Medical Council OF NEW SOUTH WALES

e-newsletter

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Welcome from the President
Professor Peter Procopis

This is the first edition of the Medical Council of NSW e-newsletter.

It aims to bring up-to-date news and items of interest to medical practitioners who practise in NSW, as well as provide a snapshot of the Council's activities and information as to the outcomes and implications of recent disciplinary hearings.

This publication, unlike the former NSW Medical Board News, will be in an electronic form rather than hard copy and is available on the Council's website. This approach ensures that the Council operates in a manner that is consistent with environmental sustainability and waste reduction.

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Medical Council membership

On 1 July 2012, the Governor of NSW appointed new members to the Medical Council following expiry of the terms of some previous appointments. The Medical Council now comprises 19 members, one less than the previous composition:

Council Members

Professor Peter Procopis (President)	Royal Australasian College of Physicians nominee
Dr Greg Kesby (Deputy President)	Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee
Dr Stephen Adelstein	Royal College of Pathologists of Australasia nominee
Professor Belinda Bennett	Legal Member nominated by the Minister
Dr Roger Boyd	Royal Australasian College of Medical Administrators nominee
Mr Antony Carpentieri	Ministerial nominee
Mr Michael Christodoulou	Community Relations Commission nominee
Dr Bruce Doust	Royal Australian and New Zealand College of Radiologists nominee
Professor Anthony Eyers	Royal Australasian College of Surgeons nominee
Professor Cheryl Jones	Universities nominee
Ms Rosemary Kusuma	Ministerial nominee
Dr Alix Magney PhD	Ministerial nominee
Mr Jason Masters	Ministerial nominee
A/Professor Rod McMahon	Royal Australian College of General Practitioners nominee
Dr Robyn Napier	Australian Medical Association nominee
Dr Julian Parmegiani	Royal Australian and New Zealand College of Psychiatrists nominee
Ms Lorraine Poulos	Ministerial nominee
A/Professor Richard Walsh	Ministerial nominee
Dr Choong-Siew Yong	Australian Medical Association nominee

Medical information
collection, sharing, access, use

Policy on data access and use for research

The Medical Council recognises that it holds information and data which could be useful for quality assurance purposes and research projects. With this in mind, the Council has endorsed a policy which outlines the processes for handling requests for such information, including application requirements for researchers. To read more about the requirements for accessing information for research held by the Council, go to: Data access and use for research policy

Performance interview reports

A performance interview is one of the mechanisms developed by the Council to explore the issues raised in a complaint concerning a medical practitioner's professional performance. The interview enables the Council to obtain further information about the matter and also assists the Council to decide whether any other courses of action are appropriate.

The Council must maintain privacy over any confidential information disclosed at the interview while at the same time being transparent about its processes. The Council must also be mindful of the complainant's expectation to be informed of the outcome of their complaint.

The Medical Council has concluded that performance interview reports should not ordinarily be released to a complainant. The Council's Position Statement on Performance Interview Reports can be read in full at: Performance interview reports

Right to information

Under the *Government Information (Public Access) Act 2009 (NSW),* (GIPA Act) which replaced former Freedom of Information legislation in 2010, members of the public may access information held by the Medical Council in one of four ways: from the Council's website which contains details about the Council, its membership and functions as well as policies and disciplinary decisions; by asking the Council what information it will release in addition to that available on the website; by informal request (there is a presumption in favour of disclosure of information unless there is an overriding public interest against disclosure) and by formal application. To read more go to Access to information (GIPA) or visit the website of the Office of the Information Commissioner - www.ipc.nsw.gov.au

Medical records – collection of, and access to personal health information

With the arrival and gradual implementation of Personally Controlled Electronic Health Records, it is timely to recall the key requirements with respect to the creation and keeping of medical records by medical practitioners.

The *Health Practitioner Regulation (NSW) Regulation 2010*, Part 4 and Schedule 2 specifies how long records should be kept, how records should be stored, how to transfer records following disposal of a medical practice, what information to include and how to alter a medical record.

