trends in corporatisation of the medical sector that are new and have the potential to adversely influence the practice of GPs. They are:

- horizontal integration, where in certain metropolitan areas, large numbers of individual general practices are being bought to form large GP corporations;
- vertical integration, that is the emergence of large corporations including GPs, specialists, diagnostic imaging and/or pathology; and
- non-medical ownership, where the shareholders of GP corporations or corporations including GP practices are not general practitioners themselves.

The ACCC paper outlines the advantages and disadvantages for GPs of working within a corporate structure, some potential ethical issues, and whether there are avenues available through the *Trade Practices Act 1984* for addressing some of these issues. The concerns about corporatisation are in areas such as undue influence over referral patterns, concentration of ownership, non-disclosure of financial interests, and interference with clinical independence. These are discussed and examples of behaviour by corporations that might constitute breaches of the provisions of the *Trade Practices Act 1984* are identified.

The question that must be addressed in this review is whether the remedies available under the *Trade Practices Act 1984* when combined with other avenues of redress such as voluntary codes of conduct etc are sufficient to protect the public from unprofessional conduct by registered medical practitioners. **Appendix 1** outlines some of the remedies available under the *Trade Practices Act 1984*.

Australian Labor Party (ALP) Discussion Paper

Concerns about the potential negative effects of corporatisation have also been identified in a discussion paper by the ALP Federal Shadow Minister for Health Ms Jenny Macklin, titled: *Protecting the Patient's Interest. Regulating the corporate control of medicine*, released in March 2001. The paper seeks comment on proposals contained in a Draft Private Members Bill titled the Health Insurance Amendment (Corporate Control of Medicine – Protection of Patient Interests) Bill 2001.

The paper states:

Whilst the corporatisation of pathology and radiology practices has been occurring for over a decade, the corporatisation of general practice is a new phenomenon. So too, is the formation of 'vertically integrated' arrangements where general practice is part of the same corporation offering radiology, pathology and other specialist services. Many people are

concerned this will change the face of medicine in Australia and dramatically increase costs for Medicare. The core concern is to maintain current ethical values, clinical autonomy and the standard of care.

The paper provides some data on the speed and extent of this change. Five key steps are identified as required to clarify the regulation of corporate medicine to protect the interests of patients. They are:

- Prevent exploitation of vertical integration by prohibiting the payment of kickbacks for making referrals to another doctor, for prescribing particular medicines, for sending people to a private hospital or nursing home, or being directed to do so by any corporate entity.
- Ensure greater choice of referrals for both doctors and patients by requiring doctors to normally provide three choices of specialist when referring patients.
- Ensure doctors disclose any financial interests they have in companies associated with goods or services that they recommend to patients.
- Work with the States to establish common standards for the registration of doctors and ensure standards for accreditation, accountability and protection of clinical independence are common across Australia.
- Establish consistent rules for the sale or transfer of medical records to protect the patient's right to know who has access to their personal medical information and to prevent such information being sold for commercial use.

A private member's bill has been prepared to achieve some of these objectives through new or expanded requirements under the Commonwealth *Health Insurance Act 1973*. The paper states that these measures will control the negative impacts of corporatisation and ensure that amalgamation of practices occurs in a way in which the public interest is protected.

Australian Medical Association (AMA) view

The Australian Medical Association has published a paper titled *General Practice Corporatisation – Scoping Paper* November 2000. The AMA's key concerns in relation to corporatisation are:

- the potential loss of capacity of GPs ability to maintain clinical independence;
- the potential for corporate priorities to influence the ethical standards of doctors;
- the potential for corporate interests to influence the volume and direction of referrals; and
- tension between the role of the profession (meeting the needs of patients) and the objectives of the corporation (meeting the needs of shareholders) and the implications for professional control of quality and standards.

The AMA notes that there are a number of models of corporatisation and that some models of corporatisation enhance general practice. However it is concerned about models that are vertically integrated, that is, concentrate general medical practices under a corporate umbrella with other services such as pathology, diagnostic imaging and specialist services.

The AMA recommends the following strategies for ensuring appropriate corporatisation:

- regulation that prohibits doctors or third parties entering into contractual and/or financial arrangements which distort clinical practices.
- either industrial representation for doctors working in the community, in corporations and medical centres or the development of a set of agreed and enforceable minimum standards for conditions of employment for employee doctors.
- the facilitation of alternative arrangements to corporatisation such as medical co-operatives, group practice networks and practice management services for small practices.

The AMA also argues that consideration should be given to the option of introducing a legislative restriction on the ownership of medical practices to ensure that such practices can only be owned by medically qualified persons.

General Practice Divisions Victoria (GPDV) view

The General Practice Divisions Victoria published a position paper in February 2001. In this paper, the GPDV:

- acknowledges the importance of concerns about maintaining clinical autonomy and ensuring practice management and ownership models that will lead to high quality, ethical, accessible care for communities.
- believes that maintenance of standards in corporate and other structures is most appropriately addressed through the RACGP Standards for General Practice.
- believes that legal ownership and regulation issues should be examined, in light of increasing corporatisation. GPDV will work to facilitate Victorian Divisions of General Practice input on these issues to the Medical Practitioners Board and the Department of Human Services.
- believes that, while Divisions of General Practice have a role in assisting and providing information to their member GPs on corporatisation issues, the individual practice-level business issues are at this time primarily a matter for the AMA.
- acknowledges that there is no formal consensus among Divisions of General Practice about which model of practice, or which owner, is most likely to achieve improved quality health care delivery at the local level.
- is interested in providing a forum for discussion of the issues surrounding the relationship between Divisions of General Practice and corporations.
- considers it has a role in obtaining clarification of Commonwealth and State government policies that may affect divisions' responses to corporatisation.

Royal Australian College of General Practitioners (RACGP) view

The RACGP is concerned about the potential threat that corporatisation poses to the standards of health care delivery and the clinical and professional autonomy of general practitioners. The College:

- supports a diversity of models of general practice provided that key elements such as standards of care, clinical autonomy and primacy of the doctor-patient relationship are maintained.
- has identified a number of potential negative and positive effects of corporatisation in its paper titled *Corporatisation of General Practice* (September 2000).

The RACGP, with the support of the AMA and the Commonwealth Government, has established the Australian General Practice Accreditation Limited (AGPAL). Its aim is to provide an independent and voluntary system of practice accreditation to enhance the delivery of services and facilities by general practices through a process of continuous quality improvement. The College has developed a guide for the Standards of General Practices that addresses structure, process and outcomes and these are assessed by accredited surveyors.

2.3 Other jurisdictions

Commonwealth

The Minister for Health and Aged Care, the Hon Michael Wooldridge MP, announced on 31 March 2001 that the Commonwealth Government would encourage corporate medical service providers to self regulate their involvement in general practice via a voluntary code of conduct. The objectives of the code would be to ensure the clinical independence and autonomy of medical practitioners working in large corporate practices and maintain the quality of services provided to consumers. The Department of Health and Aged Care is facilitating this process.

States and Territories

All state and territory governments have now completed National Competition Policy Reviews of their medical practice legislation (with the exception of Tasmania). There continues to be considerable variation in approaches to regulation of corporate medical practices across the jurisdictions. The ACT, Northern Territory and Tasmanian Medical Practice Acts restrict bodies corporate from providing medical services except through a registered medical practitioner and owners are therefore regulated through the relevant Medical Act.

The New Zealand *Dentists Act 1988* has included provisions that make it an offence for a person to direct an employee to practise dentistry in a manner detrimental to the welfare of any patient. The provision provides that no person shall be convicted of this offence unless:

- as a result of that person's direction, the employee or agent has practised dentistry in the manner directed; and
- the employee or agent has been found to have engaged in unprofessional conduct in respect of that practice by the Dental Practice Board.

A similar provision has been included in the Victorian *Dental Practice Act 1999*. However, concerns have been raised that such an offence provision could be used inappropriately in the workplace to undermine lawful directions by hospital management to employed medical practitioners.

New South Wales

The NSW *Medical Practice Amendment Act 2000* amended Part 8A of the *Medical Practice Act* to include offences and penalties for directors of companies who incite employee registered medical practitioners to engage in over-servicing, unsatisfactory professional conduct, or professional misconduct. The Director-General of the Department of Health has the power to prohibit a person convicted of such offences from operating a business that provides medical services. Changes relevant to regulation of lay owners of medical practices include the following:

- Section 36 extends the definition of unsatisfactory professional conduct to include over-servicing, giving or receiving inducements to refer, and failure to declare a pecuniary interest in making a referral.
- Section 112A makes it an offence for a person to accept from a registered medical practitioner, or their employer a benefit as inducement, consideration or reward for referring or recommending referral to the medical practitioner.
- Section 112B makes it an offence for a person to offer or give a registered medical practitioner or their employer a benefit as inducement, consideration or reward for referral or recommending referral to the health service provided by that person.
- Section 116A makes it an offence for an employer to direct or incite an employee medical practitioner to engage in over-servicing, or conduct that would constitute unsatisfactory professional conduct or professional misconduct.
- Section 116A(5) excludes public health organizations, private hospitals, day procedures centres or nursing homes from being subject to the offence provisions for directing or inciting medical practitioners to engage in over-servicing or misconduct.
- Section 116B extends the definition of who is an 'employer' for the purposes of these offences to include all the directors, secretary or executive officer as defined in Corporations Law of the corporation that employs the medical practitioner.
- Section 116D empowers the Director General of the Department of Health to prohibit those found guilty of the above offences from operating a business that provides medical services. This prohibition may be time limited and may apply to specific premises or areas.
- Section 116E creates an offence for persons prohibited under section 116D from operating a business that provides medical services.

- Section 116J empowers a person authorised by the Director-General of NSW Health to enter premises without consent or warrant for the purposes of ascertaining whether the relevant part of the NSW Act is being complied with.

Western Australia

WA Health recently completed an NCP review of the *WA Medical Act 1894* and is examining a range of options for regulation of corporate medical practices. A WA government review conducted in 1991-1993 recommended that all bodies corporate involved in providing medical services should be required to obtain registration as medical practitioners under the *Medical Act*. These recommendations were not implemented at that time but are again under consideration. Non-registered bodies would be prohibited from providing medical services. Such a requirement would need statutory exemption for some bodies, for example the State and other corporate bodies at the Medical Board's discretion.

South Australia

The SA Department of Human Services is also reviewing the South Australian *Medical Practitioners Act 1983*. The Medical Practice Bill 2001 is currently before Parliament. The Bill includes provisions that regulate non-medically qualified providers including:

- a requirement that registered medical practitioners who are employed by or in a business partnership with unregistered persons inform the Medical Board of South Australia of the names of their employers or business associates; and
- the inclusion of a new offence for persons who exert undue influence over a medical practitioner to provide a medical service in an unsafe or unprofessional manner.

Queensland

Queensland Health has recently reviewed all health practitioner legislation, and the *Health Practitioners (Professional Standards) Act 1999* establishes a framework for regulation of health professions in that state. Parliament has recently passed the *Medical Practice Act 2001*. New provisions (yet to be proclaimed) that will affect corporate medical practices are as follows:

- registered medical practitioners who practise in a name other than their own will be required to notify the Queensland Medical Board of the business name;
- a "natural person" who owns a medical practice and is not a registered medical practitioner will be required to notify the Board of the business name of the practice and his/her name and address;
- a corporation owning a medical practice will be required to notify the Board of its name and principal address, the names and addresses of the directors (if incorporated under Corporations Law) or the names and addresses of the members of the governing body of the corporation (other cases).

It will be an offence for any person to aid, abet, counsel, procure or induce (including by threats or promises) a registered medical practitioner to engage in conduct that could result in the practitioner being disciplined for unsatisfactory professional conduct. The offence will carry a maximum penalty of \$75,000.

The court may be able to prohibit, impose conditions on, or restrict the involvement of a person found guilty of such an offence in the delivery of health services.

2.4 Discussion

The problems identified above may not be unique to corporatised medical practices. However, where a corporate medical practice is owned by a registered medical practitioner, the Board can conduct a formal or informal hearing into the matter and apply sanctions if necessary. Where the practice is owned by a non-medically qualified non-registered person, the Board has few avenues available to resolve the problems if it finds that the practice management, rather than an individual medical practitioner, is at fault.

There are, however, a range of other remedies available to address these concerns:

- There are both civil and criminal remedies for fraudulent activity by unregistered owners of medical practices. For example, there are general laws that apply to all individuals who conduct a business activity (whether incorporated or not). These include the Commonwealth *Crimes Act 1914*, the *Criminal Code (CW) 1995* which address fraudulent conduct, the Victorian *Fair Trading Act 1985* and the *Therapeutic Goods Act 1958* which make provision for false and misleading advertising.
- Under common law, an employer is vicariously liable for the acts of his/her employee, if the employee is acting in the course of his/her employment. Where an employer directs an employee to take certain actions, and the employee is found to be negligent, the employer may be found liable.
- The Victorian *Health Records Act 2001* also establishes certain legal protections for consumers/patients in relation to the collection, use, disclosure and storage of their health information held by incorporated and unincorporated medical practices (see **Appendix 2**).

The question that must be addressed in this review is the extent to which the various remedies that are currently available are satisfactory, and if they are not, then what role should the Medical Practitioners Board of Victoria (MPBV) play in regulating corporate medical practices. In considering this question, it is important to understand that:

- the role of the Board is to protect the public by setting standards of practice and addressing any unprofessional conduct by individual registered practitioners;
- any proposals for amendment to legislation must comply with National Competition Policy (see page 12 of this paper).

There are a number of options for the regulation of non-medically qualified owners of medical practices at the State level. They are:

Option 1. Reliance on existing legislative and non-legislative mechanisms (No extension to the powers of the Medical Practitioners Board of Victoria)

The main arguments in support of the status quo are:

- Individual practitioners are accountable for the standard of the medical services and care they provide regardless of their employment arrangements, and are subject to the disciplinary processes of the MPBV if a practitioner fails to meet acceptable standards.
- Corporate owners who engage in unethical or illegal practices in the provision of medical services may be adequately dealt with through other mechanisms including:
 - The powers of the ACCC under the *Trade Practices Act 1984*.
 - The powers of the Health Insurance Commission under the *Health Insurance Act 1973*.
 - Codes of practice developed by the Commonwealth addressing ethical conduct by corporate medical practices.
 - Existing systems of voluntary accreditation of general practices such as the AGPAL.
- The Commonwealth has indicated its intention to work with the major corporations to establish a voluntary code of conduct to self regulate their involvement in general practice.
- There are also pressures on the Commonwealth Government to strengthen controls over corporations, for example to strengthen the powers of the Health Insurance Commission to better regulate corporations. Before reforms at the State level are framed, sufficient time should elapse to assess the impact of corporatisation and whether existing mechanisms are adequate to prevent or address any abuses.

