Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF1

GF1

NAME: GERARD JOSEPH FITZGERALD (FitzGerald)

ADDRESS: 4 BALOO STREET
HOLLAND PARK WEST QLD 4121

PHONE: (07) 33498573 (HOME)
(07) 32341137 (WORK)
0408 986098 (MOBILE)
FAX (07) 32217535 (WORK)
E-mail gerry_fitzgerald@health.qld.gov.au

DATE OF BIRTH: 9TH MAY 1953
BIRTHPLACE: ROCKHAMPTON (QUEENSLAND)
NATIONALITY: AUSTRALIAN
MARITAL STATUS: MARRIED (BARBARA ELLEN ROLFE, Ph.D.)
TWO CHILDREN

QUALIFICATIONS:

Bachelor of Medicine/Bachelor of Surgery (UQ) 1976
Foundation Fellow of the Australasian College for Emergency Medicine 1983
Bachelor of Health Administration (NSW) 1988
Fellow of the Royal Australian College of Medical Administrators 1990
Doctor of Medicine (UQ) 1990
Fellow of the Australian College of Health Service Executives 2002.

AWARDS:

Australasian College for Emergency Medicine Gold Medal 1993
Centenary Medal 2001

CURRENT EMPLOYMENT:

Chief Health Officer, Queensland Health

Ex Officio Member, Medical Board of Queensland
Ex Officio Member, Queensland Institute of Medical Research Council.
Ex-officio Member, Radiation Advisory Council

Ex-officio Member, Health and Medical Research Council of Queensland.

Chair: Queensland Medical Education Council

Member, National Health and Medical Research Council

Member Australian Health Disaster Management and Policy Committee

Member, Council of Australian Council of Healthcare Standards

OTHER POSITIONS:

Adjunct Professor, School of Population Health, University of Queensland.

Adjunct Professor, School of Health, Queensland University of Technology.

MEMBERSHIPS:

Australasian College for Emergency Medicine (Fellow)

Australasian Society for Emergency Medicine (Member)

Australian College of Ambulance Professionals (Honorary Member)

Royal Australian College of Medical Administrators (Fellow)

Australian College of Health Service Executives (Fellow)

PREVIOUS POSITIONS:

1977 Intern Mater Public Hospital, South Brisbane.

1978 Resident Medical Officer, Mater Public Hospital, South Brisbane.

1979 Medical Registrar, Ipswich General Hospital.

1980 – 1990 Director, Emergency and Outpatients Departments, Ipswich General Hospital.

1980 – 1990 Clinical Teacher University of Queensland

September 1984 - July 1985 Travelling Fellowship to the United Kingdom under Study and Research Assistance Scheme (Queensland Health Department) to study Emergency Medicine.

1990 - 1993 Medical Director, Queensland Ambulance Service

May 1993 - January 1994 Acting Commissioner, Queensland Ambulance Service.

January 1994 to January 2003 Commissioner, Queensland Ambulance Service.

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF2

GF2

HL 111 / 02

Contact:
Dr Robert Stable
(07) 3234 1170

Closing:
16 : 09 : 2002

Queensland Government
Queensland Health

CORPORATE OFFICE

Position Description

1. **Position No:** 001306

   Position Title: Chief Health Officer

   Unit/Branch/and Division: Office of the Chief Health Officer

   Location: Brisbane

   Classification Level: CM13

2. **Reports to:** Director-General

3. **Date of review:** August 2002

4. **Delegates Authorisation:** (Dr) R L Stable
   Director-General

   ..... / /

5. **Purpose of Position**

[a] To provide high level medical advice to the Minister and the Director-General on health issues, especially on standards, quality, ethics and research issues.

[b] To undertake legislative responsibilities in respect of the licensing of private hospitals.

[c] To liaise with educational institutions to ensure university programs adequately address health issues as identified by Queensland Health

[d] To facilitate liaison with educational institutions to address the medical workforce needs of Queensland Health.

[e] To provide high level advice to the Director-General on the planning and direction of priority driven research

[f] To represent Queensland Health on a number of state and national committees and councils.

6. Organisational environment and reporting relationships

The role of the Office of the Chief Health Officer is to:

- provide advice on and coordinate statewide issues relating to medical ethics and standards
- promote and coordinate Queensland Health's research agenda, particularly as it relates to priority driven research
- provide advice on the health risks and health status of Queenslanders
- provide advice on matters pertaining to the quality of health care
- provide advice on new technologies, their research and ethical basis and their application in the clinical environment
- conduct and coordinate clinical audits, where appropriate
- provide advice on matters relating to private health facilities and to license private hospitals
- manage the provision of secretariat support to the Mental Health Court.

The Chief Health Officer works closely with the two organisational divisions within Corporate Office, namely the Health Services Division and the Policies and Outcomes Division.

The Health Services Division fulfils the role of health service purchaser via a high level Health Services Council with each of the service delivery areas in this division fulfilling the role of provider. The head of this division is the General Manager, Health Services, who has overarching responsibility and accountability for all services provided in the division.

The General Manager, Health Services chairs the Health Services Council which translates, via various planning and procurement methodologies, funding for each of the three zones in Queensland Health, into service agreements with health service providers to address health outcomes, priorities and targets. The Health Services Council also consists of the Deputy Director General, Policy and Outcomes, three Zonal Managers representing each of the three zones, Manager Procurement Strategy, and Manager Statewide Health & Non Government Services Unit.

The Policy & Outcomes Division, which is headed by the Deputy Director-General (Policy and Outcomes), has a prime focus on:

- corporate/strategic planning for Queensland Health
- funds acquisition
- development of Health outcomes plans
- corporate policy development, particularly for health priority areas
- Information & Business Management
- Capital Infrastructure planning & development
- providing for compliance with corporate governance requirements
- leadership for business reforms throughout Queensland Health.

These services are provided through the following Branches located in the Corporate Office of Queensland Health:

* Health Systems Strategy Branch
* Capital Works Branch
* Information & Business Management Branch

This Division fulfils the role of funder, through the services provided by the Health Systems Strategy Branch, independent of whether resources are sourced from the Commonwealth or

State Jurisdictions. In addition, this Division also fulfils the role of asset owner via the services provided by the Information & Business Management Branch and the Capital Works Branch.

The Chief Health Officer reports directly to the Director-General and the Minister for Health. The Chief Health Officer also has statutory powers under the *Private Health Facilities Act 1999* for the licensing of private hospitals. Seven positions report directly to and are accountable to the Chief Health Officer.

An Organisational Chart is attached which reflects the above reporting relationships.

7. Primary Duties

7.1 Provide high level/strategic, professional advice to the Minister, Director-General and other Senior Executives of Queensland Health in relation to the delivery of public health services, the health status and health risks of the Queensland population and on clinical issues, clinical risk management and adverse outcomes.

7.2 Develop and implement comprehensive corporate policy frameworks and accompanying guidelines for the effective management of Queensland Health's research agenda, particularly as it relates to priority driven research.

7.3 Lead the development, implementation and evaluation of corporate strategies for the management of ethical issues and maintenance of ethical standards.

7.4 Provide professional, authoritative advice to the Minister, Office of the Director-General and other senior health executives in relation to the management/resolution of issues related to the quality of health care.

7.5 Develop, implement and maintain appropriate mechanisms for licensing of Private Health Facilities to ensure their ongoing compliance with legislation.

7.6 Provide effective departmental representation in high level negotiations and liaison with external organisations, other government departments and bodies [State and Commonwealth], major community organisations and non-government services providers.

7.7 Provide strategic advice and assistance to tertiary institutions and the State Manager, Organisational Development to ensure that contemporary health professional education addresses the medical workforce needs of Queensland Health.

7.8 Represent the Director-General and Queensland Health in major consultation and negotiation initiatives with academic institutions professional specialists and general medical practitioners in Queensland.

7.9 Provide strategic advice on horizon issues including new and emerging technologies, their evidence base and ethical application.

7.10 Manage the resources and operations of the Office of the Chief Health Officer according to contemporary business and public sector management principles and practices to ensure cost-effectiveness and the provision of high quality services to clients, consistent

with Queensland Health's vision and core values.

7.11 Develop, implement and maintain appropriate mechanisms to ensure the provision of an efficient secretariat support for the Mental Health Court in the performance of their legislative responsibilities.

7.12 Represent Queensland Health as an ex officio member of the
- Medical Board of Queensland
- Radiation Advisory Council

7.13 Represent Queensland Health as a member of the Council of the Queensland Institute of Medical Research.

7.14 Ensure there is a strategic approach to the development of contemporary human resource practices and policies including workplace health and safety, equal employment opportunity and anti-discrimination and commitment to their implementation.

8. Primary delegations and accountabilities

In addition to the responsibilities and accountabilities delegated to this position by the Minister and Director-General, this position is accountable for:

- the planning and strategy development necessary to assist in achieving the outcomes required by the Queensland Government and the Queensland Health Corporate Plan.
- the promotion of the Queensland Health corporate vision, goals, policies and priorities to staff, related industries and the Queensland public.
- the effective leadership and management of the Office of the Chief Health Officer consistent with the Corporate Plan and legislative responsibilities.
- the quality and effectiveness of high level medical advice to the Director-General and through the Director-General to the Minister and other Senior Executives on corporate direction, complex and sensitive issues, and other health issues, especially on standards, quality, ethics and research issues.
- the establishment of effective mechanisms and processes to engender positive relations and linkages with national, interstate and other industry related groups.

9. Selection Criteria

Your application for this position must specifically address each of the selection criteria listed below. It should also contain the names and telephone numbers of at least two referees, one preferably your current supervisor, who may be contacted with respect to your application. Shortlisting and selection will be based upon these selection criteria.

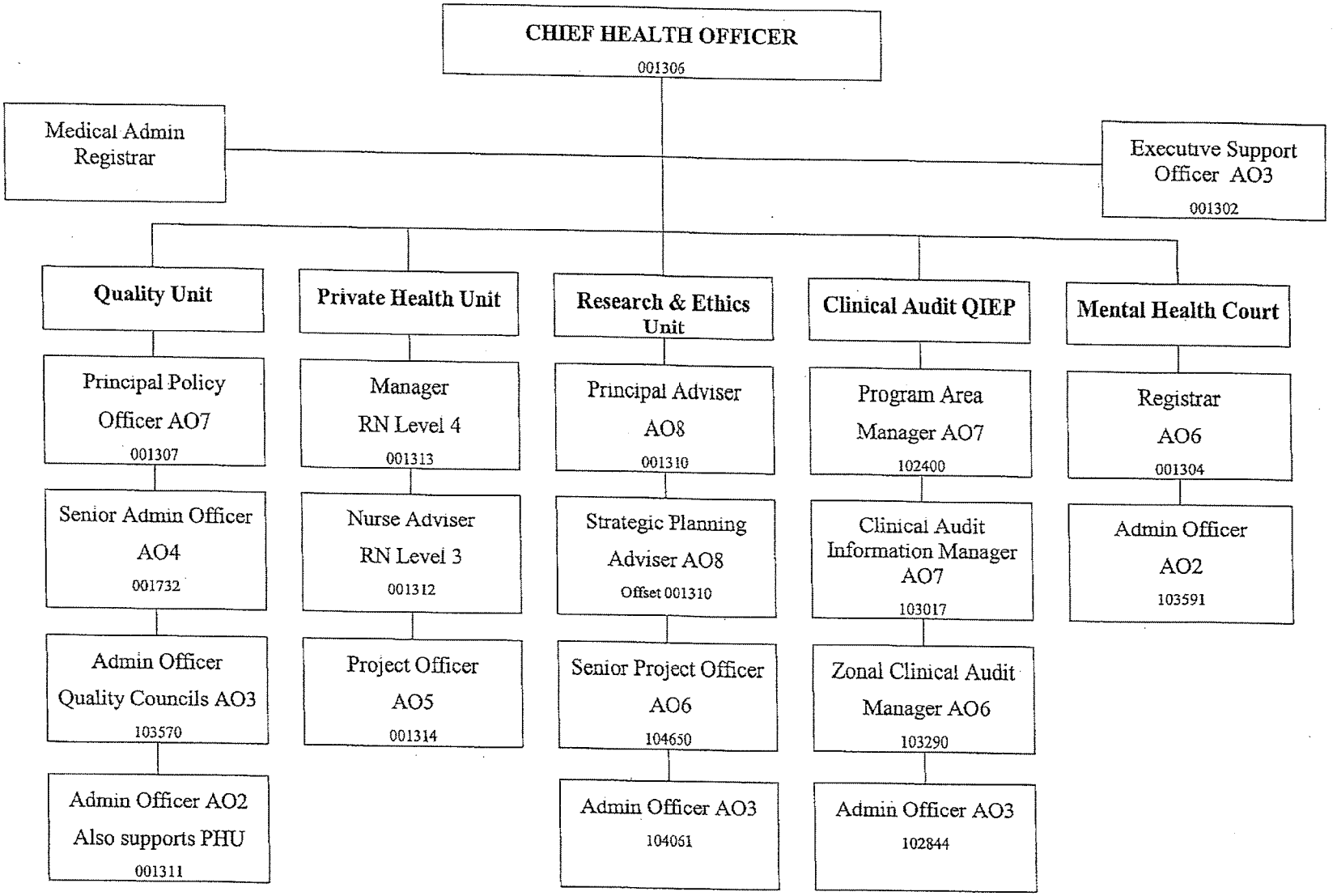
		Weighting Out of 10
SC1	Registration with or eligible for registration with the Medical Board of Queensland as a medical practitioner.	Mandatory
SC2	Proven ability to provide professional leadership at corporate executive level in the public or private health sectors.	10
SC3	Demonstrated ability to provide professional policy advice to Government and senior health executives on complex health sector management and service delivery issues.	9
SC4	Proven ability to effectively manage corporate and professional relationships with external organisations, including Government and non-Government health providers, State & Commonwealth agencies, health interest groups, professional bodies and the community at large.	9
SC5	Demonstrated high level of knowledge of contemporary international, national and local health policy and practice, particularly in relation to such areas as tertiary-sector health service management and delivery; public health; clinical standards; health ethics; health and medical research; medico-legal issues; and quality management, facility licensing and accreditation.	8

10 Additional factors

The successful applicant will be required to enter into a performance based Contract of Employment for a term of up to 5 years.

