

Submission by the Health Practitioner Registration Boards¹

on the Proposed Registration Arrangements for the National Registration and Accreditation Scheme

Introduction

This submission is made on behalf of all twelve health practitioner registration Boards except where identified. Where no comment is provided, the proposal as detailed in the consultation paper is endorsed by all Boards. In this regard, the Boards have chosen to submit only on those proposals which they believe require further consideration.

In submitting on the proposed arrangements, the Boards recognise that more detail will be incorporated in the legislation. However, to ensure that such detail is driven by sound policy positions, this submission will address both the broad policy positions proposed for registration arrangements and the lower level detail where it is considered necessary to inform the policy position.

The Boards were also pleased to note advice that an exposure draft of Bill B will be provided for review and comment as a component of the ongoing consultation.

Section 4.2 Information Required on Initial Application

Proposal 4.2.1: *It is proposed that the national boards have the power to require the following information to accompany an initial application for registration:*

- a. evidence of the applicant's qualifications and supervised practice experience that they believe qualifies them for registration*
- b. evidence of successful completion of an examination (if required) set by or on behalf of the responsible board*
- c. evidence of previous registrations and registration status, ie disciplinary history (where the applicant has been registered under another law)*
- d. information on any complaints made against the applicant to bodies such as health complaints commissioners, Commonwealth, State or Territory bodies*
- e. evidence of recency of practice (except for new graduates) (see section 9 of this paper)*
- f. workforce data required for national workforce analysis (further discussion of this will be provided in the information-sharing paper), and*
- g. any other information reasonably required by the responsible board.*

¹ Chiropractors Board of Queensland, Dental Board of Queensland, Dental Technicians and Dental Prosthetists Board of Queensland, Medical Radiation Technologists Board of Queensland, Occupational Therapists Board of Queensland, Optometrists Board of Queensland, Osteopaths Board of Queensland, Pharmacists Board of Queensland, Physiotherapists Board of Queensland, Podiatrists Board of Queensland, Psychologists Board of Queensland, and Speech Pathologists Board of Queensland.

Submission of the Boards

The Boards note that the information required does not include information about the applicant's identity. While this requirement may be implicit, the Boards propose that it should be made explicit consistent with heightened concerns over identity fraud.

Section 4.3 Criminal History Checks

Proposal 4.3.1: *There are a number of options available on or relating to requirements for criminal history checking of applicants for registration and renewal of registration:*

Option 1: *That the legislation require criminal history checks be applied to all new applicants for registration from 1 July 2010, but not to existing registrants renewing their registration.*

Option 2: *That the legislation require criminal history checks on all new applicants and at renewal of registration, but these requirements be phased in over time from 1 July 2010.*

Option 3: *The legislation require criminal history checks on all new applicants for registration, with a discretionary power for boards to require checks at annual renewal, and self-declaration obligations imposed on registrants both at annual renewal and during the registration period.*

Option 4: *That the legislation provide the power to require criminal history checks on applicants at the discretion of the relevant board, while not making checks mandatory for all applicants.*

Submission of the Boards

The Boards are of the view that mandatory criminal history screening of all applicants with a concomitant power to screen registrants is necessary in the public interest. In this regard, Option 3 is supported as each of the other options brings with it inherent flaws. Option 1 does not give the Boards the ability to screen registrants and, as such, a Board may take action only if it becomes aware of a criminal conviction/charge. The Boards should not have to rely on such a loose arrangement to deal with registrants who may represent a risk to the public.

Option 2, while phasing in screening of registrants, links that screening to the renewal of registration. The linking of this complex requirement to the renewal process is not supported for the reasons stated later in this submission. Option 4 is not supported as the Boards would, in their own protection, introduce a mandatory screening process. This is because there would be no defence against a media charge where a Board registered an individual who had, for example, a serious criminal conviction for the sexual abuse of children.

In supporting Option 3, the Boards note that this will be more cost effective as it does not require the Boards to screen registrants on renewal and would enable the Boards to conduct a rolling screen of all registrants over a pre-defined period. Additionally, such a rolling screen would provide a disincentive for false declarations to be provided by registrants on renewal. In support of that process, of course, it will be necessary for the legislation to establish significant penalties for the provision of such false declarations. Such penalties must provide a direct disincentive for false declarations and should include options for either a monetary fine or a prison sentence or both.

While Option 3 is supported, there are a number of matters that must be clarified in developing the legislation. These are as follows:

- Will the Boards have access to all convictions, including those convictions extinguished by rehabilitation of offenders legislation? Consistent with the public interest argument, the Boards should have access to all convictions.
- Will the Boards have access to current charges and charges where no conviction was achieved? Consistent with the public interest argument, the Boards should have access to all charges.
- How will criminal history screening of overseas educated applicants be achieved in the absence of such applicants being legislatively required to present a criminal history clearance certificate at the time of application? Criminal history screening must be undertaken on all applicants and in the absence of this matter being addressed, overseas qualified applicants will be excluded from the requirement.
- If an overseas educated applicant has practised in several overseas jurisdictions prior to seeking registration in Australia, should they be required to present a criminal history clearance certificate from every jurisdiction at the time of application? On the basis of risk mitigation and cost effectiveness, it is proposed that overseas applicants be required to provide criminal clearance certificates from: (a) the jurisdiction in which they gained their qualification; (b) the jurisdiction in which they were practising immediately prior to lodging an application for registration with a national board; and (c) any jurisdiction in which they have been charged or convicted of a criminal offence.

It should also be recognised that the costs of criminal history screening will be in two parts. The fee paid to the relevant police service for the screening process will be a direct cost and this is, in Queensland, currently \$23 per screen. Indirect costs will flow from staff time in the processing of additional data and the assessment of positive criminal history screens. Both direct and indirect costs will contribute to increases in the registration fee in those jurisdictions where screening is not undertaken by the Boards. It should be noted that in Queensland costs for introducing mandatory criminal history screening have been assessed and incorporated in the current registration fees of all Boards.

Section 5 Qualifications for Registration

Proposal 5.1: *It is proposed that the legislation define the qualifications for general registration to mean one or a combination of the following:*

- *an approved course of study*
- *an approved period of supervised practice (if any) (ie an internship), and*
- *an examination (if any) set by or on behalf of the responsible board.*

Submission of the Boards

The Boards are not opposed to the proposal as detailed but cautions about applying the third qualification requirement as 'stand alone'. Enabling an examination without specifying a number of limits could clearly require the Boards to consider applications in circumstances where an applicant had not completed an approved course of study or an approved period of supervised practice. Consideration should therefore be given to only enabling an examination to be required under the qualification section of the legislation in circumstances where a Board was using the examination to test the equivalence of the applicant's

qualification with the course of study approved by the Board. Alternatively the qualification section of the legislation should be silent on examinations and the matter addressed through the examination proposed under 6.1.1(d).

Submission of the Pharmacists Board of Queensland

The Board submits that it is in the public interest that the current pre-registration year for pharmacists be converted to an internship year and, as such, the examination process can be conducted as part of that internship under specific registration. It would appear to be inconsistent with the remainder of the scheme that a qualified pharmacist may practise unregistered for up to twelve months prior to being subject to the protective mechanisms provided under the professional standard processes for complaints, competence and impairment.

Proposal 5.2: *It is proposed that, in addition to the powers above relating to the IGA clause 1.25(c) to register those with approved qualifications, boards have the power to register persons who have training and experience the responsible board considers to be substantially equivalent to an approved course of study and supervised practice. This will allow a national board to recognise substantially equivalent qualifications recognised by registration authorities in another country.*

Submission of the Boards

As currently worded, this proposal is confusing as it potentially would enable the Boards to determine substantial equivalence on the basis of an applicant's 'training and experience' and in the absence of the person ever successfully completing a qualification elsewhere. The test for substantial equivalence will have to be carefully considered by the drafting group to ensure that this is not the case.

Proposal 5.3: *It is proposed that qualifications that are 'approved' by a responsible board for the purposes of registration are not 'prescribed in regulation', but rather that the legislation enables boards to publish a list of approved qualifications on a website.*

Submission of the Boards

The proposal that 'approved' qualifications be published on the website in lieu of being prescribed in regulation is supported. However, the language utilised begs the question of whether a Board can refuse to 'approve' a course which has been accredited by the contracted external accreditation body. This matter requires clarification in the consultation paper about the proposed accreditation arrangements. The Boards submit that it would be consistent with the InterGovernmental Agreement that the national Boards are the final decision maker on the approval of courses for the recommendation to the Ministerial Council. In this regard the contracted accreditor will be responsible for making recommendations for approval of an accredited course to the national board. The Boards will submit further on this matter when they have available to them the consultation paper on proposed accreditation arrangements.

Section 6.1 Powers of Boards before Deciding Applications for Registration

Proposal 6.1.1: *It is proposed that the legislation provide for a responsible board at its discretion to exercise the following powers before deciding an application for registration:*

- a. investigate the applicant*
- b. require the applicant to attend before the board to answer questions about their application*
- c. require the applicant to provide further information or any documents considered necessary by the board to decide the application*
- d. require the applicant to undergo a written, oral or practical examination to assess the applicant's competence to practise, and*
- e. require the applicant to undergo a health assessment (eg a medical examination or psychological assessment) to assess the applicant's capacity to practise.*

Submission of the Boards

The discretionary powers noted above are supported by the Boards. However, the consultation paper is silent on whether statutory timeframes will be required for decision-making. In the absence of a statutory timeframe, an incomplete application may never be considered closed and/or applicants could be treated unfairly by a Board merely refusing to give a decision on the application.