Option 2. Strengthen the powers of the Medical Practitioners Board to regulate unprofessional conduct by medical practitioners arising from the activities of corporate providers

Some of the approaches to strengthening the powers of the Medical Practitioners Board to regulate corporate medical practices include:

- Empower the MPBV to require notification of names and addresses of directors/owners of corporate medical practices, similar to the provisions of the SA Medical Practice Bill 2001 and the Queensland Medical Practice Bill Section 170.
- Establish an offence in the *Medical Practice Act* for 'employers' to direct or incite registered medical practitioners to engage in unprofessional conduct, similar to the NSW *Medical Practice Act* Section 116A and the Queensland *Medical Practice Act* Section 170.

- Empower the Secretary of the Department of Human Services to prohibit those found guilty of such offences from providing medical services or attach conditions to the provision of their services, (a form of ‘negative licensing’ that would apply only to those who had committed offences).
- Require all medical practices owned by unregistered persons to have a medical practitioner identified to the Board as being responsible for professional standards, similar to sections 127 and 115 of the NSW *Medical Practice Act* that require a medical practitioner to be nominated as responsible for record keeping and advertising.

Option 3. Amend the Health Services Act to introduce a system of licensing of corporate medical practices.

Part 4 of the *Health Services Act 1988* sets out legislative requirements for registration of health service establishments. These include private hospitals and day procedures centres. Sections 83(1)(c) and (d) of that Act empower the Chief General Manager of the Department to consider whether the applicant who is seeking to register a health service establishment is a fit and proper person to carry on the establishment, and if a body corporate, whether each director or other officer of the body corporate who exercises control is a fit and proper person. Extension of this system of regulation to registration of medical practices would allow the Secretary of the Department to:

- require applicants for registration of a medical service to be approved by the Secretary of the Department as fit and proper, and undergo various probity checks;
- renew, suspend or revoke a registration or attach conditions, limitations or restrictions to a registration;
- prohibit persons who are not “fit and proper” from operating a business that involves the provision of medical services.

This would allow the Secretary of the Department to attach conditions to a registration or to prohibit a person who was found not to be fit and proper to provide medical services only where it was necessary to protect the public. Those who have been found guilty of offences under the *Trade Practices Act* or the Criminal Code might be prohibited from providing medical services. The *Health Services Act* may be a more suitable vehicle for this type of regulation than the *Medical Practice Act* since:

- there are other similar functions carried out under the *Health Services Act* for registration of private hospitals and day procedures centres, and
- the role of the Medical Practitioners Board is to regulate the professional standards and conduct of **individual** practitioners rather than to regulate corporate behaviour.

However, licensing of every corporate medical practice is a costly and intrusive form of regulation and other less restrictive options may provide sufficient protection to the public.

2.5 What are your views?

The Department seeks your comments on:

- What evidence is available to indicate that corporate medical practices are pressuring their employee medical practitioners to engage in unprofessional conduct?
- What deficiencies exist, if any, in the current regulatory and self-regulatory frameworks that govern the provision of safe and ethical medical services by corporations?
- Is unprofessional conduct of this kind so widespread or serious as to warrant an extension of the powers of the Medical Practitioners Board of Victoria, in addition to the various other regulatory and self-regulatory mechanisms available to protect the public?
- What are the preferred models, if any, for further regulation of corporate medical practices at the State level?

3. Regulation of Nursing Agencies

3.1 Background

With the passage of the *Victorian Nurses Act 1993*, the *Nurses Act 1958* was repealed. Section 38A of the 1958 *Nurses Act* provided for the registration of nursing employment agents:

(1) Every person who at the commencement of the Nurses (Amendment) Act 1960 is carrying on for fee or reward the business or practice of arranging the supply of nurses registered under this Act for any class or classes of nursing and every person who after the said commencement desires to commence to carry on that business or practice for fee or reward shall make application to the Council in the prescribed form for registration as a nurses' agent.

Subsection 2 of the repealed Act required the Council (the forerunner to the Nurses Board of Victoria) to be satisfied that the applicant was a fit and proper person before registering a nurses' agent and issuing a certificate. The Act included an offence for practising as a nurses' agent without registration:

(8) After the expiration of six months from the commencement of the Nurses (Amendment) Act 1960 any person who carries on for fee or reward the business or practice of a nurses' agent within the meaning of this section who is not registered for the time being under this section shall be guilty of an offence against this Act.

Some nursing bodies have submitted that there is a need to reintroduce provisions requiring registration of nursing agencies. They state that there are abuses in the supply of agency nurses to hospitals and other health services. They report instances where hospital administrators request an agency to provide a Division 1 nurse, and instead, Division 2 nurses may be referred by the agency, with no advice to the hospital that their request cannot be met. By the time the shift commences, the hospital may not be in a position to refuse work to a nurse without the required qualifications and expertise, or may not be aware that they are employing nursing staff who are not properly qualified.

3.2 Existing offences

Section 63 of the *Nurses Act 1993* provides offences for persons who arrange for a person who is not a registered nurse to work as a registered nurse. The offences are as follows:

63. Offence to provide unregistered nurses

- (1) A nurse's agent must not arrange for a person who is not a registered nurse to work as a registered nurse. Penalty: 50 penalty units.
- (2) A nurse's agent must not arrange for a registered nurse to work in contravention of the terms of that nurse's registration. Penalty: 50 penalty units.
- (3) A nurse's agent must not arrange for a person who is not a nurse practitioner to work as a nurse practitioner. Penalty: 50 penalty units.

- (4) A nurse's agent must not arrange for a nurse practitioner to work in contravention of the terms of that nurse practitioner's endorsement of registration. Penalty: 50 penalty units.

The NBV has advised that no prosecutions have been made against persons under this provision and that no formal complaints have been received by the Board.

3.3 Discussion

Laws that require registration of nursing agencies within a framework of occupational regulation of the nursing profession have not been identified in other jurisdictions. It is understood that the regulations that were in place in Victoria prior to 1993 were repealed because they were considered unnecessary.

The arguments against requiring registration of nursing agencies are:

- offence provisions already exist in the *Nurses Act* to address unacceptable behaviour by nursing agencies; and
- National Competition Policy requires the Government to demonstrate first that there are significant costs to the community of unregulated operation of nursing agencies, that the benefits of introduction of a regulatory scheme justify these costs, and finally, that there are no other less restrictive alternatives to achieving these nett public benefits; and
- The problems raised require a management response rather than further regulation. The onus should be on service management to check the credentials of all nurses employed whether through agencies or not, and address problems directly with the nursing agency concerned.

In addition, the Nurses Board of Victoria is established to register and regulate the practice of individual nurses. It is not an appropriate body to regulate corporate bodies such as nursing agencies. If there is a sufficient case for regulation of nursing agencies, then the *Health Services Act* may be a more suitable vehicle.

3.4 What are your views?

The Department seeks your comments on:

- What problems exist with the operation of nursing agencies and how significant or widespread are these problems?
- How satisfactory are the current offence provisions in the *Nurses Act 1993* for dealing with these problems?
- Whether these problems are sufficient to justify the imposition of a regulatory scheme for nursing agencies or whether there are other less restrictive and costly solutions?

4. Legislative Restrictions on Inducement to Refer

4.1 Background

The Victorian *Medical Practice Act 1994* does not specifically prohibit medical practitioners from accepting or providing inducements for referral of patients. However, the definition of unprofessional conduct in section 3 of the Act could be considered to include such behaviour under the following:

- (a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered medical practitioner; or
- (b) professional conduct which is of a lesser standard than that which might be expected of a medical practitioner by her or his peers;

Under recent amendments to section 66(1) of the *Medical Practice Act*, the Board has the power to issue codes for the guidance of registered practitioners and these codes are to be taken into account by the Board when determining whether a practitioner has engaged in unprofessional conduct.

In 1984, the Victorian Parliament passed the *Medical Practitioners (Private Hospitals) Act* but it was never proclaimed. The Act established a legal requirement that medical practitioners with any direct or indirect financial interest in any private hospital to which they were making referrals, to declare this interest both to the patient concerned (or their representative) and to the then Health Commission of Victoria. The Act defined a 'notifiable interest' as extending to not only the medical practitioner but also members of his/her immediate family and applying also to any involvement of the practitioner in partnerships or corporations.

4.2 Commonwealth powers

The Commonwealth *Trade Practices Act 1974* (*TP Act*) prohibits certain collective boycotts, price fixing, exclusive dealing and market sharing, as well as anti-competitive mergers and the misuse of market power. The *TP Act* also:

- protects consumers and small businesses by prohibiting false, misleading, deceptive and unconscionable conduct;
- prohibits third line forcing, that is, where a business supplies services on the condition that the purchaser acquire goods or services from a particular third party, or a refusal to supply because the purchaser will not agree to the condition.

In addition, the Commonwealth *Health Insurance Act 1975* makes it a criminal offence for medical practitioners or non-medical owners to accept or request an inducement to refer to particular pathology providers or hospitals. Similarly, there are provisions that prohibit pathology providers offering inducements to refer.

4.3 Other jurisdictions

Section 46 of the NSW *Private Hospitals and Day Procedure Centres Act 1988* prohibits a medical practitioner or dentist advising a person to be admitted to, or arranging the

admission of, or providing or arranging medical surgical or other treatment to, a patient if the practitioner has a pecuniary interest in the hospital or centre unless the person or patient has first been advised of the interest. Regulations made under that Act define what is a pecuniary interest and how the person/patient is to be notified.

S.112A & 112B of the NSW *Medical Practice Act* make it an offence for a person to offer to or accept from a registered medical practitioner, or the employer of a registered medical practitioner, a benefit as inducement, consideration or reward for a referral to or from another health service or use of a health product. The penalties for an individual are 100 penalty units (currently \$11,000) for a first offence, and 200 penalty units (currently \$22,000) for subsequent offences. For a corporation, the penalties are 200 and 400 penalty units.

In addition, the NSW definition of 'unsatisfactory professional conduct' has been amended to include:

- accepting from a health service provider (or from another person on behalf of the health service provider) a benefit as inducement, consideration or reward for referring another person to the health service provider, or recommending another person use any health service provided by the health service provider or consult with the health service provider in relation to a health matter (section 36(1)(e)); and
- referring a person to, or recommending that a person use or consult another health service provider or a health service or a health product when the practitioner has a pecuniary interest in giving that referral or recommendation unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation (section 36(1)(f)).

A pecuniary interest is defined in section 36(2) as including:

- where the practitioner holds 5% or more of the issued share capital of the public company providing the health service or product; or
- where the health service provider is a private company and the practitioner has any interest; or
- where the health service provider is a natural person and partner of the practitioner; or
- any other circumstances prescribed in regulation.

4.4 Discussion

The Royal Australia College of Ophthalmologists (RACO) has raised concerns that the co-management of patients between ophthalmologists and optometrists has the potential to lead to kickbacks being paid for the referral of patients. RACO has requested that the Victorian Government amend the *Medical Practice Act* to ban inducements to refer. The College argues that such an amendment would provide a strong message to the profession as well as a specific process to deal with inappropriate practice. Although there has been no formal evidence that such practices are occurring, this review provides the opportunity to examine reforms in other jurisdictions and assess the extent to which similar reforms are required in Victoria.

Options for reform of this area include:

- Maintenance of the status quo, that is, continued reliance on existing mechanisms such the RACGP Quality Assurance processes, MPBV existing powers to regulate unprofessional conduct generally and to issue codes of practice, and the existing offences in the Commonwealth *Trade Practices Act* and *Health Insurance Act*.
- Amendment of the *Medical Practice Act* to incorporate similar provisions to Sections 112A, 112B, 36(1)(e), 36(1)(f) and 36(2) of the NSW *Medical Practice Act*.

4.5 What are your views?

The Department seeks your comments on:

- Whether the Victorian *Medical Practice Act* has provisions that allow the MPBV to adequately deal with inducements to refer.
- If not, then should the definition of unprofessional conduct be amended to include such conduct; and/or
- Should there be offences established in the Act in addition to the unprofessional conduct provisions; and/or
- Other alternatives for preventing inducements to refer.

5. Maintaining Professional Competence and Regulating Poorly Performing Practitioners

5.1 Background

One of the primary roles of the MPBV and the NBV is to ensure that registered medical practitioners and nurses are competent to practice their respective professions. The Boards' assessment of competence is based on the initial registration criteria, the operation of the complaints and disciplinary system and each practitioner's professional obligations to maintain his/her skills.

The current Victorian legislation empowers these registration boards to deal with medical practitioners and nurses who have engaged in 'unprofessional conduct' or whose health is impaired. **Appendix 3** sets out the Victorian definition of unprofessional conduct and the powers of the Boards to deal with impaired practitioners.

Section 14 of the *Nurses Act 1993* empowers the NBV to:

refuse to renew the registration an applicant who is otherwise qualified to be registered if he/she has not had sufficient nursing experience in the preceding 5 years to be able to practise as a nurse.

The intent of this provision is to allow the NBV to protect the public from nurses whose skills are not up to date.

The *Medical Practice Act* does not include a 'recency of practice' provision similar to the *Nurses Act*, and the MPBV powers do not provide an avenue for the assessment of competence to practice medicine if the practitioner is out of a clinical setting for some years or where no complaint concerning their practice has been made. Although the MPBV has the power, on its own motion, to initiate investigations and conduct disciplinary proceedings, these address unprofessional conduct or impairment rather than questions of ongoing competence to practise.

During the 1998-99 NCP Review, the MPBV sought an amendment to the *Medical Practice Act* to empower it to deal with practitioners who demonstrate a persistently poor level of performance but who are not impaired and where no single complaint fulfils the definition of unprofessional conduct of a serious nature. During the same review, submissions on the *Nurses Act* argued it is the responsibility of the employer to select staff with the required skills for a position, and that the recency of practice powers exercised by the NBV unfairly disadvantage women who wish to return to nursing after taking time off to raise children. Concerns have also been raised about the way the NBV administers this provision in relation to, for example, nurses who work in pathology services where their role is limited to taking blood and collecting samples for other pathology tests. Some of these nurses have not been able to demonstrate recency of practice to the satisfaction of the NBV.

The Minister for Health agreed to defer introduction of or amendment to the recency of practice powers of the MPBV and the NBV in order to allow a proper consideration of the issues and an examination of:

- The extent of the problems associated with poorly performing practitioners.

- The different models available to maintain the professional competence of medical practitioners and nurses, including recent legislative changes in NSW and Queensland, and
- What additional powers the respective boards might require if there was a net public benefit in regulating this area and no other more suitable mechanisms for maintaining professional competence and regulating poorly performing practitioners were available.