All Applications should be forwarded to:	The Vacancy Processing Officer, Queensland Health G P O Box 48 BRISBANE Q 4001
Or placed in the sealed box located in the Foyer of	12th Floor, Queensland Health Building, 147-163 Charlotte Street, BRISBANE Q 4000

Office of the Chief Health Officer
Organisational Structure

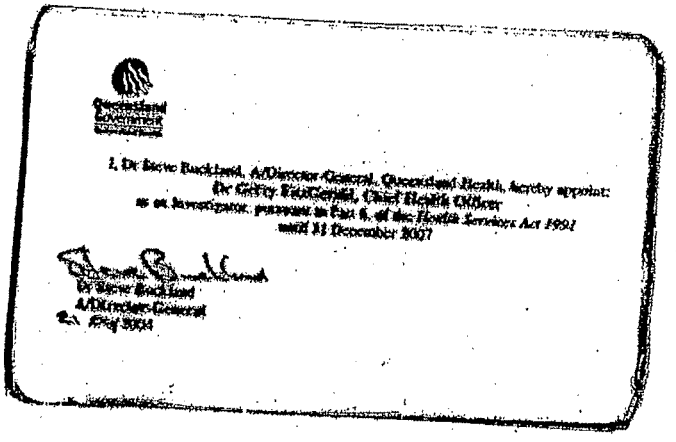


Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

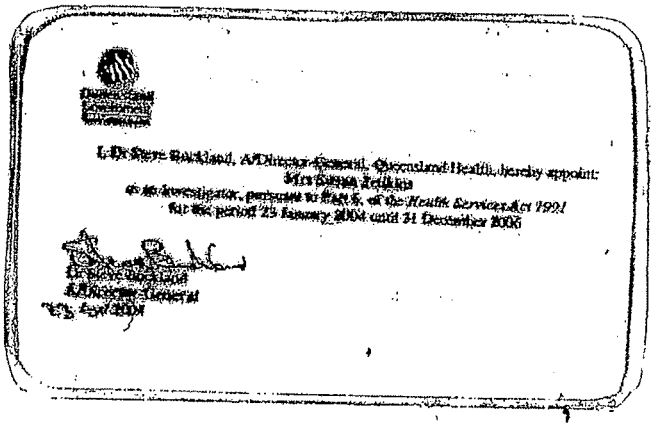
Attachment GF3

GF3



I, Dr Steve Buckland, A/Director-General, Queensland Health, hereby appoint:
Dr Gerry FitzGerald, Chief Health Officer
as an investigator, pursuant to Part 6, of the *Health Services Act 1991*
until 31 December 2007

Dr Steve Buckland
A/Director-General
[illegible] May 2004



I, Dr Steve Buckland, A/Director-General, Queensland Health, hereby appoint:
Mrs Donna Atkins
as an investigator, pursuant to Part 6, of the *Health Services Act 1991*
for the period 23 January 2004 until 31 December 2005

Dr Steve Buckland
A/Director-General
23 April 2004

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF4

GF4

Medical Board
of Queensland

RECENCY OF PRACTICE

DISCUSSION PAPER FEBRUARY 2005

CONTENTS

Foreword from the Chairperson

In March 2002 the *Medical Practitioners Registration Act 2001* ('the Act') commenced operation. The Act, which resulted from extensive consultation with the profession, professional associations and the community, has a number of primary objectives, being as follows:

- To protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way.
- To uphold the standards of practice within the profession.
- To maintain public confidence in the profession.

The Act was developed to give effect to these key objectives and to take into account the changing environment in which the profession operates, mutual recognition principles, interstate and overseas approaches to regulating the profession, and to provide statutory provision for recency of practice.

Recency of practice, when defined through this consultation process, will be directly linked to the annual renewal of registration. By introducing the recency of practice requirements, the Board will meet its legislative mandate of ensuring safe and competent practice. In addition, these requirements will inform the required standards of practice and assist in maintaining the public's confidence in the profession.

This Discussion Paper ('the Paper') commences our consultative process to define recency of practice and how it will be applied by the profession in Queensland. Your involvement in this process will ensure you will continue to be informed of all developments involving recency of practice and, more importantly, provides you with the opportunity to influence the final outcome. By making meaningful submissions to the Board in response to this Paper, you have the opportunity to help produce useful and workable outcomes to achieve the objectives detailed above.

I urge you to consider the issues raised in the Paper carefully, discuss them with your colleagues, and if you feel you can make a contribution, make a submission to the Board along with critical supporting arguments.

Dr Mary Cohn

CHAIRPERSON

Medical Board of Queensland

Making a Submission

This Paper is not a statement of the policies of the Medical Board or of the Queensland Government. It has been prepared to encourage informed comment and discussion about defining recency of practice for the purposes of s.70 of the Act.

You are invited to participate in the formulation of this definition by making a submission on some or all of the issues raised in this Paper. Readers are asked to identify the issue to which their submission relates by quoting the issue from the text of the Paper. Readers are also encouraged to make comments about any other issues which are not covered in the Paper.

It is important to remember that any proposals detailed in your submission should be capable of falling within the description of recency of practice detailed in s.70 of the Act, and should include all critical arguments supporting your proposal.

A submission of this nature is important as it will assist the Board to develop a definition for recency of practice which will then be incorporated in the *Medical Practitioners Registration Regulation 2002* ('the Regulation'). Your contribution will help ensure that the definition included in the Regulation recognizes the shared responsibility of individual practitioners and the Board in maintaining the highest standards of the profession.

If you would like your submission to be treated as confidential, please indicate this clearly in your submission. However, you should note that submissions may be subject to release under the *Freedom of Information Act 1992*. Also, all submissions may be made available to Queensland Health during any future policy development or legislative process.

For more detailed information on the above noted provisions of the Act, a copy of the legislation is available on-line as follows: www.legislation.qld.gov.au

Individuals or groups who face difficulties in making a written submission are encouraged to contact Mr Kim Hudson (Project Officer) on (07) 3235 4177.

Submissions should be addressed as follows:

Recency of Practice Submission
Medical Board of Queensland
GPO Box 2438
BRISBANE QLD 4001

The closing date for receipt of submissions is Friday, 29th April 2005.

Preamble – Why Define Recency of Practice?

Introduction

Health care professions such as medicine are regulated to protect the public, uphold standards of practice and maintain public confidence in the profession. The strong traditions of health professional regulation have increasingly been challenged in recent years and the development of the *Medical Practitioners Registration Act 2001* ('the Act') has ensued from these challenges. The Act, which commenced in March 2002, has a number of primary objectives, being as follows:

- To protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way.
- To uphold the standards of practice within the profession.
- To maintain public confidence in the profession.

To achieve these objectives, the Act contains provisions which represent a new approach to the regulation of medical practitioners and to the protection of consumers of medical services. For the first time, the Board has the explicit responsibility to base its decision to renew a registration on whether the applicant has satisfied requirements in relation to recency of practice.

The implementation of this responsibility must, consistent with the objectives of the Act, ensure the public is provided with safe and competent services from medical practitioners. Determining the recency of practice requirements is therefore a significant undertaking as such determinations will play a vital role in ensuring that appropriate standards of medical practice are achieved and maintained.

Consistent with its commitment to the open and accountable development of policy, the Board has determined that defining recency of practice will be based on a process of consultation with health care consumers, medical practitioners, professional organizations, employers and other interested parties. In this way, the development of policy will reflect both the expectations of the community and the profession.

The Legislation

The Minister for Health in the second reading speech for the thirteen health practitioner registration Bills explained the rationale underlying the new legislative provisions, including those for recency of practice, when she said:

... the purpose of this legislation is to protect the public, uphold standards of practice within the professions and maintain public confidence in the professions. These Bills have been introduced to advance and protect the public interest.

... as a major goal of the regulatory system is to ensure that standards of practice within the professions are maintained on an ongoing basis, the legislation also focuses upon the processes for renewal of registration and strategies to facilitate the ongoing competence of registrants.

... it is essential that regulatory systems monitor the competence of existing practitioners.

In stating these rationale, the Minister was, in part, referring to s.70 of the Act. This section gives some meaning to recency of practice as follows:

*(1) **"Recency of practice requirements"** are requirements, prescribed under a regulation, that if satisfied demonstrate that an applicant for renewal of general registration has maintained an adequate connection with the profession.*

(2) The requirements may include requirements about the following –

(a) the nature, extent and period of practice of the profession by the applicant;

(b) the nature and extent of any continuing professional education undertaken by the applicant;

(c) the nature and extent of any research, study or teaching, relating to the profession, undertaken by the applicant;

(d) the nature and extent of any administrative work, relating to the profession, performed by the applicant.

It is also important to note that the same legislative provisions about recency of practice have been included in all health practitioner registration legislation and all thirteen health practitioner Boards are concurrently consulting with their stakeholders to define recency of practice.

To inform the definition of recency of practice to be included in the Regulation for the medical profession, an understanding of how recency of practice will be applied is necessary. In this regard, once the definition has been included in the Regulation, applicants seeking to renew their registration will be required under s.72(5)(b) to detail the extent to which they have satisfied these requirements before renewal of registration is granted.

Before deciding on the renewal application, the Board may require an applicant, pursuant to s.74(1)(c), to undergo a written, oral or practical examination. The Board must then consider the application and, pursuant to s.75, decide to renew, or refuse to renew, the applicant's registration. In making its decision, the Board must have regard only to the extent to which the applicant has satisfied recency of practice requirements. As an alternative to refusing to renew an applicant's registration, the Board may decide, pursuant to s.76, to renew the registration on conditions the Board considers will sufficiently address the extent to which the applicant has not satisfied the requirements. Before making a final determination about renewing the registration on conditions, the Board must provide the applicant with the right to make a submission on the proposed conditions.

In addition to this right to procedural fairness, the applicant has other rights to procedural fairness protected through the requirement placed on the Board to issue them with an information notice [s 76(4) and s.77(2)] if the decision is to impose conditions or to refuse to renew registration. An information notice requires the Board to detail its decision, the reasons for the decision, the time in which the person may appeal the decision, and how the person may appeal against the decision to the District Court.

There are a number of critical points that should be understood in relation to recency of practice requirements. These are that the recency of practice requirements do not apply to all categories of registrants eligible to renew their registration. In this regard, recency of practice is:

- required for the renewal and/or restoration of general and/or specialist registration (Part 3 Division 4 Subdivisions 1-3 (see Appendix 1), ss.78 and 124);
- not required for those seeking registration in the non-practising category (s.150B-H);
- not required for those seeking renewal of special purpose registration (s.144); and
- not required for registrants subject to probationary conditions (i.e. those undertaking internship or supervised practice program).

Recency of practice is not required for the renewal of special purpose registration as the Act requires the Board to apply a higher test in deciding to renew special purpose registration. That higher test is detailed in s.131 of the Act which requires the Board to consider the eligibility of the applicant for renewal of special purpose registration based on whether the applicant is fit to practice the profession and is qualified for registration in one of the special purpose categories as detailed in ss. 132, 133, 134, 135, 136, 137 and 138.

For more detailed information on the above noted provisions of the Act, a copy of the legislation is available on-line as follows: www.legislation.qld.gov.au

Expected Outcomes

The purpose of this Paper is to stimulate discussion. It does not represent the views of the Board, nor does it represent proposed policies, procedures or guidelines for implementing recency of practice requirements. The Paper outlines the relationship between recency of practice and continued competence, describes how other medical boards and professions have defined recency of practice and identifies issues which need to be addressed during the consultation process. In undertaking the consultation process, the Board expects that the following outcomes will be achieved:

- The definition of recency of practice will be consistent with the objectives of the Act.
- Issues relevant to recency of practice will be discussed and debated to inform the definition of this concept.
- The community, the profession and other interested parties will contribute to recency of practice policy development.
- Policies and procedures for recency of practice will be cost effective and efficient to implement and maintain.

Definitions and Approaches – How Have Others Defined Recency of Practice?

Introduction

The focus on recency of practice is not unique to the medical profession in Queensland. Medical Boards in Australia and in other countries have been exposed to the challenge of ensuring that practitioners continue to be competent. The challenge has also been addressed by other occupational groups including the nursing profession.

The actions taken by Boards elsewhere, by other occupational groups and by the nursing profession may help medical practitioners in Queensland to clarify the direction they wish to take for the future. In the following summary overview of those approaches, several different models are evident. If consideration is given to one or more of these models to inform the model in Queensland, this should be done against a background of the uniqueness of the Australian society and the objectives and the structure of the Act.

AUSTRALIA

Medical Boards

NSW practitioners are required by law to complete an annual Continuing Professional Development ("CPD") return, with the Board expecting all practitioners to actively participate in relevant CPD activities.

Currently there are no legislative recency of practice requirements linked to annual re-registration in SA, WA or the ACT. However each is either planning a review of the legislation, or has a draft Bill in circulation. In WA, a working party reviewing the current Act considers that the public protection objective would be well served by establishing a link between assessing the continuing competence of practitioners and registration. The proposed *Medical Practice Bill 2001* in SA requires the Board's approval where there has been no practice for three years; with applicants being required to obtain qualifications or experience required by the Board.

The ACT is developing a new *Health Professionals Bill* with the intention of including provisions for each health profession that state the requirements for unconditional registration including the maintenance and demonstration of continuing competency, recency of practice and professional development both at the time of initial registration and annual renewal. Proposed Regulations will require the Board to consider whether the applicant's experience is recent enough and sufficient to allow safe practice according to a recency of practice schedule, which is yet to be developed.

All health professional Boards in the NT are now subject to the *Health Practitioners Act* which allows registration if the applicant has sufficient competence and capacity to practise, and allows a Board to refuse to issue a practising certificate if the health practitioner has not practised for a period of time specified by the Board. Each Board will define their recency of practice policy in the Board's Code, with the Medical Board currently specifying practice within two years.

Victoria has recently amended its *Medical Practice Act 1994* to give a discretionary power to collect from applicants for renewal of registration information on:

- the main areas of medicine the applicant has been practising in;
- any CPD undertaken in last period of registration;
- whether the applicant intends to practise during the new registration period; and
- if intending to practise, what areas will be practised in.