There are also ten National Privacy Principles (NPP) which regulate the management of personal health and other information. Under the NPP, a person has a legal right to access his/her personal health information. The Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia also sets out the standards that need to be met by medical practitioners with respect to medical records.

Closing your practice

There are several important actions that should occur when closing a practice or moving out of a practice. Patients should be given notification of the date you intend to cease practice and should be given the opportunity to collect their medical records or make alternative arrangements so that they can be passed on to the next treating doctor. Records that can be destroyed (older than seven years from the date of last consultation or, in the case of a child, when the child reaches 25 years of age) should be destroyed in a secure manner. The remaining records should be placed in storage that will allow you to access them if required.

A prominent notice should be displayed at the surgery advising patients who to contact if they require access to their medical records once the practice has closed. Medicare and the Australian Health Practitioner Regulation Agency should also be advised of the retirement or move. Under the *Health Practitioner Regulation National Law (NSW)*, practitioners are required to notify the Medical Board of Australia within 30 days, in writing of any change in the practitioner's principal place of practice or change of address that is used by the Medical Board in correspondence with the practitioner.

Doctors are urged to consult with their medical defence organisations to ensure they understand their obligations and have appropriate mechanisms in place so as to comply with relevant legislation and avoid placing patients under unnecessary distress due to records being unobtainable.

A question of ethics

Good Medical Practice: A Code of Conduct for Doctors in Australia describes what is expected of medical practitioners practising throughout Australia by their peers and the community. The Code of Conduct does this by setting out principles that characterise good medical practice and standards of ethical and professional conduct for medical practitioners.

Sexual boundaries: guidelines for doctors issued by the Medical Board of Australia confirm that good medical practice relies on trust between doctors and their patients and families and confirms that it is always unethical and unprofessional for a doctor to breach this trust by entering into a sexual relationship with a patient.

Technology-based patient consultations guidelines published by the Medical Board of Australia set out the standards of care with respect to consultations that use any form of technology, including videoconferencing, internet and telephone as an alternative to face-to-face consultations. These guidelines complement the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* and confirm that the same standards relating to all aspects of patient care are to be followed in this setting, including keeping appropriate records and ensuring colleagues are informed when patient care is shared.

Advertising - hidden dangers

Advertising of medical services is increasing, especially in areas such as cosmetic medicine and skin treatments. *Guidelines for advertising of regulated health services* published by the Medical Board of Australia provide guidance concerning medical practitioners' obligations under section 133 of the *Health Practitioner Regulation National Law (NSW)*. Doctors who advertise regulated health services must also ensure that they comply with any obligations existing under federal and state consumer protection legislation.

Notification matters

Mandatory notifications

The **mandatory requirement** for registered health practitioners, employers and education providers to notify the national agency AHPRA, if they form a reasonable belief that certain conduct has occurred, is set out in section 140 of the *Health Practitioner Regulation National Law (NSW)*.

Notifiable conduct means that a reasonable belief has been formed that a practitioner has:

- practised the profession while intoxicated by alcohol or drugs; or
- engaged in sexual misconduct in connection with the practice of the profession; or
- placed the public at risk of substantial harm in the practice of the profession because the practitioner has an impairment; or
- placed the public at risk of harm in the practice of the profession because the practitioner has practised in a way that constitutes a significant departure from accepted professional standards.

The Medical Board of Australia has published Guidelines for mandatory notifications. Practitioners should consult these guidelines or seek advice from their medical defence organisation if they are unsure about their obligations.

Other requirements to notify

The *Public Health Act 2010 (NSW)* and the *Public Health Regulation 2012 (NSW)* which commenced on 1 September 2012, contain a number of requirements that will impact on health practitioners.