Existing CPE programs

The Australian Medical Council supports continuing professional development (CPD) through the training programs provided by the Specialist Colleges. One such program, Maintenance Of Professional Standards (MOPS) is provided by the Royal Australasian College of Physicians. The program provides a formalised procedure for the annual self-reporting of activities by participants. A total of 500 credit points must be obtained within a five year cycle in either of the following ways:

Option A

- A minimum of 50 credit points and a maximum of 250 credit points from Quality Assurance activities.
- A maximum of 250 credit points can be claimed as Practice-Related CME.
- A maximum of 250 credit points can be claimed for Teaching and Research.

Option B

- Successfully undertake a Practice Quality Review that will result in the 500 credit points being allocated to the participant.
- Participants are required to accumulate a minimum of 60 credit points each year of the five-year cycle.

RACGP also has a Quality Assurance and Continuing Education Program. GPs must gain a required number of credit points through:

- clinical audit which are planned activities designed to help GPs review aspects of their clinical performance in practice which is aimed at improving patient care;
- continuing medical education which are activities designed to help doctors enhance knowledge, skills, attitudes and judgment to improve the health care of patients and the community;
- professional development which are activities that focus on the profession's role in improving the health care of the community.

5.2 Stakeholder views

Australian Medical Council (AMC) view

The AMC in cooperation with the Committee of Presidents of Medical Colleges released an Issues Paper in April 2001 titled *A National Approach to the Registration of Medical Practitioners*. The Paper states:

The aim of continuing professional development (CPD) initiatives is to ensure the community of the continued competence of those who provide medical services, and therefore the safety and quality of those services. It is appropriate, therefore, that medical registration should be linked to evidence of continuing professional competence.

The Paper reports the outcome of a Joint CPMC/AMC/Medical Boards Workshop on Professional Development held in February 2000 that confirmed the call from the profession for

the need to make the continuing certification of competence more effective without introducing additional burdens or an excessively bureaucratic system on doctors who are maintaining their professional standards.

The Workshop endorsed a new approach to the certification of continuing professional competence based on the following premises:

- a significant number of practising doctors (possibly as many as 90%) have accepted and utilised Continuing Professional Development/Maintenance of Professional Standards (CPD/MOPS) and vocational registration pathways and processes in Australia;
- most doctors strive to perform competently for most of their practising lives;
- there is little or no evidence to support or to challenge the assumption that CPD/MOPS or vocational registration improves or maintains performance or competence.

The Issues Paper proposes that a sequential model for ongoing certification of professional competence be developed as follows:

- Annual renewal of registration for specialists and general practitioners would be granted automatically on application provided the practitioners are able to provide appropriate documentary evidence of ongoing participation in CPD/MOPS programs, to the standard required by the College or CPD provider.
- Doctors who are unable or unwilling to provide such documentation would default into a pool of doctors who would be subject to a random practice audit. Consideration would have to be given to the circumstances of doctors working in rural or remote areas, those in part-time practice and older doctors to ensure that they are not disadvantaged.
- The audit may need to include some form of screening instrument or assessment and would be undertaken by trained personnel drawn from the relevant College.
- It is envisaged that the audit would be paid for by the Board of the State or Territory in which the specialist (or GP) maintains his or her principal practice.
- All doctors in the 'pool' would be audited at least once every five years.

The Issues Paper states that the use of audits to assess the competence of doctors who do not participate in CPD programs may require further consideration. The major issues are:

- Opinions vary on the frequency and timing of audits. A practitioner who is subject to audit may only be reviewed periodically compared to the annual requirement for evidence of CPD participation.
- Given the current developments in legislation, it is likely that requirements may vary between the states;
- Further research and development is required to ensure that assessment models are appropriate and sufficiently flexible to accommodate the circumstances of individual practitioners.

The AMC has sought comments on these issues by 25 May 2001.

Medical Practitioners Board of Victoria

The MPBV expressed concerns during the earlier NCP review about medical practitioners whose overall level of knowledge, skill, judgement or care in the practice of medicine is below the standard which could reasonably be expected of a practitioner of an equivalent level of training and experience but whose conduct does not fit within either the current disciplinary or impairment systems. The inclusion in the Act of powers for the Board to establish a performance assessment process for these practitioners would enable the Board to intervene to protect the public and achieve the best outcome for the medical practitioner where their practice presents risks to the public. Legislative changes would be required to empower the Board in these circumstances to direct a practitioner to undertake a specific training program.

Such a performance assessment process would aim to be educational and cooperative rather than adversarial. It would seek to address broad based problems with a practitioner's practice at an early stage through retraining, rather than waiting for complaints from patients.

Appendix 4 sets out a more detailed proposal from the MPBV for additional powers to better regulate doctors whose performance is not of an acceptable standard. The model is similar to the current arrangements for impaired doctors. The MPBV has proposed that the Act be amended to allow the Board to accept from a range of sources notifications about the professional practice of registrants.

A preliminary investigation would then be undertaken by a member of the Board who is a qualified medical practitioner and this might include an assessment of the practitioner by doctors from an independent panel of highly respected peers of the medical practitioner. The aim of the assessment would be to assess present performance and to provide constructive advice regarding re-training to improve performance. The Board would meet the cost of assessment but any re-training costs would be met by the practitioner. It is expected that re-training and remedial programs would be developed through the Specialist Colleges, medical schools and teaching hospitals.

Australian Nursing Council view

The Australian Nursing Council published a Position Statement in 2000 addressing the need for continuing competence in nursing. This is contained in **Appendix 5**. The

Statement sets out principles that regulatory authorities have agreed to observe when carrying out their responsibilities:

- that a process of self-assessment be the basis for determining the continuing competence of an individual practitioner, and,
- that this be implemented within a quality improvement framework.

Self-assessment of competence is an ongoing process whereby a nurse examines his or her practice against national competency standards accepted by the nurse regulatory authorities for registration and enrolment. Self-assessment is likely to include reflection, critical incident analysis, peer review, and evaluation of client and patient outcomes. On the basis of self-assessment, the variety of methods nurses may use to maintain competence and to improve practice may include informal and formal learning, participation in and utilization of evidence based practice and research, or other professional activities.

The Position Statement recognises that nurse regulatory authorities retain the authority to implement a system for determining continuing competence that is relevant to their jurisdiction and legislative framework.

Nurses Board of Victoria

Appendix 6 outlines the way that the NBV administers the recency of practice provision of the *Nurses Act*. In November of each year an application for renewal of registration is posted to every registered nurse. This application requires each nurse to declare whether they have had sufficient experience as a registered nurse in the preceding five years to maintain their competence.

In making this declaration the Board expects each registered nurse to undertake a self-assessment of their competence. Applicants are referred to the Australian Nursing Council national competency standards as a useful tool for assessing minimum competence for practice. Nurses are encouraged to refer to other relevant standards or competencies for specialised practice, such as the Code of Practice for Midwives in Victoria or the Australian and New Zealand College of Mental Health Nurses' standards for mental health nursing.

5.3 Other jurisdictions

A number of Australian jurisdictions have addressed or are considering whether the entitlement to re-registration should be qualified by an obligation to demonstrate continuing professional competence.

NSW Review of the Medical Practice Act

The NSW Parliament has recently amended the *Medical Practice Act* to empower the NSW Medical Board to address issues of professional competence of practitioners. The Act contains a new Part 5A titled 'Performance Assessment'. The main provisions are as follows:

- The Board may have the professional performance of a registered medical practitioner assessed if any matter comes to its attention that indicates that the professional performance of the practitioner is unsatisfactory (section 86C).

- Matters that raise a significant issue of public health or safety or a prima facie case of professional misconduct or significant unsatisfactory professional conduct must be dealt with as a complaint rather than through performance assessment (section 86D).
- Anonymous notifications concerning a practitioner's professional performance cannot proceed to performance assessment (section 86E).
- Referrals for performance assessment of a practitioner may come from the Health Complaints Commission (section 86F).
- The Board can appoint one or two assessors to conduct an assessment of a practitioner's performance (section 86G).
- The assessor(s) provides a written report with recommendations to the Board (section 86I).
- The Board may decide to take no further action, or may require a Performance Review Panel to conduct a review of the professional performance of the practitioner, or proceed with a complaint against the practitioner or refer the matter to an Impaired Registrants Panel or counsel the practitioner or direct that they participate in counselling (section 86J (1)).
- The Board must make a complaint against the practitioner if the assessment raises significant issues of public health or safety, or raises a prima facie case of professional misconduct by the practitioner or unsatisfactory conduct of a significant nature (section 86J(2)).
- The Performance Review Panel conducts a performance review of the practitioner on request of the Board (section 86K).
- The Panel may make various recommendations to the Board including:
 - that conditions be imposed on the practitioner's registration,
 - that the practitioner complete specified further education courses,
 - that the practitioner report regularly on his/her performance to the Board, or
 - that the practitioner seeks and takes advice on the management of their medical practice (section 86N).
- The Panel can direct that a practitioner's performance be reassessed at a future date and the Board can appoint assessors to conduct the reassessment (section 86O).
- There are provisions for confidential information to be excluded from the statement of a decision given to the practitioner and other persons (section 86Q).
- The Board has power to monitor compliance with any orders arising from a performance assessment and evaluate the effectiveness of orders in improving the performance of the practitioner.
- A practitioner who is subject to a performance review may appeal to the Chairperson of the Medical Tribunal on points of law, during or within 28 days after a performance review.

Queensland

Section 266 of the *Queensland Medical Practitioners Registration Act 2001* (yet to be proclaimed) gives the Medical Practitioners Board discretion to develop or recognise a CPE program and to promote it to registrants as a 'board endorsed' means of keeping up to date with developments in the practice of medicine. Having regard to the role and expertise of professional associations and educational institutions in the development and delivery of CPE programs, it is likely that the board will recognise appropriate programs developed and/or delivered by external bodies. Registrants who satisfy the requirements of a 'board endorsed' CPE program under this section are permitted to advertise the fact.

Section 266 of the *Medical Practitioners Registration Act* is a template provision that is expected to be included in all new or amended health practitioner registration acts in Queensland.

Ontario Canada

The Ontario *Regulated Health Professions Act (RHPA)* gives regulatory Colleges (the equivalent of Victorian statutory registration boards) the authority to:

- develop and maintain standards of practice;
- provide quality assurance programs;
- promote continuing competence among their members; and
- when necessary, assess a member's competence or fitness to practice.

The *RHPA* requires each college to establish a program to assure the quality of practice of the profession and to promote continuing competence among its members. The *Quality Assurance Committees* of the Colleges have broad powers to investigate the conduct or standards of practice of College members. Their objective is not to punish health professionals but, whenever possible, to apply measures that improve the quality of care provided by individual members and the profession as a whole. When necessary, the *Quality Assurance Committee* can refer a case to the Executive Committee, which in turn may refer the case to the *Fitness to Practice* or *Discipline Committee*. Conditions, limitations or restrictions may be imposed on the certificate of registration of any member whose knowledge, skills and judgement have been assessed or reassessed and found to be unsatisfactory or who has failed to participate in or successfully complete continuing education programs or remedial training specified by the Committee. (Ontario Health Professions Regulatory Advisory Council: *Weighing the Balance. A Review of the Regulated Health Professions Act*. Request for Submissions. October 1999).

United Kingdom

In January 2001, the United Kingdom National Health Service (NHS) published a report titled *Assuring the Quality of Medical Practice: Implementing Supporting doctors protecting patients*. The report outlines the establishment of the National Clinical Assessment Authority (NCAA) to work with doctors and the NHS to identify problems with poorly performing doctors early, offer appropriate support and training to enable doctors to reach a good standard of practice again as swiftly as possible. Together with a reformed General Medical Council and changes to disciplinary procedures, the new system is

designed to deal with the genuinely dangerous doctor much more quickly and effectively, before patients are harmed. (*Assuring the Quality of Medical Practice: Implementing Supporting doctors protecting patients*. Pp. 2). The report also outlines reforms that establish:

- a comprehensive program of Continuing Professional Development;
- appraisal for all doctors, underpinned by revalidation; and
- clinical audit of all NHS doctors.

Where there are doubts or concerns about a doctor's clinical performance that cannot be resolved locally, the employer (or Health Authority in the case of a general practitioner) will refer the doctor to the NCAA. The NCAA will respond quickly in giving advice or more often by initiating an assessment of the doctor's clinical practice and will provide a thorough, objective and authoritative report on the problem with advice on any action that ought to be taken (*Assuring the Quality of Medical Practice: Implementing Supporting doctors protecting patients*. Pp. 21).

5.4 Discussion

A statutory mechanism or mechanisms to ensure ongoing competence of medical practitioners and nurses might include one or a combination of the following:

- providing the registration boards with the discretion to develop or recognise CPE programs and to promote it to registrants as a 'board endorsed' means of keeping up to date with developments in the practice of medicine or nursing (similar to section 266 of the Queensland *Medical Practice Act 2001*);
- empowering the boards to require practitioners to provide evidence of participation in continuing education activities to a standard set by the relevant board;
- empowering the boards to conduct performance assessment of practitioners on reasonable grounds to be specified in legislation (similar to Part 5A of the NSW *Medical Practice Act*);
- empowering the boards to conduct performance audits of those practitioners who have not provided sufficient evidence of their continuing competence at re-registration (similar to proposals issued for discussion by the Australian Medical Council);
- empowering the boards to refuse to renew a practitioner's registration if they have not had adequate practice experience in the preceding 5 years (as in section 14 of the *Nurses Act*);
- introducing routine performance assessment for all practitioners seeking to renew their registration (similar to the United Kingdom reforms).

An alternative approach is to rely on a combination of other non-statutory and statutory mechanisms such as:

- Existing CPE programs operated by the professions and/or employers, for example, the RACGP's Quality Assurance and Continuing Education Program for GPs.

- The CPD requirements established by the various Specialist Colleges, for example the Maintenance Of Professional Standards (MOPS) provided by the Royal Australasian College of Physicians.
- Current board powers to require a practitioner to undergo further education arising from a formal or informal hearing of a complaint of unprofessional conduct, or to attach conditions, limitations or restrictions to a practitioner's registration following a formal hearing.

5.5 What are your views?

The Department seeks your comments on:

- Whether annual renewal of registration should include a statutory requirement that practitioners provide evidence of their participation in continuing professional development activities.
- If annual registration should include such a requirement, are the current provisions that empower the Nurses Board of Victoria to refuse to renew the registration of a nurse who has not had sufficient nursing practice in the previous five years a satisfactory method of ensuring professional competence?
- If not, then what other approaches might be adopted, and what, if any, powers might both Medical Practitioners and the Nurses Boards require?
- Whether the boards should be empowered to conduct performance audits of those practitioners who have not provided evidence of participation in continuing professional development activities to a standard considered acceptable by the Boards.
- Whether the model proposed by the Medical Practitioners Board in Appendix 4 is a satisfactory approach for the medical profession, or whether other models are more suitable.

