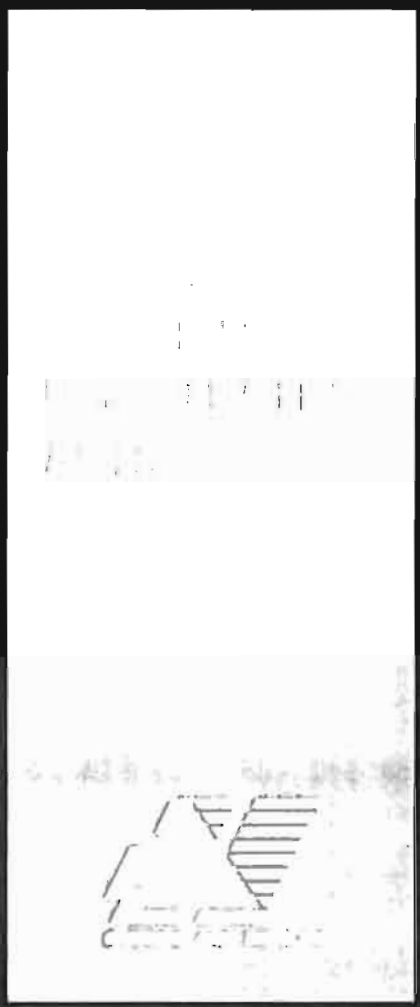
Draft Policy Paper



Chiropractors and Osteopaths Act 1979

Dental Act 1971

Dental Technicians and Dental Prosthetists Act 1991

Medical Act 1939

Occupational Therapists Act 1979

Optometrists Act 1974

Pharmacy Act 1976

Physiotherapists Act 1964

Podiatrists Act 1969

Psychologists Act 1977

Speech Pathologists Act 1979

September 1996

FOREWORD

The Queensland Government is pleased to present this Draft Policy Paper which outlines the policy framework upon which new medical and health practitioner registration Acts will be based.

This paper follows two discussion papers and 10 (profession-specific) supplementary documents which were released in September 1994 and which attracted almost 200 written responses from organisations and individuals representing both providers and users of health services.

Most of the existing laws which regulate health practitioners were enacted more than 20 years ago. As such, they do not adequately cater for the changing environment in which the health professions operate, nor do they accurately reflect contemporary needs and values in our community.

The objective of the review of health practitioner legislation has been to formulate an effective and efficient regulatory system for the health professions aimed at protecting the community and promoting quality health care standards.

The Government has considered the relative costs and benefits of legislative intervention in each policy area. In some cases, it is proposed that longstanding regulatory practices which no longer serve a useful purpose be discontinued. The proposals embrace a number of changes to the existing arrangements, all of which are designed to underpin a more effective and accountable system for the registration of health professions and the regulation of the services they provide to the public. A key proposal concerns the development of mechanisms which will support a more effective, streamlined and integrated process for handling of complaints regarding unprofessional conduct by registered health practitioners.

In short, the policies outlined in this paper are intended to provide a framework for new health practitioner legislation which will have continuing relevance as we enter the 21st century.

The public release of this Draft Policy Paper is part of the Government's on-going commitment to community consultation. While the paper outlines the Government's preferred policy position for new health practitioner laws, it also provides further opportunities for debate and comment by interested parties. It is anticipated that proposals such as those related to the regulation of "core practices" will be of great interest to the whole community.

I strongly encourage interested individuals and organisations to make submissions on the issues raised in this paper before drafting commences on the new legislation.

Mike Horan
Minister for Health

September 1996

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COMMENTS AND SUBMISSIONS

This draft policy paper outlines the Government's preferred policy on the issues raised in the discussion papers *Review of Health Practitioner Registration Legislation* and *Review of the Medical Act 1939* released in September 1994.

Due to the significant impact of this legislation on the community and the comprehensive nature of the proposed reforms, the Government has decided to place these policy proposals before the community in order to provide a further opportunity for comment before new legislation is drafted.

The Queensland Government invites you to participate in the development of this important public policy by commenting on any of the proposals put forward in this paper.

Submissions should be made to:

Health Practitioner Legislation Project
Legislation Projects Unit
Queensland Health
GPO Box 48
BRISBANE Q 4001

Ph: (07) 3225 2498
Fax: (07) 3234 1455

The closing date for receipt of submissions is 13 December, 1996.

Individuals or organisations who wish their comments to be treated confidentially should indicate this clearly (for example, by marking correspondence 'confidential'). However, any submissions made may be subject to release under the *Freedom of Information Act 1992*.

BACKGROUND TO THE REVIEW

Context of the review

The Health Practitioner Legislation Project involves a comprehensive review and reform of one-third of the health portfolio's principal legislation. The review covers 12 Acts (including the *Medical Act*) and 17 sets of subordinate legislation.

The focus of the project has been on the development of the best regulatory model for occupational regulation, rather than the question of which professions should be regulated.

The objective of occupational registration legislation is to provide for protection of the public and to ensure that health care is provided in a safe, competent and up to date manner. The policy proposals all relate directly to this objective. In addition, the recommendations have been informed by the following:

- the National Competition Policy reforms, in particular, the *Intergovernmental Competition Principles Agreement* which mandates review of anti-competitive legislation
- regulatory reform principles, including regulatory efficiency and the desirability of minimising red tape and costs to business
- the recent statutory review of the Health Rights Commission
- the recommendations of the Wright Consultancy Report regarding *Future Education and Training of School Dental Therapists in Queensland*
- the Final Report of the *Review of Professional Indemnity Arrangements for Health Care Professionals*
- the legislative model of the *Nursing Act 1992*
- interstate and overseas approaches to regulation of health practitioners
- mutual recognition principles
- legislative standards, including fundamental legislative principles.

Collectively, the health practitioner registration Acts have not previously been subject to a simultaneous and comprehensive review. Most of the Acts are based on a model which was developed early this century. Despite their common subject matter of occupational regulation, the various Acts contain differing approaches to many issues with little obvious rationale for the differences. While it is recognised that some issues are specific to individual professions, there is a need to obtain a consistent, uniform approach on matters which are common to all health professions.

The *Nursing Act 1992* has not been included in the review because of its relatively recent enactment. However, many concepts from that Act have been considered, and where appropriate, incorporated into the recommendations. The Queensland Nursing Council is presently considering the need for amendments to several areas of its legislation following nearly three years of operation under the *Nursing Act 1992*. Where appropriate, the Council will be seeking to have amendments made to the *Nursing Act* consistent with the outcomes of this review.

Consultation process

Due to the age of the legislation and the many changes in the health services environment in recent years, the review has required an extensive public consultation process. In particular, representatives of those health professions which are regulated by the legislation have been extensively consulted. Increasing community interest in services provided by health professionals has been reflected in the growing emergence of health consumer advocacy groups. Consequently, the review has also actively sought the views of health consumers.

This draft policy paper has been developed following the receipt of submissions to the two discussion papers released by Queensland Health in September 1994:

Review of Health Practitioner Registration Acts
Review of the Medical Act 1939.

These papers raised many important issues for discussion and comment regarding the legislation which registers and regulates the following health professions in Queensland:

chiropractors and osteopaths
dentists
dental technicians and dental prosthetists
medical practitioners
occupational therapists
optometrists
pharmacists
physiotherapists
podiatrists
psychologists
speech pathologists.

It should be noted that practitioners of hypnosis, dental hygienists, school dental therapists and dental assistants are also regulated under this legislation.

A total of 3500 discussion papers were distributed in September, 1994. Numerous meetings and information sessions were held with peak bodies representing both health professionals and consumers of health services.

During October and November 1994, public meetings were held in various metropolitan and regional centres throughout the State in order to obtain views from the general community.

Most major bodies affected by the legislation have made comprehensive written submissions and have provided valuable input into the development of this important public policy. A total of 197 written submissions were received in response to the two discussion papers. (A list of respondents is contained in Appendix 1).

Purpose of this draft policy paper in the review process

This draft policy paper outlines the Government's preferred policy on the major issues raised in the earlier discussion papers. The course of action proposed in relation to many issues involves significant changes in key areas of the legislation. Release of this paper provides a further opportunity for comment by interested groups or individuals before new legislation is drafted.

Following the receipt of comments on this paper, the policy directions which will underpin new health practitioner legislation will be finalised and new legislation prepared for introduction into the Queensland Parliament.

Legislative model

Because these Acts are being reviewed collectively, many respondents have raised the question of whether the Government intends to develop a single 'umbrella' piece of legislation for all the health professions. In fact, this issue has not been a consideration at this point in the review process. Rather, the focus of the review to date has been the development of policies which will underpin the new legislation. The format of the new legislation, (ie. whether there will be one Act or individual profession specific Acts or some other model), will be considered at the next stage of the review process. Issues which will be important when considering the format of new legislation will include:

- accessibility and comprehensibility of the legislation to users;
- modern legislative drafting style; and
- administrative efficiency.

SUMMARY OF RECOMMENDATIONS

Expected outcomes

The recommendations for reform of health practitioner legislation are extensive and, if adopted, will impact on most provisions of the current Acts and subordinate legislation. The major outcomes will be a more effective registration system which provides for greater protection of the public and a significantly reduced regulatory burden.

Greater public protection will be achieved by:

- enhancing the boards' ability to ensure registrants meet appropriate standards
- the effective regulation of harmful practices
- the establishment of new systems for the discipline of registrants and management of impaired practitioners
- refining the relationship between the registration boards and the Health Rights Commission.

A reduced regulatory burden will be achieved by:

- the repeal (where appropriate) of provisions which are anti-competitive or impose unnecessary restrictions on business
- the removal of unnecessary restrictions on practice by non-registrants.

Improved accountability mechanisms and changes to the composition of the boards are cornerstones of the reforms.

Overview of key recommendations

Introduction

- Accountability of registration boards to the public will be strengthened by an independent disciplinary tribunal; appropriate appeal mechanisms; revised meeting procedures with regard to minutes and declarations of interest of board members; and annual reporting obligations.
- The role of the Minister will be clarified and strengthened by an explicit reserve power of direction (for use in exceptional circumstances) and the ability to notify public sector policies to be followed by boards.
- Self funding of board functions will be achieved. However, public funding may, at the Minister's discretion, be provided for the purposes of disciplinary proceedings.
- The relationship between the Office of the Health Practitioner Registration Boards and Queensland Health will be substantially improved by the creation of a statutory office to provide responsive administrative support to the boards.
- Boards will have a greater capacity to delegate functions (subject to appropriate limitations) which will achieve significant efficiencies in administration.

Boards

- The Minister will have greater flexibility in selection and appointment of board members.
- The number of consumer members on registration boards will be increased to a minimum of two members.
- Orientation and training will be provided to board members so that boards are better equipped to administer the legislation.

Registration

- Registration eligibility criteria will be simplified. The outdated and subjective concept of 'good fame and character' will be replaced and the boards will rely on more objective indicators of character (such as whether the applicant has been convicted of an indictable offence).
- Provisions dealing with qualifications for registration will facilitate a gradual shift toward a national approach to this issue.
- Processes will be created to provide more thorough assessment of applications for registration.
- Mechanisms are proposed to ensure the ongoing competence of practitioners, for example, encouragement of continuing professional education; recency of practice; scrutiny of applications for renewal of registration.

Complaints and discipline

- Longstanding concerns about the inadequate jurisdiction of registration boards will be addressed by expanding the grounds for disciplinary action (in line with other States).
- Criticisms of the current lack of separation between the investigative, prosecutorial and adjudicative functions of boards will be addressed by the creation of a three-tiered disciplinary model. Importantly, the three tiers will involve eminent practitioners and appropriate lay persons in decision making/ adjudicative roles.

- An independent Health Practitioner Tribunal, along the lines of the current Medical Assessment Tribunal (MAT), will deal with the most serious matters. The new Tribunal will replace the MAT and will have an expanded jurisdiction to deal with all registered health professions (apart from nursing). Largely independent professional standards committees will deal with less serious practice issues in an informal, non-adversarial manner. Boards will continue to have a limited adjudicative role and will investigate all complaints.
- The accountability of the Health Practitioner Tribunal to the public will be reinforced by a requirement for hearings to be open unless there is a good reason for them to be closed.
- The needs of complainants and witnesses during disciplinary proceedings are also addressed.
- The reforms clarify the respective roles of the Health Rights Commission (HRC) and the boards and emphasise the priority that should be accorded to public interest/professional standards issues. A collaborative approach involving information sharing and accountability mechanisms is also proposed.
- Longstanding concerns about the relationship between the HRC and the boards will be addressed by a new consultative mechanism which will ensure that professional standards issues are able to be investigated by the boards.
- Boards will have appropriate powers to undertake investigations and prosecutions.

Impairment

- Consistent with recent interstate reforms, an informal, supportive process focusing on rehabilitation is proposed to deal with practitioners who are impaired.

Business and commercial issues

- The removal of restrictions on ownership of health practitioner businesses has been recommended in most professions. Special arrangements are proposed in the highly regulated professions of pharmacy and optometry. In the case of these professions, it is proposed that the current restrictions on ownership be largely maintained for the present. However, it is proposed that the matter be examined as part of the legislative review process required of all States and Territories under National Competition Policy arrangements before the year 2000. Pharmacy and optometry have the most highly regulated ownership arrangements, with similar provisions applying in most States. It is highly desirable that any reforms in this area be undertaken on a uniform national basis.
- The new legislation will contain specific offence provisions which will directly target undesirable corporate behaviour in health practitioner businesses, such as concerns about non-practitioner owner influence over clinical decision making.

Practice issues

- A new approach to regulation of practice will ensure that potentially harmful practices are restricted to registrants, but that other practices are not restricted.
- A small number of specific 'core restricted practices' have been identified as warranting controls. Submissions are sought on the most appropriate way to describe these practices.
- Other harmful practices may be restricted by way of regulation.
- A non-statutory approach to the regulation of medical call services is recommended.
- Deregulation of hypnosis is recommended.

Advertising

- Significant reductions in the controls on advertising are recommended. However, boards will retain responsibility for enforcement of a greatly reduced range of advertising offences. Advertising which is false, misleading, deceptive or harmful in relation to clinical practice matters will be prohibited.

Miscellaneous recommendations

- It is proposed that the Health Rights Commissioner investigate and report on the following issues:
  - the establishment of effective mechanisms to deal with consumer complaints about practitioner fees;
  - the nature and extent of complaints received against health service providers from non-regulated occupations, including the feasibility of extending the jurisdiction of the proposed Health Practitioner Tribunal to deal with such cases.
- It is proposed that Queensland Health investigate and report on the desirability of establishing mechanisms for the registration of students undertaking clinical placements.

- It is also proposed that Queensland Health or the Health Rights Commissioner investigate the adequacy of existing consumer protection mechanisms with regard to counselling, psychotherapy and other services of this kind provided by non-registrants.
- It is proposed that Queensland participate in national discussions on a uniform approach to mandatory professional indemnity insurance for registered health practitioners. This recommendation is consistent with the *Final Report of the Review of Professional Indemnity Arrangements for Health Care Professionals.*
- It is proposed that the legislation be reviewed 10 years after commencement.

1. OBJECTIVES OF THE LEGISLATION

The Registration Acts form one part of a system to provide for the protection of users of health services; the other main component being the *Health Rights Commission Act 1991*. New health practitioner legislation will strengthen consumer protection by ensuring that the functions and jurisdictions of these agencies are compatible and appropriately integrated.

The preferred position is that the objectives statement of the new legislation incorporate the following concepts:

- protection of the public
- ensuring that health care is delivered by the professions in a safe, competent and up to date manner.

The objectives of protection of the public and ensuring safe and competent delivery of health care underpin the recommendations of the review. They represent the 'benchmark' against which options and recommendations were assessed.

The preferred position is that the intent of the legislation will be further clarified by a statement that the Acts' objective is to be achieved principally through:

- establishing registration boards as bodies responsible for the assessment and approval of applications for registration
- providing for the protection of the public from unsafe, unprofessional or illegal practice by registered or unregistered practitioners
- promotion of high standards of professional practice, including regard for the rights of consumers of health services
- providing appropriate powers to enable registration boards and other adjudicative bodies under the legislation (ie. Health Practitioners Tribunal and Professional Standards Committees) to perform their functions.

The legislation will specify that boards and other adjudicative bodies have a duty to act independently, impartially and in the public interest.

2. REGISTRATION BOARDS

2.1 Functions and powers of boards

The preferred position is that registration boards' primary functions will be to:

- assess applications for registration
- register persons who meet the requirements for registration under the Act
- ensure that registrants continue to meet requirements and comply with conditions for registration
- maintain a register and records of practitioners
- publish and distribute information about the Act to registrants and other interested persons
- collect data about the profession on behalf of the Minister
- undertake investigations into the professional conduct and fitness to practice of registered practitioners and other matters as prescribed in the Act
- undertake disciplinary proceedings in respect of registrants
- advise, counsel or reprimand practitioners where appropriate following investigation
- accredit training courses as board-approved continuing professional education courses
- encourage participation by registrants in continuing professional education activities
- provide to the Minister a report of its work and activities and those of its committees during each financial year
- advise the Minister on matters related to the profession
- develop or adopt Codes of Practice for the profession
- consult and cooperate with other bodies responsible for registration of health professions in Queensland and other jurisdictions
- provide support to bodies approved by the Minister as responsible for developing national policies regarding registration, including assessment of appropriate qualifications
- carry out such other functions as are conferred on it by the registration Act or any other Act.

Registration boards will have a general power to undertake all activities necessary for the performance of their functions, including the standard powers that generally apply to statutory authorities. Without limiting this general capacity, boards would have the power to:

- enter into contracts
- acquire, hold, deal with and dispose of property
- engage consultants
- exploit commercially any resources of the board, including study, research or knowledge developed by or within the board
- participate in membership of any national authority established in Australia to promote consistent policies and practices among Australian authorities responsible for the regulation of the profession
- join and take part in associations whose objects are consistent with the board's functions and membership of which will assist in furthering the board's functions (membership does not include the power to provide financial assistance to such bodies, apart from normal affiliation fees, without the approval of the Minister)
- cooperate with any university, college, or other educational institution, hospital or other person or body in any State, Territory or a foreign country in order to make provision for the education or examination of persons practising or intending to practise in the profession
- provide limited "seed" funding for continuing professional education programs
- with the approval of the Minister, fund research consistent with the board's functions (eg. an evaluation of the efficacy of health assessment panels)
- with the approval of the Minister, fund "refresher" courses where there are special circumstances.

2.2 Extraordinary power to suspend or impose conditions

Currently, only the *Medical Act 1939* and the *Nursing Act 1992* make provision for the immediate suspension of practitioners in exceptional circumstances. There are no similar provisions in the other health practitioner registration Acts.

The power to immediately suspend a practitioner is essential to ensure that boards can act rapidly to protect the public from unsafe or harmful

practitioners. However, because of the serious consequences of such an action, the circumstances under which this power may be used should be clearly and narrowly defined.

The preferred position is that the chair of a board have the power to immediately suspend a registrant where such action is necessary to protect the life, health or safety of a person. The matter would then be immediately referred to a health assessment panel (where the issue relates to impairment) or the Health Practitioners Tribunal (in all other cases) for hearing within 30 days. Where the matter cannot be heard within 30 days, the board may extend the suspension for a further 30 days.

Alternatively, the chair may immediately impose conditions (other than suspension) on a registrant where such action is necessary to protect the life, health or safety of a person. Where such a power is used, the matter must be immediately referred to either a professional standards committee, health practitioner tribunal or a health assessment panel for review.

The Health Rights Commissioner must immediately refer to the board any complaint which indicates grounds for immediate suspension.

The need for this extraordinary power of suspension is further detailed in Chapter Four (Complaints and discipline) and Chapter Five (Impairment).

2.3 Subordinate legislation-making powers

In accordance with current legislative drafting practices, it is proposed to rationalise the number and types of statutory instruments (subordinate legislation) under the new Acts. Regulations, made by the Governor in Council, are considered to be the most appropriate statutory instrument under the new legislation. Many of the procedural matters currently the subject of boards' by-laws are no longer appropriate for subordinate legislation as such matters can be dealt with administratively.

A board may initiate a proposal for a new or amended regulation with the Minister.

The regulation-making powers under the Acts would include the power to make regulations on matters necessary to enable a board to carry out its statutory functions, including, but not limited to:

- prescribing certain qualifications as acceptable for registration in Queensland
- the purposes for which fees are payable under the Act/s, the amounts of fees, when fees are payable, the waiver or recovery of unpaid fees (refer section 3.8)
- regulation of harmful practices (refer section 7.3.5)
- the nature and content of board-approved continuing professional education requirements (eg. the number of hours of CPE recommended per annum)
- the nature, content and supervision requirements for pre-registration training (in those professions where relevant)
- information to be provided by registrants on application for renewal of registration (refer section 3.6.3).

2.4 Registration Boards — Membership

2.4.1 Composition of boards — extent of practitioner/consumer representation

The composition of registration boards is a cornerstone of health practitioner legislation. Importantly, all board members are appointed to represent the public interest and the Government wishes to discourage the notion that board members 'represent' professional associations or consumer associations.

In recognition of the need to strengthen the boards' awareness of the health needs and expectations of consumers, an increase in consumer membership on registration boards is proposed. However, since most business dealt with by registration boards concerns matters relating specifically to professional practice, the composition of a board must contain a majority of practitioner members. Many of the current registration Acts (eg. Medical, Optometry, Pharmacy and Physiotherapy), are not specific on the issue of whether Ministerial nominees on registration boards are required to be members of the relevant profession. The proposal for composition of boards as outlined below, will strengthen and clarify the legislative intent that registration boards should comprise a clear majority of members of the relevant profession, while at the same time provide for effective participation by members of the wider community.

The legislation will also provide a capacity to vary the size of registration boards, having regard to

the nature of the profession and the numbers of its registrants. The size of a board would be determined by the Governor in Council on the recommendation of the Minister after consultation with relevant professional associations.

The preferred position is that the composition of registration boards:

- comprise seven to 11 members
- include a majority of practitioners
- include two consumer members and a legal practitioner
- the balance of any members (depending on the size of the board) to be determined by the Minister.

In the case of the Medical Board, it is also proposed that the Chief Health Officer, Queensland Health, be ex-officio, one of the practitioner members of the Board.

2.4.2 Selection of board members

In keeping with the previously stated role of board members to represent the wider public interest, the Minister should be free to consult with relevant groups (including professional and consumer associations, unions and universities) regarding the composition of registration boards.

While in some other Australian jurisdictions, practitioner members are elected by registrants, this process is costly and may not result in the most appropriate mix of members.

The following processes are proposed in relation to the selection of board members:

- all board members will continue to be appointed by the Governor in Council
- the Minister is to nominate all members
- in deciding on nominees, the Minister shall have regard to:
  - the views of professional associations considered by the Minister to be representative of registrants
  - the views of institutions involved in the education and/or training of registrants
  - the views of community organisations considered by the Minister to have an interest in health consumer issues.
- the Minister shall have regard to the extent to which nominees are familiar with the special health needs of people from non-metropolitan and rural and remote areas, Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds, people with disabilities and women.

2.4.3 Chair and deputy chair of the board

The legislation currently provides that the chair of the board shall preside at meetings and confers upon the chair a deliberative or casting vote.

In practice, the chair is also:

- an adviser to the Minister regarding issues concerning the profession
- the public spokesperson for the board
- responsible for liaison with other boards, the profession, universities and interstate boards.

In recognition of these roles and the special position of the chair in ensuring the public accountability of the board, ***the preferred position is*** that the chair and deputy chair of boards be appointed by the Governor in Council on the nomination of the Minister. The chair must be a practitioner. However, there should be no statutory limitations on which members may be appointed as deputy chair.

2.4.4 Tenure of board members — duration of term

In determining the tenure of board members, there is a need to ensure a balance between the retention of expertise on boards and the ongoing addition of new members to boards who can bring fresh views to board deliberations. In view of this, ***the preferred position is*** that:

- all members be appointed for four years
- membership terms will be staggered so that half the board retires every two years
- members will be limited to serving two consecutive terms.

2.4.5 Board to continue

In order to ensure that there is a board in existence at all times, ***the preferred position is*** that the legislation make provision for members to continue beyond the prescribed term for three months to address any delays in the appointment of successors.

