NEW SOUTH WALES Medical Board

Board News

APRIL 2010

IMPORTANT NOTICE TO ALL DOCTORS

In preparation for the transition to the National Register, the Board will be shutting down its IT system in the period preceding 30 June 2010, and will not be accepting applications for registration beyond 18 June in order to ensure that transfer of information from the Medical Board's database to the new National database occurs seamlessly. If you anticipate needing to deal with the Board in the last two weeks of June, every effort should be made to bring your business forward, as the Board cannot guarantee that it will be able to finalise last-minute matters during this transitional period.

The end of an era

This publication will probably be the last Newsletter published under the auspices of the New South Wales Medical Board which on 30 June 2010 will be ceasing operations, after a continuous history stretching back to 30 December 1838 when the first Board Meeting was held.

On 1 July 2010, the functions of the Board will be taken over by two separate bodies, with registration becoming a national process administered by the Medical Board of Australia under the umbrella of the Australian Health Practitioner Regulation Agency. Regulatory matters concerning medical services provided in NSW will be handled by a new State-based authority to be known as the Health Professional Councils Authority. In practice, the current Board members will continue to serve on both structures wearing new hats, namely as members of the NSW Board of the Medical Board of Australia when dealing with registration matters, and as members of the Medical Council of NSW when dealing with matters concerning conduct, performance and health of medical practitioners. Regulatory business will continue to be based at the Board's Gladesville premises, while registration will be dealt with in new premises in the city. Most existing Board staff have been offered positions in one or other of the new organisations, depending on their current functions.

Practising doctors and medical students in NSW should not notice any significant change. The national registration provisions are substantially similar to those currently operative in NSW, while the proposed legislation governing the regulatory functions under the new system is based on the current Medical Practice Act. A great deal of effort is going into ensuring that the transition is seamless, and that disruption on the changeover is minimal.

I have been associated with the Board for only ten of its one hundred and seventy one year history, but I consider that the public and profession owe a debt of gratitude to the work of the Board and its members in maintaining the standards of medical practice in

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What National Registration will mean for registrants in NSW

Overall, there will be very little practical difference to doctors currently registered in NSW with the introduction of National Registration on 1 July 2010.

Confirmation of status

The Australian Health Practitioner Regulation Agency plans to write to all registrants in April confirming their current personal details and indicating what their registration status will be under the new legislation. An opportunity will be provided to correct any errors, as well as to remove duplication where multiple registrations are held. Under the National Scheme, there will just be Australian registration, ie. no need to register in more than one State or Territory.

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Medical Board

The end of an era (Continued from page 1)

this State. It would be naïve to ignore the small number of notorious cases in recent years where medical practitioners have failed to meet the standards of conduct and practice that ought to be expected of them, but it would also be naïve to suggest that any system involving a large number of human beings in complex and often difficult and demanding situations is going to be perfect. There will always be room for improvement, just as there will always be colleagues who for one reason or another fail to measure up to the expected standards, but I consider that the system which has been developed in NSW, and which will substantially carry over into the new national scheme, has served the public and the profession well.

The successful functioning of the Board would not be possible without the enormous contribution made by Board members and the considerable number of members of the profession who contribute their time and expertise to assist the Board in carrying out its responsibilities. Standing in judgment on one's peers can be difficult and confronting, but we have been very well served by our colleagues who accept this as one of their responsibilities as professionals.

The days of pure self-regulation are long gone, but I believe that the model of regulation by members of the profession with significant lay input at all levels has found an effective balance, and the contribution of public members in all aspects of Board activities must also be acknowledged.

Lastly, the whole system could not function effectively without the work of an effective secretariat, and without a doubt, the New South Wales Medical Board has been very well served in this regard. I would like to particularly acknowledge Andrew Dix who, as Registrar and CEO, has led the Board's secretariat for the last twenty two years and has in no small way been responsible for the considerable progress made by the Board over that time. His expertise in medical regulation is recognised both nationally and internationally.

1 July 2010 will mark the beginning of a new chapter in the history of medical regulation in NSW and Australia, but the change will be evolutionary rather than revolutionary, and built upon very firm foundations. In some ways, 30 June will be a sad day as we farewell an old and respected institution, but it is to be hoped that the new order will be imbued with the philosophy of the old, seeking continued regulatory improvement aimed at meeting its charter of protecting the public.

Associate Professor Peter Procopis
President, NSW Medical Board

Coroner's Act 2009 - changes

The new Coroner's Act 2009 makes some important changes that are of interest to doctors. In particular, the range of circumstances which you need to refer a matter to the Coroner has been substantially circumscribed to reduce the numbers of reports in which are predictable and non-suspicious circumstances, e.g. deaths of elderly people in hospitals and nursing homes. Other changes include:

- the requirement to report deaths resulting from the use of anaesthetics is replaced with a requirement for the reporting and investigating of deaths that are not the reasonably expected outcomes of health procedures;
- current provisions that require a death to be reported (and that prohibit a death certificate being issued) if the deceased person was not attended by a medical practitioner in the 3 months preceding death are replaced with provisions that extend that period to 6 months;
- the requirement to report a death if the deceased person died within a year and a day of an accident to which the death is attributable will no longer apply;
- a medical practitioner is authorised to give a death certificate concerning a cause of death in respect of a deceased person aged 72 years old or older who died as a result of injuries from an accident even if the accident occurred in a hospital or nursing home.

