NEW SOUTH WALES MEDICAL BOARD

Newsletter

MARCH 2006

PRESIDENT'S MESSAGE

CODE OF PROFESSIONAL CONDUCT: GOOD MEDICAL PRACTICE

One of the hallmarks of a profession is a code of conduct and ethics which is developed by the profession and sets out the duties and responsibilities of its members. Medicine has a distinguished history in this regard, from the Hippocratic Oath to the Declaration of Geneva, and many professional bodies such as the Colleges and the AMA have over the years published their views of what constitutes good professional practice. At times these have blurred the line between professional etiquette and courtesy and professional ethics.

In 2000 the New South Wales Medical Board adopted a revised version of the UK General Medical Council's Guidelines to Good Medical Practice as Board policy, indicating that it constituted the Board's view of appropriate standards of professional conduct by medical practitioners registered in New South Wales.

In 2003, the Board resolved to have these guidelines established as a Code of Professional Conduct under Section 99A of the Medical Practice Act. This statutory provision, introduced in 2000, provides that a Code of Professional Conduct can, after a statutory consultation process, be approved by the Minister for Health. The effect of approval is to give the provisions of the Code legal standing as "a relevant consideration in determining for the purpose of [the Medical Practice] Act what constitutes proper and ethical conduct by a registered practitioner".

The Board undertook the process set out in the Medical Practice Act during 2004, and on 4 July 2005 the Minister for Health approved of the Code of Professional Conduct: Good Medical Practice. A copy of the Code is enclosed with this Newsletter.

The Code is available on the Board's website. Most other Australian medical boards have adopted, or are in the process of adopting, a similar document under the auspices of the Australian Medical Council's Joint Medical Boards Advisory Committee.

Most of the Code is common sense, reflecting what we know to be good practice, and sound principles of professional conduct.

REMOTE MEDICAL PRACTICE

The 2005 national meeting of medical boards was held in Alice Springs, to coincide with the Australian Medical Council General Meeting, and the meeting of Health Ministers and senior health officials. The focus of the meeting was on the themes of workforce and areas of need, and was co-hosted by the Medical Board of the Northern Territory and the New South Wales Medical Board. The highlight of the meeting was a series of visits in small groups to a number of health facilities in and around Alice Springs, including several remote Aboriginal communities.

For the predominantly city-based Board members from around the country, much of what was seen and discussed constituted a real eye-opener, both in relation to the difficulties encountered in remote medical practice in severely disadvantaged communities, but also because of the incredible dedication and commitment of the health care workers providing services in these environments. A number of these communities are served by area of need international medical graduates, and some of the institutional difficulties faced by these doctors (such as limitations on access to Medicare and educational services for their own families) demonstrated the tangled web of difficulties that stand in the way of easy solutions to a problem that is not going to go away in the near future.

THE QUEENSLAND PATEL INQUIRY

The New South Wales Medical Board observed the Patel Inquiry in Queensland with careful attention. A key feature differentiating the New South Wales Area of Need Program from that in many other States has been that each applicant is required to undergo an independent clinical assessment regarding their suitability for the area of need position, and is subject

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PRESCRIBING OR SUPPLYING PERFORMANCE ENHANCING DRUGS

The Board continues to be concerned about complaints concerning doctors who supply anabolic steroids to sportsmen and bodybuilders. Several doctors have recently been prosecuted, and more cases are in the pipeline. It is difficult to imagine that any doctor could honestly believe that this is acceptable practice. In one recent case, the Medical Tribunal noted that 'The Tribunal does not accept the practitioner's professed ignorance of the prohibition against the prescription of steroids for non medical use.' One can only conclude that these practitioners consider that the financial or other rewards of acceding to their patients' requests outweigh the risk to their career should they get caught.