2.4.6 Extended absence of board members

If a board member is likely to be absent for more than three months, ***the preferred position is***

that the Minister be notified. The Minister may then recommend that the Governor in Council appoint a deputy to act in the member's absence.

2.4.7 Eligibility of board members

The preferred position is that board members will be deemed to be ineligible for membership if they:

- are declared bankrupt
- are found guilty of an indictable offence or an offence against the relevant registration Act
- are absent from three consecutive meetings without approval.

(There is a distinction between 'removal' from office and 'ceasing to be eligible' for office. The circumstances outlined above apply to the latter. With regard to removal from office, s.25 of the *Acts Interpretation Act 1954* specifies that the power to appoint a person to an office also includes the power to remove or suspend at any time).

2.4.8 Remuneration and entitlements

Board members are currently entitled to receive sitting fees in accordance with government policy which applies to all government boards, committees and statutory authorities. Current remuneration rates for board members are:

- ordinary members $170 per meeting
- chairs $210 per meeting

regardless of the duration of the meeting.

The preferred position is:

- the current remuneration arrangements continue to apply
- provision be made for boards to reimburse members for out of pocket expenses
- provision be made for any board member to waive receipt of meeting fees.

2.5 Orientation of board members

The provision of orientation training to new board members is considered essential, to ensure that board members are fully aware of the legislation and their responsibilities as members.

The preferred position is that the new legislation, in detailing the role and function of the Registrar, includes a function which provides for orientation training of new board members.

2.6 Meeting procedures

Boards will administratively determine procedural matters associated with the conduct of meetings. However, ***the preferred position is*** that the following matters will be prescribed in the legislation:

- the quorum will be specified
- the chair is to determine meeting times and places, and must convene a meeting when requested to do so by a quorum of members
- the chair is to preside at meetings. Deputy chair is to preside in the chair's absence
- questions are to be determined by a majority of votes. Presiding officer is to have a deliberative vote and, in the event of a tied vote, a casting vote
- meetings may be held by telephone and by other forms of distance communication;
- meetings must be minuted and where a member requests, dissenting opinions must be minuted
- custody and use of the common seal.

In addition, ***the preferred position is*** that personal and pecuniary interests of board members be dealt with in the following manner:

- members must disclose any personal or pecuniary interest in matters relating to themselves, their families and business partners where such matters relate directly or indirectly to matters under consideration by a board
- disclosures must be minuted
- members must absent themselves from deliberations and decisions regarding matters in which they, their families or business partners have a personal or pecuniary interest.

Interests which relate to all registrants, or major categories of registrants would be exempted from these requirements.

Failure to disclose a personal or pecuniary interest would be an offence.

2.7 Committees

All registration Acts currently provide for the establishment of committees for the purpose of advising a registration board on any matters relating to the exercise of its functions. Committees are restricted to providing advice and making recommendations. Boards do not have the power to delegate any of their decision-making powers to committees.

The preferred position is:

- a board should have the power to appoint committees to assist in the exercise of its functions
- membership of board committees may include non-board members
- a board may delegate any of its powers to a committee with the exception of certain powers specified below under the recommendation on 'Delegation Powers'
- committee members should be paid meeting fees determined by the Governor in Council and out of pocket expenses as approved by the board
- members of board committee's would be subject to the confidentiality provisions of the Act (see also section 5.4.1).

2.8 Delegation powers

Given the broad scope of boards' functions and powers and the potential expansion of those functions under new legislation, the power to delegate in appropriate cases is essential if boards are to exercise their functions in an effective and efficient manner.

However, statutory powers of delegation must also comply with 'fundamental legislative principles' as set out in the *Legislative Standards Act 1992*, which includes the requirement that administrative powers must be delegated only in appropriate cases and to appropriate persons. It would be clearly inappropriate for boards to delegate powers which have been conferred upon them for the purpose of the protection of the public, for example, taking disciplinary action against a practitioner, imposing conditions, or suspending a practitioner.

The preferred position is that boards may delegate any of their powers to a board member, a board committee or the Registrar with the exception of the power to:

- grant initial registration (although delegation of the power to grant provisional registration is considered appropriate)
- refuse to grant or refuse to renew registration
- suspend a practitioner
- impose conditions, limitations or restrictions on registration
- refer matters to a professional standards committee or the Health Practitioners' Tribunal
- refer matters to a health assessment panel or to make any determination following receipt of the panel's recommendations.

With the approval of the board, the Registrar is to have power to delegate any of his/her powers. (In exercising a delegation to the Registrar, the board is to specify whether a power may be sub-delegated).

2.8.1 Role of Registrar

In addition to providing administrative support to registration boards, the primary functions of the Registrar have traditionally included:

- the keeping of the register
- publication of an annual list of registrants
- ensuring compliance with disciplinary orders made by the board
- acting as complainant where offences against the Act are prosecuted.

In order to maximise administrative efficiencies, boards would be empowered to delegate a broader range of functions and powers to the Registrar. The decision to delegate powers to the Registrar would be at the board's discretion. ***The preferred position is*** that such delegations could include:

- authority to issue provisional registration to applicants who comply with statutory requirements — such decisions to be subsequently confirmed by the board
- authority to expend and manage board funds.

2.9 Accountability mechanisms

The accountability mechanisms to which registration boards are subject and which are common to all statutory bodies have been enhanced in recent years through the *Financial Administration and Audit Act/Public Finance*

Standards and the introduction of Freedom of Information and Judicial Review legislation.

In order to strengthen accountability, ***the preferred position is*** that the new legislation incorporate provisions related to:

- relations with the Minister
- annual report.

2.9.1 Relations with the Minister

Modern approaches to legislation require that a Minister's powers in relation to a statutory body be made explicit in the enacting legislation. A provision of this nature would specify the conditions under which the Minister may direct a board in relation to the performance and exercise of its statutory functions. It is proposed that the legislation specify the following responsibilities and powers of the Minister in relation to registration boards:

- to require reports and information from a board
- to notify a board of public sector policies and require them to be followed (eg. use of external consultants)
- to direct a board in the public interest. This power is to be balanced by a requirement to publicly report on such directions (in the annual report). The Ministerial power of direction would not include the power to direct a board to register/not register a person; to remove/not remove a person's name from the register, or to suspend/not suspend a person
- to make funds available to a board (by way of loan or grant) and to waive repayment
- to approve expenditure of board funds on research and refresher courses.

2.9.2 Annual Report

As with other statutory bodies, registration boards have annual reporting obligations under the *Financial Administration and Audit Act 1977*. Under section 46J(3)(a) of that Act, a Minister may direct a statutory body as to the type of information to be included in the annual report in order to enable him/her to assess the efficiency, effectiveness and economy of the statutory body and the need for its continuance. The accountability of registration boards to the public and the Parliament will be enhanced by the inclusion in the boards' annual reports of information such as statistical information regarding the number of registrants; the number of complaints, prosecutions and disciplinary proceedings; the outcomes of disciplinary proceedings and non-identifying case studies regarding disciplinary matters. The annual report must also include any direction given to a board by the Minister.

2.10 Funding and administrative arrangements

In considering administrative and funding arrangements for registration boards, the key issues raised have been:

- how to ensure a responsive support service is available to the boards
- whether the administration of registration boards should be centrally provided
- the extent to which the boards should be autonomous and operate at 'arms length' from Queensland Health
- the level of public funding, if any, which should be provided to registration boards, with particular regard to the funding of the complaints and disciplinary system.

A range of options were considered as alternatives for future funding and administrative arrangements for registration boards. These options included:

- creation of a statutory office to provide centralised administrative support to boards
- provision of administrative support by Queensland Health
- autonomous administrative arrangements by individual boards.

The preferred position is that the new legislation provide for the creation of an independent statutory body, called the 'Office of Health Practitioner Registration Boards'. As is the case with the Executive Officer of the Queensland Nursing Council under the *Nursing Act 1992*, the position of Registrar would be a statutory appointment and the Registrar would also be the accountable officer for the body. The primary function of the office would be to provide administrative and operational support to registration boards in accordance with service agreements negotiated between the office and the respective boards. Administrative functions of the office would include:

- to act as the employing authority for staff servicing the registration boards
- provision of general administrative support to boards
- maintenance of registers
- collection of fees

- provision and maintenance of accommodation and equipment
- provision of secretariat services to meetings of boards
- legal and legislative advice
- other functions as delegated by boards such as investigations and inspectorial functions.

While it is anticipated that boards and the office will readily negotiate mutually acceptable service agreements (as currently occurs between the boards and Queensland Health on a less formal basis), it is proposed that the Minister have a power of direction in circumstances where a board and the office cannot reach agreement. In order to further reinforce the accountability of the Office of Health Professional Registration Boards, it is also proposed that the Minister have the power to issue directions to the Registrar in relation to the functioning of the Office.

It is not proposed to enable boards the option of pursuing independent administrative arrangements at this time. Participation by all boards in the combined administrative structure is considered necessary in order to maintain the long term viability, accountability and potential for economies of scale of the combined administrative structure. However, it is proposed that a review of the Office of the Health Practitioner Registration Boards be undertaken within five years of the commencement of the legislation. The terms of reference for this review will include the effectiveness and responsiveness of the Office and the continued need for a statutory arrangement of this kind.

2.10.1 Funding of administrative, operational and disciplinary functions

The preferred position is that the office and the activities of boards will be, in general, entirely self-funded from revenue raised. In addition to registration fees, sources of revenue available to boards will include fines and penalties from disciplinary and offence proceedings which will be recoverable as a debt due to a board (as is currently the case). The office itself will be funded by amounts contributed by each board as negotiated in accordance with service agreements.

While boards will be responsible, (as they are at present), for meeting their legal costs of conducting disciplinary proceedings, some structural costs associated with the Health Practitioners Tribunal (HPT) will be publicly funded. These costs include salary and associated expenses of the presiding judge or judges and the salary and operating costs of providing secretariat support to the HPT.

In cases where a board considered that it was unable to meet the costs of disciplinary action because of insufficient board funds:

(a) The board could apply to the Minister for special purpose funding. Any funds extended to a board following such application would be subject to repayment within a negotiated time frame. In order to repay such funds, a board would be empowered to seek approval for a regulation to raise a specific purpose levy on registrants (disciplinary levy); or

(b) The board could apply to the Minister for special purpose funding as in (a). However, the requirement to repay such funds could be waived by the Minister in cases where it was considered that the matter involved issues of significant public interest.

The model for future administration of registration boards represents significant advantages over the present arrangements which have been in place since the mid 1960s. The primary advantage is that it creates an 'arms length' relationship between the administration of the statutory boards created under the registration Acts and Queensland Health. This will ensure that there is no uncertainty as to lines of accountability for the administration of boards and for the performance of powers, functions and duties under the legislation.

While boards are currently almost entirely self-funded (apart from the departmental contribution of accommodation and telephone costs), they have restricted autonomy in administrative and staffing decision-making processes. Separating the administrative support from Queensland Health will ensure there are no impediments to the boards in fulfilling their critical functions under the legislation. This is particularly important given the increased complexity of managing registration processes including on-going competence of practitioners, investigations and disciplinary action, managing impaired practitioners and, where necessary, prosecuting offences. The support services required by boards are no longer purely administrative in nature (eg. in receiving applications and placing registrants names on the register). Community expectations of boards are also now much higher. Boards need to be able to respond quickly and professionally to complaints, and develop pro-active and innovative approaches to ensuring safe practice (for example, through Codes of Practice). A separate administrative office will enshrine the boards' accountability for these matters and give them full autonomy to perform their powers, functions and duties under the legislation.

3. REGISTRATION

3.1 Registration criteria

The current eligibility requirements for registration varies across the professions and is summarised in Table 1.

Table 1: *Current eligibility requirements for registration*

	Spech Pathologist	Psychologist	Podiatrist	Physiotherapist	Pharmacist	Optometrist	Occupational	Medical	Dentist	Dental Technician Prosthetist	Chiropractor Osteopath
Good fame and character	x	x	x	x	x	x	x	x	x	x	x
Medically fit to practise	x	x	x	x	x		x	x			x
Qualification	x	x	x	x	x	x	x	x	x	x	x
Sound knowledge of English	(x)	(x)	x	x	(x)	(x)	(x)	x		x	(x)
Local practice knowledge	(x)	(x)		(x)	(x)		(x)				(x)
Mutual recognition		x	x	x	x	x	x	x	x	x	x
Pre-registration training		x*			x			x			

(x) *Limited to applicants with overseas qualification*
* *Supervised practice*

A number of inconsistencies and difficulties have been highlighted with regard to several of the current eligibility criteria for registration in some professions.

For example:

- *Good fame and character*
  The meaning of this term is not defined in any of the Acts. Many submissions argued that a board should be able to reject an application for registration based on more objective grounds, such as being found guilty of indictable offences, civil proceedings related to the practitioner's practice and disciplinary proceedings.
- *Knowledge of local practice conditions*
  The retention of this condition creates an inconsistency with mutual recognition principles. Under mutual recognition, registrants from other jurisdictions are entitled to register in Queensland and are not required to demonstrate local knowledge.
- *Sufficient skill in the use of English*
  While it is generally acknowledged that practitioners must have adequate communication skills to effectively provide health care to the community, it has been argued that the administration of this criterion has, on occasions, been discriminatory.

In order to establish consistency in the eligibility requirements for registration across the professions, and having regard to community concerns about some current criteria, ***the preferred position is*** that the new legislation contain two broad criteria for registration. Requirements under the following criteria must both be met before registration can be granted:

- fitness to practise
- appropriate qualifications.

In the case of pharmacy, completion of pre-registration training will also be necessary for registration as is currently the case (refer section 3.5.3).

3.1.1 Fitness to practise

Indicators of fitness to practise include:

- adequate mental and physical health
- sufficient skill in the use of English
- absence of previous findings of guilt for indictable offences in any jurisdiction
- absence of previous findings of guilt for statutory offences under an Act related to the practice of the profession in any jurisdiction
- absence of previous disciplinary proceedings related to the applicant's practice in any jurisdiction.

In assessing fitness to practise, the board would have regard to the abovementioned factors and any other factors which would be considered to render an applicant unfit to practise.

The board will determine the degree to which applicants meet each of the criteria and may choose to register or conditionally register a person in accordance with their abilities (for example, the board may register a person who is not absolutely fit or absolutely proficient in English, but is sufficiently skilled to practise within the limits set by the board). Importantly, applications for registration will not be automatically rejected because of previous convictions, health problems or language skills.

3.1.2 Appropriate qualifications

In specifying appropriate qualifications, it is intended that the legislation reflect the following principles:

- the right of applicants to have a high degree of certainty as to the specific qualifications acceptable to a board for registration purposes
- the need for a board to exercise judgement in determining the acceptability of certain qualifications for registration, particularly those obtained in other jurisdictions
- the need to provide for mechanisms which readily facilitate a national approach to the recognition of qualifications
- the current provisions of the *Medical Act*, which provide for recognition of medical qualifications from medical schools accredited by the Australian Medical Council, be retained.

Accordingly, ***the preferred position is*** that the current provisions in the Medical Act be retained and, for all other professions, qualifications for registration shall be:

i. Where there is an approved national body with responsibility for accrediting institutions providing courses in the relevant profession, the appropriate qualifications will be:
   - relevant qualifications conferred by a school (whether within or outside Australia) accredited by an approved national body or successful completion of examinations held by that body for the purposes of registration.

ii. Where there is no approved national body, the appropriate qualifications will be:
   - qualifications prescribed by subordinate legislation OR
   - any other qualification considered by the board as adequate to enable the applicant to safely practise the profession in Queensland. (Where an applicant is seeking registration based on qualifications which are not prescribed, the board may examine an applicant and, if necessary, require them to undergo such additional training, which, in the board's opinion is necessary to qualify them to safely practise the profession in Queensland).

This model encourages and supports a national approach, while at the same time embodying the essential elements of the current model.

3.1.3 Assessment of applications for registration

For the purposes of assessing applications for registration, ***the preferred position is*** that boards should have powers to undertake, where necessary, the following:

- require that applications for registration be in the form of a statutory declaration
- require the production of relevant documents or information specified by the board
- require attendance of applicants before the board or committee
- appoint a health assessment panel and require applicants to submit to assessment by the panel
- appoint examiners and require applicants to undergo examinations, including physical medical examinations, examinations o knowledge/skills.

If the board invokes the above powers, applicants must be notified and provided with the opportunity to make submissions. An avenue of appeal will be available regarding registration decisions.

3.2 Registration categories

In order to introduce a uniform approach to registration categories across the professions, yet also provide for maximum flexibility in the administration of the registration process, ***the preferred position is*** that each profession include provision for three categories of registration:

- general registration
- conditional registration
- provisional registration.

Specialist registration, which is currently available within the professions of medicine and dentistry, would continue to be available within these two professions.

The category of conditional registration will be sufficiently defined to cover the full range of specific limitations which may be desirable to place on the registration status of a practitioner, including:

- registration for a limited time
- registration with specific practice conditions or limitations, (including conditions on practice imposed by another jurisdiction)
- supervised practice.

The category of provisional registration will be utilised in cases where an applicant appears to meet the criteria for general registration but this cannot be immediately granted because, for example, the next board meeting is not scheduled for some time or the applicant is unable, at the time of application, to furnish all the required documentation. It is likely that boards will delegate decisions regarding provisional registration to the Registrar.

Notwithstanding the above, it is intended that the legislation accommodate the **existing categories** of registration for **medical practitioners** as these have been agreed to on a uniform national basis.

3.3 Registration of students and academics

3.3.1 Student registration

The innovative concept of student registration was introduced in New South Wales under the *Medical Practice Act 1992*, but has yet to be adopted in any other Australian jurisdiction.

Its introduction was in response to concerns over the absence of a mechanism for the treatment and rehabilitation of medical students whose physical or mental impairment might jeopardise their ability to practise safely and who lack the insight to undergo appropriate treatment of their own accord.

Under the NSW model, once a student is registered, the Medical Board's sole concern with the student relates to impairment. However, some professions have suggested that there is also a need for a means of dealing with misconduct or improper behaviour by students. It has been argued that this issue arises because universities have no means of preventing students from participating in clinical placements if they have a sufficient grade point average.

It has been suggested that the duties of medical students and other students undertaking clinical placements are similar to those of new graduates and that they are, in fact, providing health services.

Consultation on this issue indicates widely conflicting opinions as to the need for legislative intervention and whether registration boards should have a role in dealing with student impairment or misconduct.

The preferred position is that this issue be investigated further by Queensland Health in consultation with the Department of Education, universities, professional associations, student associations, health consumer groups and other stakeholders.

3.3.2 Registration of academics

There has been some debate as to whether academics should be registered. For example, some academics argue that registration requirements create an improper avenue for intrusion by the State into academic freedom. Others argue that regulation of academics is unnecessary where they are not providers of a health service.

This issue is of most relevance to the psychology profession where academic psychologists are required to undergo two years supervised practice to be unconditionally registered and to use the title 'psychologist'. It has been suggested that academic psychologists should be exempt from supervised practice requirements. Also at issue is whether, in fact, academics need to use the professional title in their academic position.

The argument that academics who do not provide of health services should be exempt from registration requirements has some merit, given that the purpose of registration is to protect the

public from inadequate practitioners. However, the issue of whether academics should be registered must be determined by reference to the principle that only persons who are registered may use the professional title (refer section 7.1) as this is fundamental to the registration system.

The preferred position is that it should be mandatory for all persons to be registered if they wish to use professional titles which are restricted to registrants (eg. 'psychologist', 'podiatrist'). This maintains the status quo and emphasises the principle that only registrants should be able to use protected titles.

3.4 Non-practising registration

Some of the non-medical professions have argued that there is a need for a non-practising category of registration to enable persons who are qualified, but do not practise (for example, have retired), to continue to use the professional title.

A provision establishing a non-practising category of registration for medical practitioners was inserted into the *Medical Act 1939* (s.17E) in March 1993. Persons who are eligible for registration as a medical practitioner, but who do not intend to practise, can elect to be registered subject to the condition that they do not practise medicine. To date, no medical practitioners have opted for registration under this category, however, the concept has not been widely promoted.

While there are some concerns about the usefulness of this registration category and the extent to which it will be used by practitioners, it has been advocated as an additional means of encouraging practitioners to cease practice, particularly where age is affecting their ability to practice.

The preferred position is that non-practising registration be available to all practitioners as a conditional registration category. However, to maintain the integrity of the registration system, use of the professional title by non-practising registrants must be qualified by the use of 'retired' or 'retd' after the title.

3.5 Profession specific registration issues

3.5.1 Registration — medical practitioners 'unmet area of need'

Section 17C(d) of the *Medical Act 1939* enables foreign medical graduates who have not undertaken the Australian Medical Council examinations to be conditionally registered at the discretion of the Medical Board for the purpose of enabling an area of need to be met if the board is satisfied that the person has suitable qualifications and experience to practise in the area of need.

Similar provisions operate in all other States. A number of difficulties have been highlighted in relation to 'area of need' provisions for medical practitioners, that is:

- it has been suggested that it is inappropriate for the board to have a discretion in determining whether an area of need exists and that this responsibility should rest with the Minister
- the board's sole responsibility should be to satisfy itself that the medical practitioner possesses appropriate qualifications and experience to practise in the area of need.

The preferred position is that the new legislation should clarify that 'unmet areas of need' for the medical profession are to be determined by the Minister.

3.5.2 Registration of general medical practitioners

In all Australian States, any registered medical practitioner may use the title of general practitioner or practise as a general practitioner.

The Commonwealth's *Health Insurance Act 1973* provides for a vocational register of general practitioners to ensure that general practitioners meet minimum continuing education and quality assurance requirements as determined by the Royal Australian College of General Practitioners (RACGP). Vocational registration is not compulsory, but those general practitioners who do register are able to claim higher rebates from Medicare. Public access to the names of vocationally registered practitioners can be obtained from the Health Insurance Commission.

The vocational registration system under the *Health Insurance Act 1973* offers a degree of additional protection to the public by ensuring that registrants have appropriate qualifications and experience and participate in the RACGP's continuing education and quality assurance programs.

However, it is not considered that additional protection would be afforded to the public by extending the vocational registration concept to provide for a separate State register of general practitioners.

It is not proposed that the legislation provide for the separate registration of general practitioners at this time.

3.5.3 Pharmacy pre-registration year trainees

The *Pharmacy Act 1976* and *Pharmacy By-laws 1985* currently require that pre-registration training of pharmacy graduates be undertaken for a period of 48 weeks full-time supervised practice under the direction of a registered pharmacist. The profession has identified problems with the current system in that standards for the period of supervised practice are not specified and there are no additional competencies required for preceptors providing the supervision.

The ***preferred approach is*** that the new legislation provide for the following approach in relation to pharmacy pre-registration practice:

- continue the requirement for 48 weeks full-time supervised pre-registration practice for pharmacy graduates, with the additional clarification that this period is based on a 40-hour working week and that the hourly equivalent of the 48 week period is also acceptable for this purpose
- registered pharmacists providing supervision to graduates must meet current board recommended requirements for continuing professional education (refer section 3.6.2)
- the content of training to be undertaken during the supervised practice training should be prescribed by the board
- the supervising pharmacist must certify that the prescribed training has been undertaken.

3.5.4 Education and supervision requirements for psychology graduates

Educational qualifications

Currently, to gain unconditional registration as a psychologist in Queensland, an applicant must undertake four years tertiary education in psychology followed by either two years of supervised practice or a two-year course work Masters degree.

A number of submissions to the review from groups representing the psychology profession have proposed the introduction of a six-year tertiary degree in place of the current educational and supervision requirements. However, raising educational standards of entry into a profession in one State would be inconsistent with the principles of mutual recognition legislation which has been adopted by all States and Territories. Furthermore, the effect of any higher entry level qualifications in one State could be negated or by-passed under mutual recognition laws, as an applicant could seek registration in another State and subsequently obtain registration in Queensland through the mutual recognition process. The Government is also concerned that any proposals to increase base level qualifications may create artificial entry barriers to the profession, thereby reducing access to services and increasing costs to consumers.

The preferred position is that the existing requirements for academic qualifications for psychology registrants be retained. Any future changes to qualification levels for registration as a psychologist will need to be negotiated and agreed upon at a national level.

