Medical Council OF NEW SOUTH WALES

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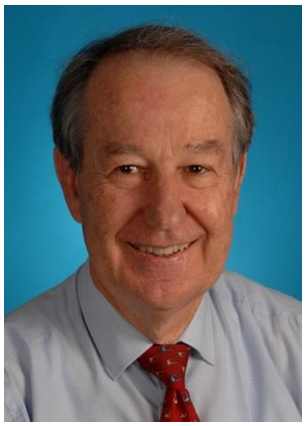
e-newsletter

SPRING 2014

Welcome from the President
Professor Peter Procopis



Welcome to the second Medical Council of NSW e-newsletter for 2014.

The e-newsletter is a way for the Medical Council to communicate with the more than 30,000 doctors across NSW on the work of the Council, and provide information and updates on topics of interest to the medical profession, both here in NSW, as well as nationally and abroad.

This edition includes a feature on the Medical Council's Performance Program, along with articles on boundary crossing and online consultations. We have also included our regular features, such as updates on changes at the Council and a snapshot of our recent disciplinary hearings.

The e-newsletter can also be viewed on the Council's website: www.mcnsw.org.au

Contents

What's new? Changes at the Council

Changes to the Council Membership

The Medical Council recently welcomed a new Council Member – Australasian College for Emergency Medicine nominee Dr John Sammut.

Dr Sammut's appointment follows changes to the Medical Council's composition, effective from 1 January this year, which required the Council Membership to include:

- A nominee from the Australasian College for Emergency Medicine;
- A nominee from the Australian and New Zealand College of Anaesthetists; and
- A medical practitioner, nominated by the Minister for Health, who is a Member of one or more of the following five colleges: The Australasian College of Dermatologists, The Australian College of Rural and Remote Medicine, The Royal Australian and New Zealand College of Ophthalmologists, The Royal Australian and New Zealand College of Radiologists, or The Royal College of Pathologists of Australasia.

Existing Council Member A/Prof Richard Walsh is the nominee from the Australian and New Zealand College of Anaesthetists and Dr Stephen Adelstein, member of the Royal College of Pathologists of Australasia, is the Ministerial nominee from the five colleges listed above. A/Prof Walsh has been a Member of the Council since 2012. Dr Adelstein joined the Council in 2008.

Dr Roger Boyd was also recently appointed to the Council for another term as the nominee of the Royal Australasian College of Medical Administrators.

The recruitment process is currently underway for a new legal member and lay member, made vacant by the departure of Prof Belinda Bennett and Antony Carpentieri respectively, earlier this year.

A list of the current Council members is published on the Medical Council website.

Call for new Members

Nominations were sought in August for suitably qualified and experienced nominees for appointment to the Medical Council.

The positions, effective from 1 July 2015, included:

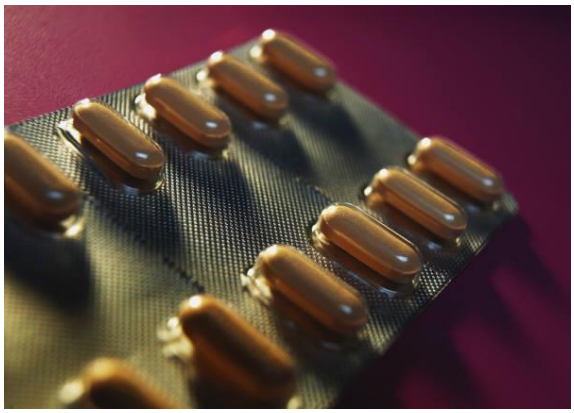
- 2x nominees of the Australian Medical Association (NSW);
- 1x nominee of the Community Relations Commission;
- 1x joint nominee of the University of Sydney, University of NSW and University of Newcastle;
- 1x nominee of the Royal Australasian College of Physicians;
- 1x nominee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists;
- 1x nominee of the Royal Australasian College of Surgeons;
- 1x nominee of the Royal Australian College of General Practitioners;
- 1x nominee of the Royal Australian and New Zealand College of Psychiatrists;
- 1x nominee of the Australian and New Zealand College of Anaesthetists; and
- 4x persons nominated by the Minister who are conversant with the interests of patients as consumers of medical services

Nominees will be selected on merit with a view to providing an appropriate range of knowledge, skills and diversity within the Council membership. It is hoped the appointments will be finalised by the end of 2014.

