

Submission on the definition of practice

Introduction

This submission identifies some of the difficulties created by the present definition of “practice” and argues that there are historical, legislative/regulatory and practical reasons why this definition is too broad. The submission also makes a suggestion regarding the way forward. In reviewing and possibly revising the definition it might be useful for the Medical Board of Australia (MBA) to first clarify the purpose of the definition of “practice” in relation to the legislated role of the MBA. It may also be necessary for the Board to consider whether it is defining medical* practice or clinical practice or something else (such as the term used in the legislation of “*practising the profession*”, noting that the Section 75 of the *Health Practitioner Regulation National Law Act 2009* states that a person with non-practising registration “*must not practise the profession*”).

The submission is not directed at the issue of “limited practising rights” for retired medical practitioners, as these are “rights” that I do not support. I have chosen not to directly answer most of the questions posed in the consultation document but I believe this submission covers all the issues.

[*All underlining in this submission is the author’s.]

Some difficulties with interpreting the definition

In the MBA/AHPRA document entitled “***Frequently asked questions (revised 13 January 2011)***”, it is stated that “*Medical practitioners with non-practising registration cannot undertake any clinical practice (as defined below). They are not permitted to prescribe or refer ...*”. Later in the same document, the definition of practice (now under review) is provided: “*Practice is any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of the Board’s standards, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession*”.

There are difficulties in interpreting this definition. First, it is confusing in that the definition refers only to practice while the introductory paragraph specifically refers to non-practising registrants not undertaking clinical practice. Secondly, it is not clear if the phrase contained in the definition “*impact on safe, effective delivery of services*” refers only to “*other roles*” or whether it applies also to “*management, administration, education, research, advisory, regulatory or policy development roles*”.

In the same document, “***Frequently asked questions (revised 13 January 2011)***”, it is stated that the MBA “*did not intend to dissuade medical practitioners from teaching or using their professional knowledge in a non-clinical setting*”. The present wording of the definition of practice is clearly in

conflict with this intent. If this remains the intent of the MBA, then the definition should be revised consistent with this intent.

There appears also to be a discrepancy between above definition of “*practice*” and the definition implied in the Board’s professional indemnity registration standard. From the same document (“**Frequently asked questions (revised 13 January 2011)**”) it is made clear that professional indemnity insurance (PPI) is not required “*where the scope of medical practice of an individual medical practitioner does not include the provision of health care or medical opinion in respect of the physical or mental health of any person, PPI will not be required for the purposes of registration*”.

The professional indemnity registration standard states that “*Health care is defined as ‘any care, treatment, advice, service or goods provided in respect of the physical or mental health of a person’*”. It is arguable that “provision of health care” and “provision of medical opinion” should be seen as an equivalent of “clinical practice”.

What is the purpose of the definition?

The purpose of any such definition of practice should be to assist the MBA in its task of protecting the community. Historically, and it is submitted in the present day, medical regulation is directed at identifying persons who are adequately trained and skilled as medical practitioners to safely care for other people (patients) and not put them at risk through lack of skill and knowledge, through being unwell and unable to practise safely or through demonstrating behaviours (usually criminal) that in the eyes of the community render them unfit for the trustworthy position that doctors are granted by the community.

In any reading of medical regulatory legislation (past and present) in Australia or elsewhere, this emphasis on safe caring for patients is so much taken for granted that “clinical practice” and “medical practice” are rarely defined. For example, “practice” was not defined in the recently repealed medical / health professional registration legislation in New South Wales, Victoria and Queensland. Where practice has been defined, the terms used clearly apply almost exclusively to patient care. Similarly, when one reads any national or international code of medical ethics or codes of good medical practice, the emphasis is almost exclusively on patient care. The following are some examples to support these contentions:

What various legislators have done:

The South Australian Medical Practice Bill 2004 contained the following definitions: “*medicine includes surgery*”; “*medical treatment includes all medical or surgical advice, attendances, services, procedures and operations*”; and “*provide (in relation to medical treatment) means provide treatment personally or through the instrumentation of another*”.