Supervision

Currently, all States require applicants for registration as a psychologist to undergo a period of conditional registration under the supervision of a registered psychologist for a period of two years before obtaining unconditional registration.

Organisations representing the psychology profession have expressed concerns about the problems of providing and/or obtaining adequate supervised practice within the current requirement for two years supervised practice before full registration is granted.

As the two year supervision component is a feature of all States' registration Acts, ***the preferred position is*** that the requirement be retained. Any concerns regarding the practice of an individual under supervision could be addressed through the imposition of further conditions upon their registration (using the board's general power in this regard).

3.5.5 Approval of training courses for dental auxiliaries

The *Dental Act* currently provides the Dental Board with the function of approving training courses for dental auxiliaries (for example, school dental therapists and dental hygienists).

The preferred position is for the Dental Board to retain this function at this time. In undertaking this function it is intended that the Board have regard to the views of the Department of Health and representatives of dental auxiliaries.

3.6 Statutory mechanisms to ensure ongoing competence

3.6.1 Recency of practice

Currently, a practitioner's suitability for registration is assessed only when they first apply and legislation creates an automatic entitlement to re-registration upon payment of the prescribed renewal fee. There is a concern that the current approach deprives boards of the opportunity to periodically determine whether a practitioner should continue to hold registration, particularly if they have not practised for many years.

In other jurisdictions and under Queensland's *Nursing Act 1992*, the entitlement to re-registration is qualified by an obligation to have practised recently, for example, within the previous five years. If an applicant for registration/renewal has not recently practised, conditions may be imposed on their registration.

Submissions to the review indicated widespread support for the introduction of mechanisms to ensure the ongoing competence of practitioners. In proposing these mechanisms, the Government is mindful of the need for a flexible approach in order to allow for health care providers to interrupt their working lives for reasonable periods without detriment to their ability to regain registration.

The preferred approach is:

- Boards will have the capacity to determine whether conditions should be placed on the registration of an applicant for renewal of registration when the applicant has not practised recently
- Boards will formulate policies specific to the respective professions on the appropriate periods and nature of work which constitutes practice, for example, the extent to which research or management is 'practice' and the minimum number of practice hours per annum
- 'Sunrise' provisions will operate within the legislation to enable boards sufficient lead time to develop recency of practice policies before the commencement of those sections of the legislation
- Practice may, at the discretion of a board, include continuing professional education activities
- In applying for renewal of registration, applicants must advise boards of the extent of their practice during the previous year. Boards are to be empowered to require further relevant information and documentation from an applicant, if necessary
- Having regard to the circumstances of each individual case, a board will determine whether conditions on registration are required
- Any conditions imposed by a board would be subject to appeal
- The costs of refresher courses (for people who have not recently practised) are not to be met by a board without the approval of the Minister.

3.6.2 Continuing education

The principal goals of continuing professional education (CPE) are to maintain and improve professional skills and ensure practitioners are acquainted with new developments in the profession.

The availability and extent of participation in CPE varies within and across the professions. It has been suggested that practitioners who are not members of a professional association or college, in particular, do not readily participate in CPE activities.

While practitioner participation in appropriate continuing professional education activities is highly desirable, numerous submissions to the review have pointed out the considerable difficulties associated with making such a requirement mandatory under the legislation. Problems include equity issues and the practical difficulties likely to be experienced by some groups in accessing CPE (for example, practitioners in rural and remote areas).

The approach favoured by the Government involves the provision of mechanisms to encourage participation in CPE, rather than making this a mandatory requirement.

The preferred approach is:

- Participation in continuing professional education will not be mandatory for registration
- Boards may develop a program for continuing professional education or adopt a program of courses/activities developed by another body on behalf of the board
- Where a board has developed or adopted a CPE Program, it will have the function of accrediting continuing professional education courses and activities. Boards could delegate accreditation decisions to a committee
- If a CPE Program is developed or adopted, boards will also prescribe the recommended number of CPE hours per annum

- Accredited courses and activities could be promoted to and by registrants as 'Board Approved'. Registrants undertaking the prescribed number of hours could advertise that they have met board recommended guidelines for continuing professional education
- Organisations seeking board accreditation of CPE courses would have to pay an accreditation fee unless the board exercised its discretion to waive it.

This approach provides statutory encouragement for continuing professional education, provides boards with the opportunity for input and quality control over practitioner education, and provides consumers with an additional means of discriminating between health practitioners. Establishment of a CPE program would be at the discretion of each board. An accreditation fee would provide for full cost-recovery by the boards.

3.6.3 Renewal of registration and information to be provided by applicants for renewal of registration

Under the current legislation, boards have no discretion regarding renewal of registration and must re-register a practitioner who pays the annual fee. The Acts do not provide boards with power to require information when practitioners renew their registration each year.

Since one of the objectives of the new legislation will be to ensure the ongoing suitability of practitioners, ***the preferred position is:***

- registrants will be obliged to provide prescribed information (see below) when applying for renewal of registration
- this information may be used by a board to determine if disciplinary or other action is required, but registration would only be withdrawn or modified as a result ofsubsequent disciplinary or impairment processes (except for recency of practice requirements, refer section 3.6.1)
- in order to ensure that accurate information is provided, it is proposed that the provisions relating to fraudulent applications also apply to applications for renewal of registration.

It is envisaged that registrants would be required to declare if they have:

- been found guilty of an indictable offence
- been found guilty of a statutory offence under any Act relevant to the practice of the profession
- become impaired or undergone any significant changes in health which might adversely affect practice
- been a party to any settlements or judgements where money has been paid to a claimant in response to allegations of negligence or other practice related matters (It is recognised that any financial settlement, of itself, is not necessarily an indication of fault; however, this position is consistent with the recommendations of the Final Report of the Commonwealth's *Professional Indemnity Review*)
- met the board's recency of practice requirements
- in the case of pharmacy and optometry practitioners, provide details of ownership arrangements of any professional practices in which the practitioner has a financial interest.

If the registrant falls into any of these categories, they would be required to provide details to the board. Information supplied for registration renewals would be in the form of a statutory declaration. The administration of these processes will have some resource implications for registration boards. Although approximately 22,000 registration renewals are received annually, in the majority of cases where the applicant has declared that requirements for renewal have been met, renewal would be a straightforward administrative process.

3.7 Registration of specialties

3.7.1 Application to professions

Medicine and dentistry are the only professions in Queensland in which registered specialties are provided for under legislation. There are currently 50 registered medical specialties and eight registered dental specialties. Almost 3000 medical practitioners and about 150 dentists areregistered as specialists in Queensland. Separate specialist registers must be maintained and an additional registration fee must be paid by specialists.

A non-statutory approach to recognition of specialist health practitioners is predominant across all Australian states and professions, with the exception of dentistry (eg. South Australia is the only other State which registers medical specialists). In states where a non-statutory approach is followed, specialist practitioners are recognised as such by virtue of their membership of or accreditation by relevant professional associations or colleges (for example, medical specialist colleges such as the Royal Australian College of Surgeons).

There is no statutory impediment to professional associations recognising specialties or creating guidelines for claiming specialist skills, although these would be binding on members only.

It must be emphasised that the absence of statutory recognition of specialties does not discourage (and should not be construed as discouraging) specialisation or specialist training.

The preferred position is that the statutory recognition of registered specialties be limited, as at present, to the professions of medicine and dentistry. The current arrangements are an integral and accepted part of those professions. Non-statutory recognition of specialties in other jurisdictions is considered to be effective and it is not proposed to extend the statutory creation of registered specialties to other occupational groups at this time as this would add unnecessarily to the regulatory burden.

3.7.2 Medical specialist qualifications

A registered medical practitioner is currently entitled to specialist registration if the practitioner has recognised specialist qualifications and skills in a prescribed speciality of medicine [s.18 *Medical Act 1939*]. The specialties and qualifications are prescribed in the Medical Regulations 1990 and include, in addition to Australian qualifications, specialist qualifications conferred by English, Scottish, Irish, South African, Canadian and United States institutions.

This approach, whereby an entitlement to specialist registration arises from the possession of prescribed overseas specialist qualifications, is inconsistent with the approach approved by the Australian Health Ministers Advisory Council (AHMAC) before the introduction of mutual recognition. The approach approved by AHMAC provided for an entitlement to specialist registration dependent upon the assessment and recognition of the qualification by the relevant Australian specialist College. The latter approach had been adopted in South Australia, the only other State which maintains a specialist register. The process for the recognition of overseas specialist qualifications involves the submission of the qualifications to the relevant Australian specialist college through the Australian Medical Council.

While the requirement that overseas specialist qualifications be assessed for recognition by the relevant Australian specialist college is supported, the process for formal assessment and recognition can be lengthy. However, in the case of overseas specialists seeking registration (for short-term appointments), a process exists whereby the acceptability of the practitioner's specialist qualifications can be determined expeditiously by the relevant Australian specialist College.

The preferred position is that a medical practitioner will be entitled to registration as a specialist within a prescribed medical specialty if the practitioner possesses:

- qualifications awarded by an Australian specialist college or
- a certificate from the Australian Medical Council stating that the practitioner has attained a satisfactory standard for recognition as a specialist.

In addition, a practitioner will be entitled to specialist registration if:

- registration is to be granted for a limited period and restricted to a single employer
- the practitioner possesses qualifications and experience which, in the opinion of the relevant Australian college are acceptable for the purpose of the practitioner practising within that specialty for that period.

3.7.3 Dental specialist qualifications

The Australian Dental Council (ADC) is examining issues relating to the registration of dental specialists with the object of achieving national uniformity in relation to:

- the qualifications required for registration as a dental specialist
- the dental specialties within which registration may be granted.

In view of this, ***the preferred position is*** that the current arrangements be retained for the registration of dental specialists pending consideration of the outcome of the ADC's examination of this issue.

3.8 Registration fees

Registration fees are the principal source of income for boards and must be set at levels which allow boards to meet their statutory and operational requirements.

In order for boards to become totally self-funding, ***the preferred position is*** that a review of registration board fee levels be undertaken before the start of the new legislation. Fee levels across boards are currently widely disparate and will, in future, need to provide an adequate basis for

boards to undertake their updated statutory functions. As at present, fees will be prescribed in subordinate legislation and adjusted annually. A revised base level of fees will be set following the review.

The new legislation will continue to make provision for the following types of fees:

- application for registration (including specialist registration where applicable)
- annual renewal of registration
- registration of additional qualifications
- recognition or assessment of overseas qualifications (where relevant)
- examination fees (where relevant)
- access to the register (where written information is provided).

Dependent on the outcome of other recommendations from the review, the new legislation will also provide for:

- a fee for board accreditation of continuing professional education courses
- a special purpose disciplinary levy.

3.9 The register

The register is a list of all registered practitioners. Use of professional title and, in some cases, the right to practice is restricted to persons on the register.

The information recorded on the register is currently detailed in the Acts and By-laws. Most legislation provides the boards with a by-law making power regarding the 'register and the manner of its keeping'. The contents of the registers of physiotherapists, dental technicians and dental prosthetists are not prescribed.

Some legislation requires the practitioner's registration category (for example, provisional, conditional, etc) to be recorded on the register. Details of conditions on registration and suspension of medical practitioners are recorded on the register. Only fully registered chiropractors and osteopaths are listed on the Register of Chiropractors and Osteopaths. Conditionally registered practitioners do not appear on the register.

With the exception of the *Dental Technicians and Dental Prosthetists Act 1991, Medical Act 1939, Pharmacy Act 1976 and Optometrists Act 1974*, all of the Acts under review currently require that, where a practitioner is suspended, the cause of suspension be recorded on the register.

The *Podiatrists Act, Optometrists Act and Dental Act* require that a list of registrants be published in the Gazette annually. With the exception of the *Medical Act* and *Dental Technicians and Dental Prosthetists Act*, all other Acts also require the annual publication of a "List" of registrants. The Medical Board has continued to publish a list of registrants, even though this is not a statutory requirement.

For most professions, the list shows a registration number, full name of the practitioner, business/home address, date of registration and their qualifications. The list does not identify conditions on practice or disciplinary sanctions.

Each register is a public document and the public have a statutory right of access to it on payment of the prescribed fee. Fees to inspect the register (in practice, the list) currently range from $2 for physiotherapists to $15 for podiatrists. In practice, there has been no charge for telephone requests for information.

The preferred position is that the requirements in relation to the keeping of the registers be standardised across the professions.

It is proposed that boards be required to keep:

- records for the purpose of effectively administering the Act
- a register of registered practitioners for public access.

The following common provisions are proposed:

Records

- With the exception of prescribed information which must be recorded, the manner of keeping the records is to be determined by the boards. The boards will be required to record the following information for at least 10 years:
  - all current and previous conditions on the registrant's practice
  - all sanctions imposed against the registrant
  - the reasons for any suspensions or cancellations of registration.

Register

- All boards should be required to have a register of registrants available for public access (including computer access). Boards may publish the register. The contents of the register should be prescribed. All registers should include the following information:

- name of the practitioner
- business address
- qualifications (including year conferred and institution)
- conditions on practice (Yes/No)
- any current suspension
- non-current disciplinary sanctions — recorded on the register at the discretion of the adjudicative body (refer section 4.8.1)
- whether the practitioner meets the board's CPE requirements (Yes/No)

◆ Where conditions are imposed on a registrant's practice, the board or adjudicative body must determine whether these conditions should be kept confidential on the grounds that it is not in the interests of the practitioner's clients to know about them (refer section 5.4.1). Unless the conditions are determined to be confidential, the public should have the right be told what they are. The practitioner should have the right to an avenue of appeal regarding the determination about confidentiality

◆ Where a practitioner is currently suspended, the reason for the suspension shall not be recorded on the register, but is to be available from the board on request. The adjudicative body must determine whether reasons for suspension are to be made available to the public

◆ The legislation will require the boards to collect data on behalf of the Minister if requested to do so. Such information could include:

- gender
- languages spoken
- special areas of practice
- membership of professional associations
- work contact details
- whether practice accommodation is wheel chair accessible

Registrants would not be compelled to provide this information.

◆ Access to the register is to be free in cases where no written or electronic information is provided, otherwise at an amount determined by Regulation. The fee is to be consistent across all registered professions

◆ A separate specialist register would be kept by those boards, (Medical and Dental), which grant specialist registration.

3.9.1 Separate registration of chiropractic and osteopathy

At present, the Chiropractors and Osteopaths Board of Queensland registers chiropractors and osteopaths on a joint register. In response to submissions, and in recognition of the separate status of the two professions, ***the preferred position is*** that the professions of chiropractic and osteopathy be separately registered. Use of titles 'chiropractor' and 'osteopath' will also be separately protected (refer section 7.1).

However, it is proposed that both professions will be regulated by a combined Chiropractors and Osteopaths Board. Of course, the Board may appoint committees to deal with various aspects of its work (refer section 2.7) including issues specific to the respective professions of chiropractic and osteopathy.

4. COMPLAINTS AND DISCIPLINE

4.0 Overview and guiding principles

In developing proposals for a new structure for the management of complaints and the discipline of registered health professionals, the following principles were considered paramount and underpin the numerous recommendations for change in this area:

- *Accountability.* The disciplinary system must be accountable to the public, including members of the profession. The public must also have confidence in the responsiveness and effectiveness of the system for managing complaints. Registrants, in turn, must be assured that the disciplinary systems to which they are subject are fair and subject to appropriate checks and balances.
- *Natural justice.* Procedural fairness must be accorded to all parties in the process, including practitioners, complainants and witnesses. Registrants, in particular, must by assured of the right to be heard by an unbiased adjudicator.
- *"Efficiency" and cost-effectiveness.* The disciplinary system must deal promptly and effectively with matters which are a potential threat to the health or safety of the public. The system must also contain sufficient flexibility to provide a range of mechanisms with varying degrees of formality and powers to impose sanctions. Less formal and less expensive processes are clearly required given the high cost of disciplinary proceedings under the current system.
- *Professional/peer involvement.* It is considered essential that eminent members of the profession are involved in the adjudication of the professional conduct of their peers. However, given the requirement for natural justice, and in particular the absence of bias rule, it is not appropriate for registration board members to exercise an adjudicative function (given the board investigates a matter, determines whether it warrants disciplinary action and presents it before a decision making body) except in the least serious matters (where the consequences for the registrant are the least significant). All adjudicative bodies must include members of the profession.
- *Community involvement.* In order to ensure a broader community/consumer perspective and to enhance public confidence in the disciplinary system, it is essential that all adjudicative bodies include a lay member.

A three-tiered disciplinary structure is envisaged for the registered health professions covered by this review. The proposed model utilises the best elements of recent interstate legislation. The appropriate disciplinary forum for any matter will be determined by the seriousness of the alleged misconduct. The adjudicative forums will be:

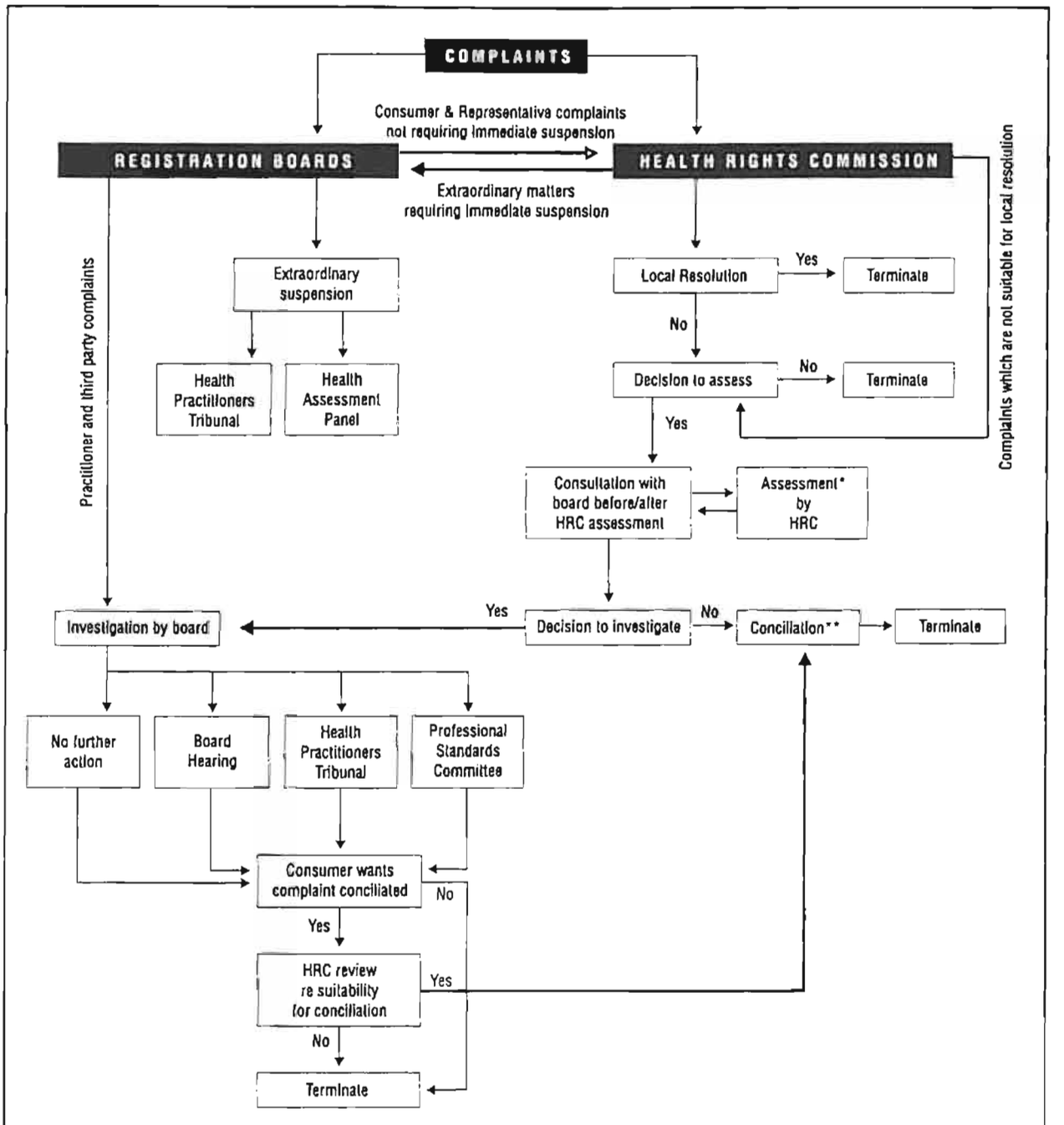
- *Registration Board.* Matters which could be satisfactorily addressed through cautioning, reprimanding, counselling or advising a practitioner would be dealt with by a board.
- *Professional Standards Committee (PSC).* Matters which would not be likely to provide grounds for deregistration or suspension of a registered health practitioner would be referred to a PSC. *PSCs would be appointed for each profession and would contain members of the profession and a consumer member. A PSC may also contain one board member.*
- *Health Practitioner Tribunal (HPT).* Matters which may provide grounds for the deregistration or suspension of any registered health professional must be referred to a HPT. The HPT would be chaired by a judge of the Supreme or District Court and would contain members of the profession and a consumer member.

4.1 Relationship between boards and Health Rights Commission

Any discussion of the disciplinary model must begin with the relationship between the boards and the Health Rights Commission (HRC) because, since the enactment of the *Health Rights Commission Act 1991*, the Commission has been the principal source of consumer complaints about registrants.

Disciplinary action against a health practitioner usually starts after a complaint has been made or information is given to either a registration board or the HRC. Numerous respondents have expressed the view that the avenues for giving information or making a complaint are not straightforward and may be discouraging to the general public.

Table 2: *Proposed complaints process*



* *Currently "Assessment" is a statutory process under the* Health Rights Commission Act 1991 *whereby the Commissioner determines how a complaint, which cannot be resolved directly between the consumer and the practitioner, should be handled (for example, whether it should be investigated or conciliated). In assessing a complaint, the Commissioner cannot use any coercive information/investigation powers, but can accept information (which is volunteered by the parties) and attempt to informally resolve the complaint, if appropriate. Many complaints are addressed during or before the conclusion of assessment and require no further action.*

** *"Conciliation" is a statutory process under the* Health Rights Commission Act 1991 *which utilises a priviliged forum for the resolution of substantial disputes, including allegations of negligence. Both parties, ie. the practitioner and the complainant, must agree to participate in conciliation. A very small proportion of complaints are conciliated. The statutory term "conciliation" should not be confused with the "conciliatory" approach used by the Commission when dealing with complaints in other ways (for example, during assessment).*

While the HRC and the registration boards have differing roles and jurisdictions in relation to complaints about health professionals, from a health consumer's perspective it would be far more equitable if the interaction between these bodies could be streamlined towards a 'one stop shop approach', but without dismantling any existing avenue of complaint.

In order to achieve a more effective approach to the handling of complaints about health professionals, ***the preferred position is*** that the new legislation provide for integrated complaint handling procedures and processes as outlined in Table 2 and discussed below:

The proposed new processes will incorporate the following features, some of which will require consequential amendments to the *Health Rights Commission Act 1991*:

- Boards to immediately refer complaints *from consumers or their representatives* to the Health Rights Commission, except where the substance of the complaint indicates that immediate intervention is required by the board. Where the board does not refer a consumer/representative complaint to the HRC, it shall, nevertheless, notify the HRC of the complaint.

  (This provision addresses what is perceived by some to be an ambiguity in the Health Rights Commission Act regarding the boards' referral obligations. If implemented, this proposal will clarify that only complaints from consumers and their representatives need be referred to the Health Rights Commission. Complaints and information from other sources, for example other practitioners and third parties, may be dealt with directly by boards. The boards may also retain those most serious complaints which require immediate intervention to protect the community).

- Practitioners and other third parties may complain to registration boards and may still complain directly to the Health Rights Commission under s. 59 (1) (d) of the *Health Rights Commission Act 1991* (that is, third parties in the public interest). The Health Rights Commission is obliged to immediately refer to the board any matter which suggests grounds for immediate suspension (that is, where such action is necessary to protect the life, health or safety of a client).

  (This provision obliges the Health Rights Commission to refer the most serious complaints directly to the board without taking any other action).