6.0 Deemed Registration

6.1 Background

The Australian Medical Council/Committee of Presidents of Medical Colleges has released an issues paper titled *A National Approach to the Registration of Medical Practitioners*. In addition to the issue of continuing professional development outlined in section 5 above, the paper proposes amendments to State and Territory Medical Practice Acts to provide for registration to be 'deemed' if an appropriate category of registration is held in another State or Territory in Australia for the purposes of portability.

The AMC/CPMC proposal is for national portability of medical registration for those practitioners with general registration and medical specialists. Practitioners would be required to maintain their registration in one of the participating jurisdictions in which mutual recognition arrangements currently apply, that is, any Australian State or Territory, or New Zealand. Once initial registration was granted in one jurisdiction, unconditionally registered doctors and registered specialists would be entitled to practise in any of the participating States or Territories, presumably without the requirement to put in a separate application for registration and pay an additional fee.

The AMC/CPMC paper proposes that the Victorian Government (along with other jurisdictions) amend its *Medical Practice Act* so that all practitioners with unconditional registration and registered specialists registered in other participating jurisdictions be 'deemed' to be registered in Victoria and entitled to practice here. All practitioners practising in Victoria would have to comply with Victorian law regardless of where their initial registration was obtained. They would also be required to notify the state of principal registration of all practice locations in other jurisdictions. Any doctor with conditional registration in one jurisdiction would be required to apply for registration in another jurisdiction in the same manner as they do presently.

Responsibility for dealing with complaints would continue to rest with the state board where the complaint originated, presumably where the service was provided.

The Department has received other submissions in support of the establishment of a national system of registration for health professions in particular for medical practitioners and nurses.

6.2 Other models for achieving national registration

Under the Australian Constitution, the Commonwealth is unable to legislate with respect to unincorporated persons who are not engaged in interstate trade. There are a number of other possible models for the establishment of national legislation for the registration of health professions. These are via template legislation, mirror legislation or a referral of powers by the States to the Commonwealth under s.51(37) of the Commonwealth Constitution. All of these models overcome constitutional barriers to the development of national laws.

Template legislation involves one jurisdiction legislating to establish a body and the other participating jurisdictions enacting complementary legislation in an agreed form to confer powers and functions on this body. Such an approach requires agreement between the participating governments, setting out the key elements of the legislative

scheme and establishing a Ministerial council or committee to make required statutory decisions.

The use of the template model involves either a State or the Commonwealth enacting legislation to establish the body in an agreed form. The other participating jurisdictions then enact complementary legislation to confer powers on the body and extend its authority to operate within that jurisdiction. The legislation could operate in all participating jurisdictions as amended from time to time (subject to the amendments being agreed by all jurisdictions according to an established process). This means that only one Parliament passes the amending legislation and it is automatically adopted as law of the other jurisdictions.

A variation on this model involves establishing the core structure and leaving issues of detail to be determined by subordinate legislation (e.g. regulations or Orders in Council) which would be implemented once their content is agreed between the jurisdictions. However, this approach is likely to be criticised on the basis that it is not sufficiently accountable to Parliaments.

Mirror legislation requires all jurisdictions to pass identical legislation to establish the national body and confer powers and functions on it. Mirror legislation is less flexible than template legislation because any subsequent changes need to be passed by all Parliaments. This is likely to lead to delays in the implementation of changes. An example of this model is the National Environment Protection Council.

6.3 Discussion

Despite significant harmonisation of regulatory requirements for the registered provisions over the last 10 years, there continues to be significant limitations with the current system of mutual recognition of health professions. The AMC paper identifies variations between jurisdictions in the legal requirements and administrative processes imposed by registration. These differences are well documented in the *Western Australian Report of a review of the Medical Act by a Working Party established by the Minister for Health*, October 1999.

The AMC paper also identifies some of the complexities with introduction of a system of deemed registration. If a system of national portability of registration is introduced, then large numbers of practitioners who currently hold multiple registrations may elect to hold their principal registration in one jurisdiction and their decision may be informed by the level of fees charged by each board. This may have financial implications for smaller boards or those where registration fees are high. In Victoria for example, registration fees for medical practitioners are relatively high to cover the Board's direct operation of the investigation, complaints handling and disciplinary functions. In other States such as NSW, some of these functions are carried out by other bodies such as the Health Complaints Commissioner and a separate Medical Tribunal, and such bodies may not be directly funded by the profession through their registration fees.

National systems similar to the model of 'deemed registration' have been established in areas such as motor vehicle drivers' licensing but such systems still require that drivers understand and comply with separate local state/territory laws. In other areas such as corporations law, States have referred powers to the Commonwealth and a single national system of law and administration applies.

In the United Kingdom, 635,000 nursing personnel are regulated by a single authority known as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

A truly national system of health practitioner registration may have significant benefits such as:

- a single registration fee and application process, allowing practice anywhere in Australia;
- uniformity of registration requirements;
- cost savings for the professions and government, and
- increased innovation and more timely implementation of reforms.

However, the complexities of implementation are significant and is subject to agreement between all States, Territories and the Commonwealth. In addition, there may be benefits in the current state based system in terms of responsiveness of administration to the needs of the profession and the public.

6.4 What are your views?

The Department seeks your comments on:

- Whether Victoria should support a model of 'deemed registration' proposed by the AMC/CPMC and seek national agreement to its implementation across all States and Territories.
- Whether 'deemed registration' is a model that should be applied to other health professions such as nurses.
- Whether there are alternative models to achieve national registration of health professions that may be preferable or whether the current state based mutual recognition system is satisfactory.

7. Regulation of nursing practice

7.1 Background

The National Competition Policy Review of the Victorian *Nurses Act 1993* conducted in 1998-99 addressed the question of whether there was a net public benefit in retaining registration of the nursing profession, including nurses registered in Divisions 1, 2 and 3. The discussion paper invited submissions on retention of restrictions on the use of the title 'registered nurse' or any other title calculated to induce a belief that a nurse is registered. The NCP Panel concluded that:

- whilst there were risks associated with the practice of nursing, there was not sufficient evidence of harm to justify introduction of a definition of nursing and additional restrictions in the *Nurses Act* on who can provide nursing services; and
- that the least restrictive method of ensuring that the public can be protected from unsafe nursing practice is to retain the legislative restrictions on who can use certain professional titles.

The Panel recommended retention of the existing nursing registration system based on protection of title only, with an independent statutory Board made up of a majority of highly qualified members of the nursing profession plus lay and legal representation.

7.2 Current Offence Provisions in the Nurses Act

Section 60 of the *Nurses Act* establishes various offences under the Act including:

- A person who is not registered nurse must not take or use the title of registered nurse or any other title calculated to induce a belief that the person is registered under the Act or claim to be registered under this Act or hold themselves out as being registered (subsection 1).
- A registered nurse must not take or use any title calculated to induce a belief that they are registered in a division of the register in which they are not registered, or hold themselves out as being registered in a division of the register in which they are not registered (subsection 2).
- A registered nurse whose registration is restricted must not take or use any title calculated to induce a belief that the nurse's registration is not restricted or claim to have or hold themselves out as having unrestricted registration (subsection 3).
- A registered nurse whose registration is subject to a condition, limitation or restriction must not take or use any title calculated to induce a belief that the nurse's registration is not subject to any condition, limitation or restriction or claim to have or hold themselves out as having a registration which is not subject to any condition, limitation or restriction (subsection 4).
- A person must not hold out another person as being registered under this Act, if the person knows or ought reasonably to know that the other person is not so registered (subsection 5).

- A person must not hold a registered nurse out as being registered in a division of the register in which that nurse is not registered if that person knows or ought reasonably to know that the other person is not so registered (subsection 6).
- A person must not hold a nurse whose registration is restricted out as having unrestricted registration if that person knows or ought reasonably to know that the other person's registration is restricted (subsection 7).

The Department has received submissions from nursing bodies arguing the need to strengthen the regulation of the nursing profession beyond the offences for use of the title 'nurse'. Submissions propose that the *Nurses Act* be amended to include provision for an offence that prohibits persons who are not registered nurses from performing nursing services. This form of regulation is known as 'protection of practice'.

Submissions have suggested that the Victorian *Nurses Act* be amended to include new offence provisions similar to section 142 of the Queensland *Nurses Act*. The offences would be along the lines of:

A person who is not a registered nurse under this Act must not perform work which in the opinion of the Board is usually done by persons registered under this Act, and

A person must not direct another person to perform work which, in the opinion of the Board, is usually done by persons registered under this Act.

The arguments put to the Department in favour of a restriction on the practice of nursing are as follows:

- The NBV should be given jurisdiction to take action with respect to Nursing Attendants, Personal Care Workers, Personal Care Attendants or other such persons where they are performing work that is also normally done by nurses. If no system of registration is provided for such workers, the Act should prohibit such persons from performing nursing work.
- The nett public benefit of retention of compulsory registration of nurses is public safety, the protection of the public and the provision of adequate and safe nursing care by persons who are qualified and experienced to provide such a service.
- The risks associated with less restrictive methods of protecting the public are inadequate monitoring of patients' conditions, the inability to assess properly, errors in the administration of drugs and general negligence. It is claimed these issues arise on a constant basis in the community even with the current legislative requirement of nurses to be registered before they are able to practise nursing.
- Unless the Act is amended to provide protection of practice, the public would be exposed to an unacceptably high level of risk.

Those who support legislative restrictions on the practice of nursing have pointed to a recent decision by Senior Deputy President Williams in the Australian Industrial Relations Commission (Dec 135700 M Print T4652) providing a definition of nursing which could be adapted for regulatory purposes. Senior Deputy President Williams interpreted the term 'nursing' as meaning 'providing care to the sick, infirm and/or those who, for any reason, are unable to look after themselves'. He included those who are not only in need of medical care but also those who are in need of assistance for the purposes of daily living. He stated that it is neither possible nor appropriate to distinguish between nursing care and personal care, and the provision of assistance with

daily living tasks is but a part of the provision of nursing care. It should be noted that this definition arose in the context of a decision by the AIRC in an application by the Australian Nursing Federation for a change to its eligibility for membership rules.

7.3 Other jurisdictions

Restrictions on the practice of nursing via a legislative definition of nursing and offences for non-nurses carrying out nursing duties have been examined in other Australian jurisdictions and overseas. At present, restrictions on the practice of nursing only apply in Queensland, South Australia and ACT. As part of implementation of National Competition Policy, these jurisdictions are reviewing their legislation and NSW is also currently undertaking a review that will look at, amongst other matters, the regulation of nursing practice.

Submissions to the Department have supported the Queensland approach, which is outlined in detail below.

Queensland

Section 142(1) of the *Queensland Nursing Act 1992* establishes an offence for any unregistered person to practise nursing or perform a nursing service for fee or reward. Queensland Health is currently conducting a National Competition Policy review of this Act and has identified this provision as a restriction on competition.

Since 1996, it is understood that the Queensland Nursing Council (QNC) has successfully prosecuted 20 persons for a breach of section 142(1) of the Act, with many of the persons also concurrently prosecuted for breaching the 'holding out' provisions under section 141 (1) (a). In each prosecution:

- the defendant was an unregistered qualified nurse who had either failed to register or renew his/her registration; and
- had been employed as a registered nurse by the employer; and
- had signed a position statement or agreement which provided details of the nursing duties the defendant was to carry out; and
- the court did not require the assistance of an expert witness to determine if the defendant was practising as a nurse or performing a nursing service, as (b) and (c) were considered to provide adequate proof.

It is understood that the QNC has not, to date, prosecuted an unqualified person for unauthorised nursing practice under section 142(1). It is understood that Queensland Health is examining options for regulation of the nursing profession including:

- Protection of title only.
- Protection of title and restriction of 'Core Practices'.
- Protection of title and a broad restriction on the practice of nursing with specific exemptions for persons such as medical practitioners (status quo).

Restrictions on the practise of nursing rely on formulation of an adequate definition of nursing that can provide a basis for prosecution of an offence. Queensland Health has done considerable research to identify the various definitions of nursing.

Queensland Health is yet to finalise its proposals for legislative reform of the *Nurses Act*.

Ontario Canada

In the State of Ontario Canada, 23 health professions are regulated under the *Regulated Health Professions Act* that came into force in 1993. In addition there are a series of profession-specific acts that establish 'Colleges'. These Colleges are not teaching institutions, but are the equivalent of Victorian health practitioner registration boards and their role is to set standards and make sure the professions comply with the RHPA and related laws.

The RHPA lists thirteen procedures that, if not done correctly and by a competent person, have a high element of risk. These 'controlled acts' are set out in **Appendix 7**, and include:

- Administering a substance by injection or inhalation.
- Putting an instrument, hand or finger
 - Beyond the external ear canal
 - Beyond the point in the nasal passages where they normally narrow
 - Beyond the larynx
 - Beyond the opening of the urethra
 - Beyond the labia majora
 - Beyond the anal verge, or
 - Into an artificial opening into the body.
- Managing labour or conducting the delivery of a baby.
- Prescribing, dispensing, selling or compounding a drug as defined in subsection 117 (1) of the *Drugs and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.

Each profession-specific Act defines the scope of practice of the profession concerned, and identifies which controlled acts registered practitioners are 'authorised' to carry out. Although the scope of practice of each profession is defined, the offence provisions prohibit use of protected titles and carrying out of controlled acts. There is no general offence provision to prevent persons other than registered nurses from practising nursing as broadly defined.

The Ontario State Government is currently conducting a review of the operation of its health practitioner regulatory system, including whether the current list of controlled acts adequately covers the full range of procedures that can cause significant risk of harm and whether any procedures should be added to or removed from the list of controlled acts. (*Ontario Health Professions Regulatory Advisory Council: Weighing the Balance. A Review of the Regulated Health Professions Act. Request for Submissions. October 1999*). The

current list of 'controlled acts' that can be legally performed by registered nurses is in **Appendix 8**.

British Columbia Canada

A similar model is being proposed in British Columbia, Canada. A Health Professions Council has been established under the B.C. *Health Professions Act* to make recommendations to the Minister for Health about regulation of health professions. The Government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts. This is designed to replace the current system where each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), with a system where only those acts which present a significant risk of harm will be reserved, and these may be shared with other professions (Health Professions Council, March 2000). The recommendations of the Health Professions Council are in **Appendix 9**.

7.4 Discussion of models

There are significant disadvantages in attempting to define what constitutes nursing or a nursing service in order to establish an offence for any person who is not a registered nurse from practising nursing. These disadvantages include:

- The overlap of nursing practice with other health professions means the potential for an increase in demarcation disputes between professions and associated additional costs to the community.
- Unless a broad range of exemptions to the practice restrictions is included for health practitioners in the legislation, many registered and non-registered health practitioners would be in breach of such provisions while practising within the normal scope of their profession.
- Unregulated care providers play an important role in assisting registered nurses to provide services. The creation of such an offence might preclude them from offering these services.
- There are various interpretations of what constitutes 'nursing' and 'nursing services' and the widely used definitions do not provide the necessary precision required for legislative drafting. Many definitions include such terms as 'nursing interventions', 'nursing diagnosis' and 'standardised procedures' that would also be problematic to define.
- The evolving nature of nursing practice means a legislative definition can become unduly restrictive on the nursing profession.