The Boards propose that reasonable statutory timeframes be incorporated in the legislation, that the statutory timeframes be modified dependent on the Boards discretion in exercising each of the above noted powers and that applicants who do not, for example, respond to the request for further information or to undertake the examination, are deemed to have withdrawn their application and, as such, have no standing to appeal.

Section 6.2 Who Makes Registration Decisions?

Proposal 6.2.1: *It is proposed that when a committee makes registration decisions the responsible board would otherwise be empowered to make, it is constituted appropriately. In order to achieve this, the legislation would require provisions that:*

- a. require a committee, when exercising registration functions, to comprise at least the following:*
 - i. a chair appointed by the responsible board who may be a registrant (from the profession regulated by the responsible board), or a non-registrant*
 - ii. at least two members who are registrants from the profession concerned*
 - iii. at least one lawyer*
 - iv. at least one community member who is not and has never been a registered practitioner in that profession, and*
 - v. no more than two thirds of members being registrants from the profession concerned*

- b. allow a committee to regulate its own proceedings, while requiring it to observe the principles of natural justice and procedural fairness, and*
- c. allow members appointed to committees to be paid the sitting fees and allowances approved by the Ministerial Council .*

Submission of the Boards

The Boards note that it is intended that a committee established by a national board for registration decision-making purposes will have the capacity to ...*act as the national board for the purposes of some decisions such as registration.*

It is then proposed that the membership of the committee be legislated. The Boards submit that in order for the national scheme to be effectively and efficiently implemented the national boards will need a broad discretion to establish committees to assist them to perform their functions. This will also necessitate the inclusion of a liberal delegation power within the legislation to enable the national board to delegate sufficient functions and decision making to its committees. The Boards submit that it is unnecessary to prescribe the structure of committees in the legislation as this could lead to an increase in both cost and complexity.

Proposal 6.2.2: *It is proposed that the legislation include powers for a responsible board to delegate, in writing, to a member of the responsible board or a member of a committee, a person employed by the National Agency, or a person engaged by the National Agency to provide services to the board, its registration powers and functions under the legislation, other than its powers to:*

- a. refuse to grant, or refuse to renew a registration or an endorsement of registration*
- b. impose conditions on a registration or endorsement of registration*
- c. impose conditions on a registration renewal or endorsement renewal*
- d. amend, vary or revoke conditions on a registration or endorsement, and*
- e. remove a person's name from the register where the person no longer meets the requirements for registration (see section '12.5 Removal from the register' of this paper).*

Submission of the Boards

The Boards support the inclusion of a delegations power as this will be a core element necessary for successful implementation of the scheme. However, given the nature of the relationship between the Agency and the Boards, it would be inappropriate for the Boards to delegate to a 'person employed by the National Agency, or a person engaged by the National Agency to provide services to the Board' in the absence of the agreement on an appropriate representative of the agency. This matter is addressed reasonably well in the Queensland legislation which provides that a Board may delegate its power under the legislation to, with the agreement of the Executive Officer, an appropriately qualified member of the office's staff.

Section 6.3 Professional Indemnity Insurance

Proposal 6.3.1: *It is proposed that the legislation require registrants (except for non-practising registrants if any) to be covered by PII arrangements at all times during the registration period, as a condition of registration, and to require registrants demonstrate coverage to the satisfaction of the responsible board, at the time registration is granted for the first time, and annually on renewal of registration.*

The legislation concerning PII must allow registrants to meet the requirements if they are covered by an employer's PII, their university's PII, or the PII of a health facility where they are a student, as well as when a registrant purchases their own PII cover.

Submission of the Boards

The requirement for mandatory PII to be evidenced on application for registration is supported with caution. That caution relates to the evidence required to support an application for registration. For those applicants who will be relying on their employers' PII, evidence of employment will be necessary at the time of application. This may be difficult, particularly for those professions which are primarily employed in the public sector or where evidence of registration is required by the insurer prior to issuing professional indemnity cover.

It should also be recognised that the costs of processing an application for registration will be increased in those jurisdictions which do not currently have this requirement. Such costs will contribute to the level of registration fees imposed under the national scheme.

The requirement for mandatory PII to be evidenced on application for renewal of registration is not supported for the reasons detailed later in this submission.

Section 6.4 Powers to Refuse to Grant Registration

Proposal 6.4.1: *It is proposed that the legislation provide powers for a responsible board to refuse to grant registration on a number of grounds, including but not limited to the following:*

- a. the applicant has not satisfied the board of their **competence to practise** in the regulated profession and this cannot be satisfactorily addressed by the imposition of conditions*
- b. the applicant's **character** is such that it would not be in the public interest to allow the applicant to practise in the regulated profession*
- c. the applicant is considered by the board to be unfit to practise because of **drug or alcohol dependency** or **physical or mental impairment***
- d. the applicant has been **convicted** of or made the subject of a criminal finding for an offence in any participating jurisdiction or an offence under a foreign law, and the circumstances of the offence are such as to render the applicant unfit in the public interest to practise in the regulated profession*
- e. the applicant has previously been registered under this Act or a corresponding previous enactment of a participating jurisdiction, and that registration has been suspended or cancelled, or during the course of that registration, the practitioner has had proceedings brought against him or her and those **proceedings have never been finalised***

*f. the applicant has been **deregistered or suspended** under a foreign law, for any reason relating to conduct that would constitute professional misconduct under this Act, or during the course of that registration, the practitioner has had proceedings brought against him or her and those **proceedings have never been finalised***

*g. the applicant has had **insufficient recent practice** experience in the relevant profession (with the time period within which an applicant must demonstrate they have practised to be determined by the responsible board, eg two years is preferred in some professions, five years in others)*

*h. the applicant's **English language proficiency** is not considered sufficient by the board for the applicant to practise in the relevant profession*

*i. the applicant does not have arrangements for **professional indemnity insurance** that the responsible board considers sufficient, or*

*j. the applicant is **disqualified from applying** for registration under this Act or a previous enactment of a participating jurisdiction.*

Submission of the Boards

There are a number of matters that the Boards wish to raise under this item. First, there is an inconsistency between 6.4.1(d) and 9.3.1(b). It would appear that there is a higher threshold for renewal of registration than for initial registration as section 9 provides for the Board to have information about charges as well as convictions. This matter needs to be clarified, as raised previously in this submission.

Second, in relation to section 6.4.1(d), the legislation should specifically provide for the Boards to take into account criminal history of an applicant whether or not the offences were committed in the course of the applicant's professional conduct. In the absence of such a provision the relevant High Court decision would preclude the Boards from taking into account offences which were committed in the course of the applicant's 'private life'.

Third, 6.4.1 (f) is supported on the basis that the definition of conduct incorporates all concepts associated with conduct, including professional misconduct, unsatisfactory professional conduct, health impairment, incompetence, etc. In the absence of a broad definition, the Boards' discretion for refusing an application for registration will be fettered.

Proposal 6.4.2: *It is proposed that the legislation provide for boards to deal with possible fraudulent registration applications. Failure to disclose relevant matters to a board (such as those listed above) might constitute a fraudulent application under the legislation. In such circumstances, the responsible board might refer the matter to the relevant State or Territory police force. In addition, it is proposed that the legislation set out a process for a responsible board to deal with a registrant whom it has reasonable grounds to believe has obtained, or is attempting to obtain registration by fraud. In such circumstances, the responsible board should be empowered to immediately suspend registration (if already granted), investigate the matter, and refer it, if necessary, for hearing by the relevant State or Territory tribunal. The tribunal would be empowered under the legislation to find that the practitioner's registration has or has not been obtained by fraud, and, if appropriate, order that the practitioner's registration be cancelled. The standard of proof that would apply in such proceedings would be on the balance of probabilities.*

Submission of the Boards

While the process as proposed provides an effective mechanism for removal of registration in the circumstances detailed, it does not protect against fraudulent activity. In this regard, for example, a fraudulent applicant for medical registration who subsequently is registered and works for two years earns sufficient monies from their fraudulent activity to take the risk if the only risk is cancellation of the fraudulently obtained registration.

Given this, a penalty provision for false and misleading statements being made on application must be included in the legislation and must be set at a level that will act as a sufficient deterrent against fraudulent activity. This would require such conduct to constitute a criminal offence so that the range of penalties extends to imposition of a substantial fine or a term of imprisonment.

Section 6.5 Refusal Process

Proposal 6.5.1: *It is proposed that the legislation provide that in the event that a board is proposing to refuse an application for registration, or to attach conditions to a practitioner's registration, the board would be required to give the applicant notice of its proposal and provide the applicant with an opportunity to make a submission to the board. It is proposed that the legislation include timeframes for this process before a board makes such a decision.*

Submission of the Boards

The consultation paper is silent: on the scope of conditions which Boards will be able to impose; whether the imposition of such conditions will be time limited; and about the process for review of conditions, particularly whether the review can be commenced by the registrant or the Board.

