AMA Queensland Submission

Multiple Amendments to Health Legislation: Medical Abortion, Clinical Incident Information and Mental Health Court

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AMA Queensland thanks Queensland Health for inviting feedback on its multiple proposed amendments to different health legislation including the:

1. *Termination of Pregnancy Act 2018* (Qld) and *Criminal Code Act 1899* (Qld) concerning medical terminations of pregnancy;
2. *Hospital and Health Boards Act 2011* (Qld) regarding information sharing for clinical incidents; and
3. *Mental Health Act 2016* (Qld) regarding use and release of Mental Health Court exhibits and court transcripts.

We must, however, again express our disappointment at the wholly inadequate timeframe given for feedback. The consultation papers were sent by Queensland Health on the afternoon of 14 September 2023 and variously set the due date as 21 or 22 September. It is impossible for stakeholders to provide considered, comprehensive feedback on some 30 pages of consultation documents within 5-6 business days. It is also concerning given AMA Queensland has previously noted such timeframes raise serious questions about the genuineness of Queensland Health's claimed desire for meaningful engagement.

The Department's cover email also states the consultation papers were 'being provided to targeted Government and external stakeholders for feedback' only. It is unacceptable that Queensland Health persists with this targeted and secretive approach to legislative amendments and does not act with transparency and accountability by publishing all such proposals. The broader public is ultimately impacted by legislative changes. All Queenslanders have a democratic right to know legislative amendments are being proposed by agencies they fund as taxpayers, purportedly in the public's interest, rather than it being disclosed to only a select few.

As such, this submission reflects just a few key issues AMA Queensland has been able to identify in the extremely limited timeframe provided. It is not comprehensive and does not represent a fulsome and considered response on behalf of our organisation. We urge Queensland Health to immediately commit to reasonable, genuine, transparent and public consultations on all legislative proposals.

Medical terminations of pregnancy EPA amendments

AMA Queensland has previously raised concerns about the ad-hoc and opaque approach Queensland Health has adopted for amendments to Extended Practice Authorities (EPAs). These proposals come at short notice and without any clear justification or evidence-base. The current proposal concerning EPA amendments for registered nurses (RNs) is another such example. Several key issues with the proposal are set out below.

- The Senate Community Affairs Reference Committee did not recommend RNs be authorised to prescribe MS-2 Step. Rather, the Committee's report only recommended 'registered midwives, nurse practitioners and Aboriginal Health Workers' be so permitted. It is highly concerning that Queensland Health is proposing expansion beyond that recommended by the Senate Committee. This cannot be justified, lacks evidence and must not be further progressed.

- Expansion of EPAs at this time also pre-empts several Commonwealth reviews that are targeted directly at non-medical prescribing, including the:

    - Nursing and Midwifery Board's Consultation Regulatory Impact Statement on RN prescribing; and
    - Federal Department of Health's Scope of Practice Review.

  Amending EPAs before these reviews are finalised risks hasty implementation and inadequate patient safety controls. AMA Queensland endorses the feedback of our Federal AMA body to the Nursing and Midwifery Board's consultation which must also be read as part of this submission (also attached).

- Doctors have raised concerns about the supports currently available for non-medical prescribers of MS-2 Step given the recent cessation of telephone support services provided by MSI Australia. We understand steps are being taken to replace this service via Healthdirect but final arrangements are as yet unclear. Permitting non-medical prescribing of MS-2 Step without these important supports risks patient safety and cannot be justified.

- It is concerning that Queensland Health's proposal includes possible removal of gestational limit requirements on the dubious grounds that 'the gestational limit for use of MS-2 Step is determined by the TGA and could be subject to change'. This is not a sensible or reasonable justification for removing the important safeguard of TGA requirements and must not be progressed.

- Doctors also raised concerns that expanding scope and making other changes to the current TGA arrangements for use of MS-2 Step could expose health practitioners to professional, legal and insurance risks. It is imperative that prescribing and use of all medications, including MS-2 Step, is consistent across jurisdictions and between state and federal agencies.