The Ontario/British Columbia approach of defining 'controlled acts' is also problematic and appears complex to administer. There are difficulties with identification of 'core practices' that are risky, intrusive or dangerous when carried out by unqualified persons, and should be restricted only to registered nurses and other identified professions. These include:

- The difficulties with implementing a system of ‘core practices’ for the nursing profession in isolation from similar reforms across all registered health professions.
- The absence of viable ‘core practices’ that relate solely to the nursing profession and that are of such a high risk nature that a core practice restriction is warranted.
- The use of core practice restrictions may narrowly define in legislation the scope of nursing practice and may not be responsive to changes over time in the practice of nursing.
- No other Australian jurisdiction imposes a core practices model for nursing.

7.5 What are your views?

The Department seeks your comments on:

- Any evidence that the public is at serious risk under the current system which restricts the use of professional titles but does not restrict via legislation who can provide nursing services.
- The costs and benefits of defining in legislation what constitutes a ‘nursing service’ and creating offences for non-nurses who provide nursing services.
- The impact such offence provisions might have on the practice of other health care professions both registered and unregistered and the provision of services in sectors such as disability, aged care and home and community care.
- The advantages and disadvantages of a regulatory approach that includes a definition of scope of practice and reserved acts.
- What acts nurses carry out that might be ‘reserved’ in legislation and what evidence there is that the public would be better protected than under the current arrangements.

8. Prescribing Rights for Nurse Practitioners

8.1 Background

A nurse practitioner is a registered nurse educated for advanced practice. A nurse practitioner works as an essential member of an interdependent health care team and the characteristics of her/his advanced practice are determined by the context of practice and educational preparation.

In 1998, the Minister for Health established the Nurse Practitioner Task Force to develop a framework and process for implementation of the role of nurse practitioner in Victoria. Following recommendations to Government from this Task Force, in November 2000 the Victorian Parliament passed the *Nurses (Amendment) Act 2000*. This Act amended the *Nurses Act 1993* and the *Drugs Poisons and Controlled Substances Act 1981* to create a legislative framework to support implementation of the role of 'nurse practitioner' including limited rights for nurse practitioners to prescribe scheduled drugs and poisons. **Appendix 10** sets out the main amendments to the *Nurses Act* and the *DPCS Act* that establish the boundaries for prescribing of scheduled drugs by nurse practitioners, and the process to establish the lists of drugs in regulation for each category of nurse practitioner.

The processes associated with the development and implementation of the Nurse Practitioner role are detailed in the *Victorian Nurse Practitioner Project, Final Report of the Taskforce* (2000). The Minister for Health has approved a staged implementation strategy beginning in the public sector and moving into the private sector. The Minister has established a Nurse Practitioner Implementation Advisory Committee (NPIAC) with member representation including nursing (NBV, ANF, Deans of Nursing, RCNA, HCSUA), medical (RACGP, AMA), pharmacy (Pharmacy Board), employer bodies (VHA) and DHS, to report on the best options for role implementation and to work through concerns of various stakeholders.

As part of the Nurse Practitioner role implementation, the Nurses Board of Victoria has been requested to:

- develop the criteria for Nurse Practitioner endorsement, educational requirements for recognition, continuing competence, accreditation of courses, and the transition period; and
- consider the processes necessary for the development of a framework for standards/competencies for Nurse Practitioners that are nationally consistent and internationally compatible.

Eleven demonstration projects were funded in 1999 and a further sixteen are scheduled to commence in 2001. The initial projects are based in the public sector and involve specialty areas such as paediatric eczema, emergency, haematology, wound management, women's health and peri-operative care. The projects under development focus on primary health care and the majority are based in rural and remote areas.

8.2 Medication Administration and the Health Services Permit

Victoria, Tasmania, and South Australia have developed flexible policies for the administration of drugs by registered nurses in remote areas. *S.19(3)* of the Victorian

DPCS Act 1981 allows the Chief General Manager (Secretary of DHS) to issue a licence, permit or warrant subject to terms, conditions, limitations or restrictions determined by the Chief General Manager. Under *S.20 (3)*, a permit issued under *S.19 (3)* authorises a person to purchase or otherwise obtain poisons or controlled substances for the provision of health services.

Bush Nursing Centres and Community Health Centres have been issued with permits under these provisions to purchase poisons and controlled substances in the various schedules, including Schedules 2, 3, 4 and 8. Many of the Health Services Permits held by centres in remote areas have been issued subject to the conditions such as:

A nurse who administers a drug of addiction or restricted substance named on the permit does so only -

- *on the written authorisation of a medical practitioner; or*
- *in an emergency –*
 - *where contact with a medical practitioner is practical, on the oral instruction of the medical practitioner, in whose opinion an emergency exists; or*
 - *where contact with a medical practitioner is not practical, if during the previous twelve months the nurse has demonstrated competence in physical assessment skills relevant to the condition for which the drug of addiction or restricted substance is administered.*

Contravention of or non-compliance with a permit condition constitutes an offence under section 46 of the *Drugs Poisons and Controlled Substances Act*.

8.3 Discussion

Under the current scheme for nurse practitioner prescribing (yet to be implemented), the process for establishing a list of drugs that can legally be prescribed by each category of nurse practitioners requires the making of a statutory rule. As outlined in Appendix 9, this requires the preparation of a Regulatory Impact Statement (RIS) and normally takes at least 6-9 months to finalise. Concerns have been raised that the RIS process is unnecessarily cumbersome and time-consuming, particularly where:

- there is a small number of nurse practitioners seeking authorisation to prescribe, and
- they work in a single agency or small number of agencies, and
- they work in a limited, specialist area of practice, and
- they are seeking the right to prescribe a small number of scheduled drugs.

Examples might include paediatric eczema nurses working at Royal Children's Hospital or haematology nurses working at Peter MacCallum Hospital.

It is proposed that *DPCS Act* and Regulations be amended to extend the Health Services Permit mechanism outlined above to authorise nurse practitioners employed by an agency that has been issued a Health Services Permit, to use sell & supply scheduled drugs, in addition to their authorisation to possess and administer. This means that the prescribing by these nurse practitioners would be activated by the issuing of a Health

Services Permit (HSP) or inclusion of appropriate conditions in an existing HSP, rather than via inclusion in regulation under the *DPCS Act* of the category of nurse practitioner and the associated list of drugs. The conditions of the authorisation set out in the HSP would include:

- the category of nurse practitioner would be specified in the permit along with the related clinical practice guidelines and list of drugs;
- all nurse practitioners in the category specified by the HSP would have obtained the required endorsement from the NBV for that category of nurse practitioner.
- the institution seeking the permit would be required to demonstrate adequate safeguards to protect the public and ensure safe prescribing practices by the identified nurse practitioners;
- the prescribing rights for the individual nurse practitioners would be:
 - in accordance with any conditions, limitations or restrictions imposed by the Health Services Permit; and
 - restricted to the premises occupied by the holder of the permit; and
 - non-transferable to other settings unless the category and the associated list of drugs had also been included in regulation under the *DPCS Act*.

All processes undertaken by the NBV, the NPAC and the PAC prior to the RIS would also be required for the issuing of a Health Services Permit to an institution. The PAC would however make a recommendation to the Secretary to issue a Health Services Permit rather than proceed to the RIS and regulation making process.

The *DPCS Act* could require annual renewal of such HSPs and there could be provisions in the Act to limit the Secretary's discretion to grant such a permit so that this mechanism is only used where there are small numbers of nurse practitioners in a single agency, who are working in a limited specialist area of practice etc, for example similar to Regulation 5(4) of the DPCS Regulations.

The advantages of such a proposal are:

- a more streamlined administrative process for introduction of prescribing rights for nurse practitioners;
- a cost effective mechanism for nurse practitioner categories that have small numbers and whose practice is restricted to identified agencies.

The disadvantages of such a proposal are:

- authorisation is tied to the agency rather than the individual nurse practitioner.
- when the nurse practitioner moves to another agency, the right to prescribe is not transferable.

8.4 What are your views?

The Department invites your comment on whether there is a need to amend the *Drugs Poisons and Controlled Substances Act* and Regulations to allow limited prescribing rights for small groups of nurse practitioners within the confines of a Health Services Permit issued to an institution, in addition to the scheme established by the *Nurses Amendment Act 2000*.

9. Appeals from Board Decisions

9.1 Background

Section 60 of the *Victorian Medical Practice Act* and section 58 of the *Nurses Act* establish a right of appeal for 'persons whose interests are affected by a Board decision, finding or determination'. The decisions that are appellable are:

- refusal of registration, endorsement, or renewal of registration;
- suspension of registration;
- conditions, limitations or restrictions placed on registration; and
- a finding or determination made at a formal hearing.

Appeal is to the *Victorian Civil and Administrative Tribunal* (formerly the Administrative Appeals Tribunal) rather than directly to the *Supreme Court of Victoria*. This is designed to streamline the process of review and reduce the costs associated with such action. The *Victorian Civil and Administrative Appeals Tribunal Act 1998* provides for appeal to the Supreme Court from decisions of VCAT, in certain circumstances. In limited circumstances it may be possible to seek judicial review by the Supreme Court pursuant to the Rules of that Court.

The Department has received submissions concerning the adequacy of these arrangements. These submissions are in two main areas:

- concerns that appeals to VCAT are by way of rehearing rather than on points of law only, and it is claimed that this has the effect of divesting the boards of the power to set and maintain standards in favour of a non-qualified tribunal.
- that there is no provision for a complainant to appeal to VCAT if a board finds as a result of a preliminary investigation that there is no evidence of unprofessional conduct and the board does not, therefore, proceed to an informal or formal hearing.

In relation to the first issue, hearing panels established by the MPBV and the NBV generally have 3-5 members, including professional representatives and legally trained members. The Medical Practitioners Board has notified the Department of a number of cases in recent years where the Board's determinations have been overturned by the VCAT after a complete rehearing of the evidence, rather than on legal or procedural matters (that is, questions of law). In some cases, this rehearing has been conducted by a single non-medically qualified VCAT member who substitutes his/her own decision as to whether the conduct in question is unprofessional. It is argued that the different weight given by the two bodies to factors in the complaints may be substantially attributable to the medical expertise of the Board.

Submissions have referred to the arrangements that applied prior to the commencement of the *Medical Practice Act* in 1994 where appeals were made directly to the Supreme Court: S.11 *Medical Practitioners Act 1970*, and suggested that this had the effect that the Medical Practitioners Board had primary responsibility for determining professional standards of medical practitioners, and that the Court's role was as a 'safety valve' in instances of errors of a legal or procedural nature. Under this legislative regime which

applied between 1984 and 1994, appeals to the Supreme Court were rare, and on points of law only.

In relation to the second issue, the *Medical Practice Act 1994* sets out the process for the making, investigation and determination of complaints against medical practitioners. Any person may make a complaint about a medical practitioner, and the Board must conduct a preliminary investigation into the complaint. The purpose of the preliminary investigation is to assess whether there is evidence of unprofessional conduct, and whether or not to conduct a formal or informal hearing. The Board may delegate the conduct of the preliminary investigation to another person, who then makes recommendations to the Board. However, the Board must make a decision whether or not to accept or reject the recommendations of the investigator and whether to proceed to a hearing.

The health practitioners registration boards are established to regulate standards and investigate unprofessional conduct. There are other avenues of redress where a complainant is aggrieved, but no unprofessional conduct has occurred. Under the Acts, the complainant is not a litigant, but rather is a witness in the case. As in criminal matters, the State takes on the 'prosecution' of the complaint, representing the public interest in investigation and determination of the allegations according to law. Whilst, the boards determine whether the allegations against the practitioner are proven, they are, as such, deciding a case between the complainant and the practitioner as a court would in adjudicating on a civil dispute.

9.2 Other Jurisdictions

The Western Australian report titled *Report of a review of the Medical Act by a Working Party established by the Minister for Health*, October 1999 sets out the key features of the disciplinary structures and appeal processes at that time in each State and Territory's medical practitioner registration legislation (see **Appendix 11**). The report identified different appeal mechanisms in the different jurisdictions, dependent to some extent on whether:

- the jurisdiction has an administrative appeals tribunal to hear appeals against decisions by administrative bodies (as in Victoria and the ACT), or
- there is a two-tiered disciplinary structure with provision for the involvement of a member of the judiciary in the more senior of the disciplinary tiers (as in NSW and Queensland). (pp 174).

The Northern Territory has a specific body – the Medical Practitioners Appeal Tribunal – for hearing appeals against decisions by the Territory's Medical Board. Tasmania and WA allow appeals on matters of fact and law to lie to the Supreme Court in their respective jurisdictions.

The WA report states:

A key concern about the current disciplinary provisions of the Medical Act arises from the perceived conflict of interest on the part of the Medical Board in combining the roles of investigation, hearing and determining the outcome of complaints (pp 143).

The report notes that three jurisdictions, NSW, SA and Qld have attempted to deal with this situation by providing for serious complaints alleging professional misconduct by medical practitioners to be heard and determined by independent tribunals presided

over by a senior member of the judiciary. While the Medical Boards in each of these jurisdictions has an involvement in determining the medical professional and lay composition of such tribunals, the tribunals themselves are independent of each Medical Board because of the involvement of a senior Judge who is appointed independently of the Board.

The WA report concluded that in proceedings where the continuing registration of a medical practitioner is under consideration, the involvement of a senior member of the judiciary should provide assurance that proceedings will be conducted fairly, impartially and having regard to the principles of natural justice. The Report recommended adoption of a two-tiered disciplinary structure similar to that under the NSW *Medical Practice Act*, with a Judge of the Supreme Court of WA appointed as Chairperson of the Medical Tribunal (Recommendation 60).

The WA report recommended:

- that there be a broad right of appeal on matters of jurisdiction, procedure, fact and law from proceedings before a Professional Standards Committee appointed by the Medical Board;
- that the Chairperson or Deputy Chairperson (a Judge of the Supreme Court) of the Medical Tribunal have jurisdiction to determine questions of procedure and law arising from proceedings of a Professional Standards Committee;
- that the full Medical Tribunal have jurisdiction to determine all other matters before it consistent with sections 87 and 88 of the NSW Medical Practice Act ;
- that appeals take the form of a rehearing of the matter, with the Medical Tribunal having power to admit new evidence, vary, quash or confirm an order made by a Professional Standards Committee, or to require the Committee to re-consider its decision;
- that appeals from Medical Tribunal decisions be on points of law only and to the Full Court of the Supreme Court of WA (pp 176).