It is submitted that these matters must be addressed in the legislation and the Boards propose that in the interests of natural justice the scope of the conditions be defined; the Boards be limited to imposing conditions for a maximum period of 3 to 5 years, the registrant be precluded from applying for a review of the conditions prior to the expiry of the period determined by the Board, and the Board be empowered to review the conditions at any stage prior to the conclusion of the 3 to 5 year period.

Section 7 Types of Registration Granted

Proposal 7.1: *It is proposed that the legislation enable a national board to grant any one of a number of different types of registration, depending on the circumstances of the applicant, and to impose conditions on a grant of registration. The proposed types and sub-types of registration are set out in Table 2 below. While the labels vary, most jurisdictions provide in some legislative form for the sub-types of registration listed under specific registration.*

Submission of the Boards

All Boards accept that common categories and sub-categories of registration will be necessary and that current registration types will have to be transitioned to the nationally agreed categories. A number of matters however will need to be clarified in regard to the proposed categories, particularly in relation to ease of communicating these to the general public.

First, it is unclear whether a registrant can hold both a general and a specific category of registration concurrently. This may be necessary, for example, where the person is eligible for general registration but not eligible for specialist endorsement in circumstances where they hold a recognised specialist qualification and experience. Without holding the specific form of specialist registration would the registrant be eligible for specialist rebates under the Medicare scheme? A further example is where an overseas trained specialist holding an academic position concurrently holds registration for teaching or research purposes and one for specialist recognition in order that they can supplement their income as academics.

Second, it is also unclear who will be determining what is an 'area of need' under the national scheme. The consultation paper is silent on this matter and in the absence of information in this regard, the Boards are not in a position to provide informed comment and transition planning may not be successfully undertaken for those who are currently registered in this category. It should also be noted that 'area of need' registration in Queensland currently only applies to the medical profession. Without detail as to the area of need process and the policy underpinning this process and its use, the Boards are not in a position to provide comment or support about this category of registration.

Third, the differentiation between specialist endorsement to general registration category and the two forms of specialist registration under the specific registration category have the potential to confuse users of the services of specialists. For example, an endorsement may appear to be a lower standard to someone with 'a recognised specialist qualification and experience' or 'internationally trained specialist' registration. While such matters could be addressed in a glossary of terms, generally members of the public will not inform themselves through such a document. As such, the descriptors attaching to specific registration as they relate to specialist registration need to be recast. Alternatively, it may be necessary to establish a fifth category of registration being for the registration of specialists.

Fourth, the teaching or research category of specific registration does not enable clinical practice to be undertaken by the registrant given the current descriptor. This is particularly a problem for the dental and medical professions for a number of reasons. With the increase in dental and medical schools over the last four years in Queensland, the shortage in dental and medical practitioners generally and the lower remuneration available to academics as compared to clinical practice, universities have found it difficult to recruit Australian qualified academics to fill positions.

In lieu, overseas academics are being recruited but this is proving difficult as the Australian Dental Council and Australian Medical Council assessment processes take up to two years. Even with the approach being proposed for national Boards to approve qualifications, there are qualifications from a number of jurisdictions where the Boards will not make precedent decisions about the qualification, preferring to assess the individual's knowledge, skill and experience to fill the academic position. As such, the only option which will be available to the Boards will be to register such applicants under the specific registration category for teaching or research.

In the absence of such registrants being able to undertake clinical practice associated with that teaching, either at a general or specialist level, recruitment and retention will remain problematic. Clinical practice is necessary for two reasons: (a) it enables the registrant to engage in paid clinical practice to supplement their academic income; and (b) it enables the registrant to maintain clinical skills consistent with their obligations to the university.

Similar issues for the medical profession in Queensland were previously addressed by amending s. 134, *Medical Practitioners Registration Act 2001* to enable the registrant to practise the profession as long as such practice was in connection with their primary teaching role and amendments are being sought to s. 119, *Dental Practitioners Registration Act 2001* to introduce the same requirements. These matters should be addressed in the national legislation.

A wider policy issue not addressed in the consultation paper is whether certain forms of specific registration should be time limited. For example, under the more flexible arrangements proposed for the approval of courses by a national Board, there should be some decreased reliance on area of need registration. However, those in this category should therefore be required to show appropriate progression towards achieving general registration and to have achieved general registration or to be recognised as a specialist within a pre-determined period. Conditions of this nature could be included in the legislation as 'standard' for the relevant category of registration and with the differentiation that 'standard' conditions are neither appealable nor subject to the notification requirement detailed in Proposal 6.5.1. Similar requirements would be necessary for sub-categories (c), (d), (e) and (g). Alternatively, the legislation could empower the Boards to issue enforceable guidelines in this regard.

Section 7.4 Student Registration

Proposal 7.4.1: *It is proposed that the legislative provisions with respect to student registration would be framed to:*

- *require only those students who are undertaking clinical training that involves contact with patients/clients to be registered*
- *empower boards to deal with students whose ability to undertake clinical training is affected by physical or mental impairment, drug or alcohol dependency, and*
- *give boards the discretion to include or not include a student category of registration.*

Alternative options are as follows:

Option 1: *The legislation include powers to register and regulate students, but only for specified professions and boards, for example, the medical and dental professions.*

Option 2: *The legislation include powers for all boards to register and regulate students, and student registration be mandatory, but only for those students who are undertaking clinical training, that is, those who are at the point in their course where they are in direct contact with patients.*

Option 3: *The legislation include powers for all boards to register and regulate students, and student registration be mandatory for students in all regulated professions, at the point of enrolment and for the duration of their course.*

Submission of the Boards

The policy underpinning the proposal that students be registered while undertaking clinical training for the purposes of addressing any health impairment of such students lacks clarity as to its intent. It is difficult to understand why it would be appropriate to register a student with a significant criminal history (which would exclude them from registration on completion of the course) but not register them on the basis of impairment. The proposal that

registration be granted for clinical training and ceased when clinical training is completed would also appear to be a costly and bureaucratic process to maintain.

If the aim of the policy is public protection, there would appear to be two options available which would be effective both in a regulation and cost basis. These two options are as follows:

- The legislation include powers for all Boards to register and regulate students and student registration be mandatory for students in all regulated professions, at the point of enrolment and for the duration of the course. Under this option it would be necessary to either charge a registration fee to the students to maintain student registration or to increase the fees paid by qualified registrants to cover the costs of maintaining student registration. This model does have a significant problem in terms of the test applied for unsatisfactory professional conduct or professional misconduct. It is difficult to conceive how a test of misconduct or unsatisfactory conduct can be applied to someone who has not fully completed a qualification and entered the profession.
- The legislation place a mandatory reporting obligation on education providers to advise Boards when the conduct or health of a student proposed a serious potential risk to the wellbeing of vulnerable persons. Such an obligation would of course be supported by protections being provided to the notifier for providing the notification in good faith. To support the mandatory reporting obligation the legislation should also empower the Boards to exclude a student from clinical practice on the basis of their conduct or health, with appropriate appeal mechanisms included for the proposed Tribunal. This negative licensing regime would be more effective both on a regulatory basis in the public interest and in reducing the cost burden.

Section 8.1 Title Protection

Submission of the Podiatrists Board

The Board notes that the table has been replicated from the IGA and does not include the title protection for podiatry. The Board requests that this be noted and that the title protection be as for the other professions.

Proposal 8.1.1: *With respect to the use of courtesy titles, such as the title ‘doctor’ or ‘professor’, it is proposed that these not be legislated as protected titles, nor reserved for use only by members of one or a number of regulated health professions.*

Therefore, unregistered persons using such titles would risk prosecution only where use of a courtesy title could, in the circumstances, lead others into believing the person is qualified and registered under the Act in a regulated health profession when they are not.

Submission of the Boards

While the Boards support the proposal, in the interests of clarity and to ensure ease of understanding by the general public, it is submitted that the legislation should require any health professional (other than a medical practitioner) who is using the title ‘doctor’ in their professional practice to incorporate a profession specific clarifier. Examples of this are as follows: Dr Joe Smith, Physiotherapist; Dr Jane Smith, Chiropractor; etc.

Section 8.3 Dentistry Practice Restrictions

Proposal 8.3.1: *With respect to protection of the practice of dentistry, it is proposed that there be defined in legislation a number of restricted acts relating to dentistry and that there be an offence for a person who carries out a restricted act and is not a registered dental care practitioner or a person who falls into a class of exempted persons (for example a registered medical practitioner). It is proposed that the restricted acts with respect to the practice of dentistry be along the following lines:*

- a. the performance of any operation on the human teeth or jaws or associated structures*
- b. the correction of malpositions of the human teeth or jaws or associated structures*
- c. fitting or intra-oral adjustment for a person of artificial teeth or corrective or restorative dental appliances, and*
- d. the performance of any operation on, or the giving of any treatment or advice to, any person that is preparatory to or for the purpose of the fitting, insertion, adjusting, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances.*

Submission of the Dental Board of Queensland

In reviewing the proposal, the Dental Board of Queensland noted that the restriction on diagnosis was implicit in the draft definition and submits that it be made explicit as detailed below. In addition, the Board was of the view that procedures was a more inclusive term than operations and submits that in any definition of procedures operations be included.