The Act can be accessed at:
www.legislation.nsw.gov.au

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What National Registration will mean for registrants in NSW

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Registration matters

From 1 July 2010, all registration matters will be handled by AHPRA, principally through the NSW State Office, while decision-making regarding registration within the State will be dealt with by the "NSW Board" of the Medical Board of Australia, functioning as a Committee of the Medical Board of Australia. Policies and procedures regarding registration are currently being developed by the Medical Board of Australia and are available for review on its website at www.medicalboard.gov.au.

Registration renewal for all medical practitioners will occur on 30 September 2010, and AHPRA will issue notices in advance. Facilities will be available for on-line registration.

Registration of International Medical Graduates will be in accordance with the national legislation and the current categories of registration will be substantially reflected in the new system. Advice will be given by AHPRA in due course regarding new procedures, but it is to be expected that the majority of existing requirements regarding, for example, English-language competency, verification of qualifications, ID checking, etc, will be carried over.

All registrants will be required to meet standards regarding professional indemnity insurance, continuing professional development and recency of practice.

Transitional provisions will ensure that all applications for registration made before 1 July 2010 can be carried over.

Complaints and notifications

As previously advised, NSW has opted out of the National Scheme in relation to the handling of complaints and notifications. These matters will be dealt with under the auspices of the proposed NSW Health Professional Councils Authority via the Medical Council of NSW. The structure of the system handling conduct, performance and health matters will be substantially the same as that currently operative under the Medical Practice Act, involving a co-regulatory relationship with the Health Care Complaints Commission. The Medical Council of NSW jurisdiction will relate to clinical or other issues arising within NSW. A registrant with a principal place of practice in NSW about whom a complaint is made in relation to an issue arising outside NSW will be dealt with under the national system in the State or Territory in which the incident occurred.

The transitional provisions will also ensure that matters in the Performance, Conduct and Health streams also carry over into the new system seamlessly.

Board membership

Members of the Medical Board are nominated by a wide range of bodies specified in the *Medical Practice Act 1992*, and are appointed by the Governor.

Recent changes to membership of the Board include the appointment of Mr Antony Carpentieri and Ms Lorraine Poulos as nominees of the Minister for Health following the expiration of the terms of Professor Helen Lapsley and Ms Maria Kelly. Dr Kerry Chant has also been appointed as a nominee of the Department of Health, replacing Dr Denise Robinson. Dr Anthony Eyers replaces retiring A/Prof Michael Fearnside as nominee of the Royal Australasian College of Surgeons and Dr Greg Kesby becomes Deputy President of the Board. Mr Michael Christodoulou has been appointed as the Community Relations Commission nominee in place of A/Professor Eugene Molodysky.

On 30 June 2010, the current Board will cease to exist. On 1 July 2010, the NSW Board of the Medical Board of Australia, consisting of the same members will come into existence to deal with registration matters. Regulatory (conduct, performance, health) matters will be handled by the new Medical Council of NSW, also consisting of the same members.

Current members of the Board and their nominating bodies are listed below.

Member	Nomination
A/Professor Peter Procopis (President)	Royal Australasian College of Physicians
Dr Anthony Eyers	Royal Australasian College of Surgeons
Dr Stephen Adelstein	Royal College of Pathologists of Australia
Professor Belinda Bennett	Minister for Health (Barrister or Solicitor)
Dr Sue Ieraci	Minister for Health
Mr Antony Carpentieri	Minister for Health
Ms Rosemary Kusuma	Minister for Health
Ms Lorraine Poulos	Minister for Health
A/Professor Rod McMahon	Royal Australasian College of General Practitioners
Mr Michael Christodoulou	Community Relations Commission
Dr Robyn Napier	Australian Medical Association
A/Professor F John Palmer	Royal Australian College of Radiologists
Dr Kerry Chant	Department of Health
Dr Denis Smith	Royal Australian College of Administrators
Professor Allan Spigelman	Universities
Dr Greg Stewart	Minister for Health
Dr Kendra Sundquist Ed.D	Minister for Health
Dr Greg Kesby (Deputy President)	Royal Australian College of Obstetricians and Gynaecologists
Professor Kay Wilhelm	Royal Australian College of Psychiatrists
Dr Choon-Siew Yong	Australian Medical Association

Obligations on de-registered and unregistered health practitioners

De-registered doctors offering a health service must inform patient and employers in writing of matters relating to de-registration or prohibition orders.

Under the *Public Health (General) Amendment (Health Practitioners) Regulation 2009*, which came into effect in March, a de-registered person must inform patients and employers, in writing, of the type of registration previously held and the date of, period and reasons for de-registration or prohibition orders.

As well as ordering de-registration, the Medical Tribunal can make a 'prohibition order' (s41A Health Care Complaints Act) in the interests of public safety, which prevents or imposes conditions on a de-registered doctor providing other services in an unregistered health field.

The legislative framework related to unregistered health practitioners is underpinned by the Code of Conduct for unregistered practitioners, prescribed by Regulations under the Public Health Act 1991 introduced in August 2008 (visit www.hccc.nsw.gov.au for information)

Unregistered health practitioners may include:

- practitioners whose registration has been suspended or cancelled for whatever reason, and who seek to practise in an area where they do not need registration
- health providers who are not required to be registered with a registration board such as naturopaths, acupuncturists and psychotherapists
- registered practitioners who provide health services that are unrelated to their registration.

Do you know who your friends are?

Practitioners are advised to think twice before they 'converse' about patients or their work on social networking sites. The usual rules about confidentiality apply, but even when patients are not identified, members of the public may be upset by the content of such postings.

The Board recently counselled a practitioner in relation to flippant and at times derogatory comments about patients from the workplace, which had been accessed on Facebook by a disgruntled patient.