In the same case, the practitioner who gave evidence as the doctor's peer stated;

> *'It is absolutely inappropriate to prescribe anabolic and androgenic corticosteroids solely in response to a patient's request.*
>
> *There are many other sources (of information) available to General Practitioners in relation to prescribing and clinical issues with regard to anabolic and androgenic corticosteroids and their prescription. Booklets have been produced by Drug and Alcohol Services around Sydney since the mid 1980's when the craze for bodybuilding really began in earnest. The guidelines for medical practitioners available through the NSW Medical Board and sent to every registered medical practitioner in NSW would provide clear and unequivocal regulations and guidance to General Practitioners. Weekly medical magazines such as the 'Medical Observer' and 'Australian Doctor' frequently contain warnings about the dangers of prescribing potentially dangerous drugs like anabolic androgenic steroids to patients on demand or for non-medical use. From time to time peer-reviewed journals will carry articles on the subject of non-medical use of anabolic androgenic steroids and the risks inherent in prescribing these drugs to a naïve population of body builders.'*

There should be no doubt about the Board's attitude to the practice of supplying performance enhancing drugs for non-therapeutic purposes. It will be treated with utmost seriousness and may well result in the deregistration of the practitioner concerned. The Board's Code of Professional Conduct: Good Medical Practice quite clearly requires doctors to act in the best interest of their patients. Given the harm known to be associated with the use of performance enhancing drugs, including death and serious, life-long morbidity, doctors who ignore this advice do so at their peril.

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March 2006

NEW REGISTRATION REQUIREMENTS FOR INTERNATIONAL MEDICAL GRADUATES

Several proposals which have been under discussion by medical boards at a national level for some years have been brought into sharper focus by the Queensland Patel Inquiry. In practical terms in New South Wales, the Patel case has accelerated the introduction of clearer and in some respect higher standards concerning English language skills and verification of credentials and good standing of international medical graduates applying for registration. These new policies largely affect IMGs applying for area of need or postgraduate training registration.

These changes reflect both the need for greater transparency and accountability, and also the greater mobility of medical practitioners, both internationally and between jurisdictions.

ENGLISH LANGUAGE TESTING

It has always been a requirement for registration in New South Wales that applicants demonstrate satisfactory communication skills, including English language skills. Following national discussions in early 2005, the Board agreed to introduce a common standard applicable in all Australian jurisdictions to all international medical graduates. The Australian Medical Council has for many years required applicants for its exams to meet objective standards of English language skills, using a variety of testing methodologies including the Occupational English Test (OET) administered by the Centre for Adult Education, or the International English Language Testing System (IELTS). Exemptions were allowed for, inter alia, applicants who were able to establish that they had undertaken their secondary education where English is the native or first language (not merely the official language).

When the Boards adopted the national standard, it was agreed in consultation with the AMC that the previous benchmark set for the IELTS should be raised, requiring all applicants to achieve a score of 7 in each of the four components of reading, writing, listening and speaking, as well as an overall score of 7.

The national agreement recognises that there would be implementation issues requiring careful consideration. Currently registered practitioners have been grandfathered, and allowance is made for applicants in the pipeline who had commenced the registration process based on the pre-existing information.

The policy, as well as creating specific exempt categories, also gives general exemption powers to the Board, and these have been applied in specific circumstances, eg. where a registrant is to work solely in a research position with no unsupervised patient contact, or where short term registration is sought for the purposes of participating in a workshop, demonstrating techniques, etc.

As with many national initiatives, different circumstances in different jurisdictions have led to anomalies in implementation, and these are being resolved at both the local and national level.

PRIMARY SOURCE VERIFICATION

Until recently, instances of applicants seeking registration based on false documentation have been fortunately few and far between in Australia. However, increased mobility of practitioners, and access to high tech means of preparing fraudulent documentation, have meant the extent of this problem has grown.

The Educational Commission on Foreign Medical Graduates of the United States has for many years run a credentials verification service which is used by a substantial number of American jurisdictions where fraudulent documentation is a much bigger problem. In essence, the ECFMG International Credentials Service (EICS) directly contacts awarding institutions to ensure that Dr X who is applying for registration based on a medical degree from Medical School Y is bona fide. The EICS then provides certification to this effect directly to the registering authority in the jurisdiction where Dr X is applying for registration.

The NSWMB requirement for Primary Source Verification (PSV) came into effect on 1 January 2006, and is being or has been adopted in several other Australian jurisdictions. The longer term objective is that all IMGs applying for registration will include PSV as a part of the registration application process, but in recognition of the need for a transitional period with the introduction of a new procedure, the Board will for a time accept evidence that an application for PSV has been lodged with the EICS by the applicant. Registration is granted in these circumstances, and is conditional upon verification being received in due course.