Given these factors, it is proposed that the restricted Acts with respect to the practice of dentistry be as follows:

- (a) diagnosis for the performance of any procedure on the human teeth or jaws or associated structures; or for the purpose of giving treatment or advice to any person that is preparatory to or for the purpose of the fitting, insertion adjusting, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances;
- (b) the performance of any procedure on the human teeth or jaws or associated structures;
- (c) the correction of malpositions of the human teeth or jaws or associated structures;
- (d) fitting or intraoral adjustment for a person of artificial teeth or corrective or restorative dental appliances; and
- (e) the performance of any procedure on, or the giving of any treatment or advice to, any person that is preparatory to or for the purpose of the fitting, insertion adjusting, fixing, constructing, repairing or renewing of artificial dentures or restorative dental appliances.

For the purpose of these restrictive acts, procedure includes an operation.

Section 8.4 Optometry Practice Restrictions

Proposal 8.4.1 *With respect to protection of the practice of optometry, it is proposed that the legislation prohibit unregistered or unauthorised persons from prescribing optical appliances. It is proposed that an optical appliance would be defined as: 'contact lenses, spectacle lenses, or any other appliance designed to correct, remedy or relieve any refractive abnormality or defect of sight'.*

Stakeholders are invited to address in their submissions whether the definition of optical appliance should be framed broadly to include all contact lenses (whether for therapeutic or cosmetic purposes),

or narrowly, to exclude 'plano' or cosmetic contact lenses.

If cosmetic contact lenses are included in the definition of a restricted optometry act, the effect would be to make it illegal to supply cosmetic contact lenses to a person, except in accordance with a prescription issued by a registered optometrist or other authorised person.

Submission of the Optometrist Board of Queensland

The Board supports the proposal to prohibit unregistered or unauthorised persons from prescribing optical appliances and is of the view that the definition of optical appliance should be framed broadly to include all contact lenses (whether for therapeutic or cosmetic purposes). The Board relies on the material detailed in attachment (A) to this submission in support of its position that all contact lenses should be included within the definition of optical appliance.

Proposal 8.4.2: *If the prescribing of optical appliances is to be a restricted act under the legislation, then it is proposed that an orthoptist who is listed with the Australian Orthoptic Board (not a statutory board in this scheme) be exempted from committing an offence for prescribing spectacle lenses in the normal course of their practice.*

Submission of the Optometrists Board of Queensland

The Board objects to the proposal that orthoptists who are recognized by the Australian Orthoptic Board should be exempted from the proposed continuation of the current legislative arrangements in each jurisdiction whereby the prescribing of optical appliances, (ie contact lenses and spectacle lenses or any other appliance designed to correct, remedy or relieve any refractive abnormality or defect of sight) is restricted to optometrists or qualified medical practitioners.

The Board notes that orthoptics is an unregulated allied health field of practice. The Australian Orthoptics Board is a company registered in Victoria, and as such there are no regulatory or statutory obligations to consumers in other states. The orthoptics profession in its current scope is concerned with the diagnosis and treatment, by means of eye exercises, of disorders of the coordination and alignment of the eyes. Orthoptists work closely with ophthalmologists in assessing such eye movement disorders, the delivery of orthoptic exercises and the conduct of certain diagnostic tests required by the ophthalmologist. The proposal would permit orthoptists to engage in primary eye care, (apart from the prescribing and fitting of contact lenses). The role of the orthoptist would be widened to permit the measurement of refractive errors and the writing of prescriptions for spectacles without the need for a prior referral.

Optometry courses in this country currently vary between a minimum program of four years and five years of full time study, and must provide a strong foundation in the biomedical sciences, as well as study of biology, chemistry, physics and mathematics. This is considered to be essential to a proper understanding of vision, optics, and disorders of the eyes and vision, and to provide optometrists, as independent practitioners, with the capacity to understand the science underpinning the professional discipline, and to evaluate and adopt new knowledge and future technology.

The training of orthoptists does not provide a scientific basis for extending their scope of practice. It is a program which is shorter than that for optometrists, has a practical emphasis

and is relatively light on the scientific foundations of the field of practice of orthoptists. Importantly, orthoptics training does not emphasize refractive errors and their optical correction or the science of optics. Instead the training is understandably concerned with the study of eye movement disorders and their treatment.

The proposal that orthoptists should be permitted to move into the field of practice which is currently occupied by the optometry profession, which has a far higher level of education in its field of professional expertise, is ill considered and cannot be in the public interest. The Board does not believe that the training of orthoptists is sufficient in its scope and depth to enable such practitioners to practice independently within the community, providing primary eye care to the public.

It should be regarded as a matter of particular concern that orthoptics practice would be revolutionized if Proposal 8.4.2 were put into effect. The orthoptics profession would be expected to rapidly grow in numbers and, having achieved independence, would soon become more remote from the present junior relationship with ophthalmologists, relying increasingly on the writing of prescriptions for spectacles as its principal activity. As inroads were made into the field of practice of optometrists and the public turned to orthoptists as primary care providers, those clients would be denied the high level of diagnostic skill across a wide range of disorders of the eyes and vision which the public now has available from an optometrist in the course of a consultation for any purpose.

The Board is firmly of the view that the National Registration and Accreditation Scheme for the Health Professions should not become a vehicle for extending the authority and practice scope of a currently unregulated group, which will then not be subject to the same rigorous accreditation and regulatory standards as apply to those professions already identified for accession to the scheme in 2010. Service delivery will not be impacted by maintaining the current scope of practice of orthoptists. This is because they are not significantly involved in private sector health care delivery.

Section 8.5 Restrictions on Spinal Manipulation

Proposal 8.5.1: *With respect to protection of the practice of spinal manipulation, it is proposed that further consideration be given to practice restrictions as detailed in the IGA at 1.28(c)ii).*

Stakeholders from the registered and unregistered professions, as well as consumers are invited to include in their submissions on this paper comments on the need, if any, for inclusion in the national legislation of a restricted act with respect to spinal manipulation, and if so, how broadly or narrowly this restricted act should be framed and what definition should be adopted.

Submission of the Chiropractors Board and Osteopaths Board

It is the submission of the above noted Boards that manipulation of the spine and extremities should be restricted as a public safety issue. Research demonstrates that to develop the fine motor skills necessary for safe manipulation takes hundreds of hours of training and must be continually practised. The Boards also note that:

- manipulation of the spine is a restricted act in at least four of the eight jurisdictions;
- an independent review as to whether spinal manipulation should be a restricted act was undertaken in 1999-2000 by PriceWaterhouseCoopers on behalf of Queensland Health; and

- the independent review concluded that due to the risk of harm associated with thrust manipulation of the spine, consumer protection benefits could be achieved from defining thrust manipulation of the spine as a core practice and restricting it to being practised by chiropractors, osteopaths, physiotherapists and medical practitioners.

On this basis, the Boards submit that thrust manipulation of the spine be restricted to the practice of chiropractors, osteopaths, physiotherapists and medical practitioners. A sample legislative model to enact the restriction is reproduced below from the *Chiropractors Registration Act (Qld) 2001*.

120A Restriction

(1) A person who is not a registrant, medical practitioner, osteopath or physiotherapist must not, in the course of providing a health service, perform spinal manipulation on a person.

Maximum penalty—1000 penalty units.

(2) This section does not prohibit spinal manipulation on a person by a student, under the immediate personal supervision of a registrant, medical practitioner, osteopath or physiotherapist, in the course of the student's training and instruction for a qualification as a chiropractor, medical practitioner, osteopath or physiotherapist.

(3) In this section—

osteopath means a person registered under the *Osteopaths Registration Act 2001*.

physiotherapist means a person registered under the *Physiotherapists Registration Act 2001*.

spinal manipulation means the high velocity application of force to a person's body that affects a joint, or group of joints, of the person's spinal column.

The Boards rely on the findings of the PriceWaterhouseCoopers report which was released for public consultation in November 2000. A copy of that report is enclosed with this submission in support of the position that manipulation of the spine be a protected practice under the national legislation.

The Boards note that the professions continue to express concerns about the quantity and quality of spinal manipulation training in pre-registration physiotherapy and medical courses. It is expected these matters will be addressed in submissions from professional associations and other national bodies.

Submission of the Physiotherapist Board

It is the submission of the above noted Board that manipulation of the spine and extremities should be restricted as a public safety issue. Research demonstrates that to develop the fine motor skills necessary for safe manipulation takes hundreds of hours of training and must be continually practised. The Board also notes that:

- manipulation of the spine is a restricted act in at least four of the eight jurisdictions;
- an independent review as to whether spinal manipulation should be a restricted act was undertaken in 1999-2000 by PriceWaterhouseCoopers on behalf of Queensland Health; and
- the independent review concluded that due to the risk of harm associated with thrust manipulation of the spine, consumer protection benefits could be achieved from defining thrust manipulation of the spine as a core practice and restricting it to being practised by chiropractors, osteopaths, physiotherapists and medical practitioners.

On this basis, the Board submits that thrust manipulation of the spine be restricted to the practice of chiropractors, osteopaths, physiotherapists and medical practitioners. A sample

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spinal manipulation means the high velocity application of force to a person's body that affects a joint, or group of joints, of the person's spinal column.