Key areas include:

- Disease notification requirements for doctors, hospitals and laboratories
- Notification of deaths arising after anaesthesia or sedation for operations or procedures

Specific advice about the obligations of health practitioners can also be accessed from:

⇨ Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) www.cec.health.nsw.gov.au/programs/scidua

⇨ NSW Ministry of Health webpage for Infectious Diseases www.health.nsw.gov.au/publichealth/Infectious

⇨ Cancer Institute www.cancerinstitute.org.au/data-and-statistics

Challenges facing junior doctors

A practical and useful website offering advice to junior doctors working long hours, not having a work/life balance and perhaps dealing with bullying or other issues in the workplace can be accessed at www.jmohealth.org.au This site offers tools for self-assessment and vignettes that describe common problems faced by JMOs today as well as suggestions for ensuring self-care, reducing stress, advice as to where to get help and other resources.

Lucire v Parmegiani & Anor [2012] NSWCA 86

In April 2012, the NSW Court of Appeal overruled a 2010 District Court decision which had held that Dr Lucire could not successfully sue Dr Parmegiani for defamation. (Dr Lucire alleges a letter Dr Parmegiani wrote to the Medical Board was defamatory). The District Court was of the view that Dr Parmegiani's letter was a "complaint" and that he could therefore rely on the defence of absolute privilege contained in section 27 and clause 15 of Schedule 1 to the *Defamation Act 2005 (NSW)*.

However the Court of Appeal held that the defence of absolute privilege set out in the Defamation Act attaches to communications made for the purpose of dealing with a complaint once the complaint has been made, that is, the defence does not apply to the making of a complaint itself.

So, individuals who made complaints prior to 1 July 2010 (the date the national registration scheme commenced) are protected against being successfully sued for defamation by provisions in the Medical Practice Act and Health Care Complaints Act. The protection however is not absolute. In short, the Court ruled that complainants have a qualified protection against being sued, so long as their complaint is made in good faith.

While this case concerned a complaint made before the *Health Practitioner Regulation National Law (NSW)* came into effect, the decision does provide some guidance concerning interpretation of the current law, because the protection from liability provisions are very similar to those under the previous law. Section 237 of the *Health Practitioner Regulation National Law (NSW)* provides protection from liability to any person who, in good faith, makes a notification or otherwise provides information (whether they rely on mandatory reporting provisions or not) under that Law.

Doctors issuing death certificates for family members

The Medical Council's guideline for self-treatment and treating relatives advises that medical practitioners should avoid treating members of their immediate family and all medical practitioners should have their own, independent General Practitioner.

The Medical Council also wishes medical practitioners to know that issuing Death Certificates for members of their family is inappropriate.

In a recent decision, the Medical Tribunal found a medical practitioner guilty of unsatisfactory conduct in relation to palliative care provided to his mother when she collapsed and then died six days later, age 70 years of age. From the time of her collapse until her death, she was treated solely by her son, a medical practitioner, who did not refer her for further investigation and management and allegedly signed her death certificate.

The Tribunal noted that the practitioner's errors in this case "*highlight the very good reason why the medical profession proscribes the treatment of family members by practitioners. This case is a stark example and reminder to the medical profession that no matter how well intentioned a doctor might be it is fraught with risk and danger to treat a member of one's own family.*

The confluence of treatment of a serious condition with the emotional reaction of being a son to the patient and also the principal source of support and information to his father and wider family have resulted in the string of errors made by the respondent."

The practitioner was reprimanded and is subject to practice conditions on his registration if he returns to practise in Australia.

Decision 8 March 2013
Decision 22 May 2013

Prescribing issues…..

Notification of lost or stolen drugs

Persons who are authorised to possess a drug of addiction (Schedule 8 substance) or a 'prescribed restricted substance' (Schedule 4D substance) are required by the NSW *Poisons and Therapeutic Goods Regulation 2008* to immediately notify the Director-General of the Ministry of Health of any loss or theft of these drugs. More information, including the form for making a notification of such loss is available at:

http://www0.health.nsw.gov.au/PublicHealth/Pharmaceutical/loststolen.asp

Completed forms should be submitted online or emailed to Pharmaceutical Services, Legal and Regulatory Services Branch at pharmserv@doh.health.nsw.gov.au

If the loss has occurred as part of a robbery, the NSW Police should also be contacted.