- The example given on page 5 of an endorsed midwife prescribing MS-2 Step when 'visiting a pregnant person's home in the post-natal period' is nonsensical given the World Health Organisation defines the postnatal period as the first 6 weeks after birth. Pregnancy is rare during this period and the safest health care for patients who do conceive in that period would be via their regular GP/medical practitioner. This example should be deleted.

Clinical incident information sharing

AMA Queensland recognises Hospital and Health Services (HHS) need to be able to act in the interests of patient and staff safety on information their Quality Assurance Committees receive following clinical incidents related to intoxication, sexual misconduct, impairment and significant departures from accepted professional standards. That said, recent Ahpra reports have demonstrated clear evidence of doctor suicide due to the inadequacies of regulatory processes. Our health workforce must be provided with sufficient protections to prevent these tragedies.

At a minimum, the wellbeing of all health practitioners must be considered and weighed before Quality Assurance Committees make such disclosures. We know delays and unnecessarily complex investigations also cause avoidable stress and harm to those wrongly or unfairly accused and must be minimised. Instances of vexatious or false allegations must also be dealt with swiftly via due process and rectification pathways.

It is imperative that any new regulatory powers granted to HHS' must not exacerbate the stress already caused to practitioners, particularly those who are simultaneously subject to Ahpra or OHO investigations. We urge Queensland Health to ensure these issues are addressed through adequate show cause or other processes and protections.

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SUBMISSION

Monday, 7 August 2023

AMA Submission to consultation regulation impact statement:

Nursing and midwifery board Registration standard: Endorsement for scheduled medicines — designated registered nurse prescribers

July 2023

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The AMA welcomes the opportunity to respond to the Consultation regulation impact statement (CRIS) that has been circulated for comment by the Nursing and Midwifery Board of Australia (NMBA) on a proposed registration standard for registered nurse (RN) prescribers.

The AMA notes that, in preparing and presenting the options set out in this CRIS, the NMBA has conducted a methodical process over a number of years, including examining the nature of the problem, the impact of proposed solutions and consulting widely. The consultation process that has been undertaken is in welcome contrast to the approach being taken by some other health professions, where the haste to impose solutions to poorly defined problems of access is placing patient safety at risk. This is undermining nationally agreed principles and processes that are intended to regulate non-medical prescribing and ensure the safety of patients.

The AMA's response to this CRIS is focused on the overriding need to ensure patient safety and is informed by:

- Health Professionals Prescribing Pathway Project Final Report (HPPP) of 2013[1]
- AMA 10 Minimum Standards for Prescribing[2]
- National Prescribing Service Prescribing Competencies Framework[3]

[1] Health Workforce Australia, *Health Professionals Prescribing Pathway Project Final Report*, November 2013.

[2] https://www.ama.com.au/position-statement/ama-10-minimum-standards-prescribing accessed 11 July 2023

[3] https://www.nps.org.au/prescribing-competencies-framework accessed 11 July 2023

The AMA places a high value on the professional role of registered nurses in working with medical practitioners and patients. We support models of care that fully utilise registered nurses' training and expertise, within their scope of practice.

In relation to prescribing, the AMA is on the record as saying it is supportive of collaborative models of health care where non-medical health practitioners, including nurses, prescribe from limited formularies within their scope of practice in a medically-led and delegated team environment and there is quality evidence of a demonstrable benefit to patients. The AMA recognises that the adoption of specific medically-led models can improve accessibility to necessary medicines while maintaining safety. However, convenience of access should never be prioritised over patient safety and each model must first demonstrate that there are appropriate safety, training and emergency protocols in place. It is important to ensure that care is not fragmented and the expansion of prescribing rights does not undermine efforts to improve anti-microbial stewardship.

The AMA also notes that proposals for extending prescribing rights to other professions are often touted as being a partial solution to address medical workforce shortages. As we are now seeing with the difficulties being faced by the residential aged care sector, in addition to nurse recruitment challenges in both the private and public hospital sectors in every jurisdiction, the reality is that Australia is also dealing with a significant shortage of nurses, with Health Workforce Australia predicting a workforce shortfall of more than 100,000 nurses by 2025, and 123,000 by 2030. Any proposed changes to professional scopes of practice should be addressed solely on their intrinsic benefits and risks – not as part of misconceived attempts to address medical (or other) workforce shortages.