The Board relies on the findings of the PriceWaterhouseCoopers report which was released for public consultation in November 2000. A copy of that report is enclosed with this submission in support of the position that manipulation of the spine be a protected practice under the national legislation.

Section 9.3 Annual Reporting Obligations on Registrants

Proposal 9.3.1: *It is proposed that the legislation require registrants to submit to their respective boards at the time of annual renewal various items of information required by the board in order to determine whether the practitioner is fit to practise. As part of such an annual return, the legislation might require reporting on a range of matters including:*

- a. how the board's continuing competence requirements have been met*
- b. if charged with or convicted/subject of a finding of guilt for an offence punishable by 12 months imprisonment or more*
- c. any medical negligence claims*
- d. if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer, and*
- e. any data required to be provided to the Ministerial Council for workforce planning purposes.*

Submission of the Boards

The Boards support the proposal that an obligation be placed on registrants to notify of compliance with relevant matters as the basis of renewal of registration. Such notification should not require the Board to review documentary evidence at the time of renewal so as to avoid a major and complex bureaucratic burden. Such a burden will limit the viability and usefulness of online renewal processes where the payment of renewal fees is separated from the submission of evidence in support of the application.

If all proposals in the consultation paper are included in the legislation, an applicant for renewal will have to:

- Report on how the Boards' continuing competence requirements have been met.
- Report if charged with or convicted/subject of a finding of guilt for an offence punishable by twelve months imprisonment or more.
- Report on any professional negligence claims.
- Report if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer.
- Provide any data required by the Ministerial Council for workforce planning purposes.
- Require registrants to demonstrate PII coverage to the satisfaction of the responsible Board.
- Require the registrant to be screened for a criminal history.

Renewal of registration to mitigate risk would be more cost effective by requiring the applicant to make certain declarations of compliance, to audit a representative sample of applicants and to include in the legislation breach provisions that provide a significant disincentive to applicants providing false declarations of compliance. Such disincentives should also address the situation where a practitioner drops PII cover after renewal. Consistent with this approach, the Boards propose that an applicant for renewal be required to:

- Declare compliance with the continuing competence guidelines issued by the relevant Board and that they will only engage in practice for which they are competent in the new registration period.
- Declare that they have reported (as will be required under Proposal 9.4.3) any charges and convictions where a finding of guilt for an offence led to a punishment of twelve months imprisonment or more.
- Declare that they have reported (as will be required under proposal 9.4.3) any professional conduct action taken against them by a foreign regulatory authority.
- Declare that they have reported (as will be required under proposal 9.4.3) any health condition that impacts on their ability to safely and competently practice.
- Declare that they have reported (as will be required under Proposal 9.4.3) any professional negligence claims where a judgement has been made or where the proceedings or part of the proceedings have been settled during the registration period.
- Declare that they have reported (as will be required under Proposal 9.4.3) if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer during the registration period.
- Declare that they have maintained PII coverage consistent with guidelines issued by the relevant Board and that they will maintain that coverage for the new registration period.
- Provide data required by the Ministerial Council for workforce planning purposes.

As previously submitted, the Boards should also be required to undertake a triennial criminal history screen of all registrants to confirm that declarations and reporting obligations in this regard have been met by all registrants. Together with the deterrent power of the proposed criminal sanctions for false declarations, the Boards are of the view that this framework will ensure public protection.

Please note that the Boards further submit that the legislation should refer to 'professional' negligence claims rather than 'medical' negligence given that it is established to regulate health professionals rather than just medical practitioners.

In addition, the legislation should limit reportable information on professional negligence claims to: (a) a judgement in relation to the claim; or (b) a settlement of the proceedings or part of the proceedings in relation to the claim. Having to report all claims provides the Boards with no solid foundation to take any action whereas having to report judgements and settlements of claims would provide such a foundation.

Section 9.4 Monitoring the Professional Competence of Registrants

Proposal 9.4.3: *It is proposed that the legislation require registrants to report to boards, at any time during the registration period, and within 30 days, on the following matters:*

- a. if charged with or convicted/subject of a finding of guilt for an offence punishable by 12 months imprisonment or more*
- b. any medical negligence claims*
- c. any withdrawal or limitation of clinical privileges or credentials by a health service body, and*
- d. any other matter set down from time to time by the Ministerial Council.*

Submissions of the Boards

There are a number of additional matters that the Boards submit should be included to ensure action can be initiated if necessary to achieve the objectives of the legislative scheme. These are that a registrant should be required to report to the relevant Board:

- If professional conduct action (investigation, discipline, imposition of conditions, entering into undertakings, impairment management, performance management, etc.) is initiated against them in a foreign jurisdiction by a foreign regulatory authority.
- If they become subject to a health condition that impacts on their ability to safely and competently practice the profession.

The Boards note that there is an inconsistency between the reporting obligation proposed under 9.4.3(c) and the annual renewal reporting obligation proposed under 9.3.1(d). The Boards submit that the reporting obligation should be consistent and based on proposal 9.3.1(d).

Section 10.1 Specialist Endorsement

Proposal 10.1.1: *Given the framework set out in the IGA, it is proposed that the legislation include the following provisions:*

- a. A general power (in the part of the legislation which sets out the broad powers and functions of the national boards) for the national boards to recommend to the Ministerial Council specialties that should be recognised for their profession, and the qualifications that the responsible board considers should apply for the purposes of endorsement of registration in each recognised specialty. This would be in addition to the role of the national boards in recommending to the Ministerial Council approved qualifications for registration purposes.*

- b. Powers for the Ministerial Council, following recommendation from a national board to:*
- i. approve those professions for which specialist recognition will operate under the national scheme*
 - ii. approve the list of specialties against which those boards referred to above will approve suitably qualified registrants for endorsement of their registration*
 - iii. approve the qualifications required for endorsement in each approved specialty, and*
 - iv. approve changes, from time to time, to the list of recognised specialties for a regulated profession and the qualification requirements for specialist endorsement within an approved specialty.*
- c. For those boards with a specialist endorsement function, the same powers as when dealing with an application for registration or renewal of registration, that is, powers to receive an application for endorsement of registration, require further information, require attendance at the board, refuse an endorsement or attach conditions to an endorsement, etc. Review rights would also apply.*
- d. Offences for registered or unregistered persons who:*
- i. Use restricted titles listed in the legislation (for example, the titles of 'medical specialist', 'surgeon' or 'dental specialist') when they are not entitled to; or*
 - ii. Hold themselves out as being registered and endorsed as a specialist under the legislation when they are not.*

Submission of the Boards

The specialist endorsement provisions as proposed are endorsed by all Boards.

Submission of the Psychologists Board

The Psychologists Board of Queensland approves of the proposal outlined in 10.1.1 that will permit an application to the Ministerial Council by the future national board of psychology. The Board recommends to the national board that application be made for the establishment of a specialist register on the following grounds:

- The profession of psychology has distinctive branches in the workplace, which are reflected in position descriptors, credentialling, professional associations, textbooks and scientific journals.
- Accredited postgraduate education and training for the practice of these various branches of psychology is available at many Australian and overseas universities.
- Employers in Australia, UK, USA, Canada and New Zealand advertise for psychologists qualified in particular areas of service, frequently by specifying the position in terms of a descriptor, e.g. clinical psychologist, sports psychologist, organizational psychologist etc.

- Public interest and safety dictate that help should be sought from a source specialized to treat a particular health problem. For example, a child with learning difficulties should not be treated by an organizational psychologist but by a specialist in Educational and Developmental Psychology. Maintenance of specialist registers would assist members of the public to locate psychologists with particular specialist expertise.
- The Psychologists Board of Western Australia has a specialist register that recognizes seven specialist areas of practice and expertise. The Psychologists Registration Board of Victoria has had a specialist register in the past. The Psychologists Board of Queensland has obtained legal advice that has permitted a policy enabling practitioners with specialist expertise to use appropriate descriptors. (http://www.psychologyboard.qld.gov.au/publications/Policies/descriptor_titles.pdf).

In view of the foregoing, the Board recognizes that the existence of these specializations provides public protection and useful distinctions that are in the public interest (especially information about qualifications and specialized services).

It therefore recommends that in the proposed National Register appropriately qualified registered psychologists should have their area of expertise entered on their record of registration. This would in effect constitute a specialist register in addition to the general register.

Consensus between the accreditation, regulation, training, and professional bodies is required to define the number of descriptors and the qualifications required for each specialty. While the recent Medicare legislation acknowledged 'eligible clinical psychologists' and 'registered psychologists', these two categories alone do not adequately reflect the diverse services in a variety of settings in which professional psychologists work.

The Board suggests that in addition to a general register of possessors of registrable generic qualifications, the following descriptors/endorsements/notations should be recognized on a specialist register:

- Clinical Psychologist
- Clinical Neuropsychologist
- Community Psychologist
- Counselling Psychologist
- Educational and Developmental Psychologist
- Forensic Psychologist
- Health Psychologist
- Organizational Psychologist
- Sport Psychologist

These nine specialist areas correspond to the existence of postgraduate education and training courses that lead to Masters or Doctorate degrees that have been accredited by the Australian Psychology Accreditation Council. They also correspond to the above nine Colleges of the Australian Psychological Society.