This information will be used as part of the current

review of the regulatory system, which is considering recency of practice issues.

In Tasmania the *Medical Practitioners Registration Act 1996* allows the Council to refuse to renew annual registration for medical practitioners seeking practising registration if they have not practised for more than 5 years. However a discretion exists to still allow registration if the applicant can show they have sufficient physical and mental capacity, and skill to practise or undertake medical teaching or research. Applicants for practising registration are also required to submit a compulsory declaration stating that they have maintained their competence and involved themselves in CPD to an extent appropriate to the style and nature of their practice.

Committee of Presidents of Medical Colleges

The Commonwealth Department of Health and Ageing has recently funded a project by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists on behalf of the Committee of Presidents of Medical Colleges to design and develop a framework that can be considered 'best practice' in the field of specialized medical CPD, based on data and information collected throughout the duration of the project, and which could be applicable to a wide variety of medical specialties.

As the project was aimed at all doctors who have completed a prescribed period of postgraduate vocational training and certified as possessing recognised expertise in a specific area of medical practice, the framework is considered to be relevant to General Practitioners as well as 'specialists' from other disciplines.

The project was driven by the belief that an ad hoc or spasmodic approach to CPD can no longer be considered acceptable, and hence a uniform approach to this issue across the different specialties would appear desirable and logical.

Three main strands of medical professionalism are identified, which are further divided into 10 components (as outlined below), in order to enable practitioners across disciplines and settings to identify areas of practice that encompass their CPD needs and activities within the 10 components.

Clinical Expertise
Medical Expertise
Clinical Judgement
Medical Informatics (Clinical)

Risk Management
Communication
Practice Management
Medical Informatics (Practice)
Personal Management and Insight

Professional Values and Responsibilities
Relationships and Accountability
Advocacy and Equity
Education

CPD activities in the 10 components are then classified as those that:

- focus on increasing knowledge;
- can facilitate changes in practice and health outcomes; and
- evaluate changes in practice and health outcomes.

The framework advocates the prospective identification of learning and, thus, CPD needs by individual practitioners, as well as an evaluation of what has been achieved throughout a defined CPD cycle. As far as possible and practicable, this evaluation should address changes that have occurred at the levels of specialist practice and behaviour, as well as health outcomes.

The framework has been designed to be broad ranging and flexible in its application and operation, with a view to what is practical and achievable at the practitioner and institutional level. CPD programs can operate on the basis of a participant portfolio, a requisite number of credit points, or a combination of both. Work is also advanced on the creation of a universal system of recognizing participation in CPD, based on the issuing of (what has been called) a *Certificate of Continuing Medical Professionalism* to indicate to professional organisations, statutory bodies, and consumers that individual practitioners are participating and are in good standing in a CPD program sanctioned by the issuing body.

The second stage of the pilot project will be testing of the program by several of the Medical Colleges. Negotiations are well under way with four colleges to pilot the program, with 30-40 Fellows from each College participating. The New Zealand Medical Council is also interested in the outcomes from the pilot and is looking at the framework for their own specialist CPD programs.

Medical Colleges

There is a link between membership and compulsory CPD for:

- The Royal Australasian College of Medical Administrators.
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which has

a mandatory CPD program in which Fellows are required to gain 150 points over 3 years, of which 25 points must be gained in practice review and risk management (PR&CRM). Fellows who fail to meet the College's CPD requirements are referred to the Fellowship Review Committee and may have their Fellowship withdrawn. The College has also developed a re-entry program to encourage Fellows who have a prolonged period of absence from practice or aspect of practice to identify their learning needs and the knowledge and skills required in their return to practise.

- New Zealand members of the Australian and New Zealand College of Anaesthetists (ANZCA) who must participate in the College's Maintenance of Professional Standards (MOPS) program. The program is annually based and requires 50 points of CPD, training, teaching and research activities and 25 points of Quality Assurance (QA) activities. Compliance leads to a Statement of Participation being awarded and 5% of returns are audited.

- The Australasian Faculty of Public Health Medicine, for all Fellows in full/part time public health medicine, all AFPHM office bearers and Fellows who are advanced trainee supervisors and mentors (500 points needed over 5 years.) AFPHM also extends special consideration to Fellows who are not practising public health medicine for more than six months in a calendar year (for maternity, long service, or sick leave etc) by allowing their suspension from participation for the calendar year. A certificate of completion is awarded at the end of the five year period if successful and 5% of returns are annually audited; and

- The Royal Australian College of General Practitioners, where members are required to declare that they will undertake the College's CPD requirements (130 points over 3 years).

All other Colleges strongly encourage CPD/MOPS participation (with the overwhelming majority of Fellows complying), and most Colleges state that employers are increasingly looking for compliance as a condition of employment for their employees.

ANZCA's 'Statement on the Standards of Practice of a Specialist Anaesthetist' states that specialist anaesthetists recognise that:

- regular work is necessary to maintain clinical skills;

- CPD is essential;

- retraining will be necessary after a period away from normal duties or starting new duties; and

- ageing may lead to a decline in standards of practice and review by colleagues may be needed to continue practice.

The Royal Australian and New Zealand College of Ophthalmologists' CPD program requires 150 hours over 3 years (Aus) or a compulsory 50 hours/year including an annual audit and peer review (NZ). A Certificate of Participation is issued to Fellows who complete their requirements and the College also issues a letter of Good Standing to those currently up to date in the College's CPD program. 5% of submissions are audited each triennium.

The Royal Australasian College of Physicians, Australasian Faculty of Occupational Medicine, has a non-compulsory CPD/MOPS program. There are no plans to make ongoing Fellowship conditional on undertaking this program.

Though MOPS is not currently mandatory for The Royal Australian and New Zealand College of Psychiatrists, 85% of Fellows participate. From January 2004 a new CPD program was introduced requiring 50 hours/year, including 10 hours of peer review. It is also hoped that the program will become mandatory in 2-3 years.

The Joint Faculty of Intensive Care Medicine has voluntary MOPS but a high rate of participation by Fellows. The program requires gaining 50 points from CPD/training, teaching and research and 25 points QA each year. After an annual return is submitted a Statement of Participation is issued to successful participants.

The Australasian Chapter of Palliative Medicine introduced its CPD policy in 2003. While it is not mandatory Fellows must complete the requirements to receive certification they are undertaking appropriate CPD. The voluntary nature of the program is also being reviewed. 5% of returns are audited each year.

Because of pressure from some branches (in particular New Zealand) to introduce a recertification program, whereby postgraduate professional bodies such as The Royal Australian and New Zealand College of Radiologists testify to the ongoing competence of each of their members, the RANZCR has modified its previous Continuing Medical Education program to be a CPD program. The new program is voluntary in Australia, though all Fellows in full/part time practice, Fellows practising temporarily overseas and practising educational affiliates are expected to participate. The program requires 180 points (hours) over three years from clinical audit, educational activities/publications, meetings and individual learning. Each year a Certificate of Compliance is issued and at the end of each three year cycle a certificate of CPD is issued to successful participants.

The Australasian Faculty of Rehabilitation Medicine

has a voluntary CPD program where all Fellows are expected to participate and submit an annual return, unless they are enrolled in the CPD program of another specialist medical college. The CPD program requires at least 60 points annually, with 500 points over a 5 year cycle (including at least 50 Quality Improvement points) required to obtain a Certificate of Completion. 15% of the Fellowship are subject to a random review of their documentation each year.

Dental

Tasmanian legislation states that the Dental Board must not issue a new certificate of registration unless the applicant has actively practised in the last 5 years unless the Board is satisfied the applicant has sufficient skill to practise. This Act has power to make a Regulation governing CPD but none has yet been passed. The Board is also waiting for the release of the Australian Dental Council/Australian Dental Association report into continuing education before considering any options for regulating CPD.

There is no legislated recency of practice provisions for dentists in WA. However auxiliaries (dental therapists, hygienists and school dental therapists) are required to be registered with the Dental Board, and where initial registration, or restoration is sought more than five years since the applicant was last registered, the applicant is required to have current knowledge and skill at a level approved by Board.

Medical Radiation Technologists

The Australian Institute of Radiography currently requires qualified practitioners who have been out of the profession for more than five years to undergo a resumption of professional practice program. This is aimed at assessing an applicant's competence to re-enter the workforce. It consists of an assessment of the applicant's skills under a Clinical Education Program involving a clinical placement followed by Competency Based Assessments and a Further Education Program where necessary.

From 1 January 2005 the AIR will introduce a mandatory CPD program based on the current voluntary biennial programme of 24 credits with at least 6 credits in either year, leading to a Certificate of Compliance in Continuing Professional Development. Policies are also being developed to link these CPD requirements with either renewal of subscriptions or to Statement of Accreditation validation. Practitioners can apply for leave of absence from the program because of absence from the workplace or other good reasons such as maternity leave. Approximately 10% of participants are randomly selected for audit.

The Australian and New Zealand Society of Nuclear Medicine's (ANZSNM) Accreditation Board recommends that individuals undertake a clinical placement program (CPP) if they have not undertaken any form of clinical practice in the last three years. This time period has been chosen to meet with the Accreditation Board's Validation of Accreditation policy and the ANZSNM's Continuing Education Program. As of January 2004, technologists have been required to gain 30 Continuing Professional Development (CPD) points in the ANZSNM's program, as well as prove recency of practice over the last three years. The Accreditation Board will automatically accept recency of practice to those practitioners demonstrating 192 hours per year over the three years (equivalent to 4 hours per week). Technologists falling short of the 192 hours/year over three years (or 576 hours total), but who previously held a statement of validation of accreditation prior to this, will be required to undergo a CPP in an approved department. The length of a CPP will be related to the length of time an individual has been absent from clinical practice. This ranges from:

- 3 months CPP for less than 576 hours of practice within the last 3 years;
- 6 months CPP for 3 to 9 years absence from clinical practice; and
- 12 months Equivalent Full Time Employment and the requirement to sit and pass an exam equivalent to the Overseas Qualification Assessment exam, as well as apply for entry in the ANZSNM Accreditation Board's Professional Development Year/Mentor Program for more than 10 years absence from clinical practice.

A statement of Resumption of Professional Practice and validation of Accreditation will be issued upon completion of the CPP. This may be used to apply for licensing or registration by the relevant state authority.

Tasmanian legislation requires practitioners to obtain an annual certificate of registration, which may be refused by the Board if it is not satisfied that the practitioner has sufficient skill to practise. The Board must not issue a certificate to an applicant who has not practiced within the last five years unless it is also satisfied the person has sufficient skill to practise.

Occupational Therapy

OT Australia allows all Australian practitioners to become Accredited Occupational Therapists by completing 60 points of CPD every 2 years. If a practitioner is re-entering the workforce after 5 years absence, they must also undertake professional mentoring as well as undertaking CPD to become accredited.

Neither WA nor SA has any legislated recency of

practice requirements. A draft WA Act would require practitioners who haven't practised for more than five years to notify the Board. The SA Board has adopted a policy that practitioners must maintain a level of professional knowledge and skill to ensure continued competency. Also those who haven't practised for 5 years continuously should, under the policy, update knowledge and skills before re-entering the workforce. New legislation is proposed to require demonstration of ongoing competency on an annual basis, but no details have been worked out yet.

Victoria, New South Wales, the Australian Capital Territory and Tasmania have no legislation and no registration Board.

Pharmacy

There are no legislated recency of practice requirements in NSW, WA and Victoria.

In NSW if an applicant for registration has not been registered for five years then the Board may refuse new registration until the applicant has passed specified testing. It is anticipated that new legislation will require an annual return to be lodged in support of registration renewal, requiring applicants to specify what CPD and development has been undertaken in the current practice period.

In Victoria a Regulation allows the Board to require retraining if an applicant was not registered for more than two years before seeking restoration of registration. The Board's guidelines also recommend 20 hours of CPD each year. In WA registration and licensing are treated separately. There is no discretion to reject an application for registration if the eligibility criteria are met, but the Board has a policy on licensing stating that if an applicant has not practised an aggregate of at least one month/year, or been involved in pharmacy over the last 3 years (teaching, certain government employment, scientific research), then they must attend in person to demonstrate competence and knowledge of current pharmacy.

In SA if a registered pharmacist has not practised for 3 or more years, then they need the approval of the Board before practising. The Board may require a refresher course or that qualifications/experience be obtained before approval to practice is given. As of 2004 SA moved to a competency based re-registration process where pharmacists will need to show recency of practice within the 3 years outlined in the Act, and a demonstrated commitment to professional development before being granted a practising certificate. For example if a person has been out of practice for more than one year but less than three, 30 ENRICH credits in the 12 months after a new practising certificate is issued is required. If the absence is more than three years then the Board will require a re-entry program to be completed.

Tasmanian legislation states that the Board must not issue a new certificate of registration to a registered person if there has been no active practice within the last five years. The Board has endorsed a policy that requires those who haven't practised for more than five years to submit a statement to a Competency Committee detailing how they have maintained their competency. The Competency Committee may then recommend to the Board what courses, supervised practice or training is required to obtain a sufficient standard to allow re-registration.

Physiotherapy

In NSW there are no specific legislative provisions concerning recency of practice but the NSW Act has provisions to:

- Record practice/CPD on annual returns;
- Refuse registration if the Board is concerned about competence;
- Allow conditional registration; and
- Conduct an inquiry about an applicant's suitability for re-registration.

An inquiry will grant registration with recommendations or conditions depending on the amount of time an applicant has been non-practising and the applicant's previous experience. The Board recommends practising 15 weeks full time equivalent (600 hours) within the last five years to maintain continuity of practice.

Victoria, Tasmania and SA require sufficient experience or active practice within the last five years before the Board will renew registration and allow practice. In Victoria and Tasmania each Board defines practice as clinical practice, research, teaching and management of physiotherapy services, and sufficient physiotherapy experience is considered to be 1000 hours over five years together with maintaining an active interest in the profession through CPD.

WA has no recency of practice requirements. However, a new draft Act proposes that physiotherapists who haven't practised for more than five years must notify the Board of this.