Facebook users are reminded that despite their privacy settings, no security measures are perfect or impenetrable. Authors cannot control the actions of other users with whom they share information, and there is no guarantee that their posted content will only be viewed by individuals known to or authorised by the author.

Unlike a face to face or telephone chat with a friend, online conversations are enduring and may come back to haunt you.

Dr Who?

Registered doctors should be able to be identified as such by members of the public. The Board is aware that some doctors practise under names that differ from their registered name for a variety of reasons.

Practising under a name other than the registered name e.g. a contraction like Dr Salmo instead of Dr Salmonella or Dr Nick instead of Dr Fred Nicholas may create problems if registration cannot be verified when a member of the public, Medicare or a hospital makes an enquiry.

The Board is required to ensure that details contained in the Register are accurate. Doctors who use a name other than their registered name must notify the Board of the name by which they are commonly known.

They should also ensure that details of their full registered name, as well as any name by which they are commonly known, is clearly and prominently visible at locations where they practise and is included on correspondence.

Resuscitation skills

As a result of a complaint in relation to the resuscitation of a patient, the Board reminds all registered medical practitioners who conduct high risk, interventional procedures to ensure their resuscitation and CPR skills are up-to-date and that they have the necessary equipment on hand. Practices should be equipped to a standard commensurate with the risks faced by their patients. Further information, including details of recent changes to CPR technique can be obtained at: www.resus.org.au

Prescribing in an emergency

In an emergency situation, the Poisons and Therapeutic Goods Regulation 2008 allows medical practitioners to prescribe via telephone, email or fax. A standard prescription must then be completed, making reference to the emergency order. The patient should not be relied upon to deliver the script. It is your responsibility to ensure that it is posted or delivered to the dispensing pharmacy within 24 hours. The National Policy for Technology-Based Patient Consultations can be accessed on the Board's website: www.nswmb.org.au/page/317/resources/policies/

Guidelines for supervising clinical observers

Registered medical practitioners may choose to supervise unregistered persons who are undertaking a clinical observership or observing clinical practice for other reasons. Usually clinical observers are unregistered international medical graduates. Unregistered clinical observers may raise public safety and insurance issues. The NSW Medical Board has accordingly developed the following guidelines with regard to the supervision of observers:

Supervision

Any institution, practice etc that allows observers to be present should have procedures in place to record details of the observer, the nature of the observership and the written consent of all supervisors willing to accept responsibility. A clinical observer must at all times be under the direct supervision of a medical practitioner who is registered in NSW without imposed conditions.

Direct supervision requires that the supervisor observe the actions of the clinical observer personally and not delegate the supervision role to a person who is not a registered medical practitioner.

All supervisors should be aware that they are professionally accountable for the actions of clinical observers under their supervision. The scope of a clinical observer's interaction with patients allowed by the supervisor should be guided by the observer's background, training and experience.

Consent

Supervisors must inform and obtain the consent of all patients with whom the clinical observer is in contact; the consent as to their presence and any supervised activities undertaken by them, may be written or verbal.

Scope of the clinical observer role

Subject to the above, clinical observers **may**:

- observe medical and surgical practice;
- conduct supervised interviews;
- conduct limited supervised clinical examinations (except for invasive or intimate examinations);
- participate in educational activities (clinical tutorials, ward rounds and clinic visits) under direct or indirect supervision;
- observe the use of paper and electronic medical information systems, health records, laboratory, radiology and other clinical reports under direct supervision.

Clinical observers **may not**:

- make entries in the patient's medical record;
- give any medical advice to a patient;
- prescribe treatment;
- take a telephone call regarding clinical matters on behalf of their supervisor or other clinicians;
- be responsible for the communication of clinical information about a patient to another medical practitioner or clinician, or to patients, their carers or families;
- independently access a patient's medical information or health records;
- make copies of clinical information (unless with the direct permission of their supervisor, and where the information does not contain details which may enable the identification of patients);
- perform or assist with any medical procedures, including minor procedures and assisting in any capacity in an operating theatre environment.

Confidentiality

It is the responsibility of the supervisor to ensure that the observer understands their obligations to follow the rules and regulations of the hospital, clinic or practice at all times with regard to patient confidentiality and confidentiality of health records.

Infection control

It is the responsibility of the supervisor to ensure that the observer complies with the rules and regulations of the hospital, clinic or private practice at all times with regard to infection control.

This may include the requirement to provide proof of immunisation prior to the commencement of the period of observation.

Pre-employment checks

Clinical observers are subject to the same pre-employment screening of other paid and unpaid health workers in the organisation or practice in which the period of observation is to occur.

This may include such screening as the Working with Children Check, the Aged Care Check and the National Criminal Record Check.

Fatigue management: Kay Wilhelm

Disclaimer

The following article by Professor Kay Wilhelm AM, MD, BS, FRANZCP, Senior Staff Specialist, Consultation Liaison Psychiatry, St Vincent's Hospital, and Chair of the Board's Health Committee, raises important issues of performance and fatigue in the workplace. This is a matter of considerable interest to the Board, though it should be noted that the views expressed in the article are those of Prof Wilhelm, and do not represent a formal position taken by the Board.

Fatigue management is now being taken more seriously affecting groups working long hours and involved in shift work. Work-related fatigue has a numbers of aspects: (1) time-on-task fatigue, ie, working too long and/or at too great an intensity; (ii) working at inappropriate times in the circadian cycle and (iii) inadequate sleep recovery time, which has both cumulative and dose-dependent effects.