The criteria for entry onto the specialist register, entitling use of the specialist title, would be award of the relevant postgraduate degree (or an equivalent overseas degree) and eligibility for membership of the relevant College of the Australian Psychological Society.

Section 11 Other Matters

Proposal 11.1.1: *It is proposed that the legislation provide for the national boards to grant registration for a period of up to 12 months and that a grant of registration be subject to annual renewal.*

It is not proposed that there be a standard registration period in legislation that applies to all practitioners, for example a calendar year or a financial year. Rather, it is proposed that the legislation enable, for example, renewals to be staggered throughout the year, with the renewal date for each practitioner falling due 12 months after they first registered or renewed their registration.

Submissions of the Boards

The proposal for annual renewal of registration for a period of up to twelve months is supported by the Boards. However, the proposal that there be no standard registration period in the legislation is problematic. This is because a standard registration period based on the calendar year will become the default registration period for the following reasons:

- The majority of new registrants each year will graduate from Australian universities during November and December.
- The majority of new registrants from foreign jurisdictions will seek registration during October to December as this is the major recruitment period to staff the public sector hospitals for the next calendar year. Recruitment is based on a calendar year to align it with the entry to post graduate education and training positions.

Unless this matter is addressed the national Boards will be exposed to a peak workload in new registrations and in renewal of registrations when access to recruiters/ employers/ applicants (due to the Christmas period) is limited.

Data provided by the national implementation team indicates that (with the exclusion of Queensland which is on a financial year registration period) approximately 40% of annual renewals already fall in December. Maintaining an anniversary date renewal process is high risk both in the quality and timeliness of processing applications for renewal and applications for registration.

The proposed spread of renewals on an anniversary date will also result in a significant loss in interest revenue which will have to be replaced by increasing the quantum of the registration fees established under the scheme. For example, in the financial renewal process used in Queensland, 90% of the annual revenue for each Board is received in May and June and then invested for the financial year with withdrawals being made only on the basis of the maximum monthly expenditure.

If renewals are spread over the calendar year on an anniversary basis the amount available to invest will be reduced. The lost revenue may be significant and, as such, it is proposed that the implementation team undertake more detailed modelling to inform the final decision in regard to determining the registration period to be included in the legislation.

Proposal 11.2.5: *It is proposed that the legislation provide a power for boards to require registrants provide details of each practice address from which they offer regulated health services. Special arrangements would be required so that the reporting obligations are manageable for locum practitioners whose practice address changes regularly.*

ALTERNATIVE OPTION: *There be no requirement to provide a practice address.*

Submissions of the Boards

The proposal that registrants provide a practice address for each practice from which they offer regulated health services is opposed on the basis of its utility and the extensive cost impact for data entry and maintenance of data. In this regard, the Boards request that it be noted:

- A significant number of the professions practice from multiple locations (for example, a VMO with rights to private practice could practice at four or more locations; a dental specialist may do sessional work at up to six different practice locations; a registered nurse may do shifts at multiple locations during each pay period).
- In costing the introduction of criminal history screening, the Office of Health Practitioner Registration Boards identified that the entry of two additional pieces of data for 27,000 registrants required a resource of 1 FTE data processor.
- It is the experience of the Office of Health Practitioner Registration Boards that registrants primarily comply with their notification of change of address obligations when they are renewing their registration and not within the 21 day period of the change occurring. If this proposal is introduced, a further complex data entry process will have to be maintained, either by the registrant directly online or by staff employed by the agency.

Given the above noted factors, a system of maintaining practice addresses of all registrants will be costly and by the very nature of the process always out of date.

The policy issue which does not appear to have been addressed is: (a) whether there will be a requirement placed on applicants to lodge applications with the office in the state in which they intend to practice; (b) whether a jurisdiction of primary practice will need to be notified to inform both workforce planning and receipt/ action of complaints and notifications; and (c) whether a jurisdiction of primary practice will need to be notified to inform which state office should manage the renewal processes for registrants practising in that jurisdiction.

These matters need to be addressed to inform implementation planning and to manage transition to the national scheme. Should it be determined that notification of a jurisdiction of primary practice will be necessary, this should not in any way reduce the rights of registrants receiving a grant of national registration. If a State of primary practice is incorporated as a requirement in the legislative scheme, notifications by registrants of changes to their State of primary practice could be incorporated in the annual renewal of registration.

Proposal 11.3.1: *It is proposed that the legislation include provision for a 'grace' period of three months following expiry of registration, during which a practitioner is 'deemed' to be registered, but that if they fail to renew by the end of this period, then the board removes their name from the relevant register.*

ALTERNATIVE OPTION: *That there is no 'grace' period and that if a practitioner fails to renew their registration on time, their name is removed immediately from the register and they may be committing an offence if they continue to practise.*

Submissions of the Boards

The Boards do not support a grace period as the argument posited is not sustained. In this regard it should be noted that those who continue to practice after the grace period would also be engaged in illegal practice and put at risk their PII coverage. The alternate position

submitted by the Boards is that those that apply during a grace period have registration granted retrospectively to the expiry date rather than prospectively as currently occurs in the majority of jurisdictions. This should address the issue raised in consultation paper. However, a penalty fee should be imposed for those using this mechanism to renew their registration after it has expired.

Section 11.4 Reinstatement to the Register

Proposal 11.4.1: *It is proposed that the legislation include provisions that allow a practitioner's name to be restored to the register, if they re-apply within a period of two years following a lapse of registration (under this Act, or a previous enactment of a participating jurisdiction), and they meet any continuing competence requirements set by the responsible board.*

ALTERNATIVE OPTION: *There be no provision for restoration to the register, and practitioners who hold outdated qualifications and let their registration lapse be required to meet current registration requirements in the event that they reapply for registration, that is, they complete either an approved course of study and supervised practice, or an approved re-entry or refresher course.*

Submissions of the Boards

The options proposed for reinstatement to the Register are not supported by the Boards because they are based on an assumption that a registrant with old qualifications has not practised the profession during the two years following their last registration. If either proposal was included in the legislation, previous registrants with old qualifications who have maintained practice, competence and CPD in a foreign jurisdiction for more than two years would be required to 'complete either an approved course of study and supervised practice, or an approved re-entry or refresher course'.

Similar problems have occurred as a result of the qualification provisions in Queensland legislation. The effect is that applicants who do not hold an approved qualification or do not hold a qualification that is substantially equivalent are not entitled to registration. It will appear nonsensical to such applicants that they be required to sit a qualifying examination or undertake a re-entry course/ supervised practice when the Board has previously determined that they are qualified for registration. To address this matter it is proposed that:

- An additional qualification for registration be included under section 5 being that the person was previously registered under the scheme (or a corresponding previous enactment of a participating jurisdiction).
- An additional basis of refusal be included under section 6.4.1 enabling the relevant Board to refuse to grant registration on the ground that previous registration held under the scheme (or a corresponding previous enactment of a participating jurisdiction) expired two or more years prior to the application.

The effect of the additional qualification and the additional basis for refusal is that a Board may grant registration to an applicant previously registered under the scheme if they meet all fitness to practise requirements as detailed under Proposal 6.4.1. Introducing this requirement will ensure that no unintended consequences impact on those who are fit to practise the profession.

Further Submissions from the Boards

There are a number of matters that are not addressed in the consultation paper which, in the Boards' view, need to be raised for consideration. These are as follows:

Protection for the Provision of Information

It is expected that Bill A will provide relevant protections for officials and supervisors acting on behalf of a Board in implementing its legislative functions. However, those protections may not be wide enough to extend to other parties a Board may seek information from relevant to registration matters. The Boards submit that facilitating the provisional information relevant to an applicant's fitness to practise from an education provider, previous employer, specialist college or professional association will value add to public protection under the scheme.

Fee Mechanisms

The consultation paper is currently silent on mechanisms related to fees. The Boards submit that:

- A power to waive fees in circumstances of financial hardship or administrative error be incorporated in the legislation.
- Pro rata payment of fees (dependent on the standard registration period legislated) not be enabled by the legislation. In this regard the registration fee paid is for registration rather than for any particular period of registration.
- The pro rata refund of fees for those that cancel their registration during a registration period not be enabled by the legislation. In this regard, the registration fee paid is for registration rather than for any particular period of registration.

Inclusion of a fee waiver power with appropriate delegations will enable the Boards to address matters where there is true financial hardship or where the fee was incurred by the applicant/ registrant due to an administrative error of the agency.

Excluding pro rata payment and refund of fees reduces a significant amount of complexity both in the design of Information Communication Technology systems and in financial processing.

Employer Obligations

A number of Queensland Boards have been required to deal with matters where a person qualified and eligible for registration has been employed or has continued in employment without being registered. This raises two matters of concern to the Boards. First, there is no obligation placed on employers to ensure that a person is registered at the time of employment or that a person continues to be registered during the course of that employment. Second, the current 'holding out' provisions generally require Boards to prove that a person held out that they were registered. Legal advice obtained indicates that this is a difficult offence to prove and is narrow in its scope.

The Boards note that there are relevant provisions in the *Nursing Act (Qld) 1992* which address such obligations for both employers and registrants. The Boards submit that consideration be given to including in the legislation the requirements detailed in ss. 77(h) and 123, *Nursing Act (Qld) 1992*.