CERTIFICATES OF GOOD STANDING

Certificates of Good Standing are a long held convention whereby medical boards communicate information regarding the registration status of a registrant to another jurisdiction where that person is applying for registration. Greater mobility of practitioners has highlighted a shortcoming in the system, namely that a practitioner can hold registration in several jurisdictions, and can produce a certificate of good standing from one of those jurisdictions even though a COGS might not be issued by the jurisdiction in which he or she has most recently practised due to disciplinary action in that jurisdiction.

To avoid this problem, the Board now requires applicants for registration to lodge certificates of good standing from every jurisdiction in which they have held registration or practised during the last five years. It debated whether it would be appropriate to require a COGS from every jurisdiction in which registration has been held, but came to the view that five years would provide a reasonable degree of confidence, without imposing too great a burden on applicants. For most applicants, this will not be a problem as they will have only been registered and working in one jurisdiction during the five year period.

The Board recognises that these new requirements add to the work involved in applying for registration in New South Wales. It is well aware of the international competition to obtain IMGs to work in areas of need, etc, but has taken the view that it cannot allow this to overshadow its need to ensure the bona fides, the good standing, and the ability to communicate of registrants in New South Wales.

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to ongoing supervision and reporting to the Board. A review of Board processes in the light of the Patel Inquiry has led to a number of procedural changes to reinforce the Board's confidence in the suitability of international medical graduates registered to work in these positions. There are currently 250 area of need registrants in New South Wales, of whom 87 are in specialist positions, 67 in CMO/RMO positions, and 96 in GP positions.

The Board's primary function is to protect the public by making sure that only suitably trained and experienced doctors are able to practise in New South Wales, and this must be seen as paramount when developing alternative pathways, such as area of need, to meet the undoubted needs of the public in areas of workforce shortage. The Board is confident that it has a good and robust system, and recognises the contribution made to this system by an enormous number of practitioners who are supervising and helping area of need doctors to fit into their communities and, where possible, to progress to permanent membership of the local medical community.

GIVING PERMISSION TO SAY WE ARE WRONG

Doctors are only human, and from time to time, we all make mistakes. Errors such as operating on the wrong side can have disastrous consequences. Even a minor mistake such as giving a wrong vaccine may be distressing for the patient or their family.

Mistakes can sometimes be avoided if a colleague (medical or otherwise, no matter how junior) has the confidence to speak up as soon as they become concerned.

Please give this simple, but effective strategy some consideration. Tell your colleagues that they have your permission to let you know if they think you are about to make a mistake. Tell them that you will be receptive to and appreciative of their intervention. Then listen to what they have to say. It may save you and your patient from disaster.

NEW MEMBERS APPOINTED TO THE BOARD

Members of the Medical Board are put forward by a wide range of nominating bodies, and are appointed by the Governor. Appointments are staggered to ensure continuity. Recent and imminent changes to membership of the Board are as follows:

- Dr Rod McMahon has replaced Dr Bernard Kelly as the nominee of the Royal Australian College of General Practitioners following the expiration of Dr Kelly's twelve year term.
- Ms Diane Robinson has resigned as the Legal Nominee of the Minister for Health and the Minister is currently considering a replacement.
- Dr Eugen Molodysky will replace Dr Jamal Rifi as the nominee of the Community Relations Commission following Dr Rifi's resignation.
- Ms Rosemary Kusuma has replaced Ms Julie McCrossin as a nominee of the Minister for Health following Ms McCrossin's resignation.

The full membership of the Board and their nominating bodies is listed below:

Member	Nominating body
A/Professor Peter Procopis (President)	Royal Australasian College of Physicians
A/Professor Michael Fearnside (Deputy President)	Royal Australasian College of Surgeons
Dr Richard Benn	Royal Australasian College of Pathologists
Dr Sue Ieraci	Ministerial nominee
Ms Maria Kelly	Ministerial nominee
Ms Rosemary Kusuma	Ministerial nominee
Ms Helen Lapsley	Ministerial nominee
Dr Rod McMahon	Royal Australian College of General Practitioners
Dr Eugen Molodysky	Community Relations Commission
Dr Robyn Napier	Australian Medical Association
A/Professor F John Palmer	Royal Australian College of Radiologists
Dr Denise Robinson	Department of Health nominee
Dr Denis Smith	Royal Australasian College of Medical Administrators
Professor Allan Spigelman	Universities nominee
Dr Greg Stewart	Ministerial nominee
Dr Kendra Sundquist (Ed.D.)	Ministerial nominee
Dr Ian Symington	Royal Australian and New Zealand College of Obstetricians & Gynaecologists
A/Professor Kay Wilhelm	Royal Australian & New Zealand College of Psychiatrists
Dr Choong-Siew Yong	Australian Medical Association
(Vacant)	Ministerial nominee (Legal)