- Grounds for complaint to the Health Rights Commission are to be expanded to include any other matter which may provide grounds for disciplinary action by a board (including an offence against any Act relevant to the practice of the profession).

  (When read in conjunction with the grounds under which a board may take disciplinary action, this provision will create parallel jurisdictions between the two agencies. This approach assists consumers by permitting the Health Rights Commission to receive all categories of health complaints).

- Where the Health Rights Commissioner decides that a complaint to the Health Rights Commission requires 'assessment' under the *Health Rights Commission Act*, consultation must be undertaken with the relevant board. The nature of the consultation process will be determined by the board and the Commission.

  (This provision preserves the Health Rights Commission's discretion to determine whether a complaint warrants assessment. However, the effect of this provision is that the Commissioner must consult with the board before the assessment commences).

- If, after consultation, the board or the Health Rights Commission believes that a complaint requires investigation, it must be referred to the board for investigation.

  (This collaborative approach ensures that the boards have early input into handling of complaints to the Health Rights Commission and provides for either the boards concerned or the Commissioner to require that a complaint be investigated. This provision emphasises that the most serious complaints should always be investigated by the boards as a priority).

- At the conclusion of the assessment, the Commissioner must again consult with the relevant board regarding all complaints.

  (This enables boards to reconsider whether the complaint requires investigation based on the information gathered during assessment and ensures that the Commissioner retains the discretion to compel a board to investigate any complaint which, in his/her view, is appropriate for the board. The current requirement to consult before referral would become redundant and could be repealed).

- Provision is to be made for boards to delegate responsibility for consulting with the Commissioner to a board member, committee of the board, registrar or staff member.

  (This approach will ensure all matters can be dealt with expeditiously).

- At the conclusion of disciplinary proceedings, the board may, if the user/representative requests, refer the complaint to the Health Rights Commission for conciliation. The Commissioner will review the complaint and determine its suitability for conciliation. At the Commissioner's discretion, the complaint may be conciliated if both the practitioner and the user agree.

  (This proposal acknowledges that some matters which are investigated by the boards may also be suitable for conciliation).

- The following information sharing arrangements are proposed:

  — Boards will have the ability to require information from the Health Rights Commission regarding any complaints made about registrants (including those terminated before assessment).

  — The Health Rights Commission will have the power to require a report of any board investigation about a registered practitioner (regardless of whether they commenced as a result of Health Rights Commission referral). The Health Rights Commission will also have the power to require further information from boards regarding such matters and to make a report to the board and/or the Minister about them.

  — Boards will notify the Health Rights Commission of the commencement of Health Practitioner Tribunal Proceedings. The Commissioner will retain the right to intervene in those proceedings and on intervention becomes a party to the proceedings.

  (These provisions provide for the free exchange of information and increase the accountability of the boards and the Health Rights Commission).

4.2 Receiving complaints

4.2.1 Statutory timeframes for complaints

Under current legislation, different rules apply to time limits on complaints made to the Health Rights Commission and to registration boards.

There is presently no time limitation on the lodgement of complaints to registration boards and, in some cases, complaints have been made many years after the alleged misconduct occurred. This limits a board's ability to effectively investigate the matter. In contrast, the *Health Rights Commission Act 1991* says the Commissioner may not take action on a health service complaint if the matter of complaint arose (and the complainant was aware of the matter of complaint) more than one year before making the complaint.

Some respondents have suggested that consumer complaints which do not fall within the timeframe of the *Health Rights Commission Act 1991* are not reaching registration boards because of confusion and lack of public information about accessing the complaints mechanisms available through registration boards.

The preferred position is that boards and the Health Rights Commission have the capacity to receive complaints and information under a common timeframe of two years from when the matter occurred or the complainant became aware of it (with discretion to extend the timeframe where a matter would, prima facie, be grounds for deregistration or suspension).

This proposal provides for consistent timeframes between the Health Rights Commission and the boards and also addresses the Commissioner's longstanding concerns about the absence of some discretion regarding the most serious complaints.

4.2.2 Circumstances under which the boards may take action

Under current legislation, complaints to the Medical Board may only be made by 'an aggrieved person' but there is no restriction on who may make a complaint or give information to other (non-medical) health practitioner registration boards.

The preferred position is that the current approach of the non-medical boards be implemented uniformly whereby action may start whenever a board receives information which indicates grounds for disciplinary action. A board may suspect there are grounds for disciplinary action as a result of a formal complaint or through information otherwise becoming known to the board.

4.2.3 Statutory protection and confidentiality

It has been suggested that health practitioners and other people with relevant information have in the past refused or been reluctant to supply information to boards for fear of reprisals or defamation actions. In part, this may be attributable to the absence of statutory protection for persons giving information

to the boards. By way of contrast, ss.135, 138 and 139 of the *Health Rights Commission Act 1991* protect persons who, in good faith, give information or a record to the Commission, and prohibits reprisals against persons who make complaints or who provide information to the Commission.

The preferred position is that statutory protection be made available to persons giving information or making complaints to registration boards, and that any information given to the boards or related to board activities will be treated as confidential (similar to provisions under the *Health Rights Commission Act 1991*.)

4.3 Grounds for disciplinary action

4.3.1 Professional conduct

The current grounds upon which boards may initiate disciplinary action are quite limited and vary considerably across the Acts under review. In summary, the most common grounds are:

- professional misconduct or conduct discreditable to the profession
- breach of Rules of Practice developed by the board
- conviction of an indictable offence, offence against the registration Act or other Act
- failure to carry out a lawful demand of the board
- ceasing to meet the criteria for registration.

In relation to professional conduct, the type of professional behaviour dealt with by registration boards is generally limited to behaviour which falls substantially below the standards of the profession, as judged by members of that profession.

In other jurisdictions such as New South Wales, more recent health practitioner legislation has taken a broader perspective on the discipline of health practitioners by including 'unsatisfactory' conduct as a ground for disciplinary action. The Victorian *Medical Practice Act 1994* requires the public perspective (as well as standards expected by the profession) to be considered when evaluating practitioner conduct.

Grounds for disciplinary action should be sufficiently broad to capture any professional behaviour which adversely impacts or has the potential to adversely impact on public health and safety or consumer health rights. Grounds should be uniform across all health practitioner registration Acts, and should be easily understood by both professionals and the public.

The preferred position is that boards have the ability to initiate disciplinary action for unsatisfactory conduct by professionals. This would include professional misconduct (ie. conduct substantially below the standard of the profession), lack of adequate knowledge, skill, care or judgement and other improper/unethical conduct. Consistent with interstate models, the policy objective is to ensure that a broad spectrum of inappropriate/unsatisfactory conduct is caught and that the focus is not merely upon behaviours which are "substantially below" the standards of the profession. Any act of sexual abuse or improper sexual contact would be captured under this ground.

It is also the preferred position that, in evaluating the practitioner's conduct, the adjudicative body have regard to both community and professional expectations.

4.3.2 Other grounds for disciplinary action

As indicated above, the current legislation provides for a range of other grounds, apart from unprofessional conduct, as a basis for disciplinary action. ***The preferred position is*** that the following grounds also apply:

- being found guilty of any indictable offence
- being found guilty of any statutory offence under an Act related to the practice of the profession (including offences against, for example, the *Health Act 1937* and *Health Insurance Act 1973*)
- breach of a condition of practice which has been agreed to by a practitioner or imposed by a board
- ceasing to meet criteria for registration.

Subject to the Government's determination regarding the enforceability of the Code of Health Rights and Responsibilities, a breach of the Code or part thereof might also provide grounds for disciplinary action.

4.3.3 Codes of practice

Codes of Practice can be used to address specific practice issues or professional conduct generally. For example, the *Pharmacy Act 1976* currently enables the board to develop a Code of Professional Conduct 'as a guide to the standard of professional conduct expected of pharmacists'. Contravention of the code is not deemed to be professional misconduct, but the board may use it as a guide to appropriate professional practice.

Some registration Acts provide that rules (or codes) of practice may be developed by boards, and that failure to comply with those rules is *deemed to be conduct discreditable or professional misconduct.* This provision has been criticised on legal grounds as reversing the onus of proof and of being inconsistent with protection of individual rights and fundamental legislative principles.

The preferred position is that boards should have the ability to make or adopt Codes of Practice in consultation with the profession, consumers and the Health Rights Commissioner. Codes of Practice must be ratified by the Minister to be valid. These codes should:

- provide guidance as to appropriate practice
- apply only to registrants
- be consistent with the Code of Health Rights and Responsibilities
- be subject to regular review
- be circularised regularly to all registrants
- be publicly accessible.

It is not proposed that a breach of a Code of Practice, of itself, provide grounds for disciplinary action. Instead, it is intended that the codes be developed or adopted by the boards as a guide to appropriate professional practice. In disciplinary proceedings the codes could be introduced as evidence of good practice. It is likely that boards will make a number of issue specific codes for their professions.

4.4 Investigation of complaints

4.4.1 Investigative and prosecutory functions

The Medical Board of Queensland and the Queensland Nursing Council currently exercise both the investigative and prosecutory[1] functions in disciplinary matters involving their registrants. With the exception of New South Wales where both of these functions are exercised by the Health Care Complaints Commission and are publicly funded, this is also the position in other Australian states.

The non-medical boards currently have no distinct statutory powers of investigation or prosecution. Instead, an 'inquiry' model is used whereby the boards have powers akin to Commissions of Inquiry. In practice, the approach is more prosecutory than inquisitorial.

In considering which body should have the primary responsibility for the investigation and prosecution of complaints about registrants, the main options considered were registration boards or the Health Rights Commission.

The preferred position is that registration boards (rather than the HRC) should investigate and, where appropriate, prosecute all complaints regarding their registrants.

This approach is supported on the following grounds:

- it is highly desirable that one body exercise the investigative and prosecutory functions
- both these functions are appropriate for boards as regulatory bodies, whereas a prosecutory function is seen by many as contrary to the purposes for which the Health Rights Commission was established (a major function being *conciliation* of complaints)
- it ensures a consistent approach to these functions and avoids the possibility of disputes or disagreements between separate bodies as to the manner in which the respective functions are exercised
- it avoids the duplication of resources that inevitably arises if these functions are exercised by separate bodies
- it supports practitioners, complainants and witnesses by ensuring they deal with only one body at the investigative and prosecutory stages of the disciplinary process
- boards possess a higher level of professional expertise in dealing with clinical and professional standards issues.

4.4.2 Decisions by boards concerning investigation

Decisions by boards to investigate and/or prosecute a complaint currently follow two separate models. In the case of medical practitioners, the Medical Board *must* investigate any complaint alleging that a practitioner is guilty of misconduct in a professional respect. If, upon investigation, the Medical Board is satisfied that a prima facie case exists, it must charge the practitioner before the Medical Assessment Tribunal or, for less serious matters, may impose disciplinary sanctions.

In the case of the other (non-medical) boards, where a board suspects on reasonable grounds

1 *Note the use of the term "prosecutory" in this document is NOT intended to imply that professional disciplinary processes are criminal proceedings.*

that disciplinary action may be required in relation to one of its registrants, it *may* hold a disciplinary inquiry. If the matters alleged against the practitioner are proven, the board may impose disciplinary sanctions. The receipt of a complaint is not a prerequisite for those boards taking disciplinary action.

The preferred position is for registration boards to undertake all investigations regarding their registrants. Investigations will be required under two circumstances:

- firstly, where complaints are made by consumers or their representatives, investigations must be undertaken if recommended by either the Board or the Health Rights Commissioner
- secondly, all complaints made directly to boards but not referred to the Health Rights Commission (ie. complaints from practitioners and third parties) will routinely be investigated, however, boards will have power to decide not to investigate a complaint if:
  - the board determines that the complaint is frivolous, vexatious or trivial
  - the subject-matter of the complaint has been previously dealt with by the board or adequately dealt with by the Health Rights Commission or another body
  - the complaint is received outside the statutory time limit for lodgement of complaints
  - the complainant withdraws the complaint
  - the complainant does not provide further particulars required by the board.

In cases where a board decides not to investigate a complaint, the board must provide a statement to the complainant specifying the grounds for its decision, having regard to the privacy of the registrant (particularly where the reason for not investigating relates to the practitioner's health).

4.4.3 Investigative powers of boards

Under s.121 of the *Health Rights Commission Act 1991*, the Health Rights Commissioner may refer complaints to a board for investigation if the board has adequate functions and powers of investigation. The Commissioner has indicated that the current absence of specific and distinct investigative powers for all non-medical boards has restricted the ability of the HRC to refer complaints to them. There is no such impediment in respect of the Medical Board

When investigating a complaint, the Medical Board or a complaints investigation committee may exercise some of the powers of a commission of inquiry under the *Commissions of Inquiry Act 1950*. Although the non-medical boards may also exercise the powers of a commission of inquiry when conducting a disciplinary inquiry, they have no specific statutory powers of investigation. When acting as a commission of inquiry, boards have substantial powers including power to:

- compel any person (by summons) to attend before a board to give evidence or produce documents
- on execution of a warrant, request police to enter premises and to search and seize evidence
- require persons to answer questions regardless of any claim of privilege on the ground of self-incrimination
- use listening devices (with the approval of a Supreme Court Judge).

The full powers of a commission of inquiry are not appropriate and it has been suggested that the investigative powers available to boards should be more tailored to those which boards would reasonably be required to exercise, having regard to their functions.

The Medical Board, when investigating a complaint, may:

- require the particulars of the complaint to be verified by statutory declaration
- constitute a complaints committee to investigate the complaint and deliver its findings and recommendations to the board and/or
- require the practitioner to provide written answers to questions put by the board or to provide other information requested by the board.

The preferred position is that, when investigating a complaint, a board may require a complainant to:

- supply further particulars of the complaint or
- verify the complaint by oath or affidavit.

If the complainant fails, without reasonable cause, to comply with such a request by a board, a board may decide not to proceed with the investigation.

Consistent with the current *Commission of Inquiry Act* powers, other powers available to investigators appointed by a board will include:

- power to require a person to attend and to provide information or documents

- power to enter and search premises, and seize evidence (with the consent of the occupier of the premises or on the execution of a warrant);
- power to seek the assistance of a police officer.

Where records have been seized during an investigation, a board may, if it is determined that the practitioner under investigation was not entitled to registration or was illegally holding out to be registered:

- return the records to the practitioner
- return the records to a practitioner of the patient's choice
- return the records to the patient
- destroy the records.

4.4.4 Investigators — appointment

As indicated above, the Medical Board can currently investigate a matter itself or delegate this function to a complaints investigation committee. Other legislative models provide for delegation of the investigative function to an officer of the board.

While, in the future, the bulk of board investigations will be undertaken by delegates, ***the preferred position is*** that a board will also retain the capacity to investigate a matter itself and for this reason it will have the same powers as an investigator, including the power to compel attendance before it of any person.

With regard to the appointment of investigators, ***the preferred position is*** that the following provisions apply to the appointment of investigators by registration boards:

- A board may appoint any person, other than a board member, to be an investigator. An investigator may investigate, on behalf of a board, any matter concerning the professional conduct of a registered health practitioner.
- Boards should be required to ensure that investigators are trained in relation to health rights and responsibilities and the concerns of special needs groups. (The Health Rights Commission could assist with training regarding these matters).
- Boards will be required to issue an identity card to each investigator. The investigator must produce the card before exercising any statutory powers of investigation.

4.4.5 Privilege

Although the Medical Board may, when investigating a complaint, compel information to be given by a medical practitioner, the *Medical Act 1939* (s.37C) provides that a practitioner is not required to provide the information if it would tend to incriminate the practitioner and, if information is given, it is inadmissible against the practitioner in any proceedings except disciplinary proceedings.

Protection against self-incrimination is also provided to persons who are compelled to give information to the HRC using its investigative powers. In addition, under s.89(5) of the *Health Rights Commission Act 1991*, information obtained using these powers is inadmissible in evidence against the person in a proceeding. Unfortunately, this provision casts some doubt on whether information obtained by the Commission from a practitioner could be used in evidence against that practitioner in disciplinary proceedings.

The preferred position is that:

- Where persons are required to provide information or documents to an investigator, it is reasonable for a person to fail to comply with such a request if compliance would tend to incriminate the person.
- Although it is proposed that the boards investigate all complaints regarding registrants, complaints regarding institutions may identify concerns about registered practitioners. For this reason, information obtained by the Health Rights Commission when conducting an investigation of a complaint is to be admissible in disciplinary proceedings by a registration board. (An amendment of s.89 of the *Health Rights Commission Act 1991* will be necessary to give effect to this proposal).

4.4.6 Action following investigation

The preferred position is that the following actions be taken following an investigation:

- An investigator, upon completion of an investigation into a complaint, is to provide a report to the relevant board. The board must provide a copy to the Health Rights Commission and have regard to any comments or recommendations made by the Commissioner.
- After consideration of the report, a board may:
  - take no further action

  or

  - if a board reasonably suspects that one of the grounds for disciplinary action against a practitioner has been met, the board may:
    - deal with the matter itself (in cases where the matter would be adequately addressed by counselling, advising,

cautioning or reprimanding the practitioner)

or

- refer the matter to *a Professional Standards Committee*
  (in cases where, if substantiated, the matter would **not be likely** to result in the suspension or deregistration of the practitioner)

or

- refer the matter to *the Health Practitioner Tribunal*
  (in cases where, if substantiated, the matter would **be likely** to result in the suspension or deregistration of the practitioner).

This approach, whereby a board has a discretion to prosecute, is consistent with the current provisions in the registration Acts (other than the *Medical Act 1939* — where there is currently no discretion) and enables boards to take into account all relevant factors (for example, seriousness of the matter, sufficiency of evidence) in determining whether a practitioner should be disciplined.

4.4.7 Timeliness of investigations

Some concerns have been expressed about the length of time boards have sometimes taken in investigating and prosecuting disciplinary matters. In some jurisdictions, legislation requires investigations to be carried out in a timely manner. For example, the New South Wales *Health Care Complaints Act 1993* contains a provision requiring the Health Care Complaints Commission to investigate complaints as expeditiously as the proper investigation of the complaint permits, particularly when the complainant is seriously ill.

The preferred position is that the new legislation require boards to investigate complaints as expeditiously as the proper investigation of the complaint permits. Such a provision is seen as necessary on the grounds that it is in the public interest to ensure that complaints are investigated in a timely manner.

4.5 Structure of the disciplinary model

4.5.1 Adjudicative Bodies

With the exception of the Medical Board, all health professional registration boards currently exercise prosecutory and adjudicative functions in all disciplinary matters concerning their registrants. Disciplinary hearings are conducted by means of a formal inquiry conducted by a board. The fact that the boards exercise both these functions has attracted criticism from time to time with allegations that boards act as 'prosecutor, judge and jury'.

In the case of medical practitioners, the separation of the prosecutory and adjudicative functions already occurs in relation to serious disciplinary matters whereby the Medical Board takes action against the practitioner before the Medical Assessment Tribunal ('the MAT') established under the *Medical Act 1939*. The MAT is a court constituted by a Supreme Court Judge who sits with two medical practitioners who act as assessors.

In view of the formality and expense that can be associated with the conduct of proceedings before a body such as the MAT, it is inappropriate and unnecessary for all disciplinary matters to be dealt with by such bodies. Importantly, boards have indicated that the high legal costs involved with the formal inquiry process may influence their decision as to whether disciplinary action should be taken against a practitioner. This leads to the issue of whether there needs to be an informal and inexpensive process for the adjudication of less serious disciplinary matters.

The preferred position is that a three-tiered disciplinary structure be established for all registered health professions under review. This would involve the boards themselves, a single Health Practitioner Tribunal (HPT), similar to the MAT, and, in addition, each board would appoint Professional Standards Committees (PSC). Consistent with recent interstate models, the jurisdiction of these bodies would be based on the seriousness of the allegation, as follows:

- matters which may provide grounds for the deregistration or suspension of any registered health practitioner must be prosecuted before a HPT
- matters which would not be likely to provide grounds for deregistration or suspension of a registered health practitioner may be referred to a PSC
- matters which could be satisfactorily addressed through counselling or advising a practitioner would be dealt with by a board.

This three-tier model provides a flexible approach to disciplinary matters by enabling less serious matters to be adjudicated through a less formal, less expensive process than that adopted for the most serious matters.

Each tier of the disciplinary model is discussed briefly below and in further detail elsewhere in this Chapter.

The Health Practitioner Tribunal (HPT):

The HPT:

- would provide uniformity and consistency in relation to the adjudication of disciplinary matters across the regulated health professions
- would provide credibility and independence to the adjudication of disciplinary matters involving health practitioners
- would avoid the duplication of resources which may result from the establishment of separate adjudicative bodies for each health profession
- would effectively replace the MAT and not involve the establishment of additional tribunals
- could be given jurisdiction to deal with matters concerning the competence or conduct of health service providers from non-regulated occupations, if this was considered appropriate by the Government following investigation and report by the Health Rights Commissioner (Refer 4.4.5).

Professional Standards Committees (PSC):

- PSCs will provide a flexible and less formal process for dealing with professional standards issues which are less serious and would not constitute grounds for suspension or cancellation of registration.
- The focus of a PSC's interaction with a practitioner is intended to be relatively informal, collaborative and, where appropriate, rehabilitative. The types of orders able to be imposed by a PSC would reflect this focus, for example, orders in relation to undertaking supervised practice or training.
- Since suspension and cancellation of registration are the ultimate disciplinary sanctions with very serious consequences for the livelihood of registrants and the safety of the community, these sanctions should only be able to be imposed through the formal mechanism of the HPT which rigidly adheres to natural justice by a full separation of prosecutory and adjudicative functions and a right to legal representation.

Action by a registration board:

Registration boards will be empowered to direct a practitioner to attend before the board, or a committee or representative of the board, in order to receive counselling or advice, caution or reprimand, in relation to a professional standards issue which has been investigated by a board. Alternatively, the board may choose to provide its adjudication in writing to the practitioner.

This process will provide boards with a means of dealing with some types of less serious professional standards matters in a manner which involves minimal levels of intervention, formality and cost.

Because of the board's role in investigating and adjudicating these matters and the less formal focus of this tier of the disciplinary system, it is not proposed that boards would be empowered to impose sanctions on a practitioner. If any further action was considered necessary, the board would need to present the matter to a Professional Standards Committee or the Health Practitioner Tribunal.

4.5.2 Health Practitioner Tribunal — membership

In relation to the membership of any proposed disciplinary tribunal:

- it is appropriate that the chairperson be a member of the judiciary as this role is a quasi-judicial one requiring independence from government (ie. separation of powers); and on the grounds that the tribunal may often be required to deal with very difficult legal issues; and that the prosecuting body and the practitioner charged are likely to be represented by senior legal counsel (ie. Queens Counsel)
- it is essential that the membership includes membership from the same profession as the practitioner charged before that tribunal
- the inclusion of consumers on disciplinary bodies is consistent with recent models in other jurisdictions. For example, the Professional Conduct Committee established under the *Nursing Act 1992* includes a consumer representative. Medical tribunals in New South Wales and South Australia also have lay membership.
- membership of any disciplinary tribunal should also be such that it can be constituted to sit on a regular basis, if necessary. This factor is relevant given concerns about the infrequency of the current MAT sittings due to the MAT Judge's other commitments in the Supreme Court.

The preferred position is that a HPT is to consist of the following four members:

- a Supreme Court Judge OR District Court

Judge (as Chairperson) — to be finally determined after consultations

- two registered members of the same profession as the person charged before the HPT. These members should be selected by the chairperson from a panel appointed by the Governor in Council and nominated by the Minister. In doing so, the Minister is to have regard to the views of professional associations considered by the Minister to be representative of the profession concerned
- a consumer member selected by the Chairperson from a panel of persons appointed by the Governor in Council and nominated by the Minister. In doing so, the Minister is to have regard to the views of community organisations considered by the Minister to have an interest in health consumer issues.

Provision will also be made for one or more judges or retired judges to be appointed as deputy chairpersons to chair the tribunal in the absence of the chair.

Wherever possible, in constituting a Tribunal for particular cases, membership of the Tribunal should include a person of the same gender as the complainant.

4.5.3 Health Practitioner Tribunal — decision-making

The preferred position is to retain the current MAT decision-making arrangements, ie. questions of law or procedure should be determined solely by the judicial member who is chairperson and all other decisions are to be made by the Chair in consultation with other members of the Tribunal. The proposed decision-making process will ensure the active participation in the proceedings by all members and, at the same time, utilise the special expertise of the judicial member in formulating decisions.

