An open letter to Federal and State Health Ministers, Ahpra and the National Boards

The safe expansion of diagnostic authority and prescribing in Australia.

We write collectively to set out shared principles to guide the safe expansion of prescribing and diagnostic authority within Australia's health system.

This letter is intended to support National Boards, Ahpra, and governments in ensuring that regulatory approaches remain aligned with patient safety, system integrity, and the realities of clinical care.

This is not a statement about professional boundaries or the capability of any profession. Rather, it addresses the **conditions required for the safe exercise of diagnostic authority over time**, particularly in clinical contexts where uncertainty is inherent and harm may emerge after the initial encounter. Older Australians and other vulnerable populations are disproportionately affected by fragmented care and medication related harm.

Context

We acknowledge the objective of improving access to care across Australia. However, we hold significant concerns regarding whether the proposed model, as currently designed, sufficiently ensures patient safety and maintains the high standards required for safe prescribing practice.

Prescribing is not a standalone technical activity and is intrinsically linked to diagnostic capability. It is the culmination of a diagnostic process that often unfolds over time. Across all areas of clinical practice, care routinely involves:

- Undifferentiated presentations at first contact
- Overlapping symptoms between benign and serious conditions (diagnostic reasoning)
- Diagnostic uncertainty as a baseline state, rather than an exception
- Reassessment, review and revision as integral components of care.

In this reality, **systems of care – not just individual capability – are critical to patient safety**.

Prescribing safety should be evaluated across the full continuum of care, not just at the point of care. This necessitates systems that enable continuity, structured follow-up and clear lines of responsibility for patient outcomes. Approaches delivered in fragmented or episodic settings risk limiting ongoing review, constraining opportunities for reassessment and increasing the likelihood of conditions being overlooked or identified too late.

As models of care evolve and prescribing roles expand, it is essential that regulatory approaches preserve and strengthen these safeguards, rather than inadvertently weaken them.

These principles are particularly relevant in the context of current consultations and policy discussions regarding the expansion of prescribing and diagnostic authority, including consideration of endorsement pathways by National Boards. The signatories acknowledge and respect the importance of these consultation processes and do not seek to pre-empt their outcomes. Rather, this statement is offered to support those processes by highlighting system-level safeguards that are critical to patient safety over time.

Core Principle

Diagnostic authority should only be conferred and exercised within systems that are capable of managing uncertainty, detecting emerging harm and ensuring accountability over time.

Simple message

Safe expansion of prescribing and diagnostic authority must be built on **systems that manage uncertainty, ensure continuity of care, and maintain clear accountability over time**—not just individual competence. The focus should be on **strong governance and care models that can detect and respond to harm early**, ensuring patient safety across the full clinical journey.

Principles of safe diagnostic authority and prescribing

1. **Diagnosis is a longitudinal process**

- Diagnosis is rarely resolved in a single encounter. It often requires:
  - Time as a diagnostic tool
  - Follow-up and reassessment
  - Recognition of evolving clinical patterns
  - Revision of initial assumptions

Safe prescribing therefore depends on systems that support ongoing clinical engagement, not just point-in-time decision-making.

2. **Safety depends on systems, not individual capability alone**

- While competence and training are essential, they are not sufficient to ensure safety in isolation.
- Safe diagnostic and prescribing practice requires:
  - Access to continuity of care
  - Mechanisms for recall and review
  - Ability to escalate or refer when uncertainty persists
  - Visibility of patient history and evolving clinical information

Regulatory frameworks must recognise that risk management is a property of systems, not solely of individual practitioners.

3. **Continuity and follow-up are core clinical safeguards**

- Continuity of care is not an aspirational feature; it is a foundational safety mechanism. It enables:
  - Early detection of diagnostic error
  - Adjustment of treatment as conditions evolve
  - Accountability for outcomes across time

Where continuity is absent or discretionary, the system's capacity to detect and correct harm is reduced.

4. **Regulatory models must be matched to the risk profile of care**

- Not all forms of care carry the same risk characteristics. Diagnostic and prescribing activities may involve:
  - Delayed harm, emerging days or weeks later
  - Diffuse harm, presenting across multiple providers
  - Low likelihood of complaint, particularly where harm is subtle or attributed elsewhere.

Regulatory approaches must be appropriate to these characteristics.
Where harm is delayed and under-detected, reliance on complaints-based systems alone is insufficient.