Effects of sleep deprivation

For healthy adults, less than 5 hrs sleep per night leads to increased drive to sleep, lowered frustration tolerance, increased anger and irritability, decline in cognitive performance and decreased manual dexterity. The effect of 18 hours of sustained wakefulness produces cognitive impairment equivalent to having a blood alcohol level of 0.5% and 24 hours of wakefulness, equivalent to a blood alcohol level of 0.1%.

Work-related effects on performance include: impaired information recall, failures of attention and new learning, poorer quality intubations, longer time to perform some operations and poorer ECG interpretation but no difference in routine bedside evaluation or detecting nodules on X-ray. The burden is also accentuated in the face of minimal staffing in hospitals at nights and weekends and in the face of long delays in 'finding beds'. Sleep deprivation leads to increases in motor vehicle accidents, 'near misses' and decreased immunity. On the interpersonal front, sleep deprived doctors can have less empathy for patients and poor communication which also translates to significant family and marital stress.

For those vulnerable to mood dysregulation, sleep deprivation can precipitate mania, while shift work can precipitate depression, particularly in settings of perceived powerless and frustration. The Board's Health Committee supports doctors dealing with these issues and encourages a proactive, problem solving approach involving individual doctors and their workplace.

Another facet often overlooked is that of sleep inertia, which occurs when someone is woken after 3-6 hours of sleep and is typified by slowed speech, substantial performance deficits, poor memory, impaired decision making. This is reversed by time awake and stimulation (eg caffeine) but little is known about effects of answering pages, phone calls responding to emergencies when awoken and in a period of sleep inertia. This is an important issue affecting all doctors on call.

When these issues are raised, the initial response by the system is to limit the hours and in the US doctors now work a maximum 90 hours week. However, mandating less work hours does not always translate into more sleep and needs to be balanced against availability of doctors, and the need for junior doctors 'to do enough time' to gain experience. However, hospitals are 24/7 services being staffed during office hours, with the rest of the time as "after hours". However, 'after hours' and 'on call' work allows junior doctors to see a broader range of clinical material.

Measures to lessen work-related fatigue

The most effective measure is sufficient sleep before and after the shift. This means a good sleep prior the preceding night. A nap prior to a long shift increases alertness throughout the shift. If possible, schedule naps during long shifts (15 minutes at 2-3 hour intervals help performance (2 hours maximum to minimise sleep inertia). It is best to wait until after 9 am to go to sleep after sustained sleeplessness: the hours from 2am to 9am are the most refractory to countermeasures and it is best to 'tidy up' any loose ends prior to sleep.

What can individual doctors do?

During the shift, it is useful to

- Ensure meal breaks, high protein snack at regular intervals, good hydration
- Have comfortable areas to withdraw and rest
- Have caffeine, for a short term boost
- Have some task rotation
- Avoid driving home while fatigued; if possible, have a bed available on site
- After a sustained shift, if rest is not possible, ask your superiors to allocate you to less complex, more routine tasks

Suggested approaches for teams and hospital systems, along with references and extra material are available on the Board's website

National Hand Hygiene Initiative

The Australian Commission on Safety and Quality in Health Care has developed a program for achieving high compliance with hand hygiene according to WHO standards. The initiative will be coordinated by the Department of Health and a rigorous education and training program in the 5 Moments for Hand Hygiene process will be implemented by Hand Hygiene Australia across all public and private hospitals in order to reduce healthcare and opportunity costs associated with *Staphylococcus Aureus bacteraemia*. For further information and a wide selection of educational and promotional material, go to: www.hha.org.au

In the Medical Tribunal

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The Medical Tribunal is responsible for hearing serious complaints against doctors. The Tribunal has the power to deregister, suspend, fine and place conditions on a doctor's registration. The Tribunal is made up of a District Court judge, two doctors and a lay person. The Health Care Complaints Commission prosecutes complaints before the Tribunal and the doctor is generally assisted by a medical defence organisation. The Medical Board appears as the opponent/respondent in Tribunal matters involving a person seeking restoration to the Register, and in matters where a practitioner is appealing a Board decision.

Note: Every effort is made to ensure accuracy and balance in these summaries, but readers are also advised to access the Board's website to read full decisions and to check the Register of Medical Practitioners to ascertain the current status of any doctor (www.nswmb.org.au). The summaries are based on decisions handed down between April 2009 and January 2010. These decisions provide valuable information to the profession and the community about standards and disciplinary processes.

Professional boundaries and breach of condition

Complaint

It was alleged that Mr Swapan Chowdhury (MBBS (India) 1979 AMC 1984) was guilty of unsatisfactory professional conduct/professional misconduct within the meaning of sections 36 and 37 of the Medical Practice Act 1992. It was alleged that between 3 March and 23 May 2003, he failed to maintain proper professional boundaries with a female patient and between 19 July 2005 and 19 September 2006, he contravened a condition imposed on his registration by a Performance Review Panel Inquiry held on 28 April 2005.

The practitioner admitted to breaching conditions on his registration.

Findings/orders

The Medical Tribunal was satisfied that Complaint 1 had not been established. Complaint 2 was admitted and was therefore found proved and he was found guilty of professional misconduct. Orders were made that the practitioner not be re-registered, not provide any health services and not make an application for review until the expiration of two years from the date that the NSW Medical Tribunal reserved its decision in this matter (27 February 2009).[1]

1. This matter has since been the subject of an appeal by Mr Chowdhury. The appeal was allowed and the Court of Appeal has remitted the matter to be redetermined in the Medical Tribunal on the question of the proper characterisation of Dr Chowdhury's conduct and any appropriate orders.