4.5.4 Health Practitioner Tribunal — administration

The preferred position is that the HPT should have a separate registry/secretariat. The position of Registrar of a HPT should not be occupied by the Registrar of the Health Professional Registration Boards, as currently occurs with the MAT. This approach is necessary to ensure that the boards and the HPT are seen as independent and that there is no potential for a conflict of interest to arise through the Registrar performing dual roles. (See also section 2.10.1 regarding funding of disciplinary functions).

4.5.5 Health Practitioner Tribunal — matters involving health service providers from non-regulated occupations

The Health Rights Commissioner has indicated that he has received complaints of a serious nature against health service providers from non-registered occupations. Although the Commissioner has the power to investigate such complaints and may make recommendations to the provider, the Commissioner has no power to compel the provider to comply with those recommendations. The majority of these matters do not lend themselves to legal action and there is no other statutory process which enables these matters to be adjudicated and appropriate sanctions imposed. It has been suggested that a HPT could be an appropriate body to deal with such practitioners.

The preferred position is that further consideration be given to extending the jurisdiction of the HPT to unregistered health practitioners. It is proposed that the Health Rights Commissioner investigate and report on this matter to the Minister for Health, outlining the nature and extent of complaints received against health service providers from non-regulated occupations and containing recommendations as to any action necessary to protect the public. The Health Rights Commissioner is to consult with representatives of the non-registered health professions regarding recommendations on this issue.

4.5.6 Lapsed registrants

At present, registration boards are not able to proceed with disciplinary action against a practitioner whose registration has lapsed after a complaint has been made.

The preferred position is that the legislation provide boards with the capacity to take disciplinary action against former registrants for behaviour that occurred while they were registered. (Similar to s.40 of the NSW *Medical Practice Act*). This would address the problem of practitioners removing themselves from the register in order to avoid disciplinary action.

In addition, boards should also have the ability to make a finding that a practitioner would have been deregistered, suspended, or that (specified) conditions would have been imposed if they had been registered. This would allow these sanctions to be imposed in other States under the Mutual Recognition legislation. Boards will be required to notify interstate jurisdictions of disciplinary findings in respect of lapsed registrants. Since it is

impossible to impose the ultimate sanction of deregistration in the case of a practitioner who is not registered at the time of disciplinary action, a significant fine should be available in these cases.

4.5.7 Professional Standards Committees — Composition

The composition of Professional Standards Committees should also reflect a reasonable degree of functional separation from registration boards in order to ensure that the rules of natural justice are observed.

The preferred position is that:

- A PSC consist of three or four persons (one of whom may be a board member). Panels of persons suitable to serve on PSCs would be appointed by the Governor in Council on the recommendation of the Minister (who will have regard to the views of relevant community, educational and professional associations). A board would select panel members to serve on a particular PSC as the need arose. A PSC is to include:
  - — two registered health practitioners from the same profession as the practitioner appearing before the PSC
  - — a consumer

  and may also include:
  - — one other person (this optional position could be a practitioner, a consumer or a lawyer).
- A board is to appoint one of the committee members as chairperson of the PSC.

While the inclusion of a board member on a PSC may be seen by some as inconsistent with the principle of the separation of the *investigatory and adjudicative* functions, the model is sustainable on the grounds that:

- a PSC is limited to dealing with less serious matters and cannot impose suspension or deregistration orders
- board representation on a PSC will enable effective communication links between the board and the committee
- a right of appeal against PSC decisions can be made to an independent tribunal, the HPT
- the majority of PSC members will be independent from the board.

4.5.8 Appeals

Currently, practitioners may appeal disciplinary decisions of boards (other than the Medical Board) to a District Court Judge. The appeal is conducted by way of a re-hearing and the Judge's decision is final. Appeals from the MAT on questions of law or jurisdiction may be made by the Medical Board or the practitioner to the Court of Appeal. Complainants (that is, the consumers treated by the practitioner) do not have appeal rights.

The revised system for complaints and discipline under the new legislation will contain appropriate avenues of appeal which are equitable and accessible. ***The preferred position is:***

- Practitioners and the boards will have a right of appeal to a HPT from decisions of a PSC
- Applications by practitioners for restoration to the register following deregistration should also be made to a HPT
- Appeals from decisions of a HPT (on questions of law and jurisdiction only) may be made by the board or the practitioner to the Court of Appeal.

4.6 Disciplinary sanctions

The objective of the disciplinary process is the protection of the community not the punishment of practitioners. This objective is often not widely appreciated by complainants who sometimes seek punitive and/or compensatory outcomes.

The range of sanctions currently available to each of the registration boards is mainly limited to cancellation of registration, suspension of registration, reprimand, and/or a small fine (maximum penalties in the range of $1000-$2000). The Medical Board of Queensland may also 'counsel' a practitioner regarding professional conduct. In practice, this is often in the form of a letter to the practitioner. De-registrations and suspensions are ordered mainly in cases of serious misconduct or health problems (impairment).

Concerns have been expressed that, while at one end of the scale, disciplinary misdemeanours may not warrant suspension or deregistration, at the other end of the scale, a reprimand may be insufficient to bring about change in practitioner conduct. Registration boards have proposed that there be a broader range of sanctions available to bring about improvement in practitioner conduct. A more flexible approach involving an appropriate hierarchy of sanctions is clearly warranted.

The nature of the orders able to be imposed by the various bodies will be graduated in order to maintain consistency with the rules of natural justice. The underlying principle being that the more serious sanctions should only be available to bodies which provide an appropriate level of separation of prosecutory and adjudicative functions, and where necessary, provide adequate representation for the parties.

The preferred position is that sanctions, as set out in Table 3, be available to an adjudicative body.

Subject to legislation regarding penalties and sentences and the rehabilitation of offenders, in imposing disciplinary sanctions and orders, adjudicative bodies may have regard to previous offences and the degree of risk posed to the community. To support adjudicative bodies in determining disciplinary sanctions and orders to be applied, registration boards must provide all information (including confidential information) held by a board about a practitioner. Adjudicative bodies will also be required to have regard to submissions made by the board regarding the appropriate sanction in each particular case.

When imposing sanctions, adjudicative bodies will have discretion to determine whether or not certain information (that is, the nature of conditions, restrictions or limitations on registration) should be confidential (that is, not recorded on the Register) and, if recorded, the duration of time it should be recorded.

Table 3: *Sanctions to be available to adjudicatory bodies*

SANCTION	ADJUDICATIVE BODIES		
	BOARD	PSC	HPT
caution or reprimand	X	X	X
advice	X	X	X
counselling	X	X	X
require a practitioner to attend, at a specified time, to be counselled, cautioned or reprimanded	X	X	X
conditions, limitations or restrictions on registration fora period determined by the adjudicative body (failure to comply may, at the discretion of the board, result in prosecution for an offence against the Act, temporary suspension pending compliance and/or further disciplinary action)		X	X
payment of a financial security (at the discretion of the adjudicative body, but with a specified maximum) to accompany a practitioner's undertaking to comply with specified conditions within a specified time period (security to be automatically forfeited for non-compliance). Appeals may be made against the amount of the security and against forfeiture of security		X	X
require a practitioner to undertake a continuing professional educational activity, including an educational course of a kind determined by the adjudicative body, to complete it within a specified period, and to report to the board on completion of the activity		X	X
require a practitioner to report to a board within a specified period of time and in a specified manner regarding compliance with conditions imposed		X	X
require a practitioner to report on practice to a specified person or persons or committee of the board		X	X
require a practitioner to seek and take advice about management of their practice		X	X
order suspension of registration			X
order cancellation of registration and set conditions under which the person may reapply for registration			X
order payment of a fine or penalty (up to a specified maximum), to be paid within a specified time			X
impose other conditions as considered appropriate		X	X

Where a practitioner was registered at the time of the misconduct, but is not registered at the time of adjudication, the prescribed maximum fine in these circumstances should be *significantly* increased. This is in recognition of the fact that most disciplinary sanctions, with the exception of monetary penalties, have no impact on practitioners who are no longer registered.

4.7 Proceedings before disciplinary bodies

4.7.1 Proceedings generally

In accordance with the three-tiered disciplinary system proposed under the new legislation, it is intended that proceedings before a PSC will be conducted with as little formality and technicality as the case permits. Consistent with the New South Wales model, the practitioner and any complainant may be accompanied by a lawyer or other adviser during the proceedings, but not be represented by that person. A board, when presenting a matter before a PSC, may be assisted but not represented by a legally qualified person.

In conducting proceedings, ***the preferred position is*** that a PSC and HPT be enabled to:

- summon any person to attend hearings and to give evidence and/or produce documents
- inform itself of any matter as it thinks fit and need not be bound by the rules of evidence
- receive and admit as evidence, judgments and findings of any court (criminal or civil) or tribunal
- have regard to the special needs of witnesses.

Proceedings before a PSC will:

- minimise the legal expenses incurred by the presenting body and greatly reduce the extent to which the costs of proceedings influences decisions as to whether a disciplinary matter should be pursued
- be less likely to intimidate or disadvantage practitioners, complainants or other witnesses involved in the proceedings, in view of the informal and less adversarial manner in which the proceedings will be conducted
- enable disciplinary matters to be heard more expeditiously and with greater frequency than currently occurs with board inquiries
- by allowing a lawyer to accompany, but not represent a practitioner (or complainant), minimise the expense and formality of the proceedings while also ensuring compliance with the principles of natural justice. The right of attendance for complainants may enhance public confidence in the disciplinary process.

4.7.2 Natural justice

The principles of natural justice (requirements of procedural fairness) should be observed in the conduct of disciplinary proceedings. In some jurisdictions, specific legislative provisions require that these principles be observed by disciplinary bodies.

The preferred position is that the new legislation contain a specific provision requiring bodies adjudicating health practitioner disciplinary matters to observe the principles of natural justice. This will reinforce and emphasise the obligations on disciplinary bodies in this regard.

4.7.3 Standard of proof

Queensland Courts have ruled that the civil standard of proof should be applied in disciplinary proceedings involving health practitioners. Under the civil standard, the disciplinary body must satisfy itself, on the balance of probabilities, that the practitioner is guilty of the alleged misconduct. This standard is lower than that applied in criminal proceedings where the guilt of an accused person must be proved beyond reasonable doubt. However, under the civil standard, the more serious the charge against the practitioner, the higher the degree to which the disciplinary body must satisfy itself of the practitioner's guilt.

The preferred position is that the civil standard of proof should remain as the appropriate standard to be applied in disciplinary proceedings involving health practitioners.

4.7.4 Status of consumer/complainant during disciplinary proceedings

Under the current law in Queensland, consumers may take civil action against a practitioner, but may not bring a case for disciplinary action. Registration boards currently determine whether or not disciplinary action will be commenced, and the board brings the case regarding the practitioner before a disciplinary body. Consumers/ complainants may be called to give evidence during proceedings but are not regarded as a 'party' to the proceedings and thus do not have the status or rights of a 'plaintiff'.

The preferred position is that the following rights of complainants be enshrined in the new legislation:

- the right to attend disciplinary proceedings (of the board, PSC or HPT) arising from their complaint. (Where a complainant is to give evidence in the proceedings, they may not attend until after their evidence has been given, except at the direction of the Chair)
- the right to be given notice of date, time and place of the disciplinary hearing
- the right to be accompanied by a legal practitioner
- the right to receive a written statement of the disciplinary body's decision (including findings and reasons) within a specified period of time.

It is not proposed that complainants be parties to the proceedings or have a right of appeal.

It is also proposed that legislative provision be made to allow complainants to be accompanied by a person of their choice to provide emotional support during a hearing.

4.7.5 Complainant/witness needs

Section 21A of the *Evidence Act 1977* defines 'special witnesses' as including a child under 12, or a person who would be likely to suffer severe emotional trauma or be disadvantaged as a witness because of intellectual impairment, cultural differences or the likelihood that they would be intimidated. The current health practitioner legislation does not make provision for the needs of special witnesses in disciplinary proceedings.

There have been increasing numbers of disciplinary inquiries concerning sexually inappropriate conduct by health practitioners. Consumers have indicated reluctance to complain about such conduct, and/or acute distress about the disciplinary process when they do pursue complaints. Their concerns include seeing the accused practitioner during the hearing, explaining intimate details of their complaint in the presence of other people, and feelings of being 'put on trial', and/or 're-abused' during the proceedings. It is likely that some such consumers would, in other jurisdictions, be considered special witnesses.

In recognition of the needs of special witnesses, the *Evidence Act 1977* provides that courts may make orders to exclude the person charged from the room in which the court is sitting, or be obscured from the view of the special witness while they give evidence or appear in court for any other purpose. The court may also exclude other persons from the room while a special witness gives evidence or may permit special witnesses to give evidence in a room elsewhere from the court sitting room. Special witnesses may have approved persons with them to provide emotional support during the giving of evidence. Courts may also accept videotaped evidence instead of direct testimony from special witnesses. None of these provisions currently apply within the disciplinary provisions of any of the health practitioner Acts.

The preferred position is that the new legislation include provisions to recognise the needs of special witnesses. Provisions similar to the *Evidence Act 1977* and the *Criminal Law (Sexual Offences) Act 1978* are proposed.

It is also proposed that the HPT should, whenever possible, include a person of the same gender as the complainant.

4.7.6 Public access to disciplinary hearings

The majority of the registration Acts require that disciplinary hearings be closed to the public unless the board or the practitioner otherwise requires. With the exception of the Pharmacy Board which has a policy of open hearings unless there is a good reason to close them, boards and practitioners have traditionally opted for closed hearings. The *Medical Act 1939* provides that Medical Assessment Tribunal (MAT) hearings may be open if either party wishes them to be. As a matter of course, MAT hearing were always closed to the public until the MAT Judge ruled in 1994 that hearings should be heard in open court on public interest grounds.

The preferred position is that proceedings of the HPT be open to the public except in special circumstances where the disciplinary body is satisfied that the hearing, or part of the hearing, should be closed. Disciplinary proceedings of the PSC are to be closed.

It is considered that this approach balances the right of the public to know about the most serious matters and the desirability of taking an informal approach to less serious matters. It was considered that open public hearings for PSCs would be inconsistent with the informal approach sought for such bodies.

4.7.7 Costs

Currently, under the non-medical registration Acts, where a board finds that a practitioner is guilty of a charge, it may order the practitioner to pay the costs of the proceedings and may determine the amount of costs to be paid. The *Medical Act 1939* does not specify whether the MAT has the power to award costs against the Medical Board or the practitioner concerned.

The preferred position is that a Health Practitioner Tribunal be empowered to award costs, including investigation costs of the board Professional Standards Committees will not be empowered to award costs since the majority of matters considered before PSCs will involve less formal procedures.

4.8 Information on disciplinary findings

4.8.1 Publication of findings

Under the current legislation, some, but not all, of the non-medical health practitioner registration Acts give boards a discretion to publish findings which result from disciplinary inquiries. The amount of information a board is entitled to publish is unclear and there is no statutory guidance as to the circumstances under which a board should order publication. In the case of medical practitioners, details of disciplinary sanctions are entered in the register or otherwise published **only** when a practitioner has been deregistered or suspended by order of the MAT.

The preferred position is that the new legislation require boards to:

- maintain a publicly accessible record of disciplinary decisions and reasons for matters which are heard in public. In the case of matters which are closed to the public, the information kept would be non-identifying information. Information would be available for inspection without charge, with charges to be applied for photocopying

and give boards discretion to:

- include non-identifying information about disciplinary actions (including decisions and reasons) in regular circulars to all registrants
- publish non-identifying disciplinary outcomes in public newspapers.

This proposal is not intended to restrict publication of identifying information (by the press, for example) where the matter is heard in public, although adjudicative bodies would be empowered to make orders suppressing the names of all parties until a determination has been made and be required to order suppression of the names of complainants unless the complainant wishes otherwise.

Boards will be encouraged to provide registrants with information about consumer rights and complaints resolution mechanisms with annual renewal notices.

4.8.2 Exchange of disciplinary information with professional associations and others

Under the current legislation, there are no mechanisms requiring registration boards to notify professional associations, specialist colleges or relevant Government agencies of disciplinary sanctions imposed on registrants. In contrast, s.119 of the *Health Rights Commission Act 1991* provides that the Commissioner may give a report of an investigation about a health practitioner to the practitioner's employer; a professional association of which the provider is eligible to be a member; the Minister; or 'any person or body that has a function or power to take action on matters raised in the report'.

The preferred position is that boards may give notification of disciplinary sanctions against registered practitioners to any one or more of the following bodies:

- registration authorities in any other jurisdiction
- specialist colleges of which the practitioner is a member or is eligible to be a member
- professional associations of which the practitioner is a member or is eligible to be a member
- an employer of the practitioner
- the Health Insurance Commission
- the Minister
- any other relevant body which a board considers appropriate in the public interest.

It is also proposed that boards be empowered to participate in national database registers with other registration authorities.

To complement this process, it is also proposed that the courts have the discretion to notify registration boards when a practitioner is found guilty of an offence.

5. IMPAIRMENT

5.1 General

Impairment is a diminished capacity to practice, usually because of a physical or mental condition or disorder. The most common causes of doctor impairment in Australia are reduced competence due to ageing, psychiatric disorder, cerebrovascular accidents and brain damage, alcohol abuse, other drug abuse, unstable insulin dependent diabetes and other chronic disorders associated with intermittent altered states of consciousness.

There is no uniform approach to 'impairment' across the existing health practitioner legislation. The legislation tends to focus on either 'medical fitness' or 'mental illness', rather than the broader concept of impairment. The *Medical Act 1939* is the only legislation under review which defines impairment, although the comprehensiveness of that definition has been challenged.

The statutory processes for dealing with questions of fitness to practice also vary. The *Dental Act 1971* and the *Optometrists Act 1974* have no provisions to deal with 'medical fitness'. The effect of the current provisions in the other non-medical registration Acts is to prevent a focus on rehabilitation. Some registration Acts require impairment to be dealt with through the disciplinary process.

Existing legislative provisions do not incorporate a flexible process which would give boards discretion in appropriate circumstances to initially adopt an informal and cooperative approach with a practitioner, rather than the formal approach of appearance before a health assessment panel.

The preferred position is that the new legislation contain a comprehensive definition of impairment, based primarily on the *Medical Act 1939*, with appropriate substitutions, for example:

- a person is considered to suffer from impairment if the person has a physical or mental impairment, disability, condition or disorder that detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to practice [their profession]
- substance abuse is considered to be a physical or mental disorder.

5.2 Process to deal with impaired practitioners

A model for the management of practitioner impairment should provide boards with powers to act promptly when necessary to protect the public, while also supporting a rehabilitative, non-coercive and non-punitive process. The model should provide for informality and cooperation in the initial stages and should recognise that impaired practitioners have health rights.

The preferred position is that the following processes for the management of impaired practitioners be provided for in the new legislation:

- boards may receive, from any source, information which indicates a registrant may not be fit to practise due to a health impairment
- a board has discretion to act on information, including powers to immediately suspend a registrant where extraordinary circumstances warrant, for example, to protect life, health or safety of patients/clients (refer section 2.2). If the registrant is suspended, the matter is immediately referred to a Health Assessment Panel (see below).

Phase I

- if suspension is not warranted, the board undertakes (by delegation) a prompt, preliminary, informal assessment, for example:
  - verification of information (for example, from informant and others)
  - collection of other relevant information, if any (for example, from treating practitioner, family, colleagues or others)
  - contact with the registrant to discuss informally (notification is made to practitioner of the concerns, but no disclosure of source of information or identity of informant without the informant's consent), and/or
  - where appropriate and where registrant agrees, arrangement for medical/physical/psychiatric/psychological examination of practitioner (the practitioner is also to receive a copy of the report/s, except where disclosure may have a detrimental effect on their physical or mental health).
- the board considers all information (including health reports) and determines appropriate course of action and must seek the registrant's agreement to a course of action. This may include an agreement to:

  - suspension for a period of time until their health or condition improves
  - obtain appropriate health care, counselling, etc.
  - restrict or limit practice for a period of time
  - abide by conditions of practice suggested by the board.
- the board will have powers to accept voluntary undertakings regarding rehabilitation and regarding conditions, restrictions or limitations on practice.
- if the registrant agrees to a course of action, the board will have powers to monitor the situation, for example:
  - receive reports from the registrant
  - receive reports from the treating practitioners (registrant also receives copies of reports, except where it may have a detrimental effect on their health).
- if a practitioner agrees, but then fails to comply with conditions etc the board may immediately suspend the registrant and refer the matter to a disciplinary hearing (the registrant having been forewarned of this possible course before agreeing to the undertaking).

Phase II

- if the registrant refuses to participate in preliminary assessment, and/or does not agree to a course of action recommended by the board, the board may immediately suspend the registrant and must immediately appoint a Health Assessment Panel to conduct an inquiry into the matter. The registrant is formally notified of this action.
- when appointing the health assessment panel, the board may also exercise powers to:
  - require the registrant to undergo medical, physical, psychiatric, or psychological examination/s (the registrant may also arrange and undertake other health examination/s and provide reports to the panel)
  - require the registrant to attend meeting/s with the Health Assessment Panel on specified date/s and time/s (the registrant may be accompanied by a lawyer or other adviser during proceedings before the Health Assessment Panel, but not be represented by that person).
- if the practitioner fails, without reasonable excuse, to attend an examination or to otherwise participate in the assessment process, the board may immediately suspend the practitioner until the practitioner agrees to participate. (Note: In New South Wales, a medical practitioner who does not participate is deemed to be impaired).
- at the conclusion of assessment, the Health Assessment Panel reports to the board on its findings as to the nature and extent of the practitioner's physical or mental impairment. The practitioner is notified of the findings and may make a submission to the board.
- after receiving the panel's report, the board then has powers to:
  - restore the practitioner's registration status
  - suspend the practitioner for a specified period of time and, upon review, either restore the practitioner's registration or suspend for a further period of time
  - order the practitioner to undertake counselling or other appropriate rehabilitation
  - impose conditions (including supervised practice) on registration in situations where the practitioner could practise safely in some but not all circumstances
  - impose other conditions to ensure continuing fitness to practise
  - require regular health reviews or other relevant reports to monitor the practitioner's progress.
- the board notifies the practitioner of its decision and the reasons for its decision
- the practitioner may appeal to the HPT against the board's decision.

5.3 Health Assessment Panels

As the panels are established to provide an independent technical assessment of a practitioner and report to the board, ***the preferred position is*** that Health Assessment Panels maintain a degree of independence from the board. However, because of the close involvement and expertise of board members in issues related to protection of the public, it is proposed that Health Assessment Panels may include one board member. Panel members will be under a statutory obligation to maintain confidentiality. A panel is to be appointed by a board and comprise at least two persons including:

- a medical practitioner

- a member of the practitioner's profession

and may also include:

- any other person considered by the board to be appropriate for the circumstances

only one of whom may be a board member.

5.4 Information on impairment

5.4.1 Confidentiality of registrant health information

In order to preserve the confidentiality of health information about a practitioner disclosed to a Health Assessment Panel, ***the preferred position is*** that the new legislation prohibit the unauthorised disclosure of confidential information in a similar manner to s.139(2) of the *Nursing Act 1992* or s.138(1) of the *Health Rights Commission Act 1991.*

5.4.2 Statutory protection for practitioners making a notification

The preferred position is that statutory protection be provided to any person who, in good faith, gives a board information regarding an impaired practitioner. The provision of information under these circumstances will not constitute a breach of confidence. It is also proposed that it be an offence to take any reprisal against a person who, in good faith, provides information to a board.

5.4.3 Mandatory notification

A mandatory obligation on practitioners to notify a board of suspected impairment could be seen as an intrusion into the right to privacy of practitioners which is not imposed on other citizens. Effective enforcement of such a provision would also be difficult, for example, it would be necessary to establish, beyond reasonable doubt, that a practitioner was aware of a fellow practitioner's impairment and knew that the impairment was affecting the practitioner's capacity to practise.