Optometry

No legislation concerning recency of practice exists in Victoria, South Australia or the ACT, though all are at various stages of reviewing their legislation. In Tasmania the *Optometrists Act 1994* states that the Board must not issue a new certificate of registration to a registered person who has not actively practised optometry in the

last 5 years, unless registering for the first time and otherwise eligible to apply. Under this Act the Board may hold an enquiry to determine the entitlement of an applicant to be registered. The Committee of Inquiry may make recommendations on whether the applicant is entitled to be registered as a practitioner and if so, whether the registration should be conditional.

Psychology

Tasmanian legislation states that the Psychology Board must not issue a new certificate of registration to a registered person who has not actively practised psychology in a 5 year period immediately preceding the due date. This is evidenced by the applicant making a declaration in respect of this requirement on their application for renewal.

South Australia has no legislation but the Psychological Board has adopted a policy that psychologists who have not practised for a continuous period of five years or more should update their knowledge and skills before re-entering the work force. Psychologists should also acknowledge the boundaries of their competence and only provide services within those boundaries, and refer clients whose needs fall outside these boundaries to more appropriate practitioners.

Chiropractors and Osteopaths

In Tasmania the *Chiropractors and Osteopaths Registration Act 1997* states that the Board must not issue a new certificate of registration to a registered person who has not actively practised in the last 5 years, unless registering for the first time and otherwise eligible to apply. Under this Act the Board may hold an enquiry to determine the entitlement of an applicant to be registered. The Committee of Inquiry may make recommendations on whether the applicant is entitled to be registered as a practitioner and if so, whether the registration should be conditional.

The ACT is currently undergoing changes to their legislation, with a new *Health Professionals Bill* due to be debated in 2004. Under the new Bill, it is envisaged that the Board will be required to address the issue of the general competency of chiropractors and osteopaths, however no firm decisions on how this will be done have been made.

South Australian legislation states that a registered chiropractor who has not practised for 5 years or more must not practise for a fee or reward without first obtaining the approval of the Board. Before giving their approval, the Board may require the applicant to undertake a refresher course or to obtain specified qualifications or experience, and any approval may be subject to conditions. The Board has also adopted a policy that chiropractors should acknowledge the boundaries of their competence and only provide services within those boundaries, and refer clients whose needs fall outside these boundaries to more appropriate practitioners.

There are no legislated recency of practice requirements for chiropractors in NSW or osteopaths in Victoria.

Podiatrists

The ACT is currently undergoing changes to their legislation, with a new *Health Professionals Bill* due to be debated in 2004. Under the new Bill, it is envisaged that the Board will be required to address the issue of the general competency of podiatrists, however no firm decisions on how this will be done have been made.

NSW and Western Australia have no legislated recency of practice requirements, though the Western Australian Board has raised this omission with their Minister and requested that legislation be introduced to remedy it.

Australian Nursing Council Inc.

In 1997 the Australian Nursing Council Inc. ('the Council') commenced a research project to identify the indicators of continuing competence in nursing. At that time, the majority of nurse regulatory authorities in Australia had either legislative provision or policies which required nurses to have practised within the previous five years in order to renew their registration. These legislative provisions and policies were based on the assumption that recent practice indicated competence to practise. However, the Council and the nurse regulatory authorities recognized that there were problems of logic and arbitrariness associated with this assumption.

The research project was undertaken by a consultancy team from the Department of Clinical Nursing at the University of Adelaide, headed by Professor Alan Pearson. It was conducted in four stages and involved consultation nationally. These four stages were:

- The identification of appropriate competency indicators.
- Analysis of Stage One data and the development of pilot instruments.
- Testing the pilot instruments.
- Consulting and surveying nurses on the optional instruments.

For the purpose of this Paper, each of the optional instruments developed for Stage Four of the project is described to enable comment on those models. These models are as follows:

Optional Instrument A

The payment of an annual re-registration fee only.

Optional Instrument B

The provision of evidence of competence based on an ANCI competency questionnaire.

Optional Instrument C

The submission of a professional portfolio

Optional Instrument D

A combination of options B and C – that is, the provision of evidence of competence based on an ANCI competency questionnaire and the submission of a professional portfolio.

Optional Instrument E

Signing a legal declaration annually (based on the document currently used by the Queensland Nursing Council).

Optional Instrument F

Verifying recency of practice.

The findings generated through extensive consultations and a random national survey of nurses showed significantly strong trends to permit the researchers to identify a preferred instrument and to construct an approach to the monitoring of continued competence in nursing by nurse regulatory authorities. These outcomes were as follows:

- The introduction of a self-assessment and legal declaration for those applying to renew their registration – the researchers indicated that the self-assessment and legal declaration about continued competence needed to be as simple as possible to: (a) avoid confusion and high administrative workloads; and (b) ensure that the nurse was absolutely clear about what they were declaring and of the responsibilities that ensued from such declaration. A copy of the self-assessment and legal declaration recommended by the researchers is placed as Appendix 2.

- The introduction of an annual random audit by nurse regulatory authorities – the researchers indicated that the purpose of the audit was to test the validity and reliability of the self-assessment and legal declaration as an indicator of competence to practise as a nurse.

- The introduction of a system of supports by professional nursing associations to assist nurses to prepare evidence for auditing purposes.

In considering the approach recommended by the researchers it was agreed by nurse regulatory authorities that two principles would underpin their development of policies and requirements in relation to continued competence of the profession. These were that: (a) the principle of self-assessment be the basis for determining continuing competence; and (b) any process for determining continuing competence be implemented within a quality improvement framework.

OVERSEAS

The General Medical Council, United Kingdom

The GMC has introduced a new system based on a licence to practise, supported by periodic revalidation. Anyone wanting to continue to practise as a doctor, including retirees who want to prescribe, will need a licence to practise.

Underpinning the new licensing requirements are the principles of *Good Medical Practice*, which include:

- Making the care of patients the first concern;

- Respecting the rights of patients to be fully informed in regard to decisions about their care;

- Keeping professional knowledge and skills up to date; and

- Acting quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise.

All doctors on the register were granted a licence to practise by the end of 2004, unless they ask not to be included. To maintain the licence to practise, doctors must take part in revalidation when asked to do so, which will be every 5 years with the first group starting in 2005.

Revalidation requires licence holders to show that they have been practising medicine in line with the principles set out in *Good Medical Practice*. There are two ways of doing this: the Appraisal route or the Independent route (or in some cases a combination of both).

Appraisal

The aims of appraisal are to:

- Set out personal and professional development needs, career paths and goals;

- Agree plans for them to be met;

- Review the doctor's performance;

- Consider the doctor's contribution to the quality and improvement of local healthcare services;

- Optimise the use of skills and resources in achieving the delivery of high quality care;
- Offer an opportunity for doctors to discuss and seek support for their participation in activities; and
- Identify the need for adequate resources to enable service objectives to be met.

Every doctor undergoing appraisal will need to prepare an appraisal folder demonstrating information, evidence and data to inform the process, which will be updated as necessary. The doctor and appraiser will agree a written overview of the appraisal, which should include a summary of achievement in the previous year, objectives for the next year, key elements of a personal development plan, actions expected of the organisation, a standard summary of the appraisal and a joint declaration that the appraisal has been carried out properly.

For doctors within managed organisations, five sets of completed annual appraisal forms can be submitted to the GMC as evidence to support revalidation. Alternatively, the evidence gathered for the appraisal process could also be submitted to the GMC as evidence to support revalidation. Whilst appraisal is designed to help doctors identify development needs and produce personal development plans, rather than assess performance, evidence of participation will show the GMC that the doctor is discussing the quality of his or her own work and keeping up to date. This is seen as a powerful indicator of fitness and overall qualification to practise medicine.

While appraisal and revalidation will be based largely or wholly on the same sources of information, and appraisal summaries will inform revalidation, the objectives of the two processes are distinct and complementary. Revalidation involves an assessment against a standard of fitness to practise in line with *Good Medical Practice*. It will allow a doctor's licence to practise to be renewed. Appraisals are concerned with the doctor's professional development within their working environment and the needs of the organisation for which the doctor works.

Independent Route

To use this route, doctors will need to show that they are adopting the principles of *Good Medical Practice* within their professional practice and are undertaking appropriate continuing medical education or professional development. Doctors will have to draw on what they have actually done in their chosen field and provide suitable evidence covering each heading of *Good Medical Practice*.

New Zealand

The recently introduced *Health Practitioners Competence Assurance Act 2003* contains provisions covering all health professions. Practitioners must hold a current practising certificate issued by the relevant authority for each profession. Each authority is required to gazette their scope of practice (a description of the contents of the profession) and set the entry requirements for registration. It is an offence for a person to hold themselves out in any way that they are a health practitioner of a particular kind unless registered, and qualified to be registered, as a health practitioner of that kind. Licensed health practitioners must not practise outside their scope of practice, including any conditions imposed on their scope of practise.

To be registered an applicant must show they have the prescribed qualifications, are fit to be registered, and are competent to practise within their nominated scope of practice. Before authorising registration, or before authorising a change to an applicant's existing scope of practice, the applicant may be required to take and pass an examination or assessment in order to show that the applicant is competent to practise within their proposed scope of practise.

After initial registration applicants must apply for an annual practising certificate, and the application must include a statement on whether the applicant is, at the date of the application, practising the profession. When assessing the application, any failure to maintain the required standard of competence (namely the standard reasonably expected of a health practitioner practising in that health practitioner's scope of practice), whether the applicant has held an annual practising certificate of the same kind sought within the last three years, and whether the applicant has lawfully practised the profession to which the application relates within the last 3 years, will all be taken into consideration by the registering authority. Unless the authority is satisfied the applicant meets the required standard of competence, the authority must not issue a practising certificate. However the authority may include new conditions or vary existing conditions in the applicant's scope of practice, and include these in the new annual practising certificate, in order to satisfy the requirement that the applicant meets the required standard of competence.

For the purpose of maintaining, examining, or improving the competence of health practitioners to practise the profession, authorities may set or recognise competence programmes for health practitioners who hold or apply for practising certificates. Any competence programme may be made to apply generally in respect of all such health practitioners, in respect of a specified health practitioner, or in respect of any class of health practitioners.

The competence programmes may consist of examinations/assessments, a period of practical training/experience, undertaking a course of instruction or an examination of clients' clinical records by another health practitioner.

Each authority may also set or recognise recertification programmes for practitioners registered with the authority to ensure that their health practitioners are competent to practise within their scope of practice. Like competence programmes, this may also consist of examinations/ assessments, a period of practical training, undertaking a course of instruction or an examination of clients' clinical records by another health practitioner, as well as examining the practitioner's clinical practices, undergoing an inspection and adopting and undertaking a systematic process for ensuring that the services provided by the practitioner meet the required standard of competence.

If a health practitioner does not satisfy the requirements of a competence or recertification programme, the responsible authority may change the practitioner's scope of practice by changing the health services the practitioner is permitted to perform, or by including conditions the authority considers appropriate.

An example of recertification programmes are those previously adopted by the Medical Council under the NZ *Medical Practitioners Act 1995*. Under these vocationally registered doctors (those allowed to practise independently in a recognised branch of medicine) are required to participate in a recertification programme approved by the Medical Council, such as a College Maintenance of Professional Standards programme or a Council approved alternative programme submitted by the practitioner. Practitioners must complete the programme in 3 years, including completing a minimum 50 hours per year, regardless of whether practising full or part time. However if a practitioner takes leave, for example study or maternity leave, the requirements for that year can be reviewed. The programmes include mandatory educational conferences, courses and workshops and peer review or team based assessment to verify that individual practitioners practise competently.

Practitioners must report their recertification activities to the Medical Council every year as part of their annual practising certificate application and each year some are audited to ensure they are meeting the programme requirements. After 2004, any practitioner not meeting their requirements may receive a competence review from the Medical Council, which may take action to impose conditions on the practitioner's annual practicing certificate and/or registration, or suspend their vocational registration.

Canada

Though health regulation falls within provincial or territorial jurisdiction in Canada, the Federation of Medical Licensing Authorities of Canada ("FMLAC") is a national association of provincial and territorial medical licensing authorities which provides a national structure for these authorities to present and pursue issues of common concern and interest.

In 1993, the FMLAC launched a project which addressed the issue of ensuring that physicians in practice maintain an appropriate level of performance for the duration of their professional lives. Through a series of national workshops, four major areas of physician performance were defined: competence, behaviour, health/fitness to practise and use of resources. A three-step system, known as the Monitoring and Enhancing Physician Performance ("MEPP") model was proposed to address the four areas of physician performance. The three steps are:

Step One — Screening of all Physicians

Step Two — Assessment of Physicians at Risk or in Need

Step Three — Detailed Needs Assessment.

In step 1 of the MEPP model, all doctors would be monitored regularly, in cycles of one to five years. The process would use practice profile data such as prescribing practices, continuing medical education credits, patient encounter data, practice profiles, and other data generated by activities like peer assessment ratings, wherein colleagues make global ratings of a colleague's performance in practice, or questionnaires administered to patients regarding their perception of the quality of care. Step 2 would involve a more careful assessment of doctors identified as at "some to moderate risk" during monitoring in step 1. Typical methods of assessment could include audits of hospital practice or procedures, office audits, and structured interviews of the doctor by trained peers. It is expected that 10-20% of doctors who seem to be at risk or "in need" in step 1 would undergo a further assessment in step 2 and that most would be found to be compliant in their practices. It is estimated that only about 2% of all doctors would need to enter step 3 of the MEPP process.

While MEPP is a national initiative in Canada, its implementation is still up to the 12 provincial and territorial governments. Some jurisdictions, like Ontario, Alberta and Quebec have been more active in introducing the MEPP model, as MEPP to some degree mirrors existing schemes in these areas.

Ontario

Canada's three most populated provinces, British

Columbia, Ontario, and Quebec, have had "peer review" programmes of the records in doctors' offices since the 1980s. For example, Ontario's licensing body, the College of Physicians and Surgeons of Ontario, carries out an office based assessment of 20 to 30 randomly selected medical records for specialists and non-specialist doctors, using explicit criteria. The practices are selected at random (but review is required of all practitioners over 70 years of age). After the selected doctor completes a questionnaire on demographic and practice profile and educational information, the review is carried out on site by a trained auditor practising in the same discipline as the doctor being assessed. If, after further interviews with peers at the college, the review indicates that a shortcoming exists, an education intervention is offered to the doctor.