In Canada, the Ontario Regulated Health Professions Act 1991 does not define medical practice but instead takes the approach of prohibiting persons other than registered medical practitioners from performing certain “controlled acts” (see section 27) including diagnosis, treatment and other roles that clearly pertain to patient care. (http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm)

Also in Canada, the British Columbia Health Professions Act 1996 does not define practice but does provide a very relevant definition of health profession as follows:

"health profession" means a profession in which a person exercises skill or judgment or provides a service related to

(a) the preservation or improvement of the health of individuals, or

(b) the treatment or care of individuals who are injured, sick, disabled or infirm;

(http://www.bclaws.ca/EPLibraries/bclaws_new/document/LOC/freeside/--%20h%20--/health%20professions%20act%20rsbc%201996%20c.%20183/00_96183_01.xml)

What various codes have stated (or implied):

The Medical Board of Australia/Australian Medical Council document "Good Medical Practice: A Code of Conduct for Doctors in Australia" is a good starting point. Apart from section 11 entitled "Undertaking research", this code is clearly addressed at clinical practice. It is very difficult to find within this document any reference to "*direct non-clinical relationship with clients, working in management, administration, education, [research], advisory, regulatory or policy development roles*". The lack of such material is surely not an oversight and instead suggests that the current MBA definition of practice (with or without the word clinical) is misguided and not related to the legislated role of the MBA. If the current definition of practice is maintained it seems clear that the MBA will need to revise "Good Medical Practice" to address this expanded definition of medical practice.

The General Medical Council document also entitled "Good Medical Practice" is similarly devoid of any material relevant to the unusually broad definition of practice that is under consideration (http://www.gmc-uk.org/guidance/good_medical_practice.asp). This document was created and revised well after the signal events at Bristol Infirmary and thus it seems unlikely that the lack of such material is an oversight.

Similarly the Australian Medical Association's Code of Ethics (<http://ama.com.au/codeofethics>) is focussed on the doctor's ethical duties to patients and the wider community, in the context of patient care and social responsibility. It is difficult to find within the Code any intimation of it applying to "*non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles*".

Taken collectively, the approaches of legislators and medical professional codes of conduct and ethics strongly indicate that clinical practice is about the direct care of patients. Medical research and health care administration appear to be the only additional roles identified by the some of these sources.

The practical issues and unintended consequences

The current broad definition of "practice" has clearly created practical difficulties for both individual medical practitioners and for institutions and organisations in which they have worked.

For individual doctors it has created uncertainty and confusion, especially for those who are not practising medicine (as 'practising medicine' is generally understood by the community). It has deterred semi-retired doctors from continuing valuable honorary work in medical student and

postgraduate education. If general registration is required for such work, these doctors face not only a much higher annual registration fee but will also face the costs of participating in continuing professional development (CPD).

The definition may also have implications for medically qualified and registered doctors elected to political office in Federal or State Parliament who use their medical knowledge (and perhaps even their community “status” as doctors) in their daily work. It may have implications for public figures such as Professor Gustav Nossal in his various roles that include promoting better health through vaccination programs, or Dr Norman Swan who uses his medical knowledge to inform his excellent work as a health reporter.

To focus the MBA more directly on these broad practical implications, I will introduce a personal note to further demonstrate some of the “real world” issues the current definition poses. I have retired from all clinical practice and have opted for non-practising registration. My current professional roles and interests include the following: medically qualified member (part-time) of the Federal Administrative Appeals Tribunal, member of the NHMRC/ARC Australian Research Integrity Committee, Commissioner of Complaints for the NHMRC and medical writer*. In at least two of these roles, it is assumed that I will bring my medical knowledge and experience to the task at hand. Under the legislation and the current definition of practice, does the MBA have a view on my registration status?

[* including two books: “Good Medical Practice: Professionalism, Ethics and Law”, published by Cambridge University Press in 2010 and “So You Want to be a Doctor? A guide for prospective medical students in Australia”, to be published by the Australian Council for Educational Research shortly.]