NSW

Under the NSW Department of Health's review of the NSW *Medical Practice Act*, the question of rehearing on appeal was also addressed. In NSW, the Medical Tribunal is chaired by a judge and includes medical practitioners as members. Appeals are to the Supreme Court on points of law only. The NSW Health Department's Issues Paper stated:

It has been suggested that appeals to the Supreme Court should be by way of re-hearing. Proponents for this point to section 171F of the Legal Profession Act which provides that appeals to the Supreme Court against a determination of a Tribunal (where the appeal concerns the loss if suffered by the complainant because of the conduct of the subject of the complaint) are to be by way of a new hearing. Fresh evidence may be admitted.

The issues paper identified the main rationale for limiting appeals from NSW Medical Tribunal decisions to points of law. The Medical Tribunal is in effect an expert tribunal with appropriate experts appointed to sit on hearings. In addition the Medical Tribunal is chaired by Judges of the District Court who have sufficient legal experience and

standing. A rehearing before the Supreme Court would be costly and lengthy delays would be involved.

9.3 Discussion

As noted above, the appeal mechanisms that exist in each State and Territory vary depending on the disciplinary structures in place. Any arrangement must observe principles of procedural fairness and natural justice. Recent reviews in Queensland, NSW and WA have opted for a two-tiered system with a Medical Tribunal separate from the Board, chaired by a Judge and including members with medical expertise appointed by the Board. Appeals from Professional Standards Committee decisions of the Boards are by way of rehearing, but appeals from the Medical Tribunals are on points of law and procedure only.

Review of the arrangements under the Victorian *Medical Practice Act* is beyond the scope of this current process, since it requires a system wide consideration of the issues and mechanisms for complaints handling and disciplinary processes for all health practitioner registration Acts. However, submissions are sought on the adequacy of the current arrangements and whether alternative models should be explored further.

9.4 What are your views?

The Department seeks your comment on the adequacy of current arrangements for conduct of registration board complaints and disciplinary functions and appeal from board decisions to the Victorian Civil and Administrative Tribunal.

10. Penalties for breaches of the Nurses Act

10.1 Background

During the passage of the *Nurses Amendment Act 2000*, some issues were raised regarding the penalties for various offence provisions of the *Nurses Act 1993*. For example, in a number of provisions, no distinction is made for differential penalties for natural persons and bodies corporate. There are also some circumstances where offences of a similar nature attract a different level of penalty.

10.2 Current penalty levels

Under the *Nurses Act*, the following offences and penalties apply:

TABLE 1: Summary of Offences and Penalties under the *Nurses Act 1993*

Note: 1penalty unit = \$100

Section	Offence	Penalty
18(3)	<i>Certificates</i> Failure by a nurse to return to the Board his/her certificate of registration following its suspension or cancellation.	20 units
18(4)	Failure by a nurse to return his/her certificate of registration within 28 days for notation of any condition, limitation or restriction on the certificate.	10 units
35	<i>Requirement to notify the Board of change of address</i> Failure by a nurse to notify the Board of any change of address within 14 days of that change.	10 units
48(2)(f)	<i>Findings and determinations of a formal hearing into conduct</i> Unprofessional conduct of a serious nature by a nurse	10 units
56A	<i>Offence to disclose information identifying complainant</i> A person who publishes or broadcasts any report of a formal hearing that would enable a complainant, witness or a nurse to be identified if a panel has determined that they not be identified or they have consented.	50 units natural person 100 units body corporate
60	<i>Claims by persons as to registration</i> Claiming to be a registered nurse when not, using restricted titles when not registered, claiming to hold unrestricted registration when not, using the title 'nurse practitioner' when not endorsed, holding out another person to be a registered nurse when they are not etc.	50 units
62(1)	<i>Claims as to additional qualifications</i> Using the title 'midwife' when not approved by Board, or holding out to be a midwife when not. Using the title 'nurse practitioner' when not endorsed or claiming endorsement in a category of nurse practitioner not included in endorsement	50 units
62(2)		50 units

Section	Offence	Penalty
62(3)		50 units
62A	<i>Fraud, forgery and false representation</i> Persons who fraudulently or by false representation obtain registration under the Act or procure a person to be registered or aid in the commission of this offence.	50 units
63	<i>Offence to provide unregistered nurses</i> Nurses agents who arrange for a person who is not a registered nurse to work as a registered nurse, or to work in contravention of the terms of their registration.	50 units
64	<i>Offence by bodies corporate</i> If a body corporate is guilty of an offence under section 63, any person concerned in the management of the body corporate and took part in the commission of the offence is also guilty.	See section 63
64A	<i>Advertising</i> A person who advertises nursing services in a manner that is false, misleading or deceptive, offers gifts or discounts without setting out conditions, uses testimonials or purported testimonials, or creates an unreasonable expectation of beneficial treatment.	50 units natural person 100 units body corporate
89	<i>Offence to obstruct a person executing a warrant</i> A person must not obstruct, threaten or hinder a person executing a warrant.	10 units

In addition to the above offences, there are offences under the *Drugs Poisons and Controlled Substances Act* for endorsed nurse practitioners who breach the conditions of their authorisation to prescribe drugs and poisons.

10.3 Discussion

From the above table, it may be considered that there are inconsistencies in the penalty levels between offences, and some offences that might have differential penalty levels for natural persons and bodies corporate do not.

10.4 What are your views?

The Department seeks your comments on:

- Whether the penalties for various offences under the Nurses Act are satisfactory.
- Whether there should be differential penalties for bodies corporate for some or all offences.

Appendix 1: Extract from the Australian Competition and Consumer Commission *Guide to the Trade Practices Act for General Practitioners.*

The ACCC has recently published a *Guide to the Trade Practices Act for General Practitioners*. The ACCC states that corporatisation means different things to different people. It defines corporatisation in the medical sector as doctors practising by means of a corporation and states:

GPs have never been legally restricted from incorporating their practices, and therefore the concept of doctors adopting the business structure of a company for their practice is not new. It is the most common business structure for GPs with 53 per cent of all GP business units being limited liability companies. (ABS business register, unpublished).

However, the ACCC has identified some trends in corporatisation of the medical sector that are new:

- horizontal integration, where in certain metropolitan areas, large numbers of individual general practices are being bought to form large GP corporations;
- vertical integration, that is the emergence of large corporations including GPs, specialists, diagnostic imaging and/or pathology; and
- non-medical ownership, where the shareholders of GP corporations or corporations including GP practices are not general practitioners themselves.

A GP who decides to work for such a corporation can become either an employee, and therefore be paid a salary, or an independent contractor, who is paid a share of the amount patients are billed. The ACCC paper outlines the advantages and disadvantages for GPs of working within a corporate structure, some potential ethical issues, and whether there are avenues available through the *Trade Practices Act* for addressing some of these issues. These fall into the following categories:

Referrals

Concerns have been raised that the corporate owners may require GPs to refer their patients to particular specialists. The ACCC has identified that depending on the circumstance, such conduct may constitute third line forcing or full line forcing in breach of the Act. Full line forcing occurs when a company requires their employees or contractors to make referrals to businesses owned by that company. Full line forcing is a breach of the Act if it can be shown that these referrals substantially lessen competition.

Concentration

The *Trade Practices Act* prohibits mergers or acquisitions that would have the effect of **substantially** lessening competition in a **substantial** market. The concept of a substantial market is only a factor in merger matters. For all other conduct subject to a competition test, the test is whether there has been a substantial lessening, preventing or hindering of competition in any market. Mergers between large corporations at the State, Territory or national level are likely to be examined by the Commission. Likewise, proposed mergers between large corporations in metropolitan areas and large country towns may need to be examined because they are likely to constitute substantial markets. Whether, at the level of a small country town, all the GPs may be able to form one corporation without raising merger issues would ultimately depend on the facts of each individual case.

Disclosure

To guard against the possibility of later being liable for misleading or deceptive conduct it may be wise for GPs to disclose to patients that they are part of a corporation and/or that the corporation has a policy of referring within the corporation.

The Act does not impose a general duty to disclose information. However, the courts have held that silence may in some circumstances amount to misleading or deceptive conduct.

Disclosure of financial interests is also important for ensuring informed decision-making by patients.

Interference with clinical independence

Some GPs have expressed concern that corporate owners may put pressure on them that would affect their clinical independence, for example in relation to:

- referrals;
- consultation targets;
- inappropriate ordering of diagnostics; and/or
- inappropriate prescription of medicine.

If a corporation is imposing clauses in a contract with a GP, or has policies that interfere with the GP's clinical independence, such conduct may raise issues under the unconscionable conduct provisions of the Act. A number of factors may be taken into account when determining whether a particular conduct is unconscionable including:

- the relative bargaining strengths of the parties;
- whether, as the result of the stronger party's conduct, the other was required to meet conditions not reasonably necessary to protect the stronger party's legitimate interests;
- the use of undue influence, pressure or unfair tactics on the part of the stronger party; and
- the extent to which the stronger party was willing to negotiate.

Whether the unconscionable conduct provisions apply to conduct by the corporate owner towards a GP will depend on the nature of the contract or the relationship. If it is an employer-employee relationship, the conduct would not be covered by the Act.

The paper outlines examples of behaviour by corporations that might constitute breaches of the provisions of the *Trade Practices Act*.

Appendix 2: Victorian Health Records Act 2001.

The *Health Records Act* was introduced into the Victorian Parliament by the Minister for Health in November 2000. The Act was finalised following the completion of a public consultation process during which comments were sought on a draft Bill. The legislation has been enacted by Parliament and is will commence operation in the first half of 2002.

The legislation establishes Health Privacy Principles that apply to the handling of health information by public and private sector organisations in Victoria, including health service providers. The principles govern the life cycle of health information, including its collection, use, disclosure and security.

The Act will apply to private corporations that own medical practices and employ medical practitioners. As a “health service provider” these corporations will be subject to the Act in relation to all of the information that they hold that is collected to provide medical services. This means that:

the organisation must maintain strict standards to ensure the confidentiality of health information;

reasonable steps must be taken by the corporation to protect health information from misuse and from unauthorised access, modification or disclosure;

a patient’s health information must generally be retained securely for 7 years (and in the case of a child, at least until he or she attains the age of 25 years);

the corporation must provide access to records where a patient seeks their health information, except in limited circumstances where refusal is permitted under the legislation. Access can be in a number of forms, including providing a copy or summary of the information, making it available for inspection, or providing an explanation of the information;

patients will have a right to seek correction of information held by the practice that is inaccurate, incomplete or misleading; and

on the sale or closure of the business, steps must be taken to notify patients so that those who wish to do so can obtain a copy of their information.

Appendix 3: Victorian Definition of Unprofessional Conduct and current powers under the Medical Practice Act 1994.

The Victorian *Medical Practices Act 1994* (s3.) defines of unprofessional conduct as meaning all or any of the following:

- (a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered medical practitioner; or
- (b) professional conduct which is of a lesser standard than that which might be expected of a medical practitioner by her or his peers; or
- (c) professional misconduct; or
- (d) infamous conduct in a professional respect; or
- (e) providing a person with a health service of a kind that is excessive, unnecessary or not reasonably required for that person's well-being; or
- (f) influencing or attempting to influence the conduct of a medical practice in such a way that patient care may be compromised; or
- (g) the failure to act as a medical practitioner when required under an Act or regulation to do so; or
- (h) a finding of guilt of –
 - (1) an indictable offence in Victoria, or an equivalent offence in another jurisdiction; or
 - (2) an offence where the practitioner's ability to continue to practice is likely to be affected because of the finding of guilt or where it is not in the public interest to allow the practitioner to continue to practice because of the finding of guilt; or
 - (3) an offence under this Act or the regulations; or
 - (4) an offence as a medical practitioner under any other Act or regulation; or
 - (5) the contravention of, or failure to comply with a condition, limitation or restriction on the registration of the medical practitioner imposed by or under this Act.

The *Medical Practice Act 1994* (s28.) allows the Board to undertake a preliminary investigation of medical practitioners whose ability to practice medicine may be affected because –

- (a) of the physical or mental health of the practitioner; or
- (b) the practitioner has an incapacity; or
- (c) the practitioner is an alcoholic or drug-dependent person

If, after preliminary investigation the Board decides that further action should be undertaken, the Board, with the agreement of the practitioner, may:

- (a) alter the way in which he or she practices medicine; or
- (b) impose conditions, limitations or restrictions on his or her registration; or
- (c) suspend his or her registration for a period of time specified by the Board.

If the registered practitioner does not agree to undergo a medical examination, reach an agreement with the Board or does not abide by an agreement reached with the Board, the Board may refer the matter to a formal hearing.

Appendix 4: Medical Practitioners Board of Victoria proposal for further powers to deal with poorly performing medical practitioners

Background

The Medical Practitioners Board of Victoria has well developed processes for dealing with medical practitioners whose conduct has been unprofessional or whose health is impaired. However, the management of the medical practitioner whose performance has been questioned has remained a problematic issue for both the Victorian Board and for many other Medical Boards around the world. In dealing with the medical practitioner who is performing poorly, the “professional conduct” and “impairment” mechanisms have proven to be unsatisfactory for both the doctor and the public.

The Board received over 500 complaints about doctors in 1999. Of these, about one third related to the standard of practice of the doctor. In the experience of the Board, the disciplinary mechanisms do not always offer the best approach to deal with such complaints.

For example, the Board may receive a number of complaints about aspects of an individual medical practitioner’s performance. In such a case, the disciplinary approach limits the responsiveness of the Board. If at preliminary investigation the Board deems that there is prima facie evidence of unprofessional conduct, it may determine to proceed to an informal hearing. At informal hearing, the panel is limited to the following determinations:

- that the practitioner undergo counselling;
- that the practitioner be cautioned;
- that the practitioner be reprimanded
- that the practitioner undertake further education of the kind stated in the determination

The powers granted by the Act do not compel the doctor to improve his or her performance and the cause of the problem has not been addressed. The Act does not even give the Board the power to ensure that the doctor has been compliant with counselling.

In some cases, there is not prima facie evidence of unprofessional conduct and therefore the Board is unable to proceed further, though there may be ongoing concerns about the doctor’s performance.

The development of a performance pathway will facilitate a formal assessment of the medical practitioner’s competence and clinical performance. The assessment may identify deficiencies that can be addressed to improve the doctor’s performance and therefore the standard of care provided to the public.

The definition of performance

While the terms knowledge, competence and performance are often used interchangeably, they refer to different things. Knowledge refers to knowing facts,

competence refers to knowing how to do something and performance refers to what someone does in practice.

Benefits of a “performance pathway” for the community

The development of a “performance pathway” will assist the Board to fulfil its primary obligation of protecting the community by appropriately managing complaints of alleged poor performance.