Section 12 Transition Arrangements

Proposal 12.1: *With respect to transition arrangements, it is proposed that transitional provisions provide for:*

- a. all persons who are registered on 30 June 2010 in one or more of the ten regulated health professions be automatically deemed to be registered under the new national scheme on 1 July 2010, on the register or division of the register specified in the transition provisions, and for the term specified in their registration renewal*
- b. all persons who have endorsements on their registration of a type available under the national scheme on 30 June 2010 be deemed to have endorsement of that type under the national scheme from 1 July 2010*
- c. all persons who have conditions imposed on their registration or endorsement of registration on 30 June 2010 in one jurisdiction be automatically deemed to have the same conditions imposed on their registration or endorsement of registration from 1 July 2010*
- d. where there are disparities between the types of registration or endorsements available under the national scheme and those conferred by existing State and Territory legislation, wherever possible registrants be migrated across to the national scheme with the widest possible scope of practice that is consistent with public safety. They would then be expected to practice within their competence, with conditions imposed only if it is considered necessary to limit their practice in order to protect the public*
- e. where a practitioner is registered in more than one jurisdiction and these registrations expire at different dates, then they be automatically deemed to be registered through until the latest date of registration that applies, unless they have conditions placed on their registration, in which case, they will be deemed to be registered through until the first expiration date that applies, and*
- f. if a practitioner holds or has held multiple registrations and has been either deregistered in one jurisdiction, or has not renewed in a jurisdiction where an investigation or disciplinary process was not finalised, then they not be automatically 'deemed' to be registered from 1 July 2010 and will be required to make a fresh application for registration with an expeditious process required.*

Submission of the Boards

Given that consultation is not yet concluded, the Boards submit that it is difficult to comment in other than a general sense about the proposed transition provisions. It should be noted that the principles underpinning the provisions as proposed are supported but the Boards are unable to provide any specific comment until the exposure draft of the legislation becomes available for review.

Sale of cosmetic contact lenses

This document has been produced by the Optometrists Board of Queensland in response to the Legislative proposal for the regulation of the sale of cosmetic plano contact lenses.

Background

In recent years in Queensland there has been an increase in unregulated sale of plano cosmetic contact lenses, especially those with opaque peripheral tints. These have been sold in a variety of outlets (e.g. the Ekka, flea-markets and in beauty therapy shops).

Current legislative framework

Contact lenses sales are regulated under the Optometrists Registration Act, 2001 under Part 4, Division 1 A, which states:

120A Restriction

- (1) A person who is not a registrant or medical practitioner must not prescribe an optical appliance to a person.

Maximum penalty –1,000 units

- (2) In this section-

“**optical appliance**” means spectacles, contact lenses or other appliance for correcting, remedying or relieving a defect of sight.

Plano cosmetic lenses are not currently included in the restrictions covered by the Optometrists Registration Act, 2001, because they do not correct, remedy, or relieve a defect of sight. This is a legislative anomaly because plano cosmetic contact lenses carry similar risks to other cosmetic contact lenses, and possibly greater risks than non-cosmetic contact lenses.

Section 1. Need for regulation

1 a. Current good clinical practice for contact lens dispensing.

The health of the eye does not differentiate between a cosmetic or corrective contact lens. In both cases, a person is placing a large foreign object on the cornea. This object, if not properly assessed and fitted by a professional and cared for by the individual wearer, has the potential to damage the eye.

Safe wearing of contact lenses requires that the practitioner assess the dimensions and shape of the anterior eye, tear film quality, anterior eye ocular health, fit and movement of the contact lens on the eye. This requires specialist equipment such as keratometers and slit-lamp biomicroscopes. If patients are found to be suitable for contact lens wear, then they need to be carefully instructed in contact lens insertion and removal, and care, hygiene and maintenance of contact lenses, and on the appropriate wearing schedule to build up daily wearing times. During this adaptation period, patients need to be reviewed by the practitioner, again using appropriate equipment. After the adaptation period, patients should be reviewed at regular intervals to ensure that asymptomatic complications do not develop.

If contact lenses are not appropriately fitted they may be either too loose or too tight on the eye. Both have the potential to disrupt the surface of the cornea, a factor which allows microorganisms to colonize the cornea and cause infections. (Young and Coleman). The

board notes that the role of contact lens fitting has been previously ignored in the legislative proposal.

Professional dispensing and prescribing reduces the risk of ocular health incidences and ocular injury. When dealing with other medical devices and pharmaceutical agents, professional dispensing is mandatory. Eye-care should not be any different from any other aspect of primary health care. There must be a consistent regulatory regime in place for both corrective and cosmetic contact lenses. It is in the public interest to ensure that eye injury risk is minimised via regulations that result in professional prescribing and dispensing.

Complications

We have reviewed literature on the optical, pathological and physiological complications of plano cosmetic contact lenses. This is contained in Appendix 1, but summarized below.

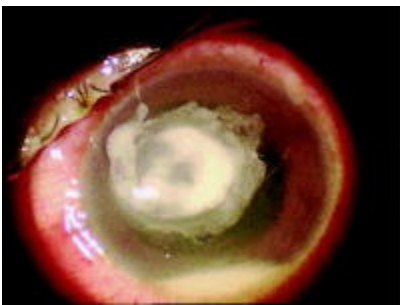


Figure 1. from Steinemann, et al, 2005. Corneal infection induced by plano opaque tint cosmetic contact lenses.

In summary

1. These complications range from corneal distortion and optical blur in the majority of cases, differing levels of irritation, to severe slight threatening corneal infections (see Figure 1). There is *prima facie* evidence that the unrestricted sale of plano cosmetic contact lenses poses a significant risk of damage to eyes and vision to wearers.
2. There is evidence that risk of severe infection arises from a combination of
 - a. poor or non-existent pre-wear assessment (which can lead to poorly fitting lenses, lenses being fitted to patients who are not suitable for contact lens wear).
 - b. poor or non-existent instruction on lens care and poor lens hygiene. (possibly lack of knowledge of insertion and removal techniques)
3. Anecdotal evidence from local practitioners and in the literature suggests that teenagers constitute a substantial proportion of users of these products.

Section 2. Regulation and Options and Board's recommendation.

Given the available evidence, the board recommends that the sale of cosmetic contact lenses be regulated. The board's position is that cosmetic soft contact lenses pose risks similar to, if not greater than, conventional lens soft contact lenses, which are currently regulated under the Optometrists Registration Act, 2001.

Good contact lens practice includes the following:

1. All contact lenses should only be dispensed after proper assessment of eye health
2. and should be properly fitted.
3. Patients need to be adequately instructed on contact lens insertion and removal.
4. Patients need to be adequately monitored after lenses are dispensed.

This means that, for all types of contact lenses, supply of contact lenses needs to take place with involvement from an appropriate eye-care practitioner.

2 a Option 1

Sale of contact lenses is restricted to supply in accordance with a prescription. Like Option 2, this option will restrict supply to those circumstances where adequate assessment of eye health and contact lens fitting has been performed and adequate instruction has been provided for care and use of contact lenses. The proposal from the legislative policy unit does not specify who would be eligible to write the prescriptions, nor does it specify who would have ability to dispense the prescriptions, and some consideration should be given to this. The board's position is that writing of such prescriptions should be limited to Optometrists and Medical Practitioners in line with the current Optometrists Registration Act. Those eligible to supply contact lenses in accordance with prescriptions should include Optometrists and Medical Practitioners, but it might be worthwhile considering other professions as in option 3.

- i. Option 1 may require further legislative and policy development in a number of areas. In Queensland there is currently no legislation on what would constitute a valid contact lens prescription and this would need to be discussed in broader detail, and might involve significant legislative development. While a model might be the Health (Drugs and Poisons) Regulation 1996 (currently used to control prescription of medicines) there are also important differences between contact lenses and prescription medicines in how they are described and how they are used.
- ii. The term "prescribe" in the Optometrists Registration Act does not have a definition in the act and may not preclude supply without a prescription. Thus it may be that if a street vendor supplies a contact lens to a patient, it might not be considered "prescribing". This is likely to remain unclear until tested in a court of law. It might therefore be useful to include a sanction in the act against "supplying" optical appliances and plano cosmetic contact lenses without a prescription. It should be 1000 penalty units, in line with the current penalty for prescribing without a prescription.
- iii. The appropriate sections of the Optometrist's Registration Act would need to be amended to incorporate plano cosmetic contact lenses into the definition "optical appliances"
- iv. The amended act would add some administrative burden on the board. It has the potential to broaden the pool of professions controlled and supervised by the board, if the act were to specify who dispensers could be.

2. b Option 2

Supply of contact lenses is restricted to supply by, or under the supervision of, an optometrist or medical practitioner. This option will restrict sale to those circumstances where adequate assessment of eye health and contact lens fitting has been performed and adequate instruction has been provided on care and use of contact lenses.

i. This option would require small legislative change, with the appropriate section of the Optometrists Registration Act, 2001 being amended to include additional restrictions. For example:

120A Restriction

(1) A person who is not a registrant or medical practitioner must not prescribe an optical appliance to a person.
Maximum penalty –1,000 units

(2) A person who is not a registrant or medical practitioner must not prescribe or supply a contact lens to a person.
Maximum penalty –1,000 units

(3) In this section-
“**optical appliance**” means spectacles, or other appliance for correcting, remedying or relieving a defect of sight..