Breach of conditions, practising without approved professional indemnity, false representations

Complaint

It was alleged that Mr Rajesh Dinakar, (MBBS (Osmania, India) 1973) a suburban GP had failed to comply with conditions imposed on his registration first by a Professional Standards Committee, again by a Section 66 Inquiry and yet again by a Medical Tribunal requiring that he complete certain educational courses. It was further alleged that Mr Dinakar was guilty of unsatisfactory professional conduct and/or professional misconduct in practising without approved professional indemnity insurance, making false representations to the Board in relation to the nature and currency of his insurance and in failing to provide information required by the Board relating to his insurance and the matters which were the subject of the conditions upon his registration.

Findings

The Tribunal was satisfied that Mr Dinakar was guilty of professional misconduct, was not currently fit to practise medicine and that deregistration was justified. The Tribunal ordered that Mr Dinakar be precluded from applying for re-registration for 6 months following his provision to the Board of documentary evidence of successful completion of the educational courses he is required to undertake.

Inappropriate prescribing

Complaint

The complaint against Dr Ian R Hutchins, (MBBS (NSW) 1976) was that he overprescribed drugs to seven drug dependent patients without exercising responsible medical judgement and without having the approval to do so. It was also alleged that Dr Hutchins' medical record keeping was inadequate.

Findings

The Tribunal was satisfied that Dr Hutchins was guilty of professional misconduct in relation to his prescribing and guilty of unsatisfactory professional conduct in relation to his record keeping. The Tribunal ordered that practice conditions be imposed on his registration prohibiting his prescribing, possessing, administering or supplying drugs of addiction and that in addition he attend counselling and further training, and that he be supervised and subject to random audits of his medical records.

Appeal – Area of need post position

Issue

Dr Willie Calimbas (MBBS Bicol Christian College, Philippines (1976)) appealed to the Medical Tribunal against the Board's decision to decline his AON registration for a post in Taree, following an adverse report from his previous supervisor in relation to his record keeping, and inability to seek assistance from his supervisor.

Findings

Dr Calimbas acknowledged that his record keeping was extremely poor but argued that this would be rectified in the new position. The Tribunal noted that he had already been given many chances, and that the primary concern was his inability to seek assistance from his supervisor.

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In the Medical Tribunal

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Evidence confirmed that the practice was unable to offer the level of supervision that he required and the offer of the position was withdrawn. Dr Calimbas withdrew his appeal and it was dismissed by the Tribunal.

Breach of critical compliance conditions

Complaint

The Board referred a complaint to the Tribunal concerning Dr Jason Martin (MBBS (Sydney) 1996), a general practitioner whose registration was subject to critical compliance conditions, including a condition that he attend for thrice-weekly urine drug testing in strict accordance with the Board's Urine Drug Testing protocol. The complaint alleged that the practitioner breached the condition in two respects – he missed a urine test on a date on which a test was scheduled and he failed to immediately notify the Board of the missed test as required by the Urine Drug Testing Protocol.

Findings

The Tribunal was satisfied that Dr Martin had breached the critical compliance condition in these two respects and in accordance with section 64(1A) of the Medical Practice Act, de-registered the practitioner and ordered that he not apply for re-registration for a period of 4 months.

Impairment

Complaint

It was alleged that Dr Ali H Kalarostaghi (MBBS (Syd) 1994) suffers from a mental disorder and by reason of that impairment is not competent to practise medicine. A second particular of the complaint related to his inappropriately prescribing medication to himself and family members.

Findings

The Tribunal found the particulars proven and that Dr Kalarostaghi's conduct amounted to unsatisfactory professional conduct. It noted that such conduct could amount to professional misconduct but that the practitioner's judgement was impaired by his mental illness. It determined that Dr Kalarostaghi be de-registered for the protection of the public.

Appeal – exemption from English language proficiency requirements

Issue

Dr Montaser Mekha (MBBS (Iraq) 1986) an international medical graduate who had failed to meet the National English language proficiency requirements, and who was therefore registered subject to conditions that he work under direct supervision at all times and not work out of hours, appealed to the Tribunal to be exempted from these conditions. He asserted that he had been able to safely practise without these conditions in the ACT and Victoria.

Findings

The Tribunal refused Dr Mekha's application to be exempted from the English language proficiency requirements and ordered that the conditions on his registration would remain.

Determination as to costs

The Tribunal considered a submission by Dr Mekha that he was unable to pay the costs of the court because he was without a job. In the circumstances, the Tribunal considered that the appropriate order for costs is that the appellant pay half the costs of the Medical Board in respect of the appeal. It was noted that the appellant represented himself at the hearing.

Professional boundaries

Complaint

Dr Derrick Perera (MBBS (Sri Lanka) 1954 FRACGP 1977) was found guilty of professional misconduct by the Tribunal for failing to observe professional boundaries during a consultation. The Tribunal found the practitioner spoke to a patient in an inappropriate manner, attempted to kiss her, placed his cheek against hers, touched her face without explanation, held her with his left hand moving around her back and his right hand on her chest, partially covering her breast and placing his right cheek on her right cheek, rolling his face towards her mouth and placing his tongue on her lips.

Dr Perera denied the allegations but the patient was found to be a credible and convincing witness who had no reason to fabricate the events she described.

Findings

Given the circumstances immediately following the consultation, the Tribunal preferred the patient's version of events and found Dr Perera guilty of professional misconduct although it was not persuaded that deregistration was warranted. The Tribunal ordered that a condition be imposed on his registration requiring a record audit.