5. **Governance and training must precede scope expansion**

- Expansion of prescribing authority should occur within clearly defined and governed care models that include:
  - Defined roles and responsibilities
  - Explicit accountability for outcomes
  - Structured follow-up and escalation pathways
  - Integration with broader clinical systems

Embedding authority without these governance structures risks shifting responsibility from system design to individual discretion.

The completion of an approved education program alone does not equate to readiness for autonomous prescribing. Clinical competence requires substantial supervised experience, work-integrated learning and ongoing mentorship to safely translate theory into practice.

Governance frameworks must also ensure that clinical decision-making remains independent and aligned with patient need. This includes considering how care settings are structured, particularly where prescribing and supply functions coexist within the same care setting. Regulatory frameworks should explicitly consider and manage potential conflicts to ensure that clinical decision-making remains clearly aligned with patient need and independent of commercial influence.

Training and credentialing must align with the realities of clinical practice, including the management of diagnostic uncertainty over time, the need for reassessment and revision and accountability for evolving patient outcomes. Safe implementation also requires transition into advanced clinical practice through mentorship, peer review, clinical governance and ongoing professional support, particularly where practitioners assume responsibility for increasingly complex clinical decision-making.

6. Prescribing authority should be linked to care models, not solely to registration

- Safe prescribing is best supported when it is embedded within care environments that provide:
  - Longitudinal patient engagement
  - Shared clinical records and information flows
  - Multidisciplinary collaboration
  - Established pathways for reassessment and review

When prescribing authority is portable across settings, these safeguards may not consistently be present.

This introduces variability in care quality and risk management capacity.

7. Accountability for diagnostic outcomes must be clear and retained

- Effective systems ensure that:
  - Responsibility for patient outcomes is clearly defined
  - There is visibility of the diagnostic pathway over time
  - Patients know where to return if their condition changes

When care becomes episodic and fragmented, accountability may become diffuse, reducing the system's ability to respond effectively when problems arise.

8. Early detection of harm must be achievable in practice

- Regulatory systems should enable:
  - identification of emerging patterns of diagnostic error
  - attribution of harm across fragmented care pathways
  - timely intervention before harm becomes widespread

Where regulatory oversight depends on harm reaching a detectable threshold, intervention may occur too late to prevent avoidable outcomes.

9. Preventive regulation is preferable to corrective regulation

- Health systems are safer when risks are addressed prospectively, through design, rather than retrospectively, through response to harm.
- Preventive approaches include:
  - Ensuring governance structures are in place before authority is expanded
  - Maintaining mechanisms to test, refine and if necessary, recalibrate models of care
  - Preserving the ability to adapt in response to emerging evidence.

10. System resilience depends on the ability to recalibrate over time

- Regulatory and policy decisions should preserve the system's capacity to:
  - Pause or adjust expansion where needed
  - Introduce additional safeguards as risks become apparent
  - Respond to new evidence without requiring widespread harm to justify change

Where authority is embedded in ways that are difficult to revisit, system resilience is reduced.

Implications for regulatory and policy settings

These principles highlight that:

- Expansion of prescribing roles should be aligned with care models that support diagnostic safety over time
- Regulatory approaches should prioritise early detection and prevention of harm, particularly where harm is not readily visible
- Decisions about professional authority should consider system-level effects, not only point-of-care performance
- The interaction between regulation, care environments and patient pathways should be explicitly assessed
- Where prescribing authority is exercised within multidisciplinary models of care, funding, governance and information-sharing arrangements should support collaboration, continuity of care and accountability for patient outcomes.

This is particularly important in contexts where prescribing is linked to diagnostic processes that cannot be reliably resolved in a single encounter.

Conclusion

Across all areas of healthcare, there is a shared recognition that:

- Diagnostic uncertainty is common
- Clinical decisions evolve over time
- Systems of care play a critical role in ensuring safe outcomes

The safe expansion of prescribing and diagnostic authority depends not only on who can perform these functions, but on whether the system surrounding those functions is designed to support them safely.

When diagnoses are uncertain, evolving or incorrect, the system must be able to detect risk, respond effectively and protect patients over time.

Call to action

We encourage Ahpra, National Boards and Health Ministers to ensure that regulatory and policy settings preserve and strengthen system-level safeguards that protect patients across the full trajectory of care.

The principles outlined in this letter are offered to support a health system that is safe, accountable, adaptive and fit for the future.

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