The preferred position is that there should be no statutory compulsion to report registrants suspected of impairment to boards. However, non-statutory approaches (for example, practitioner education and professional development) should be used by boards to encourage notification by registrants and it is anticipated that voluntary notifications by health practitioners may increase as practitioners develop more confidence in the board's approach to impairment issues.

The Health Rights Commissioner will be obliged to immediately refer to the board any complaint which suggests a practitioner may be impaired.

The legislation will also provide that notification to a board of an impaired practitioner will not contravene provisions relating to confidentiality of patient information contained in the *Health Services Act 1991* (Section 62).

6. BUSINESS AND COMMERCIAL ISSUES

6.1 Background

In Queensland, as in other jurisdictions, ownership and associated business arrangements of health professionals' practices have been subject to extensive regulation. The registration Acts place a varying range of controls on the respective professions which influence the way in which practitioners conduct their practices and business arrangements. These controls, which differ substantially between the professions, include:

- restrictions on ownership of practices by non-registrants
- constraints on the formation of business 'associations' with non-professionals or members of other professions
- prohibitions on incorporation
- board approval of business, partnership or company names
- requirement to notify the board of changes in business structures.

The original intention of these controls was to safeguard against potential conflicts of interest between commercial and business concerns, and a practitioner's professional obligations to clients. The current legislation endeavours to prevent unethical activities such over-servicing, fee splitting and the payment of commissions from patient referrals through placing controls on the involvement of non-professionals in the business ownership arrangements of a practice.

The following table illustrates the main types of commercial controls contained in the current legislation:

Table 4: *Current commercial controls — Registered health professions*

Profession	Type of Control					
	Registrant only ownership & no provision for incorporation or company structures	Registrant only ownership with provision for company ownership provided all company members are registrants	Company structure with controlling interest by registrants	Practice in own name or in association of like practitioners with practice name approved by board	Company name only approved by board	No statutory controls
Pharmacy**	X					
Optometry		X				
Chiropractic & Osteopathy			X			
Dental Technology & Prosthetics			X			
Occupational Therapy				X		
Speech Pathology				X		
Podiatry*				X		
Psychology					X	
Medicine					X	
Dentistry					X	
Physiotherapy						X

* *The* Podiatrists Act *also contains a specific provision prohibiting the opening of a podiatry practice by a person who is not a podiatrist.*
** *The* Pharmacy Act *limits the number of pharmacies in which a pharmacist may have a pecuniary interest to four.*

6.1.1 Ownership of health practitioner businesses

The primary commercial control in the current legislation is in relation to the matter of who may own or have a pecuniary interest in a health practice. Controls range from extremely tight restrictions in the case of pharmacy, to no statutory controls in physiotherapy.

In some professions, ownership is not a significant issue. However, in pharmacy and optometry, it is an issue of major concern to the profession due to the longstanding nature of the current regulatory controls and a belief that standards of care may decline if those controls are to be removed. Some organisations within the medical and dental professions are also advocating the introduction of limitations on the levels of non-practitioner ownership in their professions, despite the current absence of extensive statutory controls in the respective registration Acts.

The key issue to be resolved is whether, on public health and safety grounds, it is necessary to limit the ownership of health practices to registrants and whether there is any evidence to suggest that public health would be compromised by removal of current restrictions. Some professional associations assert that restrictions are in the public interest on the basis that:

- unrestricted ownership will lead to excessive commercialisation and lower quality services to the public
- there is a danger of undue commercial influences on the clinical practice of professionals which may lead to over-servicing and other unethical practices such as secret commissions and kickbacks
- it is simpler and less costly to discipline or prosecute a registrant for improper conduct as opposed to a company
- the current system works reasonably well.

In response to these arguments, other respondents to the review have submitted that ownership restrictions are an indirect and often ineffective mechanism for ensuring against undesirable corporate behaviour. Ownership restrictions pre-suppose differing standards of behaviour by different occupational groups and between professionals and non-professionals. It has been suggested that a more direct approach would be to make specific types of undesirable corporate behaviour the subject of effective offence provisions which would apply to both registrants and non-registrants.

Some consumer and business interests maintain that current ownership restrictions only serve to protect and insulate professionals from exposure to competition and that these restrictions have become a longstanding and firmly entrenched part of the culture of some professions.

6.1.2 Ownership of pharmacy and optometry practices by non-practitioners

All Australian jurisdictions, with the exception of the Northern Territory, currently place extensive restrictions on the ownership of pharmacies.

Under the *Pharmacy Act 1976*, ownership of pharmacies is restricted to registered pharmacists. A pharmacist may not own or have a pecuniary interest in more than four pharmacies. The legislation also restricts pharmacists from incorporating their businesses. (The only statutory exemptions to these restrictions are registered Friendly Societies and individuals who were outside these arrangements before commencement of the Act).

Similarly, the *Optometrists Act 1974* restricts ownership of optometry practices to registered optometrists. However, an incorporated body may own an optometry practice provided that all directors and shareholders are optometrists. There is no statutory restriction on the number of practices in which an optometrist may have a pecuniary interest.

The peak bodies representing these professions, as well as many individual practitioners, are vigorously opposed to any removal of the current ownership restrictions. In the case of pharmacy, it has been argued by pharmacists that the ethical and legal responsibilities of registered pharmacists make it imperative that pharmacists not be subject to the control and direction of non-pharmacists in the conduct of their profession and that:

- where a pharmacist owns the practice, he or she is in control of, and responsible for, all policy and management decisions. Non-pharmacist owners would have little or no knowledge of drugs and their associated problems and dangers
- if control and management is vested in unregistered persons, there will be a reduction in ethical practices whereby social accountability will be subordinate to the profit motive
- responsibility for improper actions can be more readily pinpointed when ownership resides with pharmacists

- relaxation of ownership controls would lead to vertical and horizontal integration of pharmacies and a possible reduction in the total number of pharmacies (ie ownership by drug companies and retail chains).

The opposing viewpoint, advocated by peak retail groups and some operators of larger pharmacies, is that ownership does not need to be restricted provided that management of the pharmacy and the performance of professional functions such as dispensing of drugs is under the control of a pharmacist.

It has also been advocated that blanket prohibitions on certain business structures and ownership arrangements have tended to provide only illusory protection against unethical practices. The potential for fraudulent or unethical behaviour exists regardless of the type of company or ownership structure through which health services are delivered. In addition to providing only partial and indirect remedies against unethical behaviour, it has been argued that current prohibitions serve to deny the professions and the public of the potential advantages which may accrue from the ability to use alternative structures for the delivery of health services.

These groups also claim that removal of ownership restrictions will allow for:

- restructuring of the retail pharmacy industry resulting in greater competition and reduced costs for pharmaceutical products
- innovation and efficiency in service delivery through an expansion of the types of retail pharmacy outlets available to the public
- more efficient business structures through wider access to potential sources of investment capital.

A somewhat similar situation applies in optometry, although the restrictions on the degree of non-professional ownership are not uniform in all the States. The peak professional body representing optometrists opposes the reduction of ownership controls which would allow optometrical practices to be owned by large optical dispensing groups. It is implied that large commercial owners could put pressure on employee optometrists to concentrate their practice on the high volume prescription of optical devices, and place less emphasis on less profitable practices such as the detection of ocular disease. At present, optical dispensing groups can only supply optical devices on the prescription of an optometrist (or ophthalmologist) not associated with the company.

Optical dispensing companies want to be able to operate a 'one stop shop' service whereby the public can undergo an eye examination, obtain a prescription for spectacles or contact lenses, and have the prescription dispensed in the one store. Independent optometrists are currently able to offer this service since many optometrists also perform their own dispensing. However, optical dispensers are currently unable to employ optometrists to provide such services.

6.1.3 National Competition Policy

Queensland's participation in the micro-economic reform process associated with National Competition Policy requires that existing regulatory restrictions of an anti-competitive nature be reviewed and reformed where necessary prior to the year 2000. Under the Inter-Governmental Competition Principles Agreement entered into between the Commonwealth and the States, anti-competitive provisions within legislation may be retained only in cases where it can be clearly demonstrated, through a transparent process, that the benefits to the community of restricting competition outweigh the costs.

The need to examine the current ownership and commercial restrictions applying to several of the health professions was highlighted by the Independent Committee of Inquiry into National Competition Policy (Hilmer Report 1993). The March 1995 report of the Industry Commission to the Council of Australian Governments (COAG) also specifically identified ownership restrictions in the health professions as anti-competitive and as contributing to higher costs for some services.

6.2 Future ownership arrangements

In order to achieve the necessary reforms in the business and commercial aspects of the legislation, ***the preferred position is*** that the following arrangements would apply to all registered health professions under review with the exception of **pharmacy** and **optometry** which are currently subject to the highest levels of practice ownership restrictions and for which special arrangements, as detailed further on, would apply:

- The registration Acts would contain no statutory restrictions on practice ownership or corporate structures for companies or associations providing health services to the public by registered health practitioners.
- Company and business names will be notified to a board (rather than approved by the board),

so that boards may be aware of the affiliations of individual practitioners with particular practices.

- Company directors/governing bodies will be required to ensure that appropriate procedures are in place to ensure against discreditable conduct by employees or other company members (for example, unauthorised disclosure of patient records by staff employed in health practices). This provision would be similar to the current s.25A of the *Chiropractors and Osteopaths Act 1979*.
- It will be an offence for company directors/governing bodies to engage in conduct or policies resulting in, or likely to result in, undue adverse influence on the professional independence or clinical decision-making activities of practitioners employed in the provision of health services to the public by the company.
- If a company or its employees or agents contravene a provision of the Act, each person who is a director of the company or a person concerned in the management of the company will be taken to have committed an offence under the legislation if that person knowingly authorised or permitted the contravention.
- In making its decision, a Court may determine that a person who is convicted or found guilty of an offence against the Act may not be eligible to be a director of a company health care practice. This proposal will entail a direct or indirect amendment to the qualification and disqualification provisions of directors under the *Corporations Law*. In view of the fact that the *Corporations Law* emanates from the national scheme for Corporations Law, it will be necessary to seek the views, and the consent if necessary, of the Ministerial Council for Corporations (MINCO).
- Penalties for company offences as outlined above will be set at a similar level to penalties for false and misleading representations under the *Fair Trading Act 1989* (maximum penalty 2000 penalty units ie. $120,000).

In the case of **pharmacy** and **optometry**, the following arrangements will apply:

- Ownership of pharmacies and optometry practices will continue to be restricted to registrants of the respective profession or associations of persons, incorporated or unincorporated, comprised exclusively of registrants (this will enable pharmacists a limited capacity to incorporate their businesses).
- An exemption to these provisions will continue to apply to allow the continued operation of Friendly Societies Pharmacies, although current provisions which restrict the expansion of pharmacies operated by Friendly Societies will remain.
- The number of pharmacies in which a pharmacist may have a pecuniary interest will continue to be limited to four.
- Provisions relating to offences by companies will be as per arrangements previously outlined for the other professions.
- As the pharmacy and optometry ownership arrangements are considered to restrict competition, their retention at this point will necessitate these arrangements being included in the Legislative Review requirements under National Competition Policy. This requires all States and Territories to develop a timetable by June 1996 for the review and, where appropriate, reform of all legislation that restricts competition by the year 2000).
- Given the existence of similar arrangements in the other States, the Queensland Government will consider seeking a coordinated review of pharmacy and optometry ownership arrangements once the protocols for such reviews are determined under National Competition Policy.

The Government's proposed approach to the regulation of ownership of health practitioner businesses will substantially reform current arrangements while also enabling further specific consideration of this issue at a national level in those professions where longstanding regulatory controls are in place in most or all jurisdictions.

6.3 Advertising by health practitioners

The registration Acts currently place varying controls on advertising by registered health professionals. These controls, which differ across the professions, include prescriptive regulations in relation to:

- the type of medium which can be used for advertising
- the size, style and content of signs, nameplates, entries in newspapers, directories and stationery
- the frequency with which entries can be inserted in the print media
- canvassing or soliciting

The effect of these controls is that many of the professions are prevented from providing non-technical information to consumers on matters such as the price of services, availability of bulk billing, after-hours access, languages spoken, and access and special facilities for people with disabilities.

A further effect of these current controls is that registration boards have been required to devote considerable time and financial resources to dealing with complaints and prosecutions in relation to advertising. A survey of complaints on all matters considered by five registration boards over a one year period (July 1993 - June 1994) indicated that, of the total number of 81 complaints received, 54 (or 66 per cent) related to advertising matters. Almost all of these complaints about advertising were made by practitioners about other practitioners.

Very few submissions to the review favoured the continuation of prescriptive controls in relation to the size, style, content and medium etc of advertising by registered health practitioners. It has been pointed out that considerable controls in relation to false, misleading or deceptive advertising already potentially exist under the Queensland *Fair Trading Act 1989*.

Consumers, registration boards or other parties currently have the right to refer advertising complaints to the Office of Consumer Affairs. The Commissioner for Consumer Affairs, as an independent party, can assess whether there are sufficient grounds to proceed with the prosecution of an offence under the *Fair Trading Act 1989*.

Substantial penalties are available under the *Fair Trading Act 1989* for making false or misleading representations in relation to the supply of goods or services (maximum penalty — 400 penalty units, that is $30,000 for individuals and 2000 penalty units, that is $150,000 for corporations). Other remedies available under that Act include:

- injunction restraining a person from carrying on a business
- injunction requiring a person to take specified remedial actions such as disclosure of information or the publication of advertisements to remedy any adverse consequences
- compensation and other remedial orders, including orders for payment of damages, directing refunds of money and directing the supply of specified services.

Under s.88A of the *Fair Trading Act 1989*, Codes of Practice can be prescribed as regulations under the Act. These regulations may prescribe a Code of Practice for fair dealing between a particular type of supplier and consumer, or by a particular type of person in relation to consumers. Although a breach of a Code of Practice does not constitute an offence under the *Fair Trading Act 1989*, other remedies under the Act, such as injunctive relief and orders for compensation, can be invoked for breaches of a code.

Given the powers of the Commissioner for Consumer Affairs, a key issue for resolution during the review has been the extent to which registration boards should continue to be involved in the control and monitoring of advertising by registered health professionals. While there has been widespread agreement over the need to reduce prescriptive advertising controls, the professions and the public have indicated an expectation that registration boards continue to exercise some jurisdiction over professional advertising.

The preferred position is to retain the involvement of registration boards in monitoring advertising, but only as it relates to clinical practice matters. Health practitioner legislation would contain a general prohibition on advertising which is:

- false
- misleading
- deceptive
- harmful

in relation to clinical practice matters.

Advertising of this nature would be an offence against the Act and would be subject to a similar level of penalties as found in the *Fair Trading Act 1989*, that is:

- maximum penalty of 400 penalty units ($30,000) for individuals and 2000 penalty units ($150,000) for corporations
- provision for injunction to restrain a person, business or company from advertising in a particular manner
- injunction requiring a person or company to take specified remedial actions such as disclosure of information or the publication of notices to remedy incorrect information.

As with other offences against the Act, these matters would be determined in the courts.

In order to add further clarity to the intent of the legislation, it could cite examples of the types of advertising which is regarded as false, misleading or harmful for the purposes of the Act, for example:

- advertising which falsely alludes to the outcomes of treatment

- falsely claiming a special area of practice expertise.

The proposed approach to advertising would be in addition to and not in derogation of the *Fair Trading Act 1989*. Under new health practitioner legislation, registration boards will maintain an appropriate degree of professional oversight of health practitioner advertising, yet unnecessary controls which have little positive benefit from a consumer perspective and which have tended to restrict the availability of information to the public will be removed.

7. REGULATION OF PRACTICE

7.1 Use of professional title

In Queensland, as in other jurisdictions, one of the principal statutory controls in health practitioner legislation is the restriction on the use of professional titles (for example, only a registered speech pathologist may use the title 'speech pathologist'). This control is considered important because it is one of the primary means by which the public can discriminate between registered and non-registered providers of health services.

Due to the age of the current legislation and changes in terminology within the health professions, some of the professional titles which are currently afforded statutory protection are no longer commonly used within the professions or by the general public.

The preferred position is that only commonly used titles (including titles used interstate and former professional titles such as 'chiropodist') be protected. The new legislation will contain an offence provision targeting anyone who falsely states or implies they are a member of the profession by use of the professional title. Under this proposal, protected titles would be as currently prescribed for all professions except physiotherapists, occupational therapists, dental prosthetists and medical practitioners.

The titles 'physiotherapist', 'physical therapist' and 'occupational therapist' will be the only titles protected for those professions. (Titles such as 'ergotherapist', 'functional therapist', 'physical therapeutist' and 'electrotherapist' will no longer be protected). The titles 'medical practitioner', 'physician', 'doctor' (with the exceptions outlined below) and 'surgeon' (or any derivatives, except dental surgeon) will be restricted to registered medical practitioners.

In recognition that chiropractic and osteopathy are separate professions, the titles 'chiropractor' and 'osteopath' should not be joined unless the registrant is registered in both professions. The title 'denturist' will also be restricted to dental prosthetists, although 'dental prosthetist' will continue to be the preferred title of the profession.

Use of the term 'consultant' will not be restricted as at present. All practitioners may use the term 'consultant' regardless of whether they hold specialist registration. This approach acknowledges that the term 'consultant' is widely used in the business world and that its special

meaning in the health context is little understood by the general community.

The use of all protected titles will be restricted to registrants, with the exception of 'doctor' (see below).

7.2 Use of Title 'Doctor'

Use of the title 'doctor' as an academic title has traditionally been confined to persons with the tertiary qualification of Doctor of Philosophy (PhD) or other doctorate qualification. Use of this title is currently restricted under the *Education (General Provisions) Act 1989* to holders of such a qualification.

By common usage, the title 'doctor' has also been adopted as a 'courtesy title' for medical practitioners. The *Medical Act 1939* enables medical practitioners to use the title 'doctor' and restricts use of the title by others (the relevant provision was inserted in 1955).

The *Dental Act 1971* [s.16(14)] state that a registered dentist may use the courtesy title 'doctor' provided it is followed by the words, 'dentist', 'dental surgeon' or 'dental practitioner'.

The courtesy title 'doctor' is also frequently used by chiropractors. Before chiropractic training was available in Australia, many chiropractors obtained the qualification of 'Doctor of Chiropractic' (DC) from a US College. There is no statutory authority in Queensland for chiropractors who do not hold doctorates to use the title 'doctor'. Some jurisdictions permit chiropractors to use the title, with varying limitations.

Submissions from some psychologists, chiropractors and physiotherapists have argued for the formal extension of the use of the courtesy title 'doctor' to those professions. Health consumer groups have indicated a preference for limiting the use of the title on the grounds that it creates a status barrier between consumers and practitioners and its wider use by other professions has the potential to cause confusion about the qualifications and types of service provided by a practitioner.

The preferred position is that the new legislation prohibit use of the title 'doctor' by all health practitioners other than:

- medical practitioners
- dentists
- those who have attained a PhD or other doctorate.

Dentists and any health practitioner (except a medical practitioner) claiming the title 'doctor' (that is, having a PhD) must also indicate their profession, for example, Dr J Smith, Dentist.

This approach reflects the current legislation for medical practitioners and dentists, but clarifies that other health practitioners with doctorates may claim the title. This approach will prohibit chiropractors without doctorates from using the title 'doctor'.

7.3 Regulation of practices by non-registrants

In Queensland and throughout Australia, the principal statutory controls in health practitioner legislation are:

- restrictions on the use of professional titles (as discussed above)
- prohibitions on who may practise the profession (for example, only pharmacists may practise 'pharmacy', as defined in the Act).

Additional statutory controls may include:

- restricting the use of particular procedures or equipment (for example, the therapeutic use of electricity is restricted to physiotherapists under the *Physiotherapists Act 1964*)
- specific limitations on the practice of registrants (for example, optometrists may not use surgery; physiotherapists may not prescribe drugs or medicine for internal use; dental prosthetists may not supply and fit a partial denture without an oral health certificate).

While all the Acts under review limit the use of professional titles, restrictions on practice vary considerably across the professions, as shown in Table 5 on the following page.

Table 5: *Current legislative restrictions on practice*

Legislation	Practice restricted to registrants
Chiropractors and Osteopaths Act 1979	Yes
Dental Act 1971	Yes
Dental Technicians and Dental Prosthetists Act 1991	Yes
Medical Act 1939	No
Optometrists Act 1974	Yes
Occupational Therapists Act 1979	No
Pharmacy Act 1976	Yes
Physiotherapists Act 1964	Yes
Podiatrists Act 1969	Yes
Psychologists Act 1977	No
Speech Pathologists Act 1979	No

Significantly, restrictions on the practice of medicine, under the *Medical Act 1939*, are minimal and the more recently regulated professions, such as psychology, occupational therapy and speech pathology, do not restrict practice to registrants.

7.3.1 Why is the practice of medicine not restricted to medical practitioners?

It could be considered paradoxical that the practice of medicine, the most potentially harmful of all the professions if practised by an unqualified person, is not restricted to medical practitioners, while the practice of other professions is tightly controlled. The absence of statutory restrictions on the practice of medicine is due to:

- strong community and professional understanding of the types of matters which require the services of a medical practitioner (which therefore reduces the need for statutory controls)
- the perceived effectiveness of other statutory controls over potentially harmful elements of medical practice (such as prescribing of drugs)
- effective controls over the employment of non-registrants in medical officer positions in hospitals and other institutions
- the legislative difficulty of satisfactorily defining the practice of medicine in a way which does not prohibit the legitimate activities of other professions and private citizens. Many people undertake activities which might come within a definition of the practice of 'medicine', (for example, 'diagnosing' an illness).

7.3.2 Defining and restricting practice

The distinction between a statutory 'definition' of practice and statutory 'description' of practice needs to be emphasised. A 'description' endeavours to comprehensively describe what the profession does in order to inform interested persons of the nature of the profession. In contrast, a 'definition' need not comprehensively describe the profession's scope, instead it defines practice *for the purposes of the Act*. The definition is used to restrict 'practice', as defined.

For most of the Acts under review, a statutory definition of the profession's 'practice' is used to prohibit practice by non-registrants. For example, the *Chiropractors and Osteopaths Act 1979* defines 'chiropractic and osteopathy' as:

> *the manipulation, mobilisation and management of neuromusculoskeletal system of the human body.*

Under this Act, it is an offence for anyone other than a chiropractor, osteopath, medical practitioner or physiotherapist to practise chiropractic and osteopathy (as defined).

Drafting workable definitions (for the purposes of restricting practice) which do not unnecessarily overlap with the legitimate scope of practice of other professions (registered and unregistered) has proved very difficult. For example, a previous government was unable to develop a workable definition of the practice of psychology and instead opted to restrict use of the professional title only. Attempts at defining the practice of psychology created significant controversy in the late 1970s during the passage of the *Psychologists Act 1977*.

Statutory definitions of the practice of the manipulative professions, in particular, is extremely difficult. In terms of current statutory definitions and clinical practice, there is overlap between the professions of physiotherapy, chiropractic, osteopathy and massage. Some nursing and podiatry duties also come within the current definition of physiotherapy.

A further difficulty with defining and restricting practice concerns the issue of enforcement. There are considerable difficulties in proving, to the satisfaction of a Court, that someone has 'practised a profession', particularly if the individual has not

attempted to use a protected professional title.

Where practice is restricted, legislation often contains exemptions for medical practitioners and other prescribed professions. The fairness and effectiveness of this approach, which assumes the exempted professions are safe to practice, has been challenged. Some groups have argued that competency, rather than professional qualification, should be the basis for exemption.

Restricting a broad 'scope of practice' to a narrow range of practitioners could be considered anti-competitive. In light of the National Competition Policy reforms, anti-competitive provisions are justified only to the extent that they achieve some broader public interest, such as the protection of the community from harm. Restricting a broad area of practice to one practitioner group has been identified as having a number of undesirable effects:

- it restricts consumers in choice of health care providers — not all activities undertaken by health professions have potential to cause significant harm, and other groups may be able to provide certain services more cheaply and just as effectively
- it prevents professions who may be in competition with the registered profession from expanding their scope of practice
- it inhibits the growth of new professions
- it suppresses the creation of new and possibly more innovative ways of providing health services, particularly in settings such as hospitals and community centres, which could result in increased service provision and lower costs.