Application for restoration to Register – irregular prescribing, own use of cannabis and breach of conditions

Issue

Mr Andrew Katelaris (MBBS (Syd) 1982) was deregistered in 2005 by the Medical Tribunal which set a non-review period of 3 years following a finding of professional misconduct for irregular prescribing of Schedule 8 and 4D drugs to family and friends, his own use of cannabis and breach of conditions on his registration. In his application for restoration, Dr Katelaris argued that he had developed insight and was a changed man.

Findings

The 2009 Tribunal did not accept that Mr Katelaris was a changed man, referring to his conviction for 4 criminal offences since 2005 and his inability to accept the 2005 decision; the application was dismissed.

Breach of conditions – inappropriate prescribing

Complaint

Mr William Gayed (MMBS (Egypt) 1964) was restored to the Register with conditions in 2000 after a period of deregistration from 1997 for inappropriately prescribing benzodiazepines and narcotic analgesics. Conditions imposed by the Tribunal in 2000 included that he not possess, prescribe or administer Schedule 4D or Schedule 8 drugs and that he inform his employers and colleagues of these conditions. It was alleged that Mr Gayed had inappropriately administered pethidine and morphine to a patient in breach of the Tribunal's conditions. Mr Gayed removed his name from the Register two months prior to the proceedings in the Medical Tribunal.

In the Medical Tribunal

Findings

The Tribunal found Mr Gayed guilty of professional misconduct and ordered that he not be re-registered and that any application for review of the decision could not be made for a minimum of 3 years.

Application under s94 for removal of a condition – not to perform breast augmentation surgery

Issue

Dr Tuan Truong (MBBS (UNSW) 1991) lodged an application under section 94 for the removal of a condition that prohibited his performing breast augmentation surgery. He made this request on the basis that conditional registration prevented him being accepted into the RACS surgical training program. The condition imposed on Dr Truong's registration related to a finding by an earlier Professional Standards Committee that he was guilty of unsatisfactory professional conduct due to the manner in which he performed breast augmentation surgery.

Findings

The Tribunal accepted Dr Truong's evidence that he had no intention of performing breast augmentation surgery. The Tribunal lifted the condition as it was no longer appropriate.

Application for restoration to Register – irregular prescribing

Issue

Mr Chuen (Wallis) Lam lodged an application for restoration to the Register after having been deregistered by the Tribunal in 2006 for unsatisfactory professional conduct and professional misconduct in relation to his prescribing of anabolic/androgenic steroids, human growth hormones, morphine and thyroxin. It was confirmed that Mr Lam had consulted with a psychologist and had been provided with techniques for managing stress and that some improvement in his assertiveness had been noted. The psychiatrist giving evidence expressed concern that Mr Lam would be able to manage aggressive and demanding patients or apply the new techniques he had learned from the psychologist.

Findings

The Tribunal found that despite Mr Lam's full admission of his conduct, his remorse and the character references, he had only recently gained insight into his behaviour and had not shown that he had adequately addressed his issues with assertiveness and stress. The Tribunal was left with real concerns that the previous behaviour was likely to be repeated and that Mr Lam had not discharged the onus on him to show he possessed adequate clinical skills to return to practice. It declined to make the Orders sought by Mr Lam (that he was a fit and proper person to practise as a medical practitioner in NSW).

Professional boundaries

Complaint

Mr Piyush Jogia was found guilty of professional misconduct arising out of his "treatment" for a young woman's "vaginal spasm". According to the patient, during the examination, the practitioner inappropriately rubbed her genital area and said, "Don't worry if you find it arousing". Mr Jogia denied the allegation and claimed, with supporting psychiatric opinion, that the patient's psychological condition "could be relevant".

Findings

The Tribunal accepted the patient's evidence and found the practitioner was not a credible witness. The Tribunal ordered that Mr Jogia's name be removed from the Register and that he be not eligible to apply for restoration for a minimum of 3 years.

Inappropriate prescribing

Complaint

It was alleged that Ms Yuk-Fun Port had inappropriately prescribed medication over a 4 year period to a patient at the request of the patient's wife and without his knowledge. Ms Port had not consulted with the patient, nor did she arrange for any monitoring of his condition or possible side effects. Ms Port admitted the allegations and conceded that her actions amounted to unsatisfactory professional conduct and professional misconduct.

Findings

The Tribunal ordered that her name be removed form the Register of Medical Practitioners, and that she not be eligible to apply for restoration until 18 December 2012.

Professional Standards Committee decisions

APRIL 2010

Following amendments to the Medical Practice Act, proceedings of PSCs constituted after 1 October 2008 are to be open to the public except where the Committee directs otherwise.

Professional Standards Committees (PSCs) are independent statutory bodies established by the Medical Practice Act. PSCs deal with complaints of unsatisfactory professional conduct against medical practitioners, which are prosecuted by the Health Care Complaints Commission (HCCC).

PSCs comprise a legally qualified Chairperson, two medical practitioners, and a non-medical member. PSCs are legally separate from and independent to the Medical Board. The Board provides administrative and technical support to PSCs, but it is not a party to proceedings.

Inappropriate prescribing

Complaint

Dr Stephen Lu (MBBS (UofQ), 1994), a Career Medical Officer came to the attention of the Board following an investigation by the Pharmaceutical Services Branch which revealed that he had inappropriately prescribed Schedule 8 and Schedule 4 Appendix D drugs for both his own and his partner's use. Section 66 proceedings were conducted which resulted in conditions being imposed on his registration including that he only issue prescriptions for hospital patients, that he not self-prescribe, and that he not prescribe for or treat his partner.