For institutions such as university medical schools, medical colleges and bodies such the NHMRC, significant contributions from medical practitioners who are no longer in active clinical practice have also been placed at jeopardy.

The MBA might wish to consider whether the difficulties created by the definition are due to the wording of the definition itself or are also related to two accompanying legislated requirements of general registration - viz the mandatory requirement for continuing professional development (CPD) under Section 109 (1) (iii) of the legislation, and the mandatory requirement for medical indemnity cover. The inflexibility of the mandatory requirement for CPD is particularly problematic when, via the very broad definition of practice, the requirement is extended into fields of endeavour not realistically covered by any of the medical college CPD programs (and probably never will be and never should be).

S 109 of the *Health Practitioner Regulation National Law Act 2009* provides that when renewing registration, an applicant must state that “*the applicant has completed the continuing professional development the applicant was required by an approved registration standard to undertake during the applicant’s preceding period of registration*”.

The continuing professional development *approved registration standard* published by the MBA states in its summary: “Medical practitioners who are engaged in any form of medical practice are required to participate regularly in continuing professional development (CPD) that is relevant to

their scope of practice to ensure that they deliver appropriate and safe care". Under requirement 4 (g) which applies to non-specialists, the option of self-directed CPD is offered and the standard then states that "Self-directed programs must include practice-based reflective elements such as clinical audit, peer review or performance appraisal etc ...". This standard thus, correctly in my view, links mandatory CPD with clinical practice in the form of patient care.

The role of the medical board

In both the *Health Practitioner Regulation National Law Act 2009* and the original explanatory notes to the bill, the first listed objective is given as "to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered". As "practise" is not defined in the Act, one has to presume (in the context of health care) that it has its commonly accepted meaning as outlined above. If this is agreed then the definition under review is well outside the intent of the legislation.

The protective role of medical boards around the world operates predominantly via the powers to deal with alleged professional misconduct by, or alleged impairment of, doctors who are engaged in the actual delivery of medical care to patients. It has been uncommon for disciplinary action to follow in other areas or roles that are fulfilled by medical practitioners. Notable exceptions include the actions of the UK GMC in addressing alleged maladministration at Bristol Infirmary, the NSW Medical Tribunal's handling of allegations of research misconduct by Dr William McBride and for a period of time, the UK GMC's active pursuit of allegations of research misconduct. (The last of these three examples has long been puzzling as in most countries research misconduct allegations seem to be ignored by medical regulators. If any reader is interested in how and why such matters were referred to the UK GMC, an explanation is contained in Chapter 5 of the third (2008) edition of "Fraud and Misconduct in Biomedical Research", edited by S Lock, F Wells and M Farthing and published by BMJ Books).

It is pertinent to observe that so long as the medical practitioner has, or did have at the relevant time, some form of registration, disciplinary action against doctors working in non-clinical areas is always open to a medical board without any requirement for such a broad definition of medical practice. Thus, for example, medical administrators who are not practising clinical medicine are still subject to disciplinary, impairment and good character provisions of the Medical Board so long as they are registered.

What should the definition of practice be?

The MBA might be wise to focus on a definition of clinical practice very much in the manner in which this is addressed in the PPI standard and as is implied in the continuing professional development standard. This will be consistent with the existing national code of practice and the AMA code of ethics and with approaches taken internationally. It will also be consistent with the overall intent of the *Health Practitioner Regulation National Law Act 2009*.

Those doctors who opt for non-practising registration (because they are indeed not practising clinical medicine), will need to be reminded that they are still subject to the conduct, impairment and good character provisions of the Act. Those who choose to work in any area outside of clinical medicine that depends in part or in whole on their being a medical practitioner will also need to be

reminded that they have a professional and ethical responsibility, but not a legal responsibility, to maintain medical knowledge and skills adequate for that area of work.

Finally, it hopefully goes without saying that I do **not** support the suggested new definition of practice contained in Option 2. The use of the term “effective delivery of health services” seems to me to simply reproduce many of the very problems that this submission - and other commentators- have identified.

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