7.3.3 Ontario model

In Ontario, Canada, the anti-competitive effects of statutory controls have been significantly reduced through an innovative approach which restricts only the practice of harmful activities, rather than the entire scope of a profession's practice. The legislation details a list of 'licensed acts' which are restricted to specified professions. The Ontario model also prohibits harmful acts generally if they are outside the profession's 'scope of practice'. The effect of the Ontario model is to permit non-registered practitioners to provide health services which are not harmful, but which may, nevertheless, come within the scope of practice of a registered profession.

The Ontario legislation took many years to develop and its effectiveness has not been adequately tested. Significantly, the approach arose out of extensive consultation with regulated and unregulated groups. Twenty-three health professions are registered in Ontario.

7.3.4 Regulation of Core Practices

The reality of health services delivery is that professions evolve, treatment modalities change, and new practices and new professions emerge. New legislation must not only address current demarcations, but must be sufficiently flexible to cater for further evolutions in the delivery of health services. Recommendations regarding the approach to regulation of practice must have regard to these realities.

Given the difficulties of the conventional approach to the regulation of practice, ***the preferred position is*** that a new statutory method, involving regulation of 'core restricted practices' be used to protect the public.

Rather than using a statutory definition to restrict a broad scope of practice, it is proposed that certain 'core restricted practices' be restricted to specified professions only. It will be an offence for any person who is not a member of a specified registered profession to undertake a core practice.

Table 6 outlines the model in principle. However, the precise definitions of core practices will be resolved following further consultation, including responses to this draft policy paper. Submissions on the detail of the model are particularly encouraged.

In presenting this model it is understood that there are a diversity of views regarding some core practices (for example, the practice of surgery below the dermis by podiatrists and the use of "tissue conditioning" by dental prosthetists). However, it should be emphasised that decisions in relation to the identification and definition of core practices will be taken only after receipt of extensive technical advice from all the relevant professions, having regard to submissions made on this Paper, in particular.

Table 6: *Proposed core practices*

Core practice	Registered professions
Performance of any operation upon the natural teeth and their associated parts	Dentist Dental auxiliary under delegation from dentist Medical practitioner
Providing (ie. fitting or dispensing) a dental prosthesis *(NB. The ability of a dental prosthetist to fit or dispense partial dentures will be conditional — refer Section 7.4.2)*	Dental prosthetist Dentist Medical practitioner
Professional dispensing of medicines, mixtures, compounds and drugs* *(NB. This provision is not in derogation of the Poisons Regulation)*	Pharmacist Any other person authorised by the Pharmacy Board
Prescribing of optical appliances for the correction or relief of visual defects and the fitting of contact lenses	Optometrist Medical practitioner
Moving the joints of the spine beyond a person's usual physiological range	Chiropractor Osteopath Physiotherapist Medical practitioner
Soft tissue surgery and nail surgery of the foot	Podiatrist Medical practitioner Nurse
Surgery (not otherwise restricted above)	Medical Practitioner Other authorised person**

* *The core practice of professional dispensing of drugs is not intended to extend current regulation of the practice of pharmacy. For example, the dispensing of substances by naturopaths would not be restricted as a result of this approach.*

** *Submissions are sought on the professions (or categories of professions) which require authorisation to practice surgery and on the preferred process for authorisation (eg. should the Medical Board determine applications from non-medical practitioners for authorisation to practice surgery).*

Exemptions to the above restrictions will apply for students and others undergoing training under the direct supervision of a registered practitioner.

7.3.5 Regulation of other practices

In addition, ***the preferred position is*** that the Governor in Council will have the power to make Regulations restricting other practices not considered to be 'core practices', in the public interest. Such matters could include, for example, the therapeutic use of electrical equipment (which could be restricted to physiotherapists, chiropractors, osteopaths, podiatrists and medical practitioners if it could be demonstrated that such restrictions are in the public interest). Subordinate legislation of this kind would require public consultation and the notification of a regulatory impact statement as mandated under the *Statutory Instruments Act 1992*.

7.3.6 Enforcement of core practice offences

Enforcement of restrictions on practice and other statutory offences is currently undertaken by the boards irrespective of whether the offence pertains to a registrant or a non-registrant.

The relatively small numbers of prosecutions in recent years may indicate that illegal practice is not a significant regulatory problem. ***The preferred position is*** that inspection and prosecution of illegal practice by non-registrants continue to be a responsibility of registration boards. However, the legislation will provide that any person (ie. a private individual, organisation or Government Department), could initiate an action in relation to a core practice offence.

Very substantial penalties would apply for illegally undertaking a 'core practice'.

7.3.7 Delegation of practices

The ability of registered practitioners to delegate practice tasks to non-registrants varies widely across the Acts under review. The issue of appropriate delegation is essentially a professional standards matter for determination by the respective professions.

The preferred position is:

- inappropriate delegation of practice tasks would, effectively, be grounds for disciplinary action (refer section 4.3.1) and
- guidance as to appropriate delegation of practice tasks could be included in Codes of Practice developed or adopted by boards (refer section 4.3.3).

7.4 Regulation of oral health practitioners

7.4.1 Regulation of operative dental auxiliaries

The major issues regarding operative dental auxiliaries are the appropriateness of the duties currently prescribed by the Dental Board and the extent of supervision/direction and control that must be provided by dentists. There is a wide divergence of views regarding the appropriateness of the current arrangements. Three main options were considered as a means of addressing this issue.

One approach would be to require the Dental Board to develop, in consultation with representatives of operative dental auxiliaries, a new list of appropriate duties for dental auxiliaries for inclusion in the legislation. Operative auxiliaries would be required to work under the oversight of a dentist, leaving the dentist to determine the appropriate level of oversight having regard to the task which has been delegated. A difficulty with this option is that consensus may not readily emerge regarding appropriate duties. This approach is highly prescriptive and has inbuilt obsolescence and rigidity.

An alternative approach would be to leave undefined the duties of operative dental auxiliaries in legislation. Dentists would have authority to delegate tasks to dental auxiliaries in accordance with good professional practice and judgement. Dentists will also determine the appropriate level of oversight having regard to the task which has been delegated. This option acknowledges that dentists are properly able to delegate tasks and that professional judgement should underpin any decision regarding delegation and oversight. Inappropriate delegation or inadequate oversight would provide grounds for disciplinary action against a dentist. This approach provides greater flexibility regarding the duties of auxiliaries and reinforces a flexible team approach to dentistry. This approach also avoids the conflict that will be inherent in any attempt to define appropriate duties.

A third option, representing the middle ground, would involve dentists determining the duties and delegations of/to the auxiliaries in their employment having regard to a Code of Practice developed by the Board. The Code would be a guide to good practice in disciplinary proceedings.

The preferred position is to implement the third option.

7.4.2 Oral health certification and provision of partial dentures

Dental prosthetists are currently prevented from supplying and fitting a partial denture unless the oral health of the patient has been certified by a dentist or medical practitioner. This provision was intended to address concerns that a dental prosthetist was not qualified to recognise oral pathology which might be exacerbated by a partial denture. It is understood that the provision was to sunset five years after the commencement of the Act because it was assumed that an appropriate training course and appropriate continuing education courses would be available by that time. It has been suggested that few dental prosthetists have undertaken appropriate education in physiology or oral pathology. Significantly, the education course for dental prosthetists has not yet been developed in Queensland.

The preferred position is that the requirement to obtain an oral health certificate continue to apply to any registrant who has not successfully completed appropriate training in this area, including training in oral pathology.

This option supports the view that formal training and continuing professional education is essential, and that only registrants who have undertaken such should be exempt from the certification requirements.

7.4.3 Controls on the employment of dental hygienists

The *Dental By-law 1988* currently regulates the employment of dental hygienists by dental practitioners. Under this law, a dentist must obtain

oard approval to employ a dental hygienist and ay only employ one hygienist per dentist.

onsistent with other recommendations in this aper, ***the preferred position is*** to remove he statutory controls on the employment of dental ygienists. If necessary, the Dental Board could evelop a Code of Practice regarding supervision dental hygienists.

7.5 Supervision of pharmacies

Section 32 of the *Pharmacy Act 1976*, in effect, requires a pharmacist to be present in the pharmacy at all times when it is open for business, except for no more than an hour between noon and 2 pm. ***The preferred position is*** that this remain at this time.

7.6 Controls on the practice of registrants — offences against the Act

The legislation under review imposes a wide range of limitations/controls upon the practice of registrants. Non-compliance with these controls is an offence against the relevant Act which may be prosecuted in a Magistrates Court. The nature of these restrictions and the corresponding offence provisions vary considerably from one profession to another. Some of the current controls include restrictions on:

- practising in a name other than the one on the register
- practising under business names without board approval
- advertising, canvassing, soliciting, and using qualifications other than those recorded on the register
- association with (including employment by) practitioners who canvass or solicit
- delegation of tasks and permitting practice by non-registrants.

Other specific restrictions/controls on practice of registrants include:

- prescribing drugs (*Physiotherapists Act 1964*, *Chiropractors and Osteopaths Act 1979*)
- performing surgery (*Optometrists Act 1974*, *Chiropractors and Osteopaths Act 1979*)
- supplying and fitting a partial denture without certification of oral health (*Dental Technicians and Dental Prosthetists Act 1991*)
- performing dental technical work without the prescription of a dentist, medical practitioner or dental prosthetist (*Dental Technicians and Dental Prosthetists Act 1991*)
- leaving a pharmacy unattended during prescribed hours (*Pharmacy Act 1976*)
- having a pecuniary interest in more than four pharmacies (*Pharmacy Act 1976*)
- selling drugs by mail-order without approval of the board (*Pharmacy By-law 1985*)
- making or accepting payment for referral of clients (*Dental Act 1971*)
- employing a dental hygienist without the approval of the board (*Dental By-law 1988*)
- employing more than one dental hygienist per dentist (*Dental By-law*).

Many of these provisions, which are currently dealt with as offences against the Act or By-laws, are either no longer appropriate or are better addressed through disciplinary mechanisms. The *Medical Act 1939* uses an extended definition of the term 'misconduct in a professional respect' (the principal ground for disciplinary action under that Act) to regulate practice by registrants. Some of the practice behaviours caught by that extended definition include:

- certification of a document in any professional capacity where the contents of the document are untrue, misleading or improper
- assisting or enabling any person to treat a patient in circumstances where the health of the public or an individual has been or is likely to be endangered by such conduct
- making a payment to, or accepting a payment from, another practitioner or any person for a referral
- failing to notify the police under certain circumstances
- failure of a pharmacist to be present on premises during reasonable operating hours of the pharmacy.

The preferred position is that boards continue to be responsible for regulation of the practice of registrants including prosecution of statutory offences (under registration legislation). Leaving aside offences related to registration, renewal and disciplinary procedures, significant practice offences under the new legislation will include:

- failure to comply with conditions on practice, including breach of undertaking
- failure to disclose to consumers a personal or pecuniary interest in a health service to which they refer or recommended to a consumer
- failure to advise an employer of conditions on practice (unless the board consents to withholding information on the grounds that it is not relevant to the employer)
- making or accepting any payment or consideration from a practitioner to whom a consumer is referred or recommended
- certifying any document in any professional capacity where the contents of the document are untrue, misleading or improper
- contravention of advertising restrictions
- falsely claiming a specialty
- falsely claiming to meet the board's continuing professional education requirements
- practising in a name other than name on the register.

In addition, where services are provided by companies and partnerships, it will be an offence to fail to notify the board of the company name and the names of directors.

It will also be an offence for a person who employs a registrant to:

- engage in conduct or policies resulting in, or likely to result in, undue adverse influence on the professional independence or clinical decision-making of employee health practitioners
- fail to have policies and procedures in place to ensure against unprofessional conduct by employees (similar to Section 25A of the *Chiropractors and Osteopaths Act 1979*).

7.7 Inspectorial powers

Offences against the Act are prosecuted in a Magistrates Court on the application of the board. In order to present evidence in support of its case that an offence has been committed, a board must gather evidence through use of its inspectorial powers. [This is distinct from the investigative process associated with a disciplinary inquiry conducted by the board, (refer section 4.4.3)].

Notwithstanding the separate nature of these processes, the inspectorial powers required by boards for investigation of alleged offences against the Act are similar to the investigative powers used during a disciplinary hearing.

The preferred position is that provisions relating to the powers of inspectors appointed by registration boards for the investigation of alleged offences against the Act by registrants be similar to those provided for the investigation of disciplinary matters (refer section 4.4.3) that is:

- Boards may appoint any person, other than a board member, to be an inspector. An inspector may investigate, on behalf of a board, any matter concerning an alleged offence against the Act.
- Boards will be required to issue an identity card to each inspector. The inspector must produce the card before to exercising any statutory powers of investigation.
- Inspectors should have the power to:
  - require a person to provide information or documents (subject to the usual right of protection from self-incrimination)
  - require a person to verify information or documents by affidavit
  - enter and search premises, and seize evidence (with the consent of the occupier of the premises or on the execution of a warrant)
  - seek the assistance of a police officer.

8. OTHER ISSUES

8.1 Regulation of hypnosis

The *Psychologists Act 1977* limits the practice of hypnosis to psychologists, medical practitioners and dentists, whether or not those practitioners have been trained in hypnosis, and to others authorised by the Psychologists Board. Few people other than psychologists have been authorised by the board, and it would appear that this process has fallen into disuse, since no approvals to practice hypnosis have been given since the 1980s. However, there are a large number of unauthorised people practising hypnosis in Queensland. A perusal of advertising material would indicate that the number could exceed 200.

The Psychologists Board has been reluctant to prosecute unauthorised practitioners of hypnosis because of perceived problems of sustaining a prosecution due to difficulties with the definition of hypnosis. This has also been an issue in other jurisdictions.

The extent to which the practice of hypnosis is potentially harmful has been the subject of considerable debate:

- overseas and recent interstate models of regulation are increasingly taking a non-statutory approach to the regulation of hypnosis
- various interstate inquiries have not supported the regulation of hypnosis (eg Victorian Social Development Committee, Working Party Report to Conference of Australian Health Ministers, NSW Government investigation)
- complaints data from interstate and locally indicate few complaints about hypnosis. Although clearly within the Health Rights Commission's jurisdiction, no complaints have been made to the Commission regarding the practice of hypnosis by unauthorised practitioners.

Submissions to the review suggested that deregulation of hypnosis would enable a broader range of practitioners in the health and caring professions (eg nurses, physiotherapists, occupational therapists, social workers, counsellors) to incorporate hypnosis into their work. This is consistent with the recommendations in the report of the Social Development Committee of Victoria.

Consideration has also been given to the fact that there are analogies between hypnosis and other techniques which are not regulated (eg. Eye Movement Desensitisation and Reprogramming [EMDR]).

Associations representing lay practitioners of hypnosis have informed the Government they have made substantial progress towards the development of a model for industry self-monitoring, including the establishment of a peak body to coordinate and monitor competency standards and codes of practice.

The preferred position is that existing controls within the *Psychologists Act 1977* over the practice of hypnosis be repealed. In addition, it is proposed that an amendment be made to the *Health Rights Commission Act 1991* to specifically state that the practice of hypnosis is a health service for the purpose of that Act and that complaints may be made to the Commission regarding hypnosis. The Health Rights Commissioner shall keep the Minister informed regarding trends in complaints about practitioners of hypnosis.

8.2 "Repressed memory therapy"

Some submissions to the review expressed concerns about the practice known as "repressed memory therapy", in particular that persons may be wrongfully accused and prosecuted as a result of 'false' memories having been induced.

"Repressed memory therapy" is commonly associated with the practice of hypnosis, whether practised by registered practitioners (such as psychologists) or alternative practitioners (such as some hypnotherapists). The Health Rights Commissioner has indicated that all complaints received to date about the use of "repressed memory therapy" have been about its use by registered psychologists. It is understood that the Australian Psychological Society has recently developed a Code of Practice concerning use of "repressed memory therapy" by psychologists.

The Director of Public Prosecutions (DPP) in Queensland has also recently developed stringent guidelines (based on those proposed by a New Zealand Court of Appeal) which must be complied with before hypnotically induced evidence of 'recovered memories' may be tendered as evidence in court public prosecutions.

The preferred position is that there be no regulation of "repressed memory therapy", but that complaints about this mode of treatment be monitored by the Health Rights Commission and

the HRC report to the Minister regarding trends in those complaints.

It has been proposed elsewhere (refer section 7.3.5) that the Governor in Council will have powers to restrict specific practices in the public interest. Should the government decide, at some point in the future, that this practice should be restricted, this avenue is available. Regulation in this manner is not recommended at this time as the DPP's guidelines are considered to provide adequate safeguards.

8.3 Regulation of counselling

Counselling and psychotherapy are conducted by a wide range of registered and unregistered practitioners, including social workers and clergy. The practices of counselling and psychotherapy are not subject to specific statutory controls in Queensland or elsewhere in Australia.

A proposal to regulate the practice of psychology (including counselling) in Queensland generated significant controversy in 1976 and was abandoned by the Government of the day. The resulting legislation restricted use of the title 'psychologist' but did not prohibit the practice of psychology by non-registrants.

Community concerns about unregulated counsellors and psychotherapists are unlikely to be appropriately dealt with by regulating the titles 'counsellor' and 'psychotherapist' under the *Psychologists Act 1977*.

The preferred position is that the Health Rights Commissioner investigate the adequacy of existing consumer protection mechanisms in regard to counselling and other services of this kind as this is an area where the public appear to be demanding greater controls.

8.4 Use of psychological tests

The psychology attachment to the 1994 Discussion Paper sought views on whether use of psychological tests should be restricted and the criteria which should be used to distinguish those tests which may only be safely used by psychologists.

The psychology profession has longstanding expertise in the administration and interpretation of psychological tests. Testing is used in assessing intelligence, personality, neurological or cognitive function. Many tests used by psychologists are also used by other professionals such as guidance officers, psychiatrists and educationalists.

The profession of speech pathology uses testing in a similar manner to psychology. It is noteworthy that the Australian Health Ministers Advisory Council (in considering the potential for harm arising out of practice by non-registrants) was not persuaded to regulate speech pathology, despite the profession's roles in testing.

The use of psychological tests has never been restricted by statute in Queensland. The majority of other states do not restrict the use of psychological tests, Victoria and Tasmania being the exceptions. The initial restriction on the use of psychological tests in Victoria in 1965 was part of a broader move to outlaw certain practices of the Church of Scientology which used psychological tests as a tool to recruit members.

In practice, the supply and distribution of psychological tests is self regulated in Queensland. The Australian Council of Educational Research (ACER) restricts the sale of tests to registered psychologists. Some areas of the profession have advocated that new legislation should 'enforce their [the publishing companies] policy' after the tests have been purchased. This would, presumably, be by making it an offence against the Act to administer or interpret a 'restricted' test. Submissions from the psychology profession have expressed concern that, in Queensland, there is currently no legislative power to enforce ACER's policy and, therefore, no means of restricting the distribution of a test once it has been purchased. However, if the public are already adequately protected by a self-regulatory approach to the sale of psychological tests, it is difficult to justify additional legislative controls.

The preferred position is to not introduce statutory restrictions on the use of psychological tests.

8.5 Ready-made spectacles

Concern has been expressed by some elements of the optometry profession concerning the potentially harmful effects of ready-made spectacles being available through pharmacies and other retail outlets. It has been argued that the ready availability of such items could cause people to defer seeking professional eye examinations and, thereby, increase risks to ocular health.

As the issue essentially concerns a safety argument over a particular product, it is considered that the professional registration Act is not the appropriate vehicle to regulate the supply of these items, if such regulation is necessary.

The preferred position is that submissions in relation to this matter be referred to the Commonwealth's Therapeutic Goods Administration for consideration as to whether the supply of ready-made spectacles requires further regulation.

8.6 Medical call services

The *Medical Act 1939* and the *Medical Call Service By-laws 1984* regulate the operation of medical call services. A "medical call service" is defined as any practice, method or arrangement whereby a medical practitioner arranges that a patient needing or desiring medical attention during the practitioner's absence, will be attended by another practitioner other than a locum tenens. A medical call service cannot be conducted without a certificate of approval from the Medical Board. The issue of a certificate is conditional upon the Board being satisfied that:

- there is a medical director responsible for the conduct of the service
- the service is to be operated in an approved area determined by the Board by reference to the number of proposed principals, population and size of area
- the headquarters for the service contains an area of rest for the practitioner on duty and has suitable facilities for carrying out minor surgery
- the service has an adequate number of practitioners, adequate transport and support services and a two-way radio system.

A medical director is required to reside within the approved area, to supervise the service and ensure that:

- the medical services provided are restricted to patients of the principal (the practitioner whose practice is serviced) although medical attention will not be refused to any patient who has no regular practitioner or in emergency situations
- proper medical records are kept
- the care of patients is passed back to the principal concerned or to another practitioner
- standing arrangements are maintained with appropriate hospitals for the admission and treatment of patients.

Medical call services are prohibited from operating between 8am and 6pm on weekdays other than Saturdays (public holidays excepted) and 8am and 12 noon on Saturdays.

Medical call services in Western Australia are subject to similar controls, but are not regulated in other States.

The preferred position is that specific legislative controls on the operation of medical call services be removed. General advertising restrictions that apply in relation to medical practices will also apply to medical call services. The rationale for this approach is that:

- Deregulation of medical call services is unlikely to have any effect on the degree of protection provided to the public. Issues concerning the competence and professional conduct of medical practitioners owning, operating or employed by a medical call service can be appropriately dealt with through the exercise of the Medical Board's registration and disciplinary functions. Similarly, unethical conduct by non-medical practitioners owning or operating a service will be caught by the appropriate offence provisions (refer section 6.2).
- It is anomalous for the conduct of medical call services to be regulated when similar controls are not seen as necessary for the conduct and operation of medical practices generally.
- It is more appropriate for the obligations imposed on medical call services to be dealt with on a contractual basis between the practitioner who engages the service and the operator of the service.
- This approach is consistent with the approach taken in relation to medical call services in most other States.

The Medical Board may, if thought necessary, develop a Code of Practice as a guide for the operation of medical call services.

8.7 Mandatory reporting obligations of medical practitioners

Various Queensland statutes impose obligations on medical practitioners to report certain matters to an appropriate authority where specified information or circumstances come to their attention.

Examples of reporting obligations imposed on

medical practitioners include:

- Where a practitioner prescribes a dangerous drug for the treatment of a patient for a period greater than two months or for the treatment of a drug dependent person, the practitioner must notify the Chief Health Officer of those circumstances (*Poisons Regulation of 1973*, regs M1.01 and M3.01).
- Where, upon examining or treating a patient, a practitioner believes the patient is suffering from a notifiable disease, the practitioner must give notice thereof to the Chief Health Officer (*Health Act 1937*, s.32A).
- Where a practitioner suspects on reasonable grounds the maltreatment of a child in such a manner as to subject or be likely to subject a child to unnecessary injury, suffering or danger, the practitioner must, within 24 hours after first so suspecting, notify a person authorised by the Chief Health Officer (*Health Act 1937*, s.76K).
- A practitioner must notify the Coroner of any death which occurs in suspicious circumstances (*Coroners Act 1958*, s.13)

The failure of a medical practitioner to inform the police:

- of any information received which indicates the commission of a crime
- when the practitioner is called to treat any wound which the practitioner is not satisfied was accidentally caused

constitutes misconduct in a professional respect (*Medical Act 1939* s.35).

It has been suggested that, if all statutory reporting obligations of medical practitioners were included in the *Medical Act 1939*, practitioners' awareness of their obligations would be enhanced.

The Office of the Parliamentary Counsel has advised that it would be inappropriate for all legislative provisions imposing reporting obligations on medical practitioners to be transferred to the *Medical Act 1939*. The specific nature of many of the reporting requirements in the various statutes are not directly related to the objectives of the *Medical Act 1939*.

The preferred position is that statutory provisions imposing reporting obligations on medical practitioners remain in those statutes in which they are currently located, rather than be incorporated into revised health practitioner legislation.

If it is considered necessary to enhance the medical profession's awareness of its reporting obligations, this could be achieved by the Medical Board distributing a document outlining these obligations to all registrants.

8.8 Accreditation of intern training hospitals

Before receiving general registration as a medical practitioner, an applicant must successfully complete a period of internship or supervised training required by the Medical Board (*Medical Act 1939*, s.17).