At a population health level, we also note the ongoing concerns about the alarming spread of anti-microbial resistance. If humanity is not to lose the enormous benefits of life-saving drugs, we need to be increasingly careful stewards of this precious resource. If not carefully done and communicated, extending the range of practitioners able to prescribe medications runs the risk of blunting the public health message that prescribing needs to be carefully targeted and calibrated.

This CRIS presents options for RNs to expand their scope of practice which essentially sets it as a yes/no for RN prescribing. At this point and on the basis of the limited information presented in the CRIS, the AMA is not supportive of RN prescribing. However, this does not mean that we fundamentally oppose it. The AMA would be prepared to consider specific models of RN prescribing of Schedule 2,3 and 4 medications (Option 2(a) in the CRIS) where this takes place in medically-led and delegated team environment, where the prescribing is within the scope of practice and in accordance with an *active prescribing agreement* as set out in the CRIS. What is missing from these options is the greater detail required for the specific models.

The examples on pages 21 and 22 provide for positive environments where RN prescribing may be appropriate. What is missing from the examples and the options is that the training and endorsement should be specific to the area that they would work in. That is the RN working in the aged care facility would have specific training and experience in aged care and the endorsement for scheduled medicines as a designated RN prescriber would be limited to this specific field. This would represent a more valuable contribution to the health system with resources directed to encouraging RNs to upskill in areas of need.

The AMA would like to see this explored with pilot studies to ensure that these models are safe and effective in the Australian context. Pending the adjustment noted above and pilot studies the AMA would be open to a modified option 2(a), although this support would also be conditional on the matters set out below being satisfactorily addressed. The AMA is **not supportive** of RN prescribing of Schedule 8 medicines (as set out in both Option 2, and Option 2(b) of the CRIS) given the higher risks involved with this category of medicines.

"Authorised health practitioner"

Only medical practitioners are trained to make a complete diagnosis, monitor the ongoing use of medicines and to understand the risks and benefits inherent in prescribing. Only medical practitioners currently meet all of the high standards required by the NPS MedicineWise Prescribing Competency Framework in order to safely prescribe independently.

The authorised health practitioner must be a registered medical practitioner and must be drawn from the specialty field relevant to the RN's endorsed field of prescribing. For example, an RN endorsed to prescribe in the field of general practice (with an agreed list of prescribable medications) would be supervised by a Specialist General Practitioner. The same would apply for example in rheumatology and all other specialties.

Accordingly, the AMA is **not supportive** of RN prescribing outside a **medically-led and delegated environment** and therefore does not support RN prescribing where the "authorised health practitioner" is a Nurse Practitioner (or other non-medical practitioner).

This is fundamental to the safety of the patients and to ensure that there are appropriate and timely referrals up to the clinical lead who will have a broader range of diagnostic skills, treatment regimes and prescribing rights should issues arise. The safety of the patient must be at the front of these models, and using workforce shortages as a reason to not pursue this is unacceptable.

Closely supervised practice

Should models of limited, specific prescribing by RNs be pursued, the AMA re-confirms its position that the period of clinical mentorship should be a **minimum of 12 months** for any non-medical practitioners and this must be with a medical practitioner. The proposal in the CRIS for a six month period of clinical mentorship is not supported.

Post registration experience

The AMA notes that the NMBA has increased the post registration experience requirement to three year's full-time equivalent (or 5000 hours) within the last six years. This is a more appropriate requirement than the two years that was earlier proposed.

The AMA is supportive of ensuring only experienced RNs are involved in any program. Noting the AMA's recommendation that this expanded role should be limited to specific fields, we expect that the experience would be in a specific field. It would be inappropriate for an RN to spend three years working in an unrelated field with differing illnesses and treatments to seek endorsement to then work and prescribe where they have limited experience.

The AMA also notes that time-based determinations of competence are outdated and unsupported by evidence. Should RN prescribing proceed, the AMA would very strongly encourage the NMBA to consider a more appropriate competency-based assessment mechanism be developed going forward.