Council Members are appointed by the Governor of NSW on the recommendation of the Minister for Health for a term of up to three years. They play an important role, variously by bringing their professional knowledge and experience to Council regulatory decisions, acting as a representative of the interests of health consumers, and by being actively involved in the effective governance of the Medical Council.

Important Update

Zolpidem warning



Doctors are being urged to remind patients of the risk of next day impairment, as well as other potential risks, before prescribing insomnia drug Zolpidem (Stilnox).

The advice follows a decision by the European Medicines Agency review panel to update the drug's product information to minimise the risk of next-morning impaired driving ability and mental alertness.

Here in Australia, the Therapeutic Goods Administration (TGA) has completed its own safety review.

Following the safety review, the TGA's Medicines Safety Update contained in the August 2014 edition of *Australian Prescriber* advises that before prescribing Zolpidem (Stilnox) doctors should:

- Discuss the risk of next-day impairment, as well as other risks;
- Ensure that patients understand the importance of not exceeding the recommended daily dose;
- Advise patients to take Zolpidem just before going to bed and not to re-administer during the same night;
- Advise patients to avoid driving or any other activity requiring mental alertness, such as operating machinery, for at least eight hours after taking zolpidem and explain that drowsiness may continue the following day.

To assist in the continued monitoring of the drug, doctors are also urged to report all adverse events involving Zolpidem to the TGA.

More information is available in the Medicines Safety Update in the August 2014 edition of *Australian Prescriber*.

Hot Topics

A step too far: Boundary crossing

Boundary crossing is one of the most common complaints against doctors dealt with by the NSW Civil and Administrative Tribunal (NCAT).

It is a serious issue that can result in de-registration, and in some circumstances, criminal charges.

As stated in the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*, "Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must [also] be ethical and trustworthy."

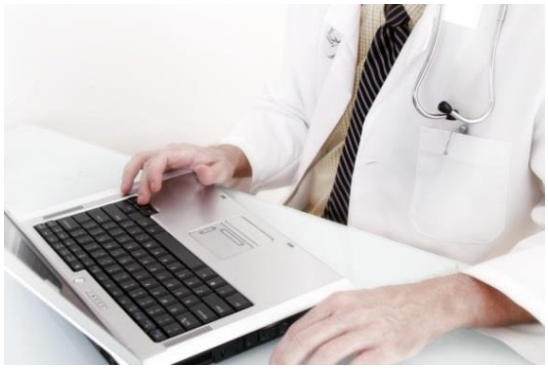
The Code of Conduct also reminds doctors that professional boundaries are integral to a good doctor-patient relationship, as they promote good care for patients and protect both parties.

It states, "good medical practice involves:

- Maintaining professional boundaries;
- Never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care (including those close to the patient); and
- Avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress."

For more information or advice about boundary crossing contact your Medical Defence Organisation.

Online consultations – Bridging the technological divide



The advancement in technology has allowed for a shift in the way consultations can be conducted, with online consultations becoming increasingly prevalent.

To provide doctors with specific guidance on technology-based patient consultations the Medical Board of Australia developed the *Technology-based patient consultations* guideline.

It defines technology-based patient consultations as "patient consultations that use any form of technology, including, but not restricted to videoconferencing, internet and telephone, as an alternative to face-to-face consultations".