The College also has policies on the requirements when re-entering medical practice and when changing scope of practice.

A physician who has been out of clinical practice for a period of three years or who has practised for less than six months in the preceding five-year period must undergo an assessment of knowledge and skills before re-entering practice. If educational enhancements are recommended as a result of the assessment, the College will facilitate the process, ensuring the educational enhancement has been undertaken. The length of time the physician would need to spend in an educational program would not be pre-determined but would be dependent upon the outcome of the educational assessment.

A physician who wishes to change the scope of their clinical practice to an area of medicine in which the physician does not have appropriate training or recent experience must undergo a College-assisted assessment of knowledge, judgment and skills before beginning to practise in the new area of focus or specialization. The assessment would involve, at a minimum, providing proof that they had completed appropriate training for the new area of focus or specialization. If educational enhancements are recommended as a result of the assessment, the College will facilitate the process, ensuring the educational enhancement has been undertaken. The length of time the physician would need to spend in an educational program or period of training would not be pre-determined but would be dependent upon the outcome of the assessment. It is the College's expectation that the physician will not begin practising in the new area of specialization until after they have successfully completed the College's assessment process and has received College approval to do so.

Alberta

Alberta claims to be the only jurisdiction in the world that has a routine mandatory performance review directed towards practice improvement for all physicians rather than identification of a small minority of poorly-performing physicians. The Physician Achievement Review ("PAR") includes all physicians every five years, promoting self-directed professional development based on feedback about strengths and areas for potential change. The focus is on performance, rather than knowledge, skills and competencies.

The first component of PAR is a series of questionnaires which collect the opinions of patients, colleagues and non-physician co-workers. A self-assessment questionnaire is also included. Composite results of the compiled responses are presented to physicians, with a comparison to the mean ratings of their peers. A small number of physicians, whose survey profiles raise questions about an aspect of practice because of atypical ratings are contacted by a physician member of the Survey Subcommittee. When further evaluation is requested or believed necessary, the Assessment Subcommittee may request that an individualised assessment consisting of a peer practice visit be undertaken.

Provisions in the Alberta *Medical Profession Act* ensure that, with very limited exceptions, information learned about a physician through participation in the PAR Program can be used for educational purposes only and cannot be used in legal or disciplinary proceedings.

Ninety-five percent of patients surveyed report that completing the survey was a good use of their time; 96% felt comfortable completing the survey in their physician's office; and 71% thought that doctors would make changes in response to their feedback. During pilot testing in 1997, 66% of 255 physician volunteers reported having initiated a change for at least one aspect of practice. A review of physicians who underwent mandatory PAR during 2000 found that 38% of those responding had or expected to make changes in their practices as a result of survey findings.

However many professionals are naturally anxious about scrutiny of their work, and many perceive the process as a threat. However, in spite of this natural reaction to assessment, 74% of physicians agreed or strongly agreed that the College should promote continuous quality improvement in medical practice. Also, 25% of physicians indicated difficulty in finding sufficient numbers of knowledgeable respondents. That difficulty and others cause a proportion of physicians to question the objectivity and relevance of the results from some respondents.

USA

The Federation of State Medical Boards of the United States ("FSMB") comprises the medical boards of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Commonwealth of

the Northern Mariana Islands and 13 state boards of osteopathic medicine. Members of these boards are also fellows of the Federation. The FSMB recognizes that, as protectors of the public health and safety, state medical boards are accountable for the quality of health care provided by physicians within their jurisdictions as well as for assuring physician licensees are competent to practise medicine In line with this the FSMB has adopted a policy on maintenance of competence which recognises that as physician assessment and remediation are critical elements in assuring physician competence, state medical boards should utilize available programs offering assessment services and require dyscompetent (failed to maintain acceptable standards of practice) physicians to participate in focused remediation programs. The FSMB encourages state medical boards to utilize the Federation's Special Purpose Examination (SPEX), which is an objective and standardized cognitive examination of current knowledge requisite for the general, undifferentiated practice of medicine. The examination is intended for physicians who currently hold, or who have previously held, a valid, unrestricted license to practise medicine in a U.S. or Canadian jurisdiction. Appropriate candidates for SPEX include physicians seeking licensure reinstatement or reactivation after some period of professional inactivity.

The policy also states that as a means of ensuring continued physician competence, programs should be implemented to enhance overall physician practice in addition to disciplining individual physicians. The FSMB suggests implementing preventive measures to enhance physician practice including sponsoring educational programs and sharing information regarding best practice and established practice guidelines.

Colorado

In the opinion of the Board of Medical Examiners, it is much easier, effective, and beneficial to the public to refuse an applicant for registration who possesses uncertain training or competence, than it is to later remove the license due to poor medical practice. Therefore Colorado does not have reciprocal licensing agreements (automatic reciprocity) with other states. The Board only grants licenses on the basis of passing their examination. All current (active or inactive) physician licenses expire on May 31 in odd numbered years. Physicians who do not renew during the renewal period need to complete a Reinstatement Application for physicians, which requires proof of compliance with the legislated continued competence rule. This states that if the physician has practised medicine only for a portion of the two year period immediately preceding the filing of the application, the Board may determine on a case by case basis in its discretion whether the physician has adequately demonstrated continued competency to practise medicine. Otherwise, to demonstrate continued competency an applicant must submit to the Board a personalized competency evaluation report prepared by a program approved by the Board and complete any education and/or training recommended by the program as a result of the evaluation prior to obtaining a license. At the discretion of the Board, the physician may be able to receive a limited license prior to completing the education and/or training recommended by the program for the purpose of facilitating the completion of such education and/or training.

Issues for Comment

What features, if any, of the international and national models used to determine and monitor recency of practice should be included in defining recency of practice under the *Medical Practitioners Registration Act 2001*?

Issues Surrounding Recency of Practice

Introduction

The growing national and international recognition that health care practitioners need to maintain their competence beyond initial qualification and registration has led to the inclusion of recency of practice provisions within the Act. This recognition was clearly articulated by the Minister for Health in the second reading speech when she said:

> *... as a major goal of the regulatory system is to ensure that standards of practice within the professions are maintained on an ongoing basis, the legislation also focuses upon the process for renewal of registration and strategies to facilitate the ongoing competence of registrants.*

This focus on 'ongoing competence' means that the definition of recency of practice must have a broader meaning in addition to a time based criterion.

To inform both the time based criterion and that broader meaning of 'ongoing competence' the Board seeks submissions on the following:

What period should constitute recent practice?

In those jurisdictions where recent practice is an eligibility requirement for renewal of registration, the timeframe set is usually within either the last 3-5 years immediately preceding the application for renewal. However, a search of the literature has not identified any arguments justifying these time periods; they are arbitrary figures.

While arbitrary, these timeframes are based on an assumption that those who have practised in the last 3-5 years will be safer and more competent in their practice than those who have not practised in the period. This may be a valid assumption given the rapid changes that take place in the health care environment, particularly in terms of evidence for practice, technologies in practice, equipment in practice and pharmacology.

The requirement for recent practice is also placed on those applying for initial registration under the Act. In this regard s.45 requires the Board, in deciding whether an applicant who has a qualification that is more than 3 years old is fit to practise the profession, to review the nature, extent and period of any practice by the applicant since they were qualified.

In regard to such timeframes for recent practice it has been fashionable to talk about the half-life of knowledge; after how long has half of one's professional knowledge become out of date unless maintained? This of course varies with the field of study, and is for the professionals in each field to determine. In making such a determination the profession should note that waiting until half a professional's knowledge is out of date before taking remedial action may well be too late and could lead to lack of quality and safety in care provided to clients. Therefore the selection of an appropriate timeframe for recent practice as an eligibility criterion for renewal of registration would publicly acknowledge that a professional with recent practice is more likely to be up-to-date than a professional who has not practised in that period.

Changing work patterns

Like other professional occupations in Australia, medical practice has been undergoing continual change in the work patterns of practitioners over at least the last decade. The Australian Institute of Health and Welfare reports:

- the medical labour force was, on average, older in 2001 (46.1 yrs) than in 1996 (44.9 yrs);
- the proportion of female practitioners continued to rise, with 30.7% in 2001, compared with 27.6% in 1996;
- medical practitioners worked an average week of 45.4 hours in 2001, a decline from 48.1 hours in 1996, while the practitioner rate rose from 260 to 275 practitioners per 100,000 population;
- in 2001, almost half (47.4%) of practitioners worked 50 hours or more per week, a decline over the five years from 1996 (52.4%);
- in 1995, 18.4% of practitioners worked fewer than 35 hours a week; the proportion increased to 20.5% in 1999. Almost 40% of female medical practitioners worked part-time in 1999, compared to 37% in 1995, but in 1999 part-time females were more likely to work between 20 and 34 hours, and slightly less likely to work under 20 hours than in 1995.

This general trend towards an increasingly part time workforce needs to be taken into account when setting recent practice targets. If a specified number of hours over a defined number of years is adopted as a recency of practice measure, the profession will have to ensure that its part time workforce can meet these targets.

Issues for Comment

What timeframe should be established for recent practice? What do you see as the advantages and disadvantages in establishing that timeframe?

Are there different timeframes which should be established for those in: (a) clinical practice; (b) research; (c) education; or (d) administration? If so, why?

Should the Regulation specify the amount of practice to have been completed within the timeframe for recency of practice?

Should recent practice lead to restrictions on practice?

Establishing a timeframe for recent practice opens a series of questions concerning what type(s) of practice are required (if at all) for the various roles carried out by health practitioners. It would appear to be fundamental that those who intend to undertake clinical roles should have some relevant recent clinical practice. However, does recent practice in research, education or administration equip a practitioner to undertake clinical practice in a safe and competent way?

In this regard s.76 of the Act provides an authority for the Board to place recency of practice conditions on a practitioner's registration which could restrict clinical practice to those who have recent clinical practice within the timeframe defined through this consultation process.

Issues for Comment

Should recency of practice in research, education or administration qualify the practitioner to undertake clinical practice?

Should recency of practice be required for renewal of registration for those engaged only in research, education or administration?

If there are different recency of practice requirements for research, education and

administration roles should these practitioners have conditions placed on their registration restricting their practice to the non-clinical role?

If conditions are placed restricting practice to the non-clinical roles how should such practitioner demonstrate clinical competence for the conditions to be removed?

Should there be a distinction between general and specialist practice; should, for example, those in recent specialist practice be allowed to transfer to general practice or should they have conditions placed on their registration restricting them to their field of specialist practice?

If conditions are placed restricting specialists to their area of specialist practice how should such practitioners demonstrate clinical competence for the conditions to be removed?

Recent Practice and the Retired Practitioner

If it is accepted that the increasingly rapid changes in modern medicine and practice places an onus on practitioners to have recent practice in order to be eligible for renewal of registration, then this raises issues in relation to the retired practitioner. One of the most contentious issues for medical regulatory authorities and the medical profession in Australia is whether retired practitioners should retain full registration thus enabling them to continue to have authority to treat, to prescribe and to refer for themselves, family members, friends and in voluntary roles for such organizations as sports clubs.

The non-practising registration category was included in the Act in 2002 to enable those retired practitioners, who were not engaged in any of the above noted practices, to continue to use the title 'doctor' without being in breach of the title restriction provisions (ss. 157 and 159) of the Act. However, there are a significant number of retired practitioners who wish to retain these clinical practice rights.

Different approaches have been taken throughout Australia in response to this issue. However, in considering these approaches it should be noted that no State or Territory has yet introduced recency of practice provisions comparable to those in the Act. Tasmania has a non-practising registration category that requires the practitioner to declare that they will not perform any clinical activity including writing prescriptions, referrals or certificates for themselves or patients. New South Wales also has a non-practising registration category with no prescribing or referral rights. In New South Wales retirees can retain general registration but they are expected to complete the same Continuing Professional Development requirements as all other general registrants regardless of their level or type of practice or whether or not such practice is for remuneration.

In Western Australia retiring doctors can be registered as an 'occasional doctor' which enables them to provide medical services on an ad hoc basis, usually for families and friends, but not part-time for a fee. They also have access to a non-practising registration category similar to that available in Queensland.

The Medical Boards in South Australia and the Australian Capital Territory place no particular obligations on retirees, but both have expressed concern that doctors should not treat family members and friends except in the case of emergency. The ACT Board also prefers no continued prescribing rights following retirement unless the practitioner retains standard registration and is subject to the same regulatory provisions as those engaged in full time practice.

While some doctors want to retain clinical practice rights (usually for themselves, family and friends) after retirement from remunerated practice, there is a considerable body of opinion that doctors (whether retired or not) should not treat themselves, family or friends at any time other than in emergencies or under controlled circumstances.

The Medical Board of New South Wales policy states that: (a) all medical practitioners should have their own independent general practitioner; (b) practitioners should not treat or prescribe for themselves or immediate family members, except in emergencies or where no help is available and only then until another practitioner becomes available; and (c) while practitioners should not give primary care to immediate family members, they may work together with an independent medical practitioner to maintain established treatment.

The Medical Council of Victoria has released a draft statement on 'Doctors Treating Their Families for Consultation'. The statement reflects the New South Wales position but also states that doctors must not prescribe for themselves and should never prescribe controlled drugs for a family member or partner except on a one-off basis in a serious emergency. The Medical Board of South Australia is also developing guidelines on these issues to apply to all doctors, whether retired or not, with existing guidelines not supportive of any doctor treating family members, except in an emergency In the United Kingdom, the General Medical Council takes a similar view, stating that while it makes sense to treat minor ailments, or take emergency action where necessary, it is a matter of common sense as well as good medical practice for doctors to avoid treating themselves or close family members wherever possible.