Models of non-medical health practitioner prescribing

The AMA would like to take this opportunity to restate its general position in relation to models of non-medical prescribing that can be supported and which, if adopted, will provide assurance of ongoing patient safety as well as timely access to necessary medicines.

The AMA supports collaborative models of health care where non-medical health practitioners work as part of a medically-led team around the patient.

Non-medical prescribing may only occur in specific situations underpinned by the following principles:

- Non-medical prescribing occurs in a medically led and delegated team environment
- Non-medical prescribing occurs in the context of 'role delegation' not 'task substitution'
- There must be formally documented, collaborative arrangements that ensure:

    - diagnosis, ongoing monitoring, and evaluation of adverse events by a medical practitioner
    - clear lines of accountability and responsibility
    - separation of prescribing and dispensing (with limited exceptions as appropriate in rural/remote circumstances).
- Non-medical health practitioners must have core skills and appropriate competencies for safe prescribing attained by completing high quality, accredited education and training courses
- Course curriculum must meet core competencies in determining when not to prescribe and/or when to refer patients to a medical practitioner
- As occurs for medical practitioners, non-medical health practitioners should be closely supervised during their first years of prescribing practice
- Non-medical health practitioner prescribers must bear some risk for their prescribing decisions.

Models of non-medical prescribing supported by the AMA include:

- continuation of therapy initiated by a medical practitioner as the predominant model

Where this is not practicable or possible:

- prescribing by a protocol or limited formulary
- initiating therapy according to protocol or symptoms
- continuing, discontinuing, and maintaining therapy according to a pre-approved protocol.

As detailed above, medical practitioners are currently the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand the full range of clinically appropriate treatments for a given condition, including when to prescribe and, importantly, when not to prescribe medicines.

A general practitioner, for example, has undertaken 10-14 years of training. Using their training, a general practitioner holistically assesses, examines, investigates, diagnoses, refers and coordinates multidisciplinary teams for patients.

A consultation between a general practitioner and a patient is not just a simple transaction about prescribing a medicine, it is a process of differential diagnosis where a range of treatments and management pathways are considered in the context of the patient. It also allows for opportunistic discussions with patients about a range of health care needs, including evidence-based prevention and screening services.

Evidence and rationale

In the interests of supporting patient safety and cost-effectiveness for the health care system, the AMA's view is that any expanded scopes of practice by non-medical health practitioners must be underpinned by a process that ensures:

- there are no new safety risks for patients
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative, medically-led healthcare models
- the training opportunities for other health practitioner groups is not diminished
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

In addition, processes for expanding scopes of practice should also ensure that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies
- there are documented protocols for collaboration with other health practitioners, in particular protocols that minimise fragmentation of patient care.

General comment

In summary, non-medical practitioner prescribing should only take place within collaborative models of health care where non-medical health practitioners work as part of a medically-led team. This consultation has observed the correct protocols and processes which is welcome, however we would like to see more detail given to the specific models on RN prescribing that the NMBA would like to see.

We note that the CRIS mentions on page 17 that not expanding the role of RNs would limit the ability of the Government to meet the commitments of the Stronger Rural Health Strategy. While we do not agree with this statement, it does present a specific situation with funding and a designated population group where a formal pilot could be run to study the safety and efficacy of these models while also positively contributing to an area of workforce maldistribution.

Any extension of prescribing rights should also be cognisant of the wider impact that this measure would have on the Pharmaceutical Benefits Scheme. Providing tens of thousands of new practitioners with prescribing rights would have impacts on the sustainability of the

scheme. The AMA is also concerned about the potential impact that these models may have on indemnity insurance for the authorised practitioner who would be taking on a greater risk. We encourage the NMBA to engage with medical defence organisations to discuss the risks and potential costs to practitioners.

AMA members greatly value the nurses they work with across the health system and many regularly state that they wish their nurses could do more. We agree there is potential for this, but we need to ensure that the expansion of scope is done safely and with the right goals in mind noting, in particular, that this will not be a solution to medical workforce shortages, which need to be comprehensively addressed as an issue in their own right.