Findings

A Professional Standards Committee Inquiry found that the practitioner was guilty of unsatisfactory professional conduct on the basis that the practitioner had used the drugs Ketamine and Ritalin for purposes not in accordance with recognized therapeutic standards and practices, had prescribed Schedule 4 Appendix D and Schedule 8 drugs for himself and his partner in an inappropriate and reckless manner, and had demonstrated a severe lack of clinical judgment. The doctor was severely reprimanded and further conditions were placed on his registration including limitations on his ability to prescribe and educational requirements relating to prescribing.

Failure to adequately investigate

Complaint

It was alleged that Dr Barry Cross (MBBS (NZ) 1985), a solo country general practitioner of some 20 years experience had failed to perform and/or order appropriate tests to confirm his (incorrect) diagnosis of spondylosis and degenerative disease of the cervical spine, and had inappropriately prescribed anti-inflammatory medication to his patient who suffered from hypertension. It was further alleged that Dr Cross failed to act on her symptoms of increasing shortness of breath, pain in the left side of her chest, neck pain, weakness and tiredness. In addition, he failed to maintain adequate clinical records in accordance with the regulations.

Findings

The Committee reprimanded the practitioner and recommended that he undergo performance assessment as the Committee found his professional performance with respect to clinical judgment lacking in specified areas.

Prescribing for head injury/ failure to adequately communicate or document

Complaint

Dr Ismail (MBBS (Saudi Arabia) 1992), an anaesthetics registrar, admitted the subject matter of a complaint that she was guilty of unsatisfactory professional conduct in relation to the circumstances in which she prescribed an increase in the dose of Oxycodone for pain relief to a patient with a head injury, failed to communicate to nursing staff the proper dispensing of oxycodone and failed to document such instructions in the medical records.

Findings

On considering the documentation provided by the parties, including submissions as to appropriate orders, the Professional Standards Committee decided a hearing was not required. Dr Ismail was reprimanded and conditions were imposed on her registration requiring her to attend a communications course.

Failure to disclose pecuniary interest

Complaint

It was alleged that Dr Yvonne Tambyrajah (MBBS (Sri Lanka) 1965), a general practitioner had contravened the Medical Practice Regulation 2003 and engaged in conduct relating to the practice of medicine that was improper or unethical by failing to disclose a pecuniary interest to persons to whom she had recommended a health product at the time of making the recommendation. The practitioner admitted all the Particulars of the Complaint with the exception of one which alleged that she failed to properly investigate the patients reported symptoms.

Findings

The Committee found Dr Tambyrajah guilty of unsatisfactory professional conduct within the meaning of section 36 of the Medical Practice Act 1992. The Complaint was proven with the exception of the Particular which was not admitted to. The Committee reprimanded the practitioner and imposed conditions on her registration.

Competence

Complaint

It was alleged that Dr William Lynch (MBBS (NSW) 1982, FRACS 1991) was guilty of unsatisfactory professional conduct in relation to his failure to advise his patient of increasingly high PSA test results and his failure to recommend to the patient that he undergo prostate biopsy.

Findings

The Committee found all but two of the Particulars of the Complaint proven and Dr Lynch guilty of unsatisfactory professional conduct. The practitioner

Continued page 11

Professional Standards Committee decisions

was reprimanded and a condition was placed on his registration, requiring him to submit to an audit of his medical practice examining his history-taking, investigations (including the recall system for follow-up of patient test results), diagnostic process and decision-making.

Failure to maintain adequate records

Complaint

It was alleged that Dr Claude Reitberger (MBBS (Syd) 1960) was guilty of unsatisfactory professional conduct in relation to his failure to maintain adequate records concerning his treatment of three patients. The practitioner's failure to maintain adequate records had already been the subject of a previous Professional Standards Committee hearing.

Findings

The practitioner was reprimanded and conditions placed on his registration requiring him to provide the Board with summaries of the requirements of the Medical Practice Act and Regulation, and the Royal Australian College of General Practitioners concerning patient record-keeping and the steps undertaken to meet these requirements. A condition requiring the practitioner to undergo an audit of his medical records was also imposed.

Inappropriate prescribing

Complaint

Dr Bashar Mahmood (MBBS (Baghdad) 1980) prescribed morphine to his patient for her alleged bladder cancer. The practitioner continued to treat her pain from "metastases to the spine" for five years without taking any steps to verify the patient's diagnosis. The practitioner was alerted to the true situation when the patient had not made an appointment with the palliative care physician to whom he had referred her. The practitioner admitted that he had inappropriately prescribed morphine for the patient without the appropriate authority and that he had failed to appropriately manage the patient's condition in circumstances where he should have recognised the she was drug dependant.

Findings

The Committee found that the conduct involved only one patient and was of the view that he should not be deprived of his authority to hold and administer narcotic drugs. It also found that Dr Mahmood failed to keep appropriate records. Dr Mahmood was reprimanded and required to undertake further education relating to the prescribing of drugs and to undergo a practice audit with particular reference to his medical record keeping.

Failure to adequately examine and missed diagnosis

Complaint

It was alleged that Dr Ross Haron (MBBS (Syd) 1986), a general practitioner and VMO at Glenn Innes Hospital, had failed to review an elderly patient's provisional diagnosis of gastroenteritis, hiatus-hernia or gastro-oesophageal reflux when she was under his care at the hospital. It was further alleged that Dr Haron did not read nursing entries prior to authorising the patient's discharge, failed to review biochemistry results and did not conduct a further physical examination before authorising the patient's discharge. After discharge, the patient subsequently underwent surgery at Armidale Hospital to repair a bowel obstruction and perforation but died.