The rationale underpinning the policy position against doctors treating themselves, family and friends is best summed up by the view of the Medical Board of New South Wales which is that because of the closeness of the relationship, a doctor cannot have the necessary objectivity to provide treatment, especially when treating themselves. The Board states further that this lack of objectivity in treatment may lead to ethical breaches by the doctor because: (a) the doctor may fail to explore sensitive areas while taking a medical history or performing a physical examination; (b) the patient may feel uncomfortable disclosing sensitive information or undergoing a physical examination; (c) patients may feel that their right to choose an independent practitioner is compromised because of fear of offending the doctor; and (d) the principles of informed consent may not be strictly adhered to.

Issues for Comment

Should the Medical Board of Queensland develop a position statement similar to that of New South Wales and Victoria in relation to doctors treating themselves, family and friends?

What timeframe should be established for recency of practice for those who are retired from remunerated practice?

Should those who have retired from remunerated practice be required to meet ongoing competence requirements (refer to next section for discussion on this issue) in order to maintain registration?

What should constitute 'ongoing competence' requirements?

The concept of competence itself is difficult to define; it can be used in a variety of ways leading to confusion surrounding the concept. Some authors have suggested that the term has been, if anything, over defined. In this regard, competence has been considered from the narrowest of perspectives as lists of tasks to be completed through to the more complex abstract abilities to provide an appropriate level of professional practice in a variety of contexts. These abilities involve a combination of knowledge, attitudes and psychomotor skills appropriate to professional service delivery.

For the purposes of this Discussion Paper, competence is defined as:

The knowledge, skills and attitudes necessary for safe, professional performance.

At the time of initial registration each applicant has demonstrated that they are qualified and fit to practise the profession; that is, they have the knowledge, skills and attitudes necessary for safe and competent professional performance. The recency of practice provisions now require the Boards to determine the requirements registrants must meet to demonstrate they have 'ongoing competence'.

Two recent (1997 and 2001) research projects commissioned respectively by the Australian Nursing Council and the Queensland Nursing Council sought to identify the indicators of continuing competence. While focused on developing the policy framework for recency of practice for the nursing profession, the literature review from both projects incorporated professional practice from a broader perspective to include health and non health professions. Each project identified a range of indicators in common use and found that while no single indicator was valid and reliable, validity and reliability were enhanced if more than one indicator was utilized. The indicators, with a summary description of, and comment on each, were as follows:

Continuing Professional Education/ Development

This indicator is described as any learning activity which enhances the provision of professional services through effective practice and performance brought about by the development of the practitioner's knowledge, attitudes and skills.

It is well accepted that practitioners have a professional responsibility to maintain, update and improve their skills throughout their professional career. However, the value of continuing professional development programs has, in the past, been questioned due to a lack of evidence that such programs have a positive impact on practitioner behaviour. Two recent medical studies have identified evidence in support of continuing professional development programs.

Mazmanian and Davis[1] identified that three major factors need to be present in order for such programs to have a positive influence in changing practitioner behaviour. In this regard, the program needs to: (a) be based upon an assessment of the practitioner's learning needs; (b) encourage interactive learning and provide opportunities to practise the skills learned; and (c) be sequenced and multifaceted. The authors concluded that:

> *To achieve its greatest potential, CME must be truly continuing, not casual or sporadic or opportunistic. Physicians must recognize the ongoing opportunities to generate important questions, interpret new knowledge and judge how to apply that knowledge in clinical settings.*

Thompson O'Brien[2] et al concluded through their Cochrane Review that continuing professional

[1] *Mazmanian P E, Davis D A* Continuing Medical Education and the Physician as a Learner. Guide to Evidence JAMA 2002:288:1057-1060
[2] *Thompson O'Brien M A, Freemantle N Oxman A D Wolf F, Davis D A, Herrin J* Continuing Education Meetings and Workshops: effects on professional practice and health care outcomes (Cochrane Review) In the Cochrane Report Issue 2, 2003 Oxford: Update Software

development can result in changes in practice if it is relevant, meets the individual's learning needs, is well constructed, there is active engagement by the individual and a commitment to updating and improving their skills and knowledge.

Professional Portfolios

A professional portfolio has been described as: (a) a private collection of evidence which demonstrates the continuing acquisition of skills, knowledge, attitudes, understanding and achievement (it is both retrospective and prospective, as well as reflecting the current stage of development of the individual); (b) something that describes learning experiences and provides evidence that concepts and principles from these experiences are being applied in practice; and (c) a dynamic, positive means to record personal career progress and to show that a person is demonstrating professional knowledge and competence.

Pearson[3] et al, through their research, identified a number of advantages and disadvantages of portfolios, being as follows:

Advantages

Perceived as an effective avenue to facilitate reflection on practice.

Perceived as having the potential to develop a critical awareness of personal and professional values and norms and for the development of self assessment and evaluation skills.

Offer a systematic way to record the effects of education and experience on personal professional development.

Preparation of a portfolio assists the practitioner to value their experience as learning, through reflection, and subsequently themselves.

Disadvantages

Portfolios are not necessarily easy to complete and tend to be time consuming.

Portfolios are difficult to assess and accredit as evidence.

Portfolios assume certain characteristics of a compiler; that is, they are active, reflective, self-directed – yet in reality many of these qualities do not flourish in the culture of the work setting.

There are many difficulties associated with the introduction and implementation of professional portfolios and there is a potential for portfolios to favour those who write well.

Examinations

An examination has been defined as the testing of knowledge or ability by questions or through demonstration. In this regard, an examination could be in the form of an essay, short answer questions, multiple choice questions, oral questioning or clinical demonstration of skills in a designed setting (this may be in a 'laboratory').

In undertaking their study, FitzGerald[4] et al found no research on the effectiveness of examinations as indicators of competence to practise. However, they did indicate that: (a) authors had suggested that examinations need to test both cognitive and psychomotor skills in order to accurately assess the competence of a practitioner; (b) essay and oral examinations had been described as possible tools for use in prior learning assessments; (c) examinations had been suggested as a possibility for physician re-registration and the details for such examinations would vary with the specialty; (d) a committee of experts from the American Dental Association and the American Association of Dental Schools had identified several examination models that might be used to determine competency to practise; and (e) laboratory testing of clinical skills was limited as the exam was a simulation and may not reflect the true nature of the practice environment and the factors that may normally (or unexpectedly) affect a clinician's performance.

Peer Review or Direct Observation

Peer review has been described as the direct observation of a practitioner's clinical performance by a more senior practitioner within the organization in order to assess the practitioner's competence. For such a review to be effective, validated tools would need to be designed and those doing the assessment trained in their use.

Patient Outcomes

FitzGerald[4] et al identified that patient outcome data had been suggested in several papers as being of use in determining the competency of a practitioner. While suggested as being the best method, it has the limitation that confounding factors may affect patient

[3]*Pearson A, Borbasi S, FitzGerald M, Walsh K. Parkes R and Lazarevic L.* A Study to Identify the Indicators of Continuing Competence in Nursing Australian Nursing Council Incorporated 1999

[4]*FitzGerald M Walsh K, McCutcheon H* An Integrative Systematic Review of Indicators of Competence for Practice and Protocol for Validation of Indicators of Competence Queensland Nursing Council 2001

outcomes that have little to do with the competence of the practitioner.

Legal Declaration and Audit

Nurse regulatory authorities in Australia have introduced the legal declaration and audit as their preferred option for 'ongoing competence' requirements for the nursing profession. In 1997-98 the Queensland Nursing Council ('the Council') implemented a self-assessment process for recency of practice and continuing competence which required each applicant on applying for renewal of registration to make a legal declaration that they had both recent practice and had engaged in activities to maintain their competence. A random sample of applications received are then audited whereby the applicant is required to present evidence in support of their self-assessment. The purpose of the audit is to test the validity and reliability of the nurse's declaration.

As part of a study conducted in 1998, the Council chose a panel of representatives from professional nursing organizations to assess a sample of 5% of renewal applications received. The results of this study indicated that 790 nurses (97.8%) who were selected for audit supplied relevant documentation to support claims of recency of practice and fitness and competence to practise nursing; 13 nurses (1.6%) failed to return any documentation or respond to further reminder notices and subsequently had their applications refused; and 5 nurses (0.6%) withdrew their application for renewal following the issue of an audit notice. In addition, the Council conducted a survey of nurses who did not renew their registration to determine the reasons for non-renewal. This survey, conducted in the first quarter of 1998, consisted of a random sample of 1,050 people who had been registered until 30 June 1997 but who had not renewed their licence by 1 February 1998. Results of this survey identified that: the largest group (44.4%) did not renew their registration because they were interstate or did not intend to practise in Queensland in 1997-98; and the remaining respondents stated that they did not meet recency of practice and/or fitness and competence requirements (36.4%), or gave other reasons.

Issues for Comment

What do you see as the advantages and disadvantages of each of the above noted indicators? (That is: continuing professional education/development, professional portfolios, examinations, peer review or direct observation, patient outcomes and legal declaration and audit.)

Given the advantages and disadvantages, what indicators would you support being incorporated as evidence for ongoing competence?

Are there any other indicators that the Board should consider? Please give a description of the indicator and its advantages and disadvantages.

Of the indicators supported, how would you recommend the Board gather evidence to inform its decision under s 75(1) and (2) which state:

(1) The board must consider the application and decide to renew or refuse to renew, the applicant's general registration.

(2) In making its decision, the board must have regard only to the extent, if any, to which the applicant has satisfied recency of practice requirements.

Future Steps – Where to From Here?

This discussion paper is only the first round of extensive consultation planned by the Board for determining the medical profession's legislative recency of practice requirements.

All practitioners are urged to consider the issues this paper raises closely, and submit their proposals, along with their critical supporting arguments, to the Board.

All submissions will be collated and analysed before preparing a draft policy and procedure on recency of practice. This draft policy will in turn be put back to those who submitted in the original round of consultation for comment.

Again, all submissions concerning the draft will be carefully collated and analysed before considering what changes need to be made to the draft policy. The Board anticipates that the draft policy and procedure for recency of practice will be available in 2005. This report will then be referred to Queensland Health for development of the Regulation.

The challenge now is for the community, the profession and other interested parties to contribute to the development of recency of practice policy. The issues raised in this Paper are intended to provide a basis for discussion, debate and collaborative action. Written submissions are invited on the issues raised in the Paper and other matters as appropriate. A summary of the issues identified in this Paper is as follows:

Issues and Comments

1. What features, if any, of the international and national models used to determine and monitor recency of practice should be included in

defining recency of practice under the *Medical Practitioners Registration Act 2001*?

2. What timeframe should be established for recent practice? What do you see as the advantages and disadvantages in establishing that timeframe?

3. Are there different timeframes which should be established for those in: (a) clinical practice; (b) research; (c) education; or (d) administration? ... if so, why?

4. Should the Regulation specify the amount of practice to have been completed within the timeframe for recency of practice?

5. Should recency of practice in research, education or administration qualify the practitioner to undertake clinical practice?

6. Should recency of practice be required for renewal of registration for those engaged only in research, education or administration?

7. If there are different recency of practice requirements for research, education and administration roles should these practitioners have conditions placed on their registration restricting their practice to the non-clinical role?

8. If conditions are placed restricting practice to the non-clinical roles how should such practitioner demonstrate clinical competence for the conditions to be removed?

9. Should there be a distinction between general and specialist practice; should, for example, those in recent specialist practice be allowed to transfer to general practice or should they have conditions placed on their registration restricting them to their field of specialist practice?

10. If conditions are placed restricting specialists to their area of specialist practice how should such practitioners demonstrate clinical competence for the conditions to be removed?

11. Should the Medical Board of Queensland develop a position statement similar to that of New South Wales and Victoria in relation to doctors treating themselves, family and friends?

12. What timeframe should be established for recency of practice for those who are retired from remunerated practice?

13. Should those who have retired from remunerated practice be required to meet ongoing competence requirements (refer to next section for discussion on this issue) in order to maintain registration?

14. What do you see as the advantages and disadvantages of each of the above noted indicators? *(That is: continuing professional education/development, professional portfolios, examinations, peer review or direct observation, patient outcomes and legal declaration and audit.)*

15. Given the advantages and disadvantages, what indicators would you support being incorporated as evidence for ongoing competence?

16. Are there any other indicators that the Board should consider? Please give a description of the indicator and its advantages and disadvantages.

17. Of the indicators supported, how would you recommend the Board gather evidence to inform its decision under s. 75(1) and (2) which state:

(1) The board must consider the application and decide to renew, or refuse to renew, the applicant's general registration.

(2) In making its decision, the board must have regard only to the extent, if any, to which the applicant has satisfied recency of practice requirements.

In responding to the above noted issues you may wish to review a copy of the *Medical Practitioners Registration Act 2001* which is accessible online as follows: www.legislation.qld.gov.au

APPENDIX 1

Division 4—Renewal of general registrations

Subdivision 1—Preliminary

70 Meaning of "recency of practice requirements"

(1) **"Recency of practice requirements"** are requirements, prescribed under a regulation, that if satisfied demonstrate that an applicant for renewal of a general registration has maintained an adequate connection with the profession.

(2) The requirements may include requirements about the following—

(a) the nature, extent and period of practice of the profession by the applicant;

(b) the nature and extent of any continuing professional education undertaken by the applicant;

(c) the nature and extent of any research, study or teaching, relating to the profession, undertaken by the applicant;

(d) the nature and extent of any administrative work, relating to the profession, performed by the applicant.

Subdivision 2—Applications for renewal of general registrations

71 Notification of imminent expiry of registration

The board must give a general registrant notice of the imminent expiry of the registration at least 60 days before the expiry.

72 Procedural requirements for applications

(1) A general registrant may apply to the board for the renewal of the registration.

(2) The application may only be decided by the board if it is received within the period—

(a) starting—

(i) 60 days before the expiry of the registration; or

(ii) on an earlier day, if any, stated in the notice given to the registrant under section 71; and

(b) ending immediately before the expiry.

(3) The application must—

(a) be in the approved form; and

(b) be accompanied by—

(i) the registration fee; and

(ii) any documents, identified in the approved form, the board reasonably requires to decide the application.

(4) Information in the application must, if the approved form requires, be verified by a statutory declaration.