“**Contact lens**” means a lens designed to be worn in contact with a person’s cornea.

ii. The amended act would require a minimum additional administrative burden on the board. The board’s task would be to ensure that sellers of contact lenses had the registration credentials currently scrutinized by the board.

2.c Option 3

Restrict the sale of cosmetic contact lenses to by, or under the supervision of, registered health practitioners or registered nurses. Practitioners which are covered by this list include: *Registered Nurses, Chiropractors, Dental Practitioners, Dental Technicians and Dental Prosthetists, Medical Radiation Technologists, Occupational Therapists, Optometrists, Osteopaths, Pharmacists, Physiotherapists, Podiatrists, Psychologists, Speech Pathologists.*

The stated purpose of Option 3 is to ensure that “persons with appropriate training and expertise in infection control will be available to explain use and care.”

The board contends that the list of practitioners covered by this proposal is largely comprised of practitioners without training in contact lens infection control, and with inadequate knowledge of insertion and removal techniques, and with inadequate knowledge of patient assessment and contact lens fitting techniques. We also think that the list also means that the lenses are likely to be dispensed in circumstance where inadequate equipment will be available to assess lenses. The proposal suggests that this list be restricted to certain health professionals (e.g. Registered nurses, pharmacists, medical practitioners, optometrists) if necessary to exclude practitioners who may not have the same level of knowledge in relation to lens care and use. The board contends that the necessary restrictions to ensure safe contact lens wear, will mean that mean that only optometrists and medical practitioners will be included in this list, effectively turning Option 3 into Option 2.

i. If a broad list of practitioners is included in Option 3 then there would need to be some monitoring of practitioner contact lens training and skill. There may also need to be some determination of what training is adequate. Option 3 does not outline how such training would be given, nor how it would be assessed. Such monitoring would be necessary to prevent practitioners from engaging in procedures in which they are not adequately skilled.

ii. Option 3 will impose a more complicated administrative burden on the Optometrist's board. Whereas the board currently administers the prescription of optical appliances by two professions, (optometrists and medical practitioners), Option 3 will mean that the board will have regulatory duties involving some 15 professions. Checking appropriate qualifications in some retail situations (e.g. flea markets) would pose particular practical problems. More-over Option 3 creates a situation where the practice of some professions is administered by more than one board, and this may lead to areas of confusion in disciplinary matters.

The board believes Option 3 will not provide sufficient safeguards in terms of patient assessment, contact lens fitting, after care or hygiene.

2d. Option 4

Incorporate the sale of cosmetic contact lenses into the definition of 'beauty therapy' in the Public Health (Infection Control for Personal Appearance Services) Act 2004 to administer appropriate control standards.

The board agrees with the legislative proposal's assessment that this option offers no guarantee that sellers will have an understanding of contact lens care, use, and hygiene and will not be able to provide specific assistance to customers. The board's view is that this option will not provide adequate protection to the public.

Section 3. Other considerations

The legislative proposal lists 4 or 5 main requirements for a regulatory model. The board contends that requirement A is incomplete.

A. that the product is sold with appropriate instructions on use, cleaning, and storage to avoid eye infection and injury. There is sufficient evidence from Steinemann et al, (2003, 2005) that inadequate fitting of contact lenses is implicated in the serious complications listed. Thus *requirement A* should also include that: eye health and lens fit is appropriately assessed to avoid eye infection and injury.

In these circumstances Options 1 and 2 will ensure that requirement A is met. Options 3 and 4 will not.

B. That the product sold is of a safe quality.

This is likely to be met by Options 1,2 3.

C. That the restrictions may be monitored and enforced within existing regulatory regimes to minimize cost and further administrative burden.

From the board's point of view Option 2 would be the easiest to administer, because it represents the smallest change to the existing legislative framework. Option 1 is more more complicated, because it requires some discussion about what will constitute an adequate contact lens prescription, may need additional legislation to proscribe supply without a prescription, and if there is limitation on the professions which can dispense contact lenses, there may be additional professions to administer. Option 3 as discussed above has the potential to be quite complicated in its administration, given the large number of professions which could be administered, and the additional requirements to ensure adequate practitioner training.

D. That the restrictions only limit competition and the operations of businesses to the extent necessary to protect the health of the public.

Only Options 1 and 2 address good fitting and pre-sale assessment of patient health and suitability. These represent the safest options. Option 3 is likely to result in poorly fitting lenses being dispensed to unsuitable candidates, although appropriate hygiene instructions given under this option are likely to partly decrease the risk of infections. Option 4 is likely to result in poorly fitting lenses being dispensed to unsuitable candidates and poor lens hygiene and have the highest rates of complications. The board recognises that Options 1 and 2 restrict competition, but contends that only Options 1 and 2 provide sufficient public safety.

E. That the restrictions not be so onerous or costly as to promote unrestricted internet sales and sharing of cosmetic contact lenses.

This final requirement is difficult to assess. Sharing of contact lenses is likely to occur in circumstances where users do not view the product as a medical device and have not been properly educated in the risks of sharing. In this regard Options 1,2 and perhaps 3 are likely to decrease the risks of sharing. Option 4 may well increase sharing, with users trading readily available colours and designs. There will also be patient groups for whom sharing is more likely; on anecdotal evidence, teenage girls. Options 1 and 2 are likely to limit access to cosmetic contact lenses by this group and decrease overall rates of sharing. A targeted health education campaign may also decrease sharing in this group.

Purchasing lenses via the internet is likely to occur with all four options, and again may not be driven only by the impetus of cost reduction. Again, trivializing the product by lower levels of regulation may drive internet sales. Regulating contact lens sales through Options 1 and 2 is likely to decrease the incidence of impulse buying through traditional sources.

Appendix 1

Complications arising from wearing cosmetic opaque tint plano contact lenses.

1b. Cosmetic contact lenses. Soft contact lenses are made from flexible materials which have some gas permeability, to allow oxygen to pass from atmosphere to the cornea, and for respired gases to pass out of the cornea into the atmosphere. Transparent tints can be added to the lens, which have little effect on the physiological interaction between lens and eye.

The un-regulated sale of plano cosmetic contact lenses has been largely in the area of opaque tinted soft contact lenses. Opaque tint cosmetic contact lenses have additional pigment added to their surfaces, to give an altered appearance to the underlying iris. These effects can mimic natural irises of different colours, and have a therapeutic role in restoring normal appearance to irises which have an abnormal appearance due to deformity or trauma. Opaque tinted contact lenses can, however be made with almost any pattern as “special effects” lenses.

1c. Optical Performance

Incorrectly fitted contact lenses (cosmetic or not) may fit too loosely and have the potential to move excessively on the eye. This can blur and impair vision, and may be a hazard when driving.

When opaque tint cosmetic contact lenses are placed on the eye in the majority of cases they cause circular zones of corneal distortion which can lead to wearers perceiving “haloes” and “ghosting” around objects, sometimes for several hours after the lenses have been removed. (Voetz et al 2004). Even in the absence of complications, opaque tint cosmetic contact lenses have been found to decrease visual acuity, decrease peripheral vision, decrease the ability to see low contrast objects in high medium and low light levels. (Spraul et al, 1998)

1d. Physiological Complications from cosmetic contact lenses.

The therapeutic use of cosmetic contact lenses is associated with complications including conjunctivitis and keratitis in 40% of patients. (Kanemoto et al, 2007), although most of these complications are mild.



Figure 2. Severe bilateral corneal infections caused by opaque tint cosmetic contact lenses in an immuno-compromised patient (Colin et al, 2006).

Use of opaque tint cosmetic contact lenses, without adequate practitioner involvement, has been associated with serious corneal infections which have the potential to blind patients (Steinemann et al 2003; Connell et al, 2004; Steinemann et al, 2005 (Figure 1.), Lee et al,

2007.), including progression to perforation (Colin et al, 2006) in an immuno-compromised patient (Figure 2). In a significant proportion (1/6 to 1/3) of cases of serious complications from opaque tint cosmetic contact lens wear (from unlicensed providers), there was evidence that poorly fitting lenses (tight lens syndrome and limbal indentation) may have been a contributing factor and the reported levels of poor fitting are likely to underestimate the true levels of poor fits. (Steinemann, et al 2003, Steinemann, et al 2005). As a consequence of these complications, the US Food and Drug administration issued a warning against obtaining decorative contact lenses without proper prescription and fitting by a qualified eye care professional. (FDA News October 21, 2002)

In Australia, opaque tinted plano cosmetic contact lens use in a 13 year-old female, resulted in a painful necrotic cornea ulcer which resolved with corneal scarring and thinning and the eye losing sight to beyond the level for legal blindness. (Li et al 2006). In this case the wearer had not been properly fitted or instructed in contact lens wear and had borrowed the lenses from a friend. Anecdotal evidence is that, locally, teenagers make up a significant proportion of wearers purchasing opaque tint cosmetic contact lenses through unregulated sources, which appears to be also the case in other countries (Lee et al, 2007.) with 33% of patients with serious complications in one case series being teenagers, (Steinemann et al, 2005).

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