Findings

The Committee found three of the five particulars proven and that Dr Haron was guilty of unsatisfactory professional conduct and ordered that he be cautioned. The Committee noted that Dr Haron accepted full responsibility for his role in the poor care received by his patient and that he gave detailed evidence about the ways in which he had altered his practice as a result of the case.

Failure to refer to clinical notes

Complaint

It was alleged that Dr Richard Foster (MBBS (Tasmania) 1982, FRANZCR 1992), an experienced oncologist had failed to refer to clinical notes when preparing radiation treatment for a patient. The patient subsequently received radiation to the wrong side of their lung. Dr Foster admitted the complaint, and was remorseful.

Findings

The Committee found Dr Foster guilty of unsatisfactory professional conduct. However after noting the action taken by Dr Foster to prevent similar events, it determined it was unnecessary to make any orders.

Failure to adequately manage post-operative care

Complaint

It was alleged that Dr Robert Elliott (MBBS (Syd) 1972 FRACS 1982) had failed to review the post-operative x-rays, prior to the discharge of a patient who underwent knee replacement under his supervision. During the surgery, notching of the anterior cortex of the distal femur occurred. The x-ray indicated that the patient had sustained an undisplaced fracture of the left femur which is likely to have occurred during the surgery. The patient had significant difficulty mobilising during the recovery period and ultimately required additional surgery after further x-rays showed that the fracture had become displaced. Dr Elliott admitted all the particulars of the complaint and made changes to his practice including making twice-weekly ward rounds at a time when his registrar could be present.

Findings

The Committee reprimanded Dr Elliott and imposed a condition on his registration requiring him to submit a log of all patients operated upon at the hospital concerned, ward rounds undertaken concerning these patients and the registrars who accompany him on these rounds.

Failure to adequately assess and manage

Complaint

It was alleged that Dr Donald Tan (MBBS (Malaya, Singapore) 1971) had failed to obtain an adequate drug history of a patient who received Rapid Opiate Detoxification (ROD) and needed to be opiate-free for 48 hours prior to the procedure. It was alleged that Dr Tan knew or ought to have known at the time of administering naltrexone that the patient had taken opiates in the 24 hours prior to the procedure.

Findings

The Committee found all aspects of the complaint proven, reprimanded Dr Tan and imposed conditions on his registration

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Professional Standards Committee decisions

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barring him from performing further ROD procedures and requiring him to participate in regular pharmacotherapy peer review group meetings.

Lack of information and skill

Complaint

The complaint against Dr Emmanuel Varipatis (MBBS (NSW) 1979), a general practitioner who practices complementary and integrative medicine related to his administration of high dose IV Vitamin C therapy to a patient with a history of renal disease. When providing this treatment, Dr Varipatis was not aware of, and did not have sufficient experience in relation to the likely adverse outcomes of using this treatment for a patient with renal disease. The patient suffered severe consequences. He also admitted that he had failed to adequately monitor the patient and to notify the patient's treating renal physician about abnormal test results.

Shortly after the incident, the NSW Medical Board had imposed several conditions on the doctor's practice to ensure that he thoroughly assess patients with renal disease before administering Vitamin C, and requiring him to submit to audits of his medical records.

Findings

The Committee considered the evidence concerning Dr Varipatis' compliance with his conditions and the steps he had taken to prevent a similar incident from occurring such as amending consent forms and communicating with other treating doctors. The Committee found Dr Varipatis guilty of unsatisfactory professional conduct and reprimanded him.

Lack of orientation and support for new staff, cardiothoracic unit

Complaint

It was alleged that Dr Khoi Bui (MBBS (Adelaide) 1995) had failed to properly consult with senior staff before performing a procedure on a patient. During the procedure, the patient's heart was perforated and he died 3 days later.

Findings

In finding that the complaint against Dr Bui was either not proven of if proven, not to be a significant breach of the expected standards, the Committee commented on the systems in place at the John Hunter Hospital at the time of the incident and expressed concern about the lack of orientation and support for new staff of the cardiothoracic unit.

Competence

Complaint

It was alleged that Dr Irfan Kuroz (MBBS (Syd) 1990) failed to diagnose, adequately treat and manage a patient who presented with moderate chest pain and a history of recent previous myocardial infarct. It was also contended that Dr Kuroz made a diagnosis of costochondritis for which he prescribed Tramal but failed to note this or other clinical findings in the medical records. The patient died of a heart attack on a train going to work within 30 minutes of leaving the surgery.

Findings

The Committee found all Particulars of the Complaint proven, and ordered that Dr Kuroz be reprimanded and conditions be imposed on his registration including the requirement to submit to a random audit of his medical records.

Shortage of medical staff, inexperience and inadequate record keeping

Complaint

The complaint against Dr Nicole Williams (MBBS (UoN) 2003) alleged that she had failed to discuss the prescription of analgesia or to ensure that entries were made in the medical records in relation to a sixteen year old patient who died at RNS Hospital after she was hit in the head by a golf ball.

Findings

In its decision, the Committee noted the shortage of medical staff on the day the patient died, the fact that Dr Williams had been on the neurological unit for less than 2 weeks and had no previous experience in neurosurgery prior to working at RNS Hospital and had received no formal education or orientation regarding general issues, including the use of analgesia. The Committee found Dr Williams guilty of unsatisfactory professional conduct in relation to her record-keeping, but did not find it necessary to make any protective orders.

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