Fentanyl patches – accidental overdose and abuse

Disclaimer
The following is an excerpt from a paper on Fentanyl – Abuse and Misuse, developed by NSW Ministry of Health Drug and Alcohol Clinical Policy Unit for distribution to health professionals. While this is a matter of interest to the Medical Council, it does not represent a formal position taken by the Council.

Fentanyl, a potent opioid analgesic available in five strengths providing controlled release at various rates over 72 hours, is approved for use (patches) in the management of chronic pain. Fentanyl is a high affinity, high efficacy medication with a small therapeutic index; the difference between an analgesic dose and an overdose is very small and for this reason, even highly opiate-tolerant patients can easily reach overdose levels.

Situations exposing patients to risk of overdose include:

- incorrect prescribing or dispensing of the appropriate strength
- forgetting to remove a (replaced) patch, effectively administering a double dose
- increased skin temperature, such as fever, use of electric blanket, or intense physical exercise.

To read more about opioid prescribing in chronic pain, go to:

http://www.nps.org.au/medicines/pain-relief/opioid-pain-relievers
http://www.painedu.org/soapp.asp

Disciplinary hearings snapshot

Disciplinary complaints against medical practitioners are prosecuted by the Health Care Complaints Commission. While the more serious complaints (that have the potential to result in suspension or cancellation of a practitioner's registration) are heard before the Medical Tribunal, complaints which are unlikely to result in suspension or cancellation are heard before a Professional Standards Committee.

Decisions that can be published are available on the Council's website shortly after the decision is handed down and can be found at: Decisions

The following summaries of recent disciplinary decisions provide a snapshot of the issues that can result in a practitioner being dealt with before a Medical Tribunal or a Professional Standards Committee. The full decision for each matter is included in the list of decisions for 2011 or 2012 at:
Medical Tribunal Decisions
Professional Standards Committee Decisions

Medical Tribunal matter – boundary crossing

The complaint before the Medical Tribunal concerned two aspects of a psychiatrist's care of a 25 year old female patient suffering from attention deficit hyperactivity disorder and borderline personality disorder. The psychiatrist admitted all the particulars of the complaint and was found to have failed to maintain professional boundaries with the patient, whose father had been a friend and whose step-mother was a member of the psychiatrist's review group. The Tribunal noted that the psychiatrist had previously come before a Professional Standards Committee on account of transgressing professional boundaries with another patient.

The transgressions with the more recent patient included taking an ecstasy tablet when it was offered by the patient, then having a four day sexual relationship with her. On a number of occasions, the psychiatrist attended the patient's home to obtain emotional support from her. He also provided the patient with paid work in his office and financial support in the form of rental payments, hotel accommodation and gifts, as well as food. The psychiatrist declined to follow the advice of colleagues to refer himself to the Council, refused to accept counselling, and self-prescribed fluoxetine. He also failed to refer the patient to another psychiatrist. He did eventually undergo treatment from another psychiatrist, for depression.

The other aspect of the psychiatrist's care which was complained of was his inappropriate prescribing for the patient. He wrote prescriptions for dexamphetamine, despite knowing that the patient had a history of drug abuse. He also wrote the patient prescriptions for narcotic analgesics and antipsychotic medications when he was no longer formally consulting with the patient. The Tribunal noted that there were significant dangers associated with this practice.

While the psychiatrist had closed his practice in June 2011 and was no longer registered by the time of the Tribunal hearing, he put forward a proposal as to how the public would be safeguarded, should he return to practice. He submitted he would not undertake psychotherapeutic work but would instead focus on medico-legal matters and would work within a group practice and attend peer reviews and education meetings. However, the Tribunal determined that the evidence established that the psychiatrist had not been a fit person to remain on the Register at the time of the events which were the subject of the proceedings and further, that he had failed to establish that he had since undergone a reformation of character. The Tribunal therefore disqualified the psychiatrist from registration and ordered that he not apply for re-registration for a period of 18 months.