Among its many recommendations, the guideline advises doctors who advise or treat patients in technology-based patient consultations should:

- Apply the usual principles for obtaining their patient's informed consent, protecting their patient's privacy and protecting their patient's rights to confidentially;
- Make a judgement about the appropriateness of a technology-based patient consultation and in particular, whether a direct physical examination is necessary; and
- Keep an appropriate record of the consultation.

More information or advice about technology-based patient consultations should be sought from your Medical Defence Organisation.

Communication between practitioners

A number of complaints recently received by the Medical Council highlight the importance of communication between doctors.

There have been a few cases where there was confusion between a specialist and a general practitioner as to which of them was to order an MRI scan that the specialist believed was indicated. Each party assumed that the other would be arranging the test, causing delay in the diagnosis of a serious condition in each case.

These cases serve as a timely reminder of doctors' obligations under the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

The Code of Conduct states that "good medical practice involves communicating clearly, effectively, respectfully and promptly with other doctors and healthcare professionals caring for the patient."

It further points out that patient care is enhanced when there is "clear communication between all healthcare professionals involved in the care of the patient".

Policy update: Treating self, others and issuing cremation certificates

The Medical Council is currently undertaking a review of our Guideline for self-treatment and treating relatives to include recommendations on the completion of death certificates and cremation documents for family members. It follows a request from the State Coroner for further clarification on the issue.

In the interim, as stated in the guideline, doctors are reminded that wherever possible, they should avoid treating members of their immediate family, for reasons such as professional objectivity and patient autonomy, which may be compromised. The Medical Council also advises that all doctors should have their own, independent GP and should not initiate self-treatment.

For further information or advice about self-treating or the treatment of family members contact your Medical Defence Organisation. You may also wish to read a recent article by Douglas Kamerow, published in the British Medical Journal titled, *Doctors treating their families*.

Spotlight on the Medical Council's Performance Program

Overview of the Performance Program

The Medical Council's Performance Program, introduced in October 2000, represents the culmination of intensive research, consultation and development.

The Program is designed to complement the Medical Council's Conduct and Health Programs by providing an alternative pathway for doctors who are neither impaired nor guilty of unsatisfactory professional conduct or professional misconduct, but for whom the Medical Council has concerns about clinical performance. Matters dealt with under the Performance Program do not have the characteristics of reckless, unethical, criminal or wilful conduct that would require disciplinary action. The Program aims at early intervention – addressing concerns, before they potentially escalate.

Rather than focusing on an individual complaint or notification, the Performance Program is concerned with the totality of a practitioner's performance. The Program aims to provide a positive and supportive framework in which to address professional performance in a non-disciplinary way that is both protective of the public and in the best interests of the profession and its members. The focus is on remediation, re-skilling and providing doctors with extra support, with further action taken, if required.

As at June 30 this year there were 99 doctors involved in the Performance Program. While for some doctors involvement in the Program can initially be daunting, many find benefit in the Program, using it as an opportunity to improve their practice and quality of patient care.

The Medical Council's expectations of doctors are set out in the Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia. The Code sets out principles that characterise good medical practice and the standards expected of doctors by their professional peers and the community.

Further information about the Performance Program is available on the Medical Council website.

Performance Assessments – why, and what's involved?

The Medical Council has a number of tools available to determine whether a medical practitioner's professional performance is satisfactory – one being a Performance Assessment.

When the Medical Council decides a Performance Assessment is to be held, the medical practitioner is advised by telephone and then in writing. They are also provided with the details of the matters giving rise to the assessment, a copy of the Performance Program Handbook which sets out the process for the assessment, and they are invited to provide information to assist in the assessment process.

Performance Assessments normally take place in the medical practitioner's place of practice, at a time agreed to by the medical practitioner. Assessments are generally conducted by two or three independent doctors. Assessors are selected for their skill, training and experience in a given field of medicine. At least one Assessor is experienced in the practitioner's field of practice. For example, a rural general practitioner would usually be assessed by two GPs, at least one of whom with experience in rural practice. As many of the skills and attributes that are assessed are generic across the medical profession, it is not necessary for all assessors to be matched exactly to the training and practice profile of the medical practitioner.

