

To:

The Australian Health Practitioner Regulation Agency (AHPRA)
practice.consultation@ahpra.gov.au

Response to Public consultation Paper on the definition of practice

1 December 2011.

In response to your request for feedback on the common definition of “Practice” used by the 10 health professions regulated under the Health Practitioner Regulation National Law Act, I respectfully submit my comments for your consideration.

Re: The Definition:

“Under the current definition, a person in any role who uses their skills and knowledge as a health practitioner in their profession is deemed to be practising. This definition is not limited to direct patient/client care, but includes using professional knowledge in a direct non-clinical relationship with patients/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. Therefore, anyone with a qualification as a health practitioner who is working in anything related to health could be deemed to be “practising”. This is regardless of whether their job could be done by someone who is not a qualified practitioner.”

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

Yes.

- i) It is impossible to predict and prescribe all the roles practitioners will fill, nor whether the use of their skills and knowledge will have an impact on safe and effective delivery of services,
- ii) The professional occupations and associated roles encompassed in the definition of “Practice” (and others not yet foreseen by the definition) should be required to maintain registration as a health practitioner in order to ensure currency of knowledge which then supports the authority of expert opinion. The knowledge required to provide expert advice, opinion and decision input is best maintained by adherence to the registration standards of Continuing Professional Development and Recency of Practice.

However some professional occupational categories in which the professional knowledge is applied may not require Professional Indemnity Insurance. The requirement for P.I.I. would best be determined in the individual circumstances in consultation with the insuring organisation and may already be included in the workplace contract.

Re: Direct clinical roles / patient or client health care

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

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

Yes. The practitioner should be registered in their area of practice, but what is their area of practice? Current attempts to define specific areas of expertise have problems:

- i) They prohibit treatment of cases in multiple treatment diagnoses;
- ii) A practitioner may be insured in one area but not another, thereby inhibiting the practitioner in initiating treatment.

Re: Indirect roles in relation to care of individuals

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

Question 3: Do you support this statement? Please explain your views.

Yes. Supervisors and advisors should maintain registration in order to provide authority of opinion and expertise which would be informed by the Continuing Professional Development standard.

Re: Non-clinical roles / non-patient-client care roles

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

Question 4: Do you believe that health practitioners in non-clinical roles / non-patient-client care roles as described above are “practising” the profession? Please state and explain your views about whether they should be registered and if so for which roles?

Yes. As previously stated in Question 1 above, it is impossible to predict and prescribe all the roles practitioners will fill, nor whether the use of their skills and knowledge will have an impact on safe and effective delivery of services. If it can be anticipated that the individual will use their skills and knowledge as a health practitioner in their profession then they should be registered.

Re: Education and Training

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

Question 5: For which of the following roles in education, training and assessment should health professionals be registered?

- Settings which involve patients/clients in which care is being delivered ie when the education or training role has a direct impact on care, such as when students or trainees are providing care under the direction, instruction or supervision of another practitioner
- Settings which involve patients/ clients to demonstrate examination or consulting technique but not the delivery of care
- Settings which involve simulated patients/clients
- Settings in which there are no patients/clients present

All of these roles should require registration for similar reasons outlined in Question 4 above: If it can be anticipated that the individual will use their skills and knowledge as a health practitioner in their profession then they should be registered.

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

As previously stated, it is not possible to predict and prescribe all the roles practitioners will fill, nor whether the use of their skills and knowledge will have an impact on safe and effective delivery of services. If it can be anticipated that the individual will use their skills and knowledge as a health practitioner in their profession then they should be registered in order to maintain currency of knowledge through Continuing Professional Development. (CPD)

Re: Options for consideration

“In determining whether the current definition of “practice” is appropriate the following options are proposed.

Option 1 – No change

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

The current definition of “practice” captures all activities and settings in which an individual with qualifications as a health practitioner might be involved professionally. It protects the public by requiring health practitioners to be registered and to meet the registration standards.”

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

Yes. I support Option 1 – “No change” thereby requiring slight modification to the National Standards through the following reasoning:

The purpose of National Registration

One of the aims of national registration is to deliver an efficient and effective scheme for all health professionals. The purpose of this consultation paper is to assist the National Boards to create a common definition of practice, thereby assisting the delivery of an efficient and effective scheme.

The current definition of Practice relies upon definitions within the National Standards

The current definition of “practice” is contained in the “various registration standards”.

As the consultation paper states “Any change to the definition of ‘practice’ requires a change to the registration standards in which the definition is embedded.”

The reverse situation can be argued: It is the standards which define the true nature of the concept of practice and as such develop a mental construct of practice which needs to be acceptable to all, and workable in all professions.

The standards are:

- Continuing professional development
- Recency of practice
- Professional Indemnity Insurance.