Medical Tribunal matter – clinical standards

Complaints of unsatisfactory professional conduct and the more serious professional misconduct concerned the care and treatment of a patient provided by an experienced general practitioner specialising in cosmetic surgery, who had no previous disciplinary history. The practitioner was alleged to have invited the patient to undergo a new procedure for a breast lift surgery involving threads, in circumstances where:

- There was no physical need for the procedure and no informed consent was obtained from the patient about the procedure and its risks, and
- There was no physical examination of the patient's breasts.

The procedure itself was performed by a visiting overseas surgeon, but in the practitioner's private treatment room with the practitioner assisting. The patient developed post-operative complications and the practitioner was advised to remove the threads. The practitioner did not take this action and failed to refer the patient to another practitioner for about five months. The complaint also alleged a failure to maintain appropriate medical records and a lack of adherence to aseptic procedures in the practitioner's private treatment rooms.

The Medical Tribunal found both complaints proven and that the practitioner's conduct represented a serious departure from acceptable standards of medical care. The practitioner had not researched the full extent of the proposed surgery and failed to understand the extent of responsibility for the patient's post-operative care. The Tribunal reprimanded the practitioner, suspended the practitioner from performing cosmetic surgery for six months, imposed practice restrictions (including supervision, regular audits of medical records, and inspections of premises to monitor compliance with infection control standards) and ordered some further education.

Professional Standards Committee matter – ordering experimental tests

The complaint alleged that a general practitioner, with a special interest in complementary / integrative medicine, was guilty of unsatisfactory professional conduct in relation to the ordering of Genosense Polymorphism Essay testing (GPE) and Circulation Cancer Cell (CCC) tests when such tests were not an accepted practice and were considered experimental, and when there was no need for the GPE test to be undertaken. The patient had inflammatory breast cancer and on the recommendation of her oncologist, the patient sought out a general practitioner to co-ordinate her care. It was also alleged that the practitioner did not communicate adequately with the patient's oncologist or make appropriate disclosure as to the costs of the tests to the patient.

While there was evidence before the Committee that integrative medicine practitioners use such tests to inform their clinical practice, the Medical Oncology Group in Australia opined that these tests were not part of standard medical oncology practice in Australia. At the outset, the Committee said that the efficacy of GPE and CCC testing was not the issue before them and noted *"There is clearly lively debate in Australia regarding GPE and CCC testing."*

The Committee found all of the particulars of the complaint proven and found that the practitioner's conduct in ordering the CCC testing, when such testing was not an accepted practice and was considered experimental, amounted to unsatisfactory professional conduct. The practitioner was reprimanded.

Professional Standards Committee matter – false information about CPD

A complaint alleged that a specialist physician was guilty of improper and unethical conduct because he had provided false information concerning his continuing professional development (CPD) activities. The practitioner had submitted application forms for annual renewal of registration to the NSW Medical Board which stated he had attended meetings at a hospital in NSW and meetings at offices and hospitals in New York between 2006 and 2008.

The practitioner initially characterised his statements as an administrative oversight. During the hearing, the practitioner conceded he had considered that submitting false information concerning his CPD activities for three years was 'a white lie' and that no action should be taken because providing evidence of CPD at the time was not mandatory. He submitted his actions were improper, but not unethical.

The Committee stated in its decision: *"[The practitioner's] actions, in deliberately, knowingly and repeatedly providing false information, reveal a significant level of disrespect for the processes of that registration authority. The Committee considers that [the practitioner] has infringed reasonable standards of honesty and propriety and in this regard his conduct is disreputable."*

This conduct was found to be both improper and unethical. The practitioner was found guilty of unsatisfactory professional conduct and reprimanded.