(5) The approved form must require the applicant to state the following—

(a) whether the applicant suffers from any ongoing medical condition, of which the applicant is aware, that the applicant knows or ought reasonably to know adversely affects the applicant's ability to competently and safely practise the profession;

(b) if there are recency of practice requirements relevant to the applicant, details of the extent to which the applicant has satisfied the requirements

73 General registration taken to be in force while application is considered

(1) If an application is made under section 72, the applicant's general registration is taken to continue in force from the day it would, apart from this section, have expired until—

(a) if the board decides to renew the applicant's general registration—the day a new certificate of general registration is issued to the applicant under section 77(1); or

(b) if the board decides to refuse to renew the applicant's general registration—the day an information notice about the decision is given to the applicant under section 77(2); or

(c) if the application is taken to have been withdrawn under section 74(4)—the day it is taken to have been withdrawn.

(2) Subsection (1) does not apply if the registration is earlier cancelled under this Act or suspended or cancelled under the *Health Practitioners (Professional Standards) Act 1999*.

Subdivision 3—Decision on applications

74 Inquiries into applications

(1) Before deciding the application, the board—

(a) may investigate the applicant; and

(b) may, by notice given to the applicant, require the applicant to give the board, within a reasonable time of at least 30 days stated in the notice, further information or a document the board reasonably requires to decide the application; and

(c) may, if the board is not satisfied the applicant has satisfied recency of practice requirements, by notice given to the applicant, require the applicant to undergo a written, oral or practical examination within a reasonable time of at least 30 days stated in the notice, and at a reasonable place.

(2) The board may require the information or document mentioned in subsection (1)(b) to be verified by a statutory declaration.

(3) The purpose of an examination under subsection (1)(c) must be to assess any effect the applicant's non-satisfaction of the requirements has on the applicant's ability to competently and safely practise the profession.

(4) The applicant is taken to have withdrawn the application if, within the stated time, the applicant—

(a) does not comply with a requirement under subsection (1)(b); or

(b) does not undergo an examination under subsection (1)(c).

75 Decision

(1) The board must consider the application and decide to renew, or refuse to renew, the applicant's general registration.

(2) In making its decision, the board must have regard only to the extent, if any, to which the applicant has satisfied recency of practice requirements.

(3) If there are no recency of practice requirements relevant to the applicant, the board must decide to renew the applicant's general registration.

76 Recency of practice requirements are not satisfied

(1) This section applies if the board is not satisfied the applicant has satisfied recency of practice requirements.

(2) The board may decide to renew the applicant's general registration on conditions **("recency of practice conditions")** the board considers will sufficiently address the extent to which the applicant has not satisfied the requirements.

(3) Before deciding to renew the registration on recency of practice conditions, the board must—

(a) give notice to the applicant—

(i) of the details of the proposed conditions; and

(ii) of the reason for the proposed imposition of the conditions; and

(iii) that the applicant may make a written submission to the board about the proposed conditions within a reasonable time of at least 14 days stated in the notice; and

(b) have regard to any written submission made to the board by the applicant before the stated day.

(4) If the board decides to renew the registration on recency of practice conditions, it must as soon as practicable—

(a) also decide the review period applying to the conditions; and

(b) give the applicant an information notice about the decisions.

(5) The imposition of the conditions takes effect on the later of the following—

(a) when the information notice is given to the applicant;

(b) immediately after the day the registration would have expired, other than for its renewal.

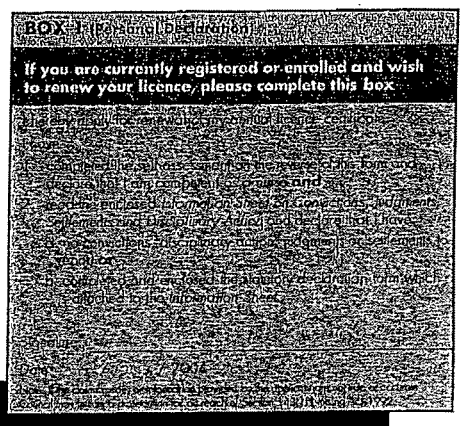
77 Steps to be taken after application decided

(1) If the board decides to renew the applicant's general registration, it must as soon as practicable issue a new certificate of general registration to the applicant.

(2) If the board decides to refuse to renew the applicant's general registration, it must as soon as practicable give the applicant an information notice about the decision.

(3) Without affecting section 76(2), if the board decides to renew the applicant's general registration, the renewed general registration is subject to the conditions, including, for example, probationary conditions, attaching to the registration immediately before the decision takes effect.

APPENDIX 2



COMPETENCE FOR PRACTICE – SELF ASSESSMENT

In accordance with Section 75 and Section 54 *Nursing Act 1992*, the Council must be satisfied that all nurses applying for renewal of their annual licence certificate have practised in the relevant area of nursing within the five years preceding the application and are competent to practise nursing. You should complete all parts of the self-assessment before signing the declaration on the front of this form. If your application is selected for random audit you will be required to provide documentary evidence to support your self-assessment declaration.

A I have been employed as a licensed nurse for a period of time within the 5 years prior to this application

or

My employment in the 5 years prior to this application has maintained my nursing competence and has equipped me to fill a position requiring registration/enrolment as a nurse and in undertaking my role responsibilities I have used nursing knowledge and skill

or

I have completed one of the following accredited courses or approved equivalent within 5 years prior to this application: (i) pre-registration, (ii) pre-enrolment, (iii) midwifery (iv) mental health, (v) re-entry

The course may have been commenced prior to the five year period.

yes ☐ no ☐

Note: There is no minimum period of practice required Any length of practice in the 5 year period is acceptable if, based on your self assessment, you can notify Council that you are competent to practise as a nurse in Queensland

and

B I held a current licence certificate in the appropriate jurisdiction during all periods of practice as a nurse or employment which maintained my nursing competence

yes ☐ no ☐

Note: The licence or authorisation to practise must have been valid for the jurisdiction in which the practice occurred, e g for practice in Victoria a Victorian licence is required

and

C My practice in the preceding 5 years is relevant to this application for renewal

yes ☐ no ☐

Note.

- *Any period of unlicensed practice that has previously been investigated by Council should not preclude you from answering 'Yes' to this question*
- *Enrolled nurse practice is not acceptable as evidence of practice for renewal as a registered nurse*
- *Practice as a midwife or as a mental health nurse is acceptable as evidence of practice for renewal as a registered nurse A midwife - only must have practised as a midwife in the five year period*
- *Practice as an assistant in nursing (or similar designation such as personal care attendant) is not acceptable as evidence for renewal as a registered or enrolled nurse.*

D I continue to improve my knowledge, skills and judgement to ensure that my practice is safe and competent

yes ☐ no ☐

Note: Some examples of compliance with this statement include but are not limited to:

- *continually identifying knowledge, skills, judgement, application and attitude gaps and taking appropriate action to improve and enhance the quality of your practice*
- *promoting a positive image of nursing by your practice*
- *having recent workplace performance appraisals that confirm your safety and competence for nursing practice*
- *undertaking any professional improvement activities in the last 12 months which were aimed at enhancing your nursing practice*
- *assessing learning needs, implementing learning plans and evaluating that learning in terms of its impact on your practice*

and

E My state of health is such that I am capable of carrying out nursing duties without endangering any patient

yes ☐ no ☐

and

F I practise within my own level of competence and my level of competence is appropriate for my area of practice

yes ☐ no ☐

and

G I adhere to the Code of Ethics for Nurses in Australia

yes ☐ no ☐

If you can answer **'Yes'** to all of the above questions, please proceed to the Personal Declaration on the front of this form

If, based on your self assessment, you are unable to answer **'Yes'** to all of these statements, **BUT CONSIDER THAT YOU ARE ELIGIBLE FOR RENEWAL**, you may make submission for individual assessment In this case please read the information in the enclosed brochure

DISCUSSION PAPER FEBRUARY 2005

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Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF5

Medical Board Registrations:

Table 1 the Number of interns registered in Queensland compared with the number of graduands from the University of Queensland.

Year	Interns	Graduands	Year
2003	210	228	2002
2004	254	215	2003
2005	245	221	2004

Note: the 2002 graduating year should become the 2003 interns.

The current distribution of short term registrants

Area of Need registrants	Hospital	880
	GP	420

The remaining short term registrants include those undertaking education programs, research, teaching etc.

The Medical Board ahs over recent years become increasingly stringent in regard to Area of need applications. Table 2 demonstrated that the Medical Board has made greater use of the application of conditions on registration and has refused to register an increasing number of applicants.

Year	Applications	Conditions	Refused
2003	1231	0	9
2004	1402	63	26
2005	1254	121	41

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF6

GFG

MEDICAL BOARD OF QUEENSLAND
REGISTRATION HANDBOOK

Purpose:

The purpose of this handbook is to guide the process of registration of medical practitioners by the Medical Board.

The aim is to ensure the safety of the community by registering medical practitioners who have the necessary qualifications and experience to practice the profession in Queensland and to ensure consistency and appropriateness of decisions in regard to registration.

Authority:

The Medical Board of Queensland has approved this handbook after consultation with Queensland Health and the appropriate stakeholders including the AMA, professional Colleges and recruitment agencies.

Registrations Authority:

The registration of medical practitioners is determined by three Act of Parliament.

The Medical Practitioners Registrations Act 2001 aims to protect the public, uphold standards and maintain public confidence. It achieves this by establishing the Medical Board, providing for the registration of medical practitioners, imposing obligations on persons who practice the profession and providing means for compliance with the Act.

The Health Practitioners Registrations Boards Administration Act 1999 provides for the establishment of the Health Practitioners Registration authority which provides administrative services to the Registrations Boards including the Medical Board.

The Health Practitioners Professional Standards Act 1999 which provides for means of monitoring professional conduct and for managing variations from accepted standards.

Administrative arrangements:

The MBQ meets twice per month to consider the issues relating to the registration of medical practitioners. The MBQ has three principal subcommittees:

- The Registration Advisory Committee (RAC) responsible for advising the Board on the registration of medical practitioners
- The Complaints Advisory Committee (CAC) responsible for advising the Board on the management of complaints against medical practitioners
- The Health advisory Committee (HAC) responsible for advising the Board on the management of medical practitioners with health concerns.

The Board along with other health practitioners' boards are supported by a single administrative body. This body provides administrative support to the board including the role of Chief Executive who has certain delegated authority to act on behalf of the Board. Administrative staff employed by the Chief Executive receive and review applications for registration and ensure that the documentation is complete and appropriate and prepare decision making instruments for consideration by the Registration Advisory Committee and the Board.

Categories of registration:

There are several categories of registration for medical practitioners.

General registration is available to medical practitioners who have completed either:

- A medical degree at a University accredited by the Australian Medical Council. This includes the medical schools in Australia and New Zealand, or
- Medical practitioners who hold general registration in another State or Territory of Australia under the Mutual Recognition arrangements, or
- Medical practitioners who hold a degree from another medical school and who have completed the Australian Medical Council Examination.

Applicants for General Registration may be registered with or without restrictive conditions. Those conditions may include conditions relating to restricted scope of practice or conditions relating to requirements for additional training and/or experience.

Specialist registration is available to medical practitioners who hold qualifications and experience relevant to the area of specialist practice. The qualifications are specified in the regulations to the MPRA and are attached to this handbook as *Attachment 1*. Only Queensland and South Australia maintain a separate Specialist Register.

Special Purpose registration is available to medical practitioners who hold a degree from a Medical School that is not accredited by the AMC or who have not completed the AMC examination. Special purpose registration is restricted to the following special areas.

- Postgraduate study (S132)
- Supervised training to prepare for the a clinical examination which may include the AMC examination or a specialist examination. (S133)
- Medical teaching or research (S 134)
- Practice in Area of Need (S135) as determined by the Minister.
- Study or training to obtain a qualification in a specialty (S 136)
- Practice in the public interest (S 137)
- Practice in General Practice (S 138) which permits permanent registration of a medical practitioner who has completed the FRACGP or equivalent as specified in the regulation.

Applicants for practice in an Area of Need must demonstrate that they hold appropriate qualifications and experience for the position identified in the application and that the position has been determined as an Area of Need by the Minister or his delegate.

Applicants seeking to practice as a specialist in an Area of Need must apply through the Australian Medical Council for assessment by the relevant College to determine if in the opinion of the relevant College the individual holds sufficient training and experienced to fill the requirements of the Area of Need specialist position.

Documentation:

Applicants for registration need to present relevant documents to enable assessment of their training and experience and its relevance to the application. This documentation should include:

- A completed application form
- Proof of identity as specified in the AMC requirement (Attachment 2)
- Curriculum Vitae
- Area of Need certificate (If appropriate)
- Certificate of Good Standing
- Copies of relevant degrees and other qualifications
- Evidence of English language proficiency or if relevant an application for exemption
- Payment of appropriate fees

New Registrations:

Graduates of AMC Accredited Medical Schools:

New graduates seeking registration for the first time

Process

1. Admin staff to review the documents and determine all documentation is complete.
2. Any concerns to be referred to Deputy Registrar or Assistant Registrar for consideration
3. A schedule of registrants to be prepared
4. The schedule to be endorsed by the RAC.
5. Schedule of new registrants to be submitted to the Board for approval.

Criteria

- All new registrants to be registered with the condition that they must complete a minimum of twelve months of postgraduate training in an accredited training post during which time they must complete a minimum of ten week in each of surgery, medicine and emergency medicine.

General registrants seeking removal of internship conditions

Process

1. Admin staff to check the presence and acceptability of the certificate of completion of intern training issued on behalf of the PMEFQ,
2. Any concerns to be referred to the Deputy or Assistant Registrar and if necessary to the RAC for determination.
3. A Schedule to be prepared
4. The Schedule to be endorsed by the RAC
5. The schedule to be approved by the Board.

Criteria

- Any registrant who has not satisfactorily completed the requirements of the conditions imposed on their registration should be referred to the RAC for consideration.
- The RAC may recommend additional requirements prior to further consideration of the request to remove intern conditions. These additional requirements could include:
    a. Further training or experience and/or
    b. Further assessment including assessment by a professional panel.
- The RAC may recommend that the application to remove intern conditions be refused and the applicants registration be cancelled on the grounds that the registrant has not complied with the conditions imposed on the registration.