The Assessment is broad-based and is not limited to the particulars of the matter that triggered the assessment. It can involve the observation of consultations and procedures, a review of records and facilities and a clinical practice interview. Its purpose is to observe a doctor in his or her own environment, with patients, to assess whether their performance is of a standard expected of a medical practitioner of an equivalent level of training or experience.

After a Performance Assessment is conducted, a report is prepared for the Medical Council's Performance Committee, to determine what further action, if any, should be taken. If no performance deficiencies are identified no further action is taken. If performance issues are raised, however, there are a number of options available to the Committee, including arranging counselling for the practitioner or referral to a Performance Review Panel. A Performance Review Panel is a formal process which reviews the doctor's performance by considering the report and the practitioner's written submission and verbal responses to determine whether any further action, such as the imposition of conditions on the practitioner's registration, is required.

In the 2013/14 financial year 25 Performance Assessments were held, and 21 outcomes determined. Of those, 11 doctors were referred to a Performance Review Panel, seven required no further action, and three received counselling.

More information about Performance Assessments can be found on the Medical Council website.

National Focus

CoRS now available online

The Medical Board of Australia recently announced that requests for a Certificate of Registration Status (previously known as Certificates of Good Standing or Certificate of Current Professional Status), known as CoRS, can now be lodged online, via the Australian Health Practitioner Regulation Agency (AHPRA) portal.

In the past, this was only a manual process which required a form to be either posted or hand-delivered to an AHPRA office.

When seeking registration or employment that requires registration outside of Australia, doctors are often required to provide a CoRS to the regulatory authority in that jurisdiction.

AHPRA took over responsibility for providing CoRS when national registration was introduced in 2010. Prior to the change, it was the responsibility of the former Medical Board of NSW (now the Medical Council).

More information about requesting a CoRS is available on the AHPRA website.

International Focus

IAMRA Conference

Representatives from the Medical Council joined medical regulators from across the globe for the 11th International Conference on Medical Regulation in London, England, last month.

The topic of this year's International Association of Medical Regulatory Authorities (IAMRA) Conference, held from 9-12 September, was *Medical Regulation – Evaluating risk and reducing harm to patients.*

The Conference was an opportunity for more than 300 delegates from more than 50 countries to learn and share ideas on a range of topics around the key functions of medical regulation, including, but not limited to:

- Quality assurance;
- Professional standards; and
- Disciplinary processes.

The Medical Council's Medical Director, Dr Stuart Dorney, who was among the attendees, said the Conference was an opportunity to mix and engage with other Australian regulators, as well as regulators from all over the world.

"The experienced reinforced to me that NSW has an excellent regulatory system," Dr Dorney said.

He noted a presentation by Baroness Onora O'Neill, philosopher and chair of the UK Equalities and Human Rights Commission, titled *"How to maintain trust in the profession?"* as one of the more interesting presentations.

"Baroness O'Neill spoke about trustworthiness and pointed out that trust is multilayered – a patient's trust in a doctor involves judgement by the patient of the doctor's competence, honesty, and reliability," Dr Dorney said.

She also warned of imposing a heavy system of accountability on doctors that interferes with their core work, quoting one doctor who said, 'It takes longer to do the paperwork than to deliver the baby."

Her take-home message was that the important job in regulation is to identify the poor performers without interfering with all the good performers."

More information about the IAMRA is available on the IAMRA website.

Disciplinary Hearings Snapshot

The following summaries of recent disciplinary decisions provide a snapshot of the issues dealt with by the NSW Civil and Administrative Tribunal (NCAT) and Professional Standards Committees.