The community will be further assured that the Board is active in maintaining the standards of practice and performance of the medical profession, thereby gaining the confidence of the Victorian public.

Benefits of a “performance pathway” for the medical profession

The medical profession will also benefit from the development of a “performance pathway”. Where there are allegations of poor performance, doctors can be assured that they will be managed in a fair and appropriate manner. Inherent in the proposed process is the independent assessment of performance by peers and the development of appropriate re-training or remedial action. The ultimate aim of the program will be to assist doctors whose performance has been questioned to remain in active but safe practice. Such an approach would appear to have clear advantages over the present disciplinary process for both the profession and the public.

Present ways of dealing with the poorly performing doctor

The *Medical Practice Act 1994* places constraints on the Board’s ability to deal in an effective and helpful manner with the doctor whose performance is alleged to be poor. Notification is usually via the complaints pathway and an attempt is made to deal with the matter under the Board’s disciplinary or impairment mechanisms, often with unsatisfactory outcomes.

1. A specific incident of serious outcome for the patient

The Board may receive a complaint regarding a medical practitioner that relates to a specific incident of care that has had a poor outcome. This may be due to poor performance or error of judgment and does not necessarily include actions that imply unprofessional conduct. Nevertheless, the doctor’s performance appears to be below the standard that is expected of the doctor in the view of the public or the doctor’s peers.

In some instances, the outcome may have resulted in serious consequences to the patient, but the doctor’s conduct (i.e. the doctor’s behaviour, the attention he or she provided and his or her general intent) may not be in question.

The question then may arise: Is this an instance of mishap or human error that is quite out of keeping with the doctor’s usual standard of performance, or is it representative of a general impairment of performance? It is recognised that in a lifetime providing tens of thousands of instances of care, a doctor may miss a vital sign on examination, fail to consider a diagnostic possibility, make an error in a procedure or fail to communicate clearly. It is however also possible that there have been other instances of poor performance that have not led to complaints from patients, have been overlooked by colleagues and have not previously been brought to the attention of the Board.

Another consideration is whether the error was so serious that the doctor's general ability should be formally assessed, even though it may appear to have been an isolated event. At present there is no formal mechanism for assessment and remedial action, except perhaps as a consequence of a formal hearing.

2. Repeated complaints of a similar nature

There are a small number of medical practitioners who have been the subject of a series of complaints about their practice of medicine. Each individual complaint may not meet the criteria for serious unprofessional conduct. However, considered together the complaints suggest that there may be questions of performance. There is no mechanism under the Act that allows the Board to intervene effectively to investigate this or impose conditions that would lead to its correction unless it is considered that the doctor is impaired because of ill health.

In both of these instances, the Board has been relatively powerless to protect the public from a doctor whose practice is incompetent, exceeds his level or area of competence or who repeatedly make similar mistakes.

The new proposal

The following proposal addresses the issue of the poorly performing doctor. It follows very closely the model that has been developed for the management of the impaired doctor that the Board has found useful in both protecting the public and in ensuring natural justice to the doctor.

1. Notification of poor performance

It is anticipated that notifications of poor performance would be from patients, the Health Services Commissioner, concerned colleagues, hospital administrators, Health Insurance Commission and the Drugs and Poisons Unit of the Department of Human Services. There would be an opportunity for referral from the Learned Medical Colleges and perhaps even from medical indemnity organisations.

The Board may also determine that referral to the performance pathway is indicated during or at the conclusion of a preliminary investigation into the professional conduct or health of a medical practitioner or alternatively during or at the conclusion of an informal or formal hearing.

It would be beneficial to grant immunity from civil liability to registered health practitioners who report a colleague to the Board, where the notification is in good faith.

2. The response of the Board

Where the Board receives information that indicates that a medical practitioner may be performing poorly, it may determine to refer the matter to the performance pathway. If there is insufficient information to proceed, the Board may obtain further details or not proceed further.

In conducting a preliminary investigation into the performance of the medical practitioner, the Board will appoint one of its medical members to conduct the investigation. The doctor whose performance has been questioned will be informed of the preliminary investigation in writing and by registered mail. The nature of the concerns will be advised and the doctor will be asked whether he or she agrees to assessment by one or more registered medical practitioners who are peers. This assessment will not be conducted by a member of the Board.

To ensure that the transparency of the process is maintained, the doctor who is alleged to be performing poorly will receive a copy of the assessment report and will be invited to discuss the report with the preliminary investigator. The discussion will focus upon any adverse findings and ways to deal with these findings.

The outcome of this discussion may be that a more formal assessment is recommended to clarify the need for further education or retraining. It may also provide an opportunity to negotiate conditions on registration including requiring retraining, the appointment of an appropriate mentor if required and for the provision of reports to the Board.

This meeting is expected to be a positive initiative with an emphasis on maintaining the doctor in safe medical practice. However, a breakdown in negotiations may result in a formal hearing.

3. The Assessment

Any assessment of the performance of a medical practitioner must be guided by the principles of natural justice, fairness and transparency. The aim will be to assess present performance and to provide constructive advice regarding re-training to ultimately improve performance.

The assessment process will be arranged by the Board and will be undertaken by a panel of highly respected peers of the medical practitioner.

The Learned Colleges will be asked to play a key role in the assessment process by nominating appropriately qualified assessors and defining clinical standards.

For example, if a Cardiologist were alleged to be performing poorly, the Royal Australasian College of Physicians would be asked to nominate a panel of two senior fellows of the College who have specialised in Cardiology. The assessment process may then comprise an audit review of the practice, a technical review of procedural performance and an oral examination that examines knowledge base. The panel may reasonably expect that the cardiologist perform at least to the standard of a junior consultant.

4. Opportunities for re-training

The Board will liaise with the Learned Colleges, medical schools and teaching hospitals to develop mechanisms for setting up tailored re-training and remedial programs. The needs of the individual will be established at the initial assessment and at the completion of the program, objective evidence of improvement will be expected.

Implementation of the proposal

In order to be permitted to proceed down a performance pathway, legislative amendment is required.

The implementation of the proposal may not necessarily depend on working out a satisfactory and inclusive re-training program (presumably at arm's length from the Board), as it may, in the early stages, be worked out on an individual need and ad hoc basis. The Health program provides precedence for this. It may be premature to expect development of detailed programs of retraining before the Board has obtained some experience of the need for such programs.

The current absence of programs for re-training in some areas of medical practice should not inhibit the Board's development of a process of response to complaints of poor performance.

Funding

It is anticipated that the Board would pay for the initial assessment.

The medical practitioner will be responsible for any costs of further formal assessment and education and re-training.

Appendix 5: Australian Nursing Council. Position Statement: Continuing Competence in Nursing.

Introduction

The following position statement has been developed by the ANCI in consultation with the Australian nurse regulatory authorities with the intent of informing the public, employers and the nursing profession about nurses continuing to maintain their competence.

Preamble

Nurses, registered, enrolled and authorised to practice in Australia are regulated and accountable to the community for providing quality care through safe, ethical and effective practice, and for maintaining the competence necessary for practice.

Nursing takes place within dynamic environments. Nurses who are licensed to practise are expected to be able to demonstrate competence within their area of practice. Rising consumer expectations, demographic and social changes, changing relationships between health workers, new technology, a greater focus on research and evidence based practice, and new therapeutics allowing a greater capacity to treat a range of health problems underpin the need for nurses to maintain their competence.

Today, there is increasing demand for greater accountability from all health professionals for the outcomes of their practice. Employers also have the responsibility to ensure that those they employ to provide a service are safe and competent to practice.

It is reasonable for the public to expect that health professionals, including nurses, maintain their competence to practise. The state and territory nurse regulatory authorities promote and maintain standards of nursing practice, in the public interest, in accordance with legislative requirements. The accountability of nurse regulatory authorities is to carry out their functions in line with their respective legislation. Nurse regulatory authorities are committed to supporting continuing competence.

Continuing Competence

Competence is the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area¹. Continuing competence is the ability of nurses to demonstrate that they have maintained their competence in their current area of practice.

The Code of Ethics for Nurses in Australia² and the Code of Professional Conduct for Nurses in Australia³ makes reference to the need for nurses to maintain standards of practice and the responsibility of each nurse to maintain the competence necessary for current practice.

The nurse regulatory authorities have agreed that action taken in relation to their responsibility regarding continuing competence would be underpinned by the following two principles:

- that a process of self-assessment be the basis for determining the continuing competence of an individual practitioner, and,
- that this be implemented within a quality improvement framework.

Self-assessment of competence is an ongoing process whereby a nurse examines his or her practice against national competency standards accepted by the nurse regulatory authorities for registration and enrolment. Self-assessment is likely to include reflection, critical incident analysis, peer review, and evaluation of client and patient outcomes. On the basis of self-assessment, the variety of methods nurses may use to maintain competence and to improve practice may include informal and formal learning; participation in and utilization of evidence based practice and research, or other professional activities.

Nurse regulatory authorities retain the authority to implement a system for determining continuing competence that is relevant to their jurisdiction and legislative framework.

References

- Australian Nursing Council Inc (2000) ANCI National Nursing Competency Standards for the Registered Nurse, 3rd Edition
- Australian Nursing Council Inc (1993) ANCI Code of Ethics for Nurses in Australia
- Australian Nursing Council Inc (1995) Code of Professional Conduct for Nurses in Australia

Appendix 6: Submission from the Nurses Board of Victoria on the administration of Section 14 Recency of Practice provisions in the Nurses Act.

One of the primary purposes of the *Nurses Act 1993* is the protection of the public. The Act reflects the need for registered nurses to have maintained their knowledge and skills. Under s.14 of the Act, the Nurses Board of Victoria may refuse to renew the registration of a nurse if it is not satisfied the applicant has had sufficient nursing experience in the preceding five years or on any other grounds which the Board might refuse to register a person.

Renewal of registration process

In November of each year an application for renewal of registration is posted to every registered nurse. This application includes a section, which asks the nurse to declare whether they have had sufficient experience as a registered nurse in the preceding five years to maintain their competence.

In making this declaration the Board expects each registered nurse to undertake a self-assessment of their competence. Applicants are referred to the Australian Nursing Council national competency standards, which are a useful tool for assessing minimum competence for practise. In addition other standards or competencies for specialised practice may also be useful tools, such as the Code of practice for midwives in Victoria or the Australian and New Zealand College of Mental Health Nurses' standards for mental health nursing.

Other points for nurses to consider prior to signing the declaration are provided. These include the following questions:

- What professional development activities aimed at enhancing my nursing competence have I completed over the past 12 months?
- How have I been assessing my knowledge, skills and professional judgement and where necessary taking action to improve the quality of my practice?
- Did my recent workplace performance appraisal confirm my competence to practice?
- Have I promoted a positive image of nursing by my practice?

The Board does not quantify the amount of experience required for renewal of registration as the recency of practice policy review conducted in 1997 clearly identified that there are many variables other than 'time' that individuals take into consideration when quantifying their continuing competence.

In order to prompt the applicant to engage in a self-assessment which is necessary to complete the self-declaration and to provide the Board with some evidence that confirms the self-declaration, the applicant is asked to complete some questions regarding their practice status.

Unless the applicant answers YES to either questions 1 or 2 or 3 below the renewal is not processed and the applicant is invited to review their responses or to submit a

submission to the Board which demonstrates how they believe they have been able to maintain their competence.

Practice Status

Most recent nursing position held:

Is this your current position? Yes No

1. Are you currently employed or self-employed in a role for which nursing registration is required?

Yes No →



Go to step

B

2. Since January 1996 have you practised in a role for which nursing registration was required?

Yes No → Refer overleaf



Go to step B

3. Have you completed a pre-registration nursing course or a re-entry course since January 1996?

Yes No → Refer overleaf

Go to step B

* Unless you answer "Yes" to question 1 or 2 or 3 your registration will not be renewed.

The Board recognises the diversity of nursing practice. For the purpose of renewal of registration, nursing experience gained in the areas of management, education, research, consultancy and clinical practice over the last five years is sufficient. Clinical practice may include community nursing, occupational health nursing, psychiatric nursing, midwifery, palliative care nursing, rural nursing and aged care to name only a few.

The Board's policy in this area is intentionally flexible to cover the breadth of nursing practice in Victoria. The following scenarios are examples of situations in which nurses have successfully renewed their registration under current Board policy:

- A registered nurse answered no to questions 1,2 and 3 on the application form. She also indicated she was employed as a CEO of a hospital. Board staff contacted the nurse by telephone and discussed her response with her. It was identified that registration as a nurse may not be an essential criteria for the role of a Chief Executive, however it certainly is desirable for people managing health services to have had a professional background in health. The applicant amended her responses and the application was approved.
- A registered nurse answered no to questions 1,2 and 3 on her application form. The supporting documentation attached to her application indicated that she was using her nursing skills in complementary therapies which she was practising and teaching. In light of the evidence the nurse submitted with her application, and following a discussion with staff of the Board about the

application of the competency standards in relation to her practice, the nurse was then able to sign the declaration. Her renewal application was then approved.

- Another registered nurse was caring for her severely ill child at home. Accompanying the nurse's application was a letter explaining why she was experiencing difficulty in completing the practice status questions. In addition another letter from the child's medical practitioner supported the nurse's clinical skills and explained that if she was not caring for the child at home then the child would have had to have had numerous admissions to hospital for care. The nurse concerned was contacted and as result she completed the declaration and practice status questions and her application was approved.

Over the last seven years two submissions concerning renewal of registration have been made to the Board requiring the Board to exercise its discretionary powers.

The first case involved a registered nurse working part-time as a personal care attendant in a hostel. She had last practised as a registered nurse five years prior to her application for renewal of registration. Her subsequent part-time employment was not considered by the Board to be sufficient to renew her registration and she was advised that she would need to demonstrate competence by undertaking a re-entry or supervised practice program. The other case involved a registered nurse who had last been employed as a clinical nurse six years ago. Her submission identified her research activities that she had done 4 years prior to the application and the Board granted renewal of her registration on the basis of this information.

Under the Appeal provisions of the *Nurses Act 1993*, a person whose interests are affected by the Board's decision to refuse renewal of registration may appeal to the Victorian Civil and Administrative Tribunal (VCAT). Since the *Nurses Act 1993* came into effect in July 1994 there have been no appeals to VCAT in this area.

In circumstances where the Board does not renew a nurse's registration they are advised of the options to pursue should they wish to practise as a nurse at a later date. There are two ways in which a nurse may re-enter practice to be given an opportunity to demonstrate competence prior to re-registration. Either successful completion of an accredited re-entry program or successful completion of a period of supervised practise at an approved health service facility.

Each nurse is accountable and responsible for the maintenance of his/her competence in whatever setting the practice occurs. A clinical update or refresher program may be negotiated between the registered nurse and health service facility to facilitate movement between practice settings and short periods away from practice. These programs do not require Board approval.