Interstate general registrants seeking general registration

Process

1. Admin staff to check the documents and in particular the Certificate of Good Standing.
2. Any concerns to be referred to the Deputy Registrar or Assistant Registrar and to the RAC if necessary.
3. A Schedule to be prepared and submitted to the Executive Officer
4. The Executive Officer to approve the Schedule and provide a copy to the Board for noting

Criteria

- Applicants are entitled to deemed registration under the Mutual Recognition Act.
- Any conditions imposed by another State or Territory registration body should be imposed on the registration.

Interstate general registrants seeking specialist registration

Process

1. Admin staff to check the documents and in particular the Certificate of Good Standing.
2. Any concerns to be referred to the Deputy Registrar or Assistant Registrar and to the RAC if necessary.
3. A Schedule of applicants to be prepared and submitted to the RAC for endorsement.
4. The Schedule to be submitted to the Board for approval.

Criteria

- Applicants must hold Fellowship of the relevant specialist College or hold qualifications considered by the College to be equivalent.

General registrants applying for Specialist Registration

Process

1. Admin staff to review the documentation for completeness.
2. Refer any concerns to Deputy Registrar or Assistant Registrar.
3. Schedule to be prepared and forwarded to the "RAC for endorsement.
4. Schedule to be submitted to the Board for approval.

Criteria

- Applicants must hold Fellowship of the relevant specialist College or hold qualifications considered by the College to be equivalent

AMC Graduates

AMC graduates applying for General registration

Process

1. Admin staff to review all documentation to ensure completeness.
2. Refer any concerns to Deputy Registrar or Assistant Registrar.
3. Refer to the RAC to determine conditions of registration.
4. Submit to the Board for approval

Criteria

- As a general rule, new applicants should be registered on condition that they are supervised for a period of time which ensures that they are safe to practice.
- AMC graduates would be registered on conditions which ensure that they have the necessary competence to practice the professionion in the Australian environment.
- Those conditions should seek to determine that the registrant has a broad knowledge of medical practice and has sufficient familiarity with

the Australian health care system to enable them to function in a manner similar to Australian Graduates.

- The factors to be considered include:
  - Length of time since first registration
  - Any breaks in experience.
  - Knowledge of the Australian Health care system
  - Demonstrated experience in general medical care
  - Vocational focus

- General registration without conditions may be available is the candidate has:

  - Been in continuous clinical practice for a period of five years
  - Had greater than twelve months clinical experience in Australia

- General registration with conditions could include:

  - A period of up to twelve months supervised practice in a specific vocational stream. This could be applied to AMC graduates who have more tan five years experience in a particular vocations stream but who do not have significant practice experience in Australia.
  - A period of up to twelve months experience in general medical experience. This would be applied to AMC graduates who have completed fewer than five years of postgraduate experience and who have not completed general multidisciplinary experience

International Medical Graduates without AMC qualifications

International medical graduates seeking to practice in supervised hospital posts including Intern, JHO, SHO positions

Process

1. Admin staff to review documents for completeness
2. Refer any concerns to Assistant Registrar or Deputy Registrar for determination.
3. Present as a schedule to the RAC for consideration and to the Board for endorsement.
4. Conditions of registration may include:
   a. Requirement for supervised practice if the registrant has not completed equivalent experience to Australian internship conditions.
   b. Requirement for performance reports
   c. Identification and approval of a supervisor in accordance with trhe Guidelines for Supervision (Attachment)

Criteria

- Need to ensure that the candidate has the necessary experience for the position.

International medical graduates seeking to practice in middle level hospital posts including Registrar or Principal House Officer posts.

Process

1. Admin staff to review documents for completeness
2. Refer any concerns to Assistant Registrar or Deputy Registrar for determination.
3. RAC to review suitability of experience for the position.
4. Present as a schedule to the Board for endorsement.

Criteria

- Conditions of registration may include:
  - Requirement for performance reports
  - Identification of a supervisor

International medical graduates seeking to practice in General Practice

Process

1. Admin staff to review document for completeness.
2. Refer to RAC for determination of suitability based on the previous experience and the nature of the position sought.
3. Present to the Board as a schedule for discussion and endorsement.

Criteria

- Candidates with extensive experience in General Practice in a health care system similar to Australia's and with familiarity of the Australian Health care system may be suitable for sole practice or for bone fide locums under the broad supervision of a mentor (level 4 supervision).

- Candidates with broad clinical experience in a similar health care system and with familiarity with the Australian health care system may be suitable for appointment to a joint practice with level 3 supervision.

- Candidates with broad clinical experience in a hospital environment but no GP experience may be suitable for positions in group practice under the direct supervision of an Australian Supervisor Level 2

Area of need specialists

Process

1. Administrative staff to review the documentation for completeness and accuracy and to undertake appropriate investigations

Criteria

Registration renewals:

General or specialist registrations

Process

1. Admin staff receive application and check all details.
2. Any concerns should be raised with Deputy or Assistant Registrar who can refer to the RAC if necessary.
3. EO to authorise renewals.

Criteria

Special purpose registrants seeking renewal of registration in current position (Note if changing position should be considered new registration).

Process

1. Admin staff to receive application and check all details.
2. Any applicant who has been registered for more than two years should be requested to advise on progress towards permanent registration.
3. Any registrant with more than five years registration should be referred to RAC.
4. Check performance report. If any concerns raised should be referred to the Deputy or Assistant Registrar and brought to RAC for determination.
5. Presented to Board as a schedule of renewals for approval.
6. In the event that registrants have concerns raised regarding their performance, they may be registered on condition that the deficiencies identified in the performance report are addressed through a performance improvement plan and that progress be reported to the board on a regular (quarterly) basis.

Schedule of New graduates seeking registration

The following individual have been assessed as having completed the requirements of an AMC accredited medical school and are recommended for registration by the Medical Board of Queensland.

Names:

Signed Deputy Registrar

Endorsed Chair RAC

Approved Chair MBQ

Schedule of registrants seeking removal of conditions

The following individuals have been assessed as having completed the requirements of an intern program and are recommended for registration by the Medical Board of Queensland.

Names:

Signed Deputy Registrar

Endorsed Chair RAC

Approved Chair MBQ

Attachments:

1.

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF7

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MEDICAL BOARD OF QUEENSLAND.
GUIDELINES FOR SUPERVISED PRACTICE

Purpose:

The purpose of this document is to provide guidance to supervisors and to registrants who are required to practice under supervision.

Preamble:

Supervision requirements may apply to registrants in the following circumstances.

1. Graduates of Australian Medical Schools who are registered with internship conditions in accordance with Section 57 of the Medical Practitioner Registration Act 2001.
2. Registrants who have given an undertaking to the Board that they will only practice under supervision.
3. Registrants who are required as a condition of their registration to practice under supervision. This may occur in a number of circumstances:
    a. Registrants subject to intern conditions prior to meeting the requirements of general registration.
    b. Overseas trained doctors who have not completed the Australian Medical Council examinations.
    c. Registrants who are required to work under supervision as a consequence of poor health, poor performance or disciplinary action.

Internship:

Graduates of Australian Medical Schools who are eligible for General Registration may be registered to practice in accordance with a prescribed internship and to complete that internship to the satisfaction of the Board and within the period prescribed by regulation. Inherent in the "prescribed internship" is supervision of practice. The nature of this supervision is prescribed in the internship arrangements.

Levels of supervision:

Level 1 Direct Supervision

With Level 1 supervision the supervisor takes direct and principal responsibility for the patient. The supervisor must be available at all times when clinical care is being provided. The supervised registrant is thus in a supportive role only. This occurs mostly with students but may also be utilised to register an individual who has not completed all registration requirements but for whom supervised practice may still be appropriate. For example, where the registrant has not demonstrated command of the English language.

Level 2 Contemporaneous supervision

With Level 2 supervision the supervisor shares responsibility for the individual patient with the registrant. Thus the supervisor should be in the workplace at all times. The supervised registrant is responsible for ensuring that they practice within the confines

determined by the supervisor and that the supervisor is informed of the management of individual patients.

Level 2 supervision is most likely to occur in the circumstances of Internatioanl medical Graduates (IMGs) completing pre-registration requirements.

This level of supervision does not include solo practice nor should it include on-call, weekend or home visit work unless on return to work a supervisor is present.

The supervisor should enter into an agreement with the registrant regarding the scope of practice and should ensure there are mechanisms in place in the workplace to monitor the work of the registrant.

The work environment must be such that there is at least general oversight of the registrant's practice by other registered medical practitioners who can give guidance or recognise and initiate action if a threat to patient safety is emerging.

The Board accepts that on rare occasions there may be an exception to the requirement that another colleague be present at all times. For instance, where a registrant is permitted to work on weekends and the only other colleague who is rostered on is unable to work due to unexpected personal reasons such as illness. The Board does not expect the registrant to withhold treatment to patients. However the registrant must notify the principal supervisor as soon as possible of the circumstances which led to him/her practising unsupervised and also of the services provided. Should this occur on a weekend the registrant is to contact the principal supervisor as soon as possible after 9am on the following Monday.

Level 3 broad supervision

With level 3 supervision the supervisor is responsible for ensuring that the practice of the registrant is in accordance with acceptable standards and that there are mechanisms in place to ensure that the registrant is practising at a safe standard. The registrant takes responsibility for individual patient care. The supervisor maintains an indirect responsibility for the patient through ensuring that appropriate safeguards are in place for monitoring performance and referral as required.

Level 3 supervision is similar to that applying to junior hospital staff or to general practitioners in group practices under the supervision of a general registrant.

The registrant is permitted to work alone from time to time. The registrant can do home visits and periods of duty that include on-call and after hours. When the registrant is practicing alone, he/she must have telephone access to his/her supervisor.

Upon commencing a new position the supervisor and registrant must formulate an agreement in regard to the scope and limits of practice and should meet regularly to monitor practice performance including workload and any significant clinical issues. This agreement may alter over time as the supervisor is satisfied with the progress and performance of the registrant. Thus the extent of supervision will vary over time as the registrant becomes more confident.

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Level 4 distant supervision

With level 4 supervision the registrant takes full responsibility for individual patients. The role of the supervisor is to provide broad overview of the practice of the registrant (mentoring). The supervisor should put in place mechanisms whereby they may be consulted on an individual patient should the registrant require assistance. In addition the registrant and supervisor should put in place mechanisms whereby an overview of the registrant's practice may be conducted periodically.

Selection of an appropriate position and supervisor:

Prior to accepting a position or changing circumstances it is important that the registrant who is subject to supervisory arrangements obtains the approval of the Board in regard to the appropriateness of the position and the supervisory arrangements. In addition, if there are any proposed changes to the approved work arrangements (e.g. hours of work, on-call, nature of practice) at his/her current or proposed place of practice, these also must be approved by the Board prior to the new arrangements being implemented.

The registrant will also need to identify an appropriate supervisor who will be responsible for providing supervision or for ensuring that appropriate supervisory arrangements are in place.

In the circumstances of hospital doctors, the Principal Supervisor will generally be the Director of Medical Services, Medical Superintendent or the Director of Clinical Training.

In the circumstances of private practice the Principal Supervisor will need to be approved by the Board. The Principal Supervisor must be an experienced practitioner practising in the same discipline as the registrant.

The Supervisor and practice (including hospital and health services) must be able to comply with the requirements of the level of supervision required.

In either circumstance the Principal Supervisor may delegate day to day supervision to another medical practitioner(s) provided that the other practitioner is not themselves subject to supervisory conditions.

The role of the Board:

It is the responsibility of the Board to determine the supervisory requirements of the registrant and to identify and approve the supervisory arrangements.

The board will provide a Checklist which must be completed when considering a new position or a change in work arrangements, and returned to the Board for approval. The registrant should allow at least 5 days following the Board's receipt of the Checklist to arrange for any new position or change in work arrangements to be considered for approval. Failure to comply with this requirement may render the registrant in breach of their undertaking/condition. [1]

[1] The checklist is a tool used by the Health Assessment and Monitoring Unit (HAM) to gain details of a new position being considered by a registrant. Once it is received the information is verified

Role and Responsibilities of the Supervisor:

The supervisor should be a person who has consented to act as a supervisor and should be approved by the Board. The supervisor should comply with the requirements of the level of supervision required. The relationship between supervisor and registrant should be professional. Thus persons who are directly related to the individual will not be approved as supervisors. Supervisors should not themselves be subject to supervisory arrangements.

The supervisor should be made aware of the reasons for supervision and provided with a list of undertakings/conditions.

The supervisor should take reasonable steps to ensure that the registrant is practising safely by such measures as direct observation (where it is relevant to the level of supervision), individual case review, periodic performance review and remediation of identified problems.

The supervisor should notify the Board immediately if there are concerns in relation to the registrant's clinical performance, health or non-compliance with conditions or undertakings. The supervisor must ensure that the registrant is practising in accordance with the approved work arrangements and most notify the Board of non-compliance with or of any proposed changes to those arrangements.

The supervisor should inform the Board if he/she is no longer able to provide the level of supervision that is required.

The supervisor should provide reports as required by the registrant's conditions or undertakings and comply with the Board's requirements as to format and frequency.[2] These reports should be timely, objective and as accurate as possible. They should identify both strengths and weaknesses including any problems (if applicable) and what has been done in terms of follow-up or remediation.

Role and Responsibilities of the Registrant:

The registrant must take reasonable steps to ensure safe practice by such measures as seeking assistance from other practitioners, cooperation in individual case review, periodic performance review with the supervisor and seeking remediation of identified problems.

The registrant must seek assistance if there are concerns in relation to the registrant's health, clinical performance or compliance with any conditions/undertakings.

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and additional information is sought if required. The registrant is then advised if the position is approved or not and that he/she may accept the position.

[2] The supervisor is provided with a report proforma which is individually tailored to the particular clinical setting and level of supervision. The purpose of the proforma is to provide meaningful information which will assist the Board make decisions with respect to monitoring.

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The registrant must ensure that he/she is practicing in accordance with the approved work arrangements and ensure that the supervisor complies with the Board's reporting requirements.

Management of breaches of supervisory arrangements:

Should it be identified that the supervisory arrangements have not been complied with then the Board reserves the right to take appropriate action in regard to the registrant.