Therefore any prohibitive aspects of the standards which decrease the efficiency and effectiveness of the scheme for all health professionals should be changed.

The elegant solution: Align the Standards with the implicit model of “Practice”

The current definition of practice rests on the implementation of the standards and the definitions contained therein. Any person who satisfies the standards is registered and deemed to be practising and subject to the national law.

Confusion caused by implicit constructs within the Standards

Within the standards two implicit and contradictory constructs are utilised in the word “Practice” which causes difficulty. The first implicit construct can be called the “Direct Clinical Care” model or DCC model. DCC can be regarded as the classic image of the “*One-on-one practitioner and client interaction*” typically in a confidential closed door office environment in private or government funded facilities.

This model creates the current difficulties for determining who is and who is not practicing and who therefore requires registration. The DCC model requires examination and removal from the National Standards.

The second inferred construct is seen within the current definition of practice which specifically names the professions of management, administration, education, research, advisory, regulatory or policy development. The model of practice implicit in these professions is clearly not the DCC model because as the definition itself states: “...Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non clinical relationship with clientsand any other roles that impact on safe effective delivery of services in the profession”.

The model of practice in these other roles could be described as “*No personal interaction with client*”, with concomitant expectation of delivery of safe and effective services *as an outcome of the use of professional knowledge* by the individual. This model can be defined as “Professional Knowledge Application” or PKA model.

Current difficulties of the Direct Care Model

If we remove the DCC model and simply enforce the standards inferred by the PKA model, then all difficulties will be resolved with one exception.

The current requirement for 10 hours of peer consultation within the CPD standard in the Psychologists registration requirements works only within the DCC model of practice. In other areas of practice such as research, academia, policy and government the requirement for 10 hours of peer consultation is impracticable and in many cases unworkable.

For example it would be difficult for a government policy advisor or administrator utilising his/her professional knowledge in psychology to obtain peer consultation for his/her applied efforts in creating new policy or maintaining administrative requirements. Some circumstances may necessitate written confidentiality agreements to which relevant peers may not wish to commit due to current and future unpredictable legal and administrative complexities.

Additionally it would be almost impossible for researchers and educators in the process of writing materials for coursework, book publication, online training and other areas to obtain peer consultation due to:

- The unlikely availability of local peers in applied fields of research,
- Original proprietary work subject to intellectual property restraints in conjunction with commercial confidentiality requirements would prohibit transmission of information to third parties, who may inadvertently or deliberately transmit the property,
- Providing the “Consultee” with the opportunity to capitalise on original thinking of “Consultor”. This spectre is relevant in academic research, Government programs and Policy area, commercial research and educational programs,
- Client confidentiality restrictions may prevent provision of relevant details when discussing case studies,

- Prohibitive cost factors: Individuals not working in say a university, group practice office or government agency with other professionals would have to pay for consultation which is an unfair financial burden,
- Paid consultation would require written confidentiality agreements to which most peers would be reluctant to commit,
- Peers may disagree with the individual practitioner seeking re registration due to professional jealousies or intellectual failings, refuse to sign the consultation document and prevent registration of the individual thereby requiring intervention by the relevant board or even legal action, potentially against the board.

Current contradiction within the definition

The requirement for 10 hours recorded and signed off peer consultation fits the DCC model but does not fit the PKA model of practice and therefore contradicts the current definition of practice which includes ANY role, including but not restricted to direct clinical care.

Proposed solution:

Retain current definition of practice via more efficient CPD standards.

The requirement for 10 hours peer consultation only exists in the CPD requirements for Psychologists registration. The removal of this requirement would enable retention of the current definition of practice across all health professions without change and simultaneously remove the need to predict and prescribe every role where registered practice may occur.

An example of a more equitable method of gaining peer consultation comes from the CPD requirements for Physiotherapists which states: “Professional development activities means participation in formal learning activities, such as attendance at courses or conferences, as well as non-formal learning gained through experience and interaction with colleagues.” (Emphasis added)

In a similar style, Nurses and Midwives are required to participate in at least 20 hours of continuing nursing professional development per year which must be “relevant to the.....context of practice”, thereby removing narrowly prescriptive statements of peer characteristics.

Ongoing CPD requirements are appropriate and beneficial to continued professional education and development. However overly prescriptive statements of requirements hinder progress of developments within professions and also create disincentives for practitioners to take on various and as yet unpredictable roles and endeavours. CPD should act as a motivating stimulus for progress and development, not as prohibitive limiter of professional application.

Revisiting the registration standards across all health professions and including the common PKA model of practice would relieve the current attempt to define practice which suffers the inability to predict all possible future scenarios in practising and applying the profession in which one is trained.

You may publish this submission.

Yours sincerely,

By email only

A Hely
Registered Psychologist,
B.Sc. (UNSW), M.A. (Syd)