NCAT matter – Prescribing

A general practitioner received a reprimand and had conditions placed on his medical registration after being found guilty of unsatisfactory professional conduct and professional misconduct. The genesis of the complaint, brought by the HCCC, was a request by the general practitioner, made in 2010, to restore his prescribing and other rights in respect of Schedule 8 drugs, which had been voluntarily surrendered in 2003.

The general practitioner's request led to an investigation by the Pharmaceutical Service Branch of NSW Department of Health, which found prescribing irregularities in respect of Schedule 4 D drugs benzodiazepines, Pethidine, Tramal, and Panadeine Forte. The investigation found a number of the patients for whom prescriptions were written by the practitioner were, or had been, on an opioid treatment program. Later investigations also focussed on the practitioner's medical records.

The HCCC alleged the general practitioner did not exercise proper medical judgment when issuing prescriptions and did not keep proper clinical records. The general practitioner admitted his conduct in respect of the prescribing and record keeping complaints constituted unsatisfactory professional conduct, but did not believe it amounted to professional misconduct. The Tribunal found otherwise.

The Tribunal ordered that the general practitioner be reprimanded and that his registration be subject to a number of conditions, including but not limited to, that he shall not possess, supply, administer or prescribe any Schedule 8 drug, as defined by the *Poisons and Therapeutic Goods Act 1966* (NSW). The Tribunal further ordered that he complete three education courses, and pay 50 per cent of the HCCC's costs.

Professional Standards Committee matter – Unsatisfactory Professional Conduct

An obstetrician and gynaecologist was found guilty of unsatisfactory professional conduct after conducting a vaginal and rectal examination on a patient in the supine position, and then again while they were in a standing position, without any clinical benefit in conducting such an examination in the standing position. The patient had consulted the obstetrician and gynaecologist for chronic pelvic pain and long-standing endometriosis.

The Committee found the obstetrician and gynaecologist engaged in conduct that demonstrated that the skill or judgement possessed, or care exercised, was significantly below the standard reasonably expected of a practitioner of an equivalent level of training and experience. The Committee imposed a number of conditions on the obstetrician and gynaecologist's medical registration. These included, but were not limited to, that he must not perform vaginal examinations on a patient in a standing position, other than for those in labour, that he must not perform a rectal examination on a patient in a standing position, and that he must appoint a mentor, to report to the Medical Council every three months on their contact, and advise the Medical Council of any concerns about his professional conduct or communication skills.

Professional Standards Committee matter – Unsatisfactory Professional Conduct

A General Practitioner was reprimanded and had conditions placed on their registration – requiring them to complete a course in medical ethics and engage a mentor – after being found guilty of unsatisfactory professional conduct for commencing a sexual relationship with a former patient with whom he had ended the therapeutic relationship on the same evening as the relationship commenced. The doctor self-notified about the relationship to the Medical Council.

The General Practitioner told the Committee that on reflection he should have dealt with these matters differently. He acknowledged that he had a lengthy therapeutic relationship with patient and appreciated that he should have left more time between terminating the doctor/patient relationship and starting a relationship with the patient.

In considering the matter, the Committee referred to the *Medical Board of Australia: Sexual Boundaries: Guidelines for Doctors*, which advises that "it may be unprofessional for a doctor to enter into a sexual relationship with a former patient, if this breaches the trust the patient placed in the doctor". In determining whether trust may have been breached, the Board advises the following should be taken into account: the duration of care provided by the doctor; the level of vulnerability of the patient; the degree of dependence in the doctor-patient relationship; the time elapsed since the end of the professional relationship; the manner in which and reason the professional relationship was terminated; and the context in which the sexual relationship was established.

The Committee noted the General Practitioner had treated the patient for a lengthy period of time, had provided her with psychological and emotional support and that she was a vulnerable patient. The Committee considered that terminating the doctor/patient relationship after dinner and immediately prior to entering into a sexual relationship did not afford the general practitioner adequate time to reflect on these factors. For this reason the Committee determined the general practitioner's conduct was inappropriate and unsatisfactory.