The relevant period of internship must be undertaken at an intern training hospital accredited by the board.

In exercising this role, the board acts upon recommendations made by the Postgraduate Medical Education Committee (PGMEC) of the University of Queensland. The board has representation on the PGMEC.

While the board issues accreditation certificates to the relevant training hospitals, the accreditation process is substantively undertaken by the PGMEC which receives annual funding from the board in the sum of $200,000 for this purpose. The PGMEC has developed detailed accreditation guidelines and an accreditation program to enable it to review progress made by training hospitals in implementing the recommendations contained in these guidelines.

The concept of the accreditation of intern training hospitals is supported as a means of maintaining and improving the standard of intern training programs. It is also appropriate for the board to satisfy itself that an intern training program is acceptable for the purpose of enabling a graduate to be registered.

However, despite the board's current practice in this area, there does not appear to be any statutory power under the *Medical Act 1939* for the board to accredit intern training hospitals.

The preferred position is that there be no statutory power conferred on the Medical Board for the accreditation of intern training hospitals. The legislative requirement for the completion of a period of internship would specify that the internship must be undertaken at a hospital accredited by the PGMEC or by such other body prescribed for this purpose.

8.9 Surgical procedures to save a life

Subject to certain exceptions, it is unlawful for medical treatment to be rendered to a person without that person's consent. One exception is the common law doctrine of necessity which enables treatment of an urgent and life-saving nature to be given without the patient's consent.

Section 52 of the *Medical Act 1939* constitutes another exception to the general rule. The section authorises the performance of a surgical procedure in a hospital or institution to save or prolong the life of a patient where the patient is incapable of consenting by reason of a mental disability and no relation is reasonably available to consent. The Medical Superintendent or medical practitioner in charge of the hospital or institution is authorised to consent on behalf of the patient save where he or she is the practitioner attending the patient in question.

It is unclear whether s.52 is intended to apply in cases where a patient requires emergency treatment and whether the term 'mental disability' includes a state of unconsciousness.

Section 52 suggests that a patient's relative has authority to provide consent to medical treatment on behalf of a patient who is incapable of consenting. However, a relative of an adult patient cannot provide a legally binding consent in respect of medical treatment rendered to that patient.

The Queensland Law Reform Commission, in its draft report titled '*Assisted and Substituted Decisions: Decision-making by and for people with a decision-making disability*', recommended that legislation be enacted to:

- authorise a person to appoint a decision-maker to make certain decisions (including to consent to certain types of medical treatment) if the person's decision-making capacity is impaired
- establish an Assisted and Substituted Decisions Tribunal with functions including the making of certain health care decisions for persons with impaired decision-making capacity.

Subject to finalisation of government policy regarding guardianship legislation and assisted and substitute decision-making, ***the preferred position is*** that a Medical Superintendent or other medical practitioner in charge of a hospital or other institution be authorised to consent to the performance of a medical procedure to save or prolong life in circumstances where the patient is incapable of consenting as a result of mental disability (including unconsciousness).

The appropriateness of locating this power in an Act concerned with the registration of medical practitioners has been questioned. It may be more appropriate for legislative provisions relating to this issue to be included in other legislation such as that proposed by the Queensland Law Reform Commission dealing with consent to medical treatment and assisted and substitute decision-making. The future location of this type of provision will be resolved in consultation with the Office of the Parliamentary Counsel.

8.10 Prescribing rights — notification of Queensland Health information

Medical practitioners, dentists, optometrists and podiatrists have privileges under the *Poisons Regulations 1973*. However, there is no statutory mechanism for Queensland Health to notify registration boards of:

- a practitioner's contravention of the *Health Act 1937* (including *Poisons Regulations 1973*)
- when a practitioner's prescribing rights have otherwise been withdrawn or restricted by the Chief Health Officer.

These circumstances usually arise from a practitioner's self-administration of a dangerous drug or from improperly prescribing for drug dependent persons. Withholding information of this kind from the boards inhibits the institution of appropriate disciplinary or impairment proceedings in order to protect the public.

If boards were advised about changes to prescribing rights, they could consider whether disciplinary or impairment proceedings were required. If, as a result of those proceedings, a sanction (including conditions on practice) was recorded against the practitioner, boards in other States could be notified under the *Mutual Recognition Act 1992*. Restriction or withdrawal of prescribing rights is not a disciplinary sanction imposed by the board and, therefore, cannot be notified to boards in other states under mutual recognition arrangements. Consequently, a practitioner who has prescribing restrictions imposed in Queensland may move interstate and practise without restrictions.

Currently, under some circumstances, notification to registration boards is likely to contravene Section 62 of the *Health Services Act 1991*.

The preferred position is:

- Queensland Health be required to notify the

relevant board where it formally commences proceedings against a registrant for any offence against the *Health Act 1937* or other Act administered by the Minister.

- Queensland Health will be required to notify the relevant board of any modifications to the prescribing rights of a registered health practitioner.
- Health practitioner legislation will provide an exemption from the confidentiality provisions (Section 62) of the *Health Services Act 1991* for the purpose of providing information to a registration board.
- Withdrawal of prescribing rights or other limitations imposed by the Chief Health Officer under the *Health Act 1937* will be recorded on the register.

8.11 Mandatory disclosure of interests in health services

It is regarded as unethical for medical practitioners to refer patients to institutions or services in which the practitioner has a financial interest without full disclosure of such interest. (AMA Code of Ethics).

In some Australian jurisdictions, legislation mandates disclosure of such interests. For example, the South Australian *Medical Practitioners Act 1983* requires practitioners who have, or whose close relatives have, an interest in a hospital or nursing home, to disclose to the Medical Board prescribed details concerning that interest within 30 days of acquiring that interest. Such practitioners are prohibited from referring a patient to that hospital or nursing home unless that interest has been disclosed to the Medical Board and the patient.

Mandatory disclosure of personal or financial interests to the client is in the public interest as it:

- promotes the principle that decisions to refer clients should be based solely on the practitioner's professional judgment and not be influenced by the practitioner's personal or financial interests
- ensures that the client has an opportunity to choose not to be referred to the particular health care service or institution as a consequence of the disclosure being made by the practitioner.

While most cases requiring disclosure are likely to involve referrals by medical practitioners, inter-professional referrals (for example, between dentists and dental prosthetists) as well as between practitioners from the same profession can occur in circumstances where the duty of disclosure would arise.

The preferred position is that where a health practitioner or close relative of that practitioner has a personal or pecuniary interest in any heath care service (including sole practitioner) or institution, that practitioner must, before referring a person to that service or institution, disclose particulars of that interest to the person. It would be an offence to fail to inform the client and successful prosecution of the offence could provide grounds for disciplinary action.

8.12 Employer obligations

Consistent with the provisions of the *Nursing Act 1992*, ***the preferred position is*** that employers of registered health practitioners have the following obligations regarding employment of such practitioners:

- to ensure that an employee is registered at the time of employment
- to notify the registration board if they are not satisfied that an employee is registered.

8.12.1 Employment of medical practitioners

The preferred position is that the current prohibitions on the employment of non-registrants as medical practitioners in hospitals and other health institutions be retained.

8.13 Board advice to the Minister regarding privileges under health legislation

Various aspects of practice undertaken by health professionals are subject to other health legislation apart from the registration Acts (for example, the *Health Act 1937*).

The preferred position is that registration boards be empowered, through the relevant legislation, to advise the Minister on the suitability of registrants (or classes of registrants) for privileges which may be conferred under legislation administered by the Minister for Health (such as prescribing rights under the *Poisons Regulation 1973*.)

For the purposes of formulating advice, the boards will have the power to require information from registrants. Where the advice relates to an

individual registrant (rather than a class of registrants), a right of reply to adverse comment is to be available. It is to be noted that the role of the board is advisory only.

8.14 Mandatory display of registration certificate

The Discussion Paper on this review referred to the suggestion that practitioners be required to prominently display certificates of registration. It was anticipated that such certificates would include some or all of the information on the register.

Mandatory display of registration or practising certificates is not required in any of the most recent health practitioner legislation in Australasia (for example, Qld *Nursing Act 1992*, NSW *Medical Practice Act 1992*, Victorian *Medical Practice Act 1994*, or the New Zealand *Medical Practitioners Bill 1994*).

In practice, many health practitioners do, in fact, display their initial certificate of registration. This certificate commonly shows the practitioner's name, registration number, date of initial registration and qualifications. However, there is no uniform legislative requirement in Queensland for the issuing of registration certificates on an annual basis. The common procedure is for a certificate to be issued when a person first becomes registered, and for receipts to be issued on payment of annual renewal fees. Therefore, any changes to registration status after initial registration (such as, imposition of conditions, limitations or restrictions on practice) do not appear on a practitioner's registration certificate.

Even if annual certificates were to be issued, the problem of policing and enforcing a legislative requirement to display certificates would arise. It is considered that the cost of regularly inspecting health care premises to ensure registration certificates are displayed is not warranted.

Some practitioners regularly practice in more than one location, and some practice in settings where it would not be feasible for every registered practitioner to display a certificate (such as hospitals).

The preferred position is that the display of registration certificates not be mandatory. However, registration boards could encourage registrants to display certificates wherever practicable.

8.15 Hygiene and infectious diseases

The issue of roles and responsibilities in ensuring that health practitioners' premises and equipment meet acceptable standards of hygiene was canvassed in the discussion papers. The question was raised as to whether the Registration Acts should be the means through which such requirements are regulated.

The broader issue of infection control practices across a wider range of community settings (that is, not just limited to health practitioner environments), was also canvassed in the recently released discussion paper on New Population Health Legislation for Queensland, as part of the review of the *Health Act 1937*.

The proposal put forward in that discussion paper is that a new *Population Health Act* should contain a requirement for a designated range of risk environments (including health practitioner practices) to have recognised infection control protocols in place. The legislation would provide for the recognition of existing codes and protocols developed by responsible professional bodies.

The proposal to include such requirements within a new *Population Health Act* rather than the Registration Acts is supported.

8.16 Practitioner records — abandoned

Sections 67-71A of the *Medical Act 1939* give the Medical Board power to deal with medical records that have been abandoned. The object of the provisions is to ensure that the confidentiality of patients' medical records is preserved. The provisions are not concerned with the financial records of a medical practice.

None of the other health practitioner registration Acts contain provisions relating to abandoned health records.

It is essential that an effective mechanism exists to preserve the confidentiality of health records that have been abandoned. The boards are considered to be the appropriate bodies to be conferred with the necessary powers and responsibilities in relation to abandoned health records.

The preferred position is that all boards should have specific powers to ensure the safeguarding of abandoned patient records relating to health services provided by a registrant.

Boards' powers in relation to such records should include the power to:

- take possession of the records and, for this purpose, an inspector/investigator appointed by a board may exercise the relevant powers of entry, search and seizure conferred under the registration Acts
- require that the records be retained in the possession of a practitioner or other person subject to conditions or be transferred to a practitioner or other person
- authorise the destruction of the records if satisfied the retention of the records is unnecessary.

A board must deliver records held by it to a claimant if satisfied the claimant is entitled to possession of the records.

A board's powers may be exercised in relation to the records of a deceased practitioner with the consent of that practitioner's personal representatives or beneficiaries.

8.17 Mandatory professional indemnity insurance

Some health professional organisations and registration boards have suggested that indemnity insurance should be a requirement for registration. Without indemnity insurance, there is some risk that a patient will not be able to recover damages from a negligent practitioner.

Indemnity arrangements for health practitioners were recently examined by the Commonwealth Government's *Review of Professional Indemnity Arrangements for Health Care Professionals* (PIR). The *Final Report* (November 1995) concluded that:

> *"On balance the PIR considers that there are strong public policy reasons to support government legislation requiring all health professionals, who have the potential to cause significant harm to their patients, to have adequate professional indemnity cover as a condition of practice" [Recommendation 128].*

The PIR recommends that any person who holds themselves out as a health care provider (including non-registered practitioners) should be required to have adequate indemnity cover. Various enforcement options are discussed in the Report, which recommends that the issue be referred to AHMAC for development of an agreed strategy. The Report suggests that nationally consistent legislation, to be enacted by all States, is highly desirable.

In light of the proposal that this matter be considered on a national basis by AHMAC, ***the preferred position is*** that professional indemnity cover not be a requirement for registration of health practitioners at the present time but that Queensland participate in national discussions on this matter.

8.18 Practitioner fees

Concerns have been raised about the apparent lack of accessible mechanisms for dealing with consumer complaints about health practitioners' fees. At present, the available avenues would appear to be:

- withhold payment, in which case the practitioner may sue the consumer in the Magistrates Court to recover the outstanding fee. The consumer would need to demonstrate the unreasonableness of the fee charged
- the Health Rights Commission, which may attempt to resolve fee complaints informally, but has no powers to require payment or reduction in the level of a fee
- the Alternative Dispute Resolution Program under the Community Justice Program which can provide for voluntary mediation when both parties are willing to participate in the mediation process
- in the case of medical fees, a consumer may request the Medical Board to review an account on the grounds that it is unreasonable or excessive (s.48 *Medical Act 1939*). This provision has rarely been used and it is probable that there is limited public awareness of this avenue.

Some consumers have indicated that complaints about fees should be dealt with by registration boards as part of their function to protect consumers from unscrupulous and dishonest practitioners.

The capacity of consumer protection legislation to be used in complaints about fees is unclear as the jurisdiction of the Small Claims Tribunal does not extend to health professionals. Consumers may initiate action to resolve disputes with 'traders', but this is not interpreted as applying to disputes with professionals.

At this stage, it is not recommended that boards be involved in disputes regarding practitioner fees, although, in order to reduce the number of disputes about fees, boards should encourage registrants to provide adequate information to consumers

about fees and charges. A statutory obligation to display fees is not supported, as this would prove impractical in many situations.

This issue has been raised as being of significant concern to consumers of health services and clearly requires further detailed consideration. However, the resolution of the problem is beyond the immediate scope of this review. The *Health Rights Commission Act 1991* [s.33(1)] provides a mandate for the Commission to conduct an inquiry, on the request of the Minister, about any matter related to the provision of health services.

The preferred position is that the Health Rights Commissioner conduct an inquiry and make recommendations regarding avenues for the resolution of disputes about health practitioner fees and consumer education options.

8.19 Review of legislation

The preferred position is that a statutory review of the new health practitioner registration legislation be undertaken 10 years from commencement of the legislation.

APPENDIX 1

Submissions to the Health Practitioner Registration Act and Medical Act Review (1994)

Albany Forest Physiotherapy & Rehab *Submission H082*

AMA Queensland Branch *Submission M017*

Amcal Chemists *Submission H045*

Anderson, Mrs Lynette *Submission M016*

Anti-Discrimination Commission *Submission M009*

APPPQ Legislative Review Committee *Submission H084*

ASEHA *Submission M027*

Association of Dental Prosthetists Qld Inc *Submission H129*

ASUM Queensland Branch *Submission H034*

Australian Academy of Hypnotic Science *Submission H098*

Australian & New Zealand College of Anaesthetists (incl Aust Society of Anaes) *Submission M033*

Australian Association for Exercise & Sports Science, Dept of Biomedical Science, *Submission H064*

Australian Association of Occupational Therapists Qld *Submission M011/H120*

Australian Association of Professional Hypnotherapists and NLP Practitioners *Submission H063*

Australian Association of Social Workers Ltd *Submission H087*

Australian Association of Speech & Hearing, Qld Branch *Submission H115*

Australian Association of Speech & Hearing (Sunshine Coast Branch) *Submission H058*

Australian Dental Association, Qld Branch *Submission H118*

Australian Institute of Medical Scientists, Queensland Branch *Submission H022*

Australian Institute of Pharmacy Management, Qld Chapter *Submission H006*

Australian Natural Therapists Association Ltd, Queensland Branch *Submission H003*

Australian Optometrical Association, Queensland Branch *Submission H062*

Australian Orthopaedic Association *Submission H054*

Australian Osteopathic Association *Submission H074*

Australian Physiotherapy Association, Qld Branch *Submission H106*

Australian Podiatry Association (Qld) Inc *Submission H028*

Australian Prosthodontic Society, Qld Branch *Submission H119*

Australian Psychological Society, Qld Branch *Submission H103*

Australian Psychological Society, Sunshine Coast Regional Group *Submission H056*

Australian Society of Clinical Hypnotherapists *Submission H010*

Australian Society of Hypnosis, Queensland Branch *Submission H021*

Baillie Henderson Hospital, Occupational Therapy Regional Interest Group *Submission H057*

Better Hearing Australia — Brisbane Branch *Submission H052*

Brian Job Optical *Submission H039*

Brisbane Consumers Association *Submission H113*

Brisbane Orthopaedic & Sports Medicine Centre *Submission H015*

Brocx, Mr Derk *Submission H032*

Bullock, Ms Leslie *Submission H128*

Bureau of Ethnic Affairs *Submission H130/M059*

Burke, Ms Denise *Submission H094*

Burns, Mr Ron *Submission H101*

Cairns Base Hospital, Occupational Therapy *Submission H066*

Caxton Legal Service *Submission M046*

Chiropractors and Osteopaths Board of Queensland *Submission H078*

Chiropractors Association of Australia (Queensland) Ltd *Submission H061*

Christian Science Committee on Publication for Qld *Submission H013*

Clowes, Mrs J A *Submission H011*

College of Clinical Neuropsychologists *Submission H121*

Committee of Qld Medical Colleges *Submission M055*

Confidential *Submission H042*

Confidential *Submission M019*

Confidential *Submission M020*

Confidential *Submission M026*

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Confidential *Submission M031*

Confidential *Submission H081*

Confidential *Submission H086*

Confidential *Submission H002*

Consumers Health Advocacy Qld *Submission H008/ M007*

Cresswell, Mr Mark *Submission H135*

Dental Assistants Association Qld Inc *Submission H065*

Dental Board of Queensland *Submission H116*

Dental Hygienists Association of Australia, Qld Branch *Submission H044*

Dental School, The University of Queensland *Submission H070*

Dental Technicians and Dental Prosthetists Board of Queensland *Submission H117*

Dental Technicians Licensing Committee Victoria *Submission H023*

Dental Therapists Discussion Group *Submission H050*

Department of Occupational Therapy, Prince Charles Hospital *Submission H080*

Department of Occupational Therapy, The University of Queensland *Submission H012*

Department of Pharmacy, The University of Queensland *Submission H027*

Department of Physiotherapy, Prince Charles Hospital *Submission H089*

Department of Physiotherapy, The University of Queensland *Submission H097*

Direct Contact Lens Supplies *Submission H136*

Doctors Health Advisory Service *Submission M029*

Doctors Reform Society of Queensland Inc *Submission M023*

Don Gardiner's Chemmart *Submission H075*

Downs, Dr Barry *Submission M008*

Driving Interest Group, AAOT Qld Inc *Submission H017*

Environmental Health Branch, Queensland Health *Submission M049*

Ericksonian Hypnosis Association of Australia *Submission H060*

Ethnic Communities Council of Queensland Inc *Submission M015*

Family Care Medical Service Pty Ltd *Submission H127/ M056*

Faulding Distribution Pty Ltd *Submission H047*

Forbes, Dr H *Submission M032*

Forsberg, Mr Christopher *Submission H029*

Gardiner, Ms Elizabeth *Submission H018*

Gold Coast Hospital *Submission M004*

Goodman, Ms Philippa *Submission H014*

Hambleton, Dr Steven *Submission M036*

Hand Therapy Centre *Submission H088*

Henry, Mr Geoff *Submission H072*

Hermit Park Medical Centre *Submission M050*

Hypnosis Clinic, Blacow, Mr John *Submission H055*

Impact Health Consulting *Submission M034*

Inner Brisbane North Health Region Group *Submission H126*

Ipswich Hospital *Submission M013*

Juides, J P *Submission H073*

Kelly, Dr Paul *Submission H030*

Khursandi, Dr Diana *Submission M028*

Kilminster, Ms Meredith *Submission H093*

Lawrence, Dr Joan *Submission M030*

Marriott, Ms Judith *Submission H024*

Mason, Mrs Karen *Submission H085*

Medical Board of Queensland *Submission M061*

Medical Superintendents Association of Queensland *Submission M043*

Medical School, The University of Queensland *Submission M005*

Mills, Mr/s E J *Submission M022*

Minter Ellison Lawyers *Submission M052*

Muller, Mr John *Submission H035*

Multicap *Submission H004*

Narangbah Pharmacy *Submission H049*

National Association of Medical Deputising Services Australia *Submission M060*

North Qld OT Group, Australian Association of Occupational Therapists *Submission H038*

Northern Regional Health Authority *Submission H033*

NSW Health — Physiotherapists Registration Board *Submission H133*

Occupational Therapists Board of Queensland *Submission H079*

Office of the Cabinet Queensland *Submission H124/ M053*

Office of the Health Professional Registration Boards *Submission H122/M051*

Office of the Legal Friend *Submission M042*

OPSM Pty Ltd *Submission H048*

Optometrists Board of Queensland *Submission H107*

Oral & Maxillofacial Surgery Training Program (Qld) *Submission H007*

Ovens, Miss Carolyn *Submission H046*

Overseas Trained Doctors Association of Australia *Submission M024*

Peninsula & Torres Strait Regional Health Authority, Community Health *Submission H090*

People With Multiple Sclerosis Queensland *Submission H040/M035*

Pharmaceutical Society of Australia, Qld Branch *Submission H100*

Pharmacy Board of Queensland *Submission H071*

Pharmacy Guild of Australia, Qld Branch *Submission H051*

Physiotherapists Board of Queensland *Submission H111*

Podiatrists Board of Queensland *Submission H076*

Professional Clinical Hypnotherapists and Examiners of Australia *Submission H026*

Psychologists Board of Queensland *Submission H123*

QAHM Bundaberg Branch *Submission M018*

QAMH Gold Coast *Branch Submission M045*

QDL Pharmaceuticals *Submission H053*

Qld Guidance & Counselling Association Inc *Submission H016*

Quadrio, Dr Carolyn *Submission H069*

Queensland AIDS Council *Submission M048/H114*

Queensland Anti-Discrimination Commission *Submission H009*

Queensland Audit Office *Submission H091/M037*

Queensland Consumers Association Inc *Submission H113/M057*

Queensland Counsellors Association *Submission H037*

Queensland Friendly Societies Pharmacies Association *Submission H068*

Queensland Hypnosis Society *Submission H083*

Queensland Mental Health Consumers Advisory Group *Submission M044/H110*

Queensland Nurses Union of Employees *Submission H099*

Queensland Nursing Council *Submission M038/H095*

QUT Kelvin Grove Campus *Submission H112*

RANZCP (Qld Branch) *Submission M021*

Rose Bay Hypnotherapy Centre *Submission H109*

Royal Australasian College of Radiologists Qld Branch *Submission M014*

Royal Australian College of Ophthalmologists *Submission H041*

Royal Australian College of Surgeons, Qld State Committee *Submission M040*

Royal Brisbane Hospital *Submission M025*

Rural Pharmacists Group *Submission H031*

Salaried Pharmacists Association, Queensland Branch *Submission H020*

Society of Hospital Pharmacists of Australia, Qld State Branch *Submission H059*

Spackman, Miss Wendy *Submission M006/H005*

Speech Pathologists Board of Queensland *Submission H077*

Speech Pathology Dept, Prince Charles Hospital *Submission H092*

Spellbound Productions *Submission H043*

Step Out of the Shadow Consumer Network *Submission H104/M041*

Stingel, Ms Kerry *Submission H025*

Sunshine Coast Regional Health Authority *Submission M002/H019*

Superpharm Supermarket & Pharmacy *Submission H001*

Terry White Group *Submission H105*

Toowoomba Health Services *Submission H102*

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Trade Practices Commission — Utilities & Deregulating Industries *Submission M039*

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Tridec Pty Ltd *Submission H131*

Twiddle, Mr Alan *Submission H134*

Vaughan, Mrs Mary *Submission M012*

Wells, Mrs L *Submission M010*

West Moreton Regional Health Authority *Submission M054/H125*

Wilkie, Dr William *Submission M003*

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Women's Health Centre *Submission M047*

Worker's Compensation Self Help & Support Group *Submission M058*

Wright Consultancy Qld Pty Ltd *Submission H108*