In the interests of the public and the profession the Board will be looking into ways of strengthening the renewal process to provide the public with increased assurance that a registered nurse has maintained their competence. Within a quality improvement framework the Board will examine options that may be applied in the future.

Appendix 7: Controlled Acts restricted under the Regulated Health Professions Act of Ontario Canada

A 'controlled act' is any one of the following done with respect to an individual.

- Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
- Performing a procedure on tissues below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surface of the teeth, including the scaling of teeth.
- Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
- Setting or casting a fracture of a bone or a dislocation of a joint.
- Administering a substance by injection or inhalation.
- Putting an instrument, hand or finger
 - Beyond the external ear canal
 - Beyond the point in the nasal passages where they normally narrow
 - Beyond the larynx
 - Beyond the opening of the urethra
 - Beyond the labia majora
 - Beyond the anal verge, or
 - Into an artificial opening into the body.
- Applying or ordering the application of a form of energy prescribed by the regulations under this Act (i.e. Regulated Health Professions Act)
- Prescribing, dispensing, selling or compounding a drug as defined in subsection 117 (1) of the Drugs and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
- Prescribing a hearing aid for a hearing impaired person
- Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
- Managing labour or conducting the delivery of a baby.
- Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response (RHPA, section 27).

Appendix 8: Authorised acts in the Ontario Nursing Act 1991

Scope of Practice

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. 1991, c. 32, s. 3.

Authorized acts

4. In the course of engaging in the practice of nursing, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

- Performing a prescribed procedure below the dermis or a mucous membrane.
- Administering a substance by injection or inhalation.
- Putting an instrument, hand or finger,
 - beyond the external ear canal,
 - beyond the point in the nasal passages where they normally narrow,
 - beyond the larynx,
 - beyond the opening of the urethra,
 - beyond the labia majora,
 - beyond the anal verge, or
 - into an artificial opening into the body.

1991, c. 32, s. 4. Additional requirements for authorized acts

5. (1) A member shall not perform a procedure under the authority of section 4 unless,
- the performance of the procedure by the member is permitted by the regulations and the member performs the procedure in accordance with the regulations; or
 - the procedure is ordered by a person who is authorized to do the procedure by section 5.1 of this Act or by the *Chiropody Act, 1991*, the *Dentistry Act, 1991*, the *Medicine Act, 1991* or the *Midwifery Act, 1991*. 1991, c. 32, s. 5 (1); 1997, c. 9, s 1.

Appendix 9: British Columbia, Canada Health Professions Council Recommendations for Scope of Practice Statements and Reserved Acts for the professions of Registered Nurse and Licensed Practical Nurse.

The Council's Post-Hearing Update of Preliminary Reports published in March 2001 for Registered Nurses and April 2001 for Licensed Practical Nurses recommends scope of practice statements and reserved acts for each of these categories of nurse. They are:

Registered Nurses

Scope of Practice:

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health; the prevention, treatment and palliation of illness and injury, primarily by assessment of health status, planning and implementation of interventions; and co-ordination of health services.

Reserved Acts:

- Performing a nursing diagnosis by making a clinical judgement of the patient's mental and physical condition that can be ameliorated or resolved by appropriate interventions of the nurse or nursing team to achieve outcomes for which the nurse is accountable.
- For the purposes of wound care, performing the following physically invasive or physically manipulative act of procedures on tissue below the dermis or below the surface of the mucous membrane: cleansing, soaking, irrigating, probing, debriding, packing, dressing.
- For the purposes of establishing peripheral intravenous access and maintaining patency using a solution of normal saline (0.9 per cent), performing the physically invasive or physically manipulative act of venipuncture.
- For the purposes of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)
 - Into the external ear canal, including applying pressurized air or water;
 - Beyond the point in the nasal passages where they normally narrow;
 - Beyond the pharynx;
 - Beyond the opening of the urethra;
 - Beyond the labia majora;
 - Beyond the anal verge; or
 - Into an artificial opening into the body.

- Administering or compounding a drug listed in Schedule II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

Reserved Acts on the Order of a health practitioner authorised under legislation to perform the act:

- Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by injection or inhalation, except as provided in the above reserved act.
- For purposes other than wound care, performing the physically invasive or physically manipulative act of procedures on the tissues below the dermis, below the surface of a mucous membrane and in or below the surface of the cornea.
- For the purposes of treatment, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)
 - Into the external ear canal, including applying pressurized air or water;
 - Beyond the point in the nasal passages where they normally narrow;
 - Beyond the pharynx;
 - Beyond the opening of the urethra;
 - Beyond the labia majora;
 - Beyond the anal verge; or
 - Into an artificial opening into the body.
- Applying a hazardous form of energy including diagnostic ultrasound and X-ray.
- Administering or compounding by any means a drug listed in Schedule 1 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.
- Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.
- Allergy challenge testing or allergy desensitising treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

Note: An order is defined and can apply to an individual client or to more than one individual by means of an indirect order, i.e. protocols or clinical guidelines or medical directives.

Licenses Practical Nurses

Scope of practice

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the prevention, treatment and

palliation of illness and injury, including assessment of health status and implementation of interventions.

Reserved acts

For the purpose of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- into the external ear canal, including applying pressurized air or water, for the purpose of cleaning patients' external ear canal, taking their tympanic temperature and using an otoscope to examine cerumen build up;
- beyond the labia majora, but excluding the insertion of intrauterine devices, for the purpose of performing hygiene measures and washing beyond the labia majora to the urethral and vaginal orifice;
- beyond the anal verge, for the purpose of performing rectal checks on patients whose assessment warrants this intervention.

Reserved acts to be performed only if the act is ordered by a health professional who is authorized by legislation to perform the act

- Performing the following physically invasive or physically manipulative acts:
- procedures on tissue below the dermis or below the surface of a mucous membrane;
- administering a substance, other than a drug, by subcutaneous injection, inhalation, irrigation or instillation;
- putting an instrument, hand or finger(s):
- into the external ear canal, but excluding cerumen management;
- beyond the opening of the urethra;
- beyond the labia majora, but excluding the insertion of intrauterine devices;
- beyond the anal verge; or
- into an artificial opening into the body.
- Administering orally or by subcutaneous injection a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

Appendix 10: Victorian Nurse Practitioner Prescribing Rights

Recent Amendments to the Nurses Act

The nurse practitioner is a registered nurse educated for advanced practice in identified categories of nurse practitioner that are to be determined by the Nurses Board of Victoria.

Sections 8B(1) and (2) of the Act and Sections 66(1)(ea), (eb) and (ca) of the Act empower the NBV to endorse the registration of a nurse registered under Divisions 1, 3 or 4 of the Act as a nurse practitioner. This endorsement is granted on the basis of completion of a course of study accredited by the Board **and** clinical experience that the Board is satisfied qualifies the nurse to use the title nurse practitioner.

Sections 62(2) and 62(3) of the Act establish offences for anyone other than a registered nurse with the required endorsement from the Nurses Board to use the title 'nurse practitioner'. A nurse practitioner must also identify the category of practice to which their endorsement relates.

Nurse practitioners who have obtained the required qualifications and been endorsed by the Board will be legally able to prescribe a limited range of scheduled drugs and poisons within their category of nurse practitioner. This will allow:

- extension of health services to patients in rural and remote settings;
- improved outreach services to patients with particular health needs such as psychiatric patients, homeless people etc;
- more efficient and comprehensive delivery of health services in primary health care and a range of specialist settings such as emergency, diabetes, haematology, women's health, wound management and drug and alcohol services.

Authorisation of Nurse Practitioners to prescribe drugs and poisons

Some categories of nurse practitioner are to be authorised under the *Drugs Poisons and Controlled Substances Act* to obtain, possess, use, sell or supply scheduled 2,3,4 and 8 drugs and poisons.

Clauses 48 and 49 of the *Nurses Amendment Act 2000* (yet to be implemented) amend the *DPCS Act 1981* to include nurse practitioners as authorised persons under that Act to obtain, possess, use, sell and supply drugs and poisons in schedules 2,3,4 and 8.

Clause 52 of the *Nurses Amendment Act* amends the *DPCS Act* to empower the Governor in Council to make regulations to prescribe the list of schedule 2,3,4 and 8 poisons that members of identified categories of nurse practitioner are authorised to prescribe.

The authorisation of an individual nurse practitioner to prescribe drugs and poisons will be limited to the list of drugs prescribed in regulation under the *DPCS Act* for the category of nurse practitioner to which their endorsement relates.

Once these provisions are proclaimed, it will be an offence under the *DPCS Act* for a nurse practitioner to:

- prescribe drugs and poisons that are not included in the list that they have been authorised to obtain, possess, use, sell, supply, or
- prescribe drugs and poisons that are on the list but for a purpose outside the category of practice to which their endorsement relates. It may also constitute unprofessional conduct under the *Nurses Act*.

There may be categories of nurse practitioner determined by the Board that are not authorised to prescribe pursuant to the *DPCS Act* – these categories will not be the subject of regulations under the *DPCS Act* [sub-section 8B(1) of the *Nurses Act* as amended].

Process for approval of list of drugs

The following is the process that has been established via legislation for establishing the list of drugs that nurse practitioners in a particular category may legally authorised to prescribe:

- Under sections 79(3), 79(4) and 80(2) of the *Nurses Act 1993* (as amended by the *Nurses Amendment Act 2000*), the NBV sets up a Nurse Practitioner Advisory Committee (NPAC) with expertise relevant to category of nurse practitioner that seeks authorization under the *Drugs Poisons and Controlled Substances Act* to prescribe.
- The NPAC considers the clinical practice guidelines and training of the category of nurse practitioner and, when satisfied that these are sufficient to adequately protect the public, makes a recommendation to the NBV to proceed with seeking inclusion of the category of nurse practitioner in regulation under the *DPCS Act*.
- The NBV may accept the recommendation of its NPAC and then make a submission to the Minister seeking his action in making a statutory rule to set out a list of drugs in respect of the category of nurse practitioner. In this submission, the NBV sets out its process (including the range of expertise on the advisory committee as well as consulted) in coming to its decision to recommend prescribing rights for a category of nurse practitioner and a list of drugs.
- The Minister refers the NBV submission to the Poisons Advisory Committee (PAC) for advice on whether the process and the range of experts consulted has been satisfactory.
- The PAC advises the Minister on whether it supports the NBV submission.
- If the Minister accepts the PAC advice, he instructs that a Regulatory Impact Statement (RIS) and a draft statutory rule be prepared. All statutory requirements must be met concerning what is included in a statutory rule (for example, alternatives to making subordinate legislation to achieve the same result and social, economic and environmental impact) and for the process (for example, public advertising of the proposal).

A nurse who has undergone sufficient training and clinical practice and has been endorsed by the NBV to use the title ‘nurse practitioner’ cannot prescribe or supply drugs identified in the clinical practice guidelines for their category of nurse practitioner unless/until there is a list of drugs prescribed in the regulation under the *DPCS Act* in respect of that category of nurse practitioner. Once the list of drugs is prescribed in the *DPCS Act*, any nurse practitioner whose registration has been endorsed for a particular

category of nurse practitioner will be authorized under the *DPCS Act* to possess, use, sell or supply the drugs listed in regulation.

Changes to the lists of drugs contained in regulation require the same process as outlined above for making of the initial list.

Appendix 11: Key Features of the Disciplinary Structures and Appeal processes in State and Territory Medical Practitioner Registration Legislation

Source: WA Report of a review of the Medical Act by a Working Party established by the Minister for Health, October 1999, pp139 -144.

TABLE 1: DISCIPLINARY STRUCTURES - SUMMARY OF APPROACHES

Key features	Jurisdictions
Single-tiered disciplinary structure, with all disciplinary powers vested in the respective Medical Board	ACT, NT, WA
Two-tiered disciplinary structure, with the Medical Board having control over the appointment of members to both components of the disciplinary structure	Tasmania Victoria
Two-tiered disciplinary structure, with provision for a Tribunal independent of the Medical Board and presided over by a member of the judiciary to deal with more serious complaints	NSW, SA Queensland

TABLE 2: APPEAL AGAINST THE EXERCISE OF DISCIPLINARY POWERS IN EACH JURISDICTION

Jurisdiction	Appeal body	Comments
ACT	Administrative Appeals Tribunal (AAT) of the ACT	The AAT has power under its own legislation to confirm, vary or quash any decision of the Medical Board of the ACT. Appeals against decisions of the AAT are to the Supreme Court of the ACT on matters of law only.
NSW	Medical Practitioners Board Professional Standards Committee appeals to Medical Tribunal. Appeals against Medical Tribunal to Supreme Court of NSW.	Tribunal empowered to hear matter anew and admit fresh evidence. Appeals on matters of law relating to proceedings of Medical Tribunal to Supreme Court of NSW, only with leave of Chairperson of Tribunal. Appeals against disciplinary power by Tribunal to Supreme Court.
NT	Appeals to Medical Practitioners Appeals Tribunal established under Medical Act & comprising Chief Magistrate & 2 medical practitioners.	Tribunal has power to dismiss appeal, revoke or vary decision or require Board to re-hear matter. Appeals against Tribunal decisions on matters of law only to Supreme Court of NT.
Queensland	Appeals from decisions of professional	Appeals from Health Practitioners Tribunal on matters of law and jurisdiction only, to

	standards committees are to the Health Practitioners Tribunal.	Queensland Court of Appeal.
South Australia	Appeals from Medical Board decisions and Medical Practitioners Professional Conduct Tribunal to Supreme Court of SA	Matters of both fact and law.
Tasmania	Appeals from Medical Council and Medical Complaints Tribunal to Supreme Court of Tasmania	Matters of both fact and law.

List of Abbreviations

ACCC	Australian Competition and Consumer Commission
ACT	Australian Capital Territory
ALP	Australian Labor Party
AMA	Australian Medical Association
AMC	Australian Medical Council
ANF	Australian Nursing Federation
BC	British Columbia
CPD	Continuing Professional Development
CPMC	Committee of Presidents of Medical Colleges
DHAC	Department of Health & Aged Care
DPCS	Drugs Poisons and Controlled Substances
GPDV	General Practice Divisions – Victoria
HCSUA	Health and Community Services Union of Australia
MOP	Maintenance of Professional Standards
MPBV	Medical Practitioners Board of Victoria
NBV	Nurses Board of Victoria
NCAA	National Clinical Assessment Authority
NCP	National Competition Policy
NHS	National Health Service
NPIAC	Nurse Practitioner Implementation Advisory Committee
PAC	Pharmacy Advisory Committee
RACGP	Royal Australian College of General Practitioners
RACO	Royal Australasian College of Ophthalmologists
RCNA	Royal College of Nursing of Australia
RHPA	Regulated Health Professions Act
RIS	Regulated Impact Statement
SA	South Australia
VHA	Victorian Hospitals Association
WA	Western Australia