TECHNOLOGY-BASED PATIENT CONSULTATIONS

A variety of technologies have been adopted as alternatives to face to face consultations with patients. In many instances, this has been a positive development, giving patients access to services that would otherwise be unavailable to them. In some situations, the use of technology is ill advised and potentially detrimental to patient wellbeing. This policy applies to any technology-based patient consultations, which are defined as:

> *patient consultations that use any form of technology (eg video-conferencing, internet, telephone) as an alternative to face to face consultation.*

POLICY

1. Regardless of the method of consultation with a patient, the standards set out in the Medical Practice Act 1992 and in the Board's Code of Professional Conduct: Good Medical Practice apply.
2. Doctors who advise or treat patients in technology-based consultations:
   i. should be particularly aware of Standard 1.1 which states that good clinical care includes an adequate assessment of the patient's condition, based on the history and clinical signs and appropriate examination; and Standard 1.2 which states that in providing care, doctors should keep colleagues well informed when sharing the care of patients,
   ii. must first confirm to their satisfaction the identity of the patient at each consultation. Doctors should be aware that it may be difficult to ensure unequivocal verification of the identity of the patient in these circumstances,
   iii. must give an explanation to the patient of the particular process involved in the technology-based consultation,
   iv. must make their identity known to the patient,
   v. must ensure that they communicate with the patient to;
      - establish the patient's current medical conditions and history and concurrent or recent use of medications including non-prescription medicines,
      - identify the likely cause of the patient's condition,
      - ensure that there is sufficient clinical justification for the proposed treatment,
      - ensure that the proposed treatment is not contra-indicated.

      This particularly applies to consultations where the practitioner has no prior knowledge and understanding of the patient's condition/s and medical history or to access to their medical records.
   vi. are ultimately responsible for the evaluation of information used in treatment, irrespective of its source. This applies to information gathered by a third party who may have taken a history from, or examined the patient,
   vii. must be confident that a direct physical examination would not add important information to inform their treatment decisions or advice to the patient. This particularly applies to consultations where the practitioner has no prior knowledge and understanding of the patient's condition/s and medical history or to access to their medical records,
   viii. must make a clear, accurate and legible record of the consultation,
   ix. must make appropriate arrangements to follow the progress of the patient by monitoring the effectiveness and appropriateness of the recommended treatment and by informing the patient's general practitioner or other relevant practitioners.
3. In an emergency situation, it may not be possible to practise according to this policy. If an alternative is not available, a technology-based consultation should be as thorough as possible and ensure that more suitable arrangements are made for the continuing care and follow up of the patient.

URGENT INVESTIGATION RESULTS

Notwithstanding the very best efforts of all involved, pathology and imaging reports will, from time to time be generated after hours; occasionally quite late at night.

Pathologists and Radiologists have an ethical obligation to act on a result that that indicates an immediate threat to the life or wellbeing of the patient concerned. It is a source of much frustration that some referring doctors fail to provide an after-hours contact number at the time of requesting the pathology or radiology investigation, sometimes leaving no alternative to involving the police in contacting the patient.

You should be aware that the Board's Code of Professional Conduct: Good Medical Practice states that;

> *You should be satisfied that when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors.*

The provisions of the Code are relevant considerations in determining what constitutes proper and ethical conduct by a registered medical practitioner. Of course, it is desirable that the problem is avoided rather than investigated as a result of an adverse patient outcome.

You are strongly advised to review this aspect of you practice to ensure that you are not exposing yourself or your patients to unnecessary risk.

FITNESS TO DRIVE: WHAT ARE YOUR OBLIGATIONS IN RELATION TO UNFIT DRIVERS?

From time to time, doctors may encounter a patient whose medical condition makes them unfit to drive. This encounter may occur outside the formal driver assessment process and doctors may be concerned about balancing patient confidentiality against concerns for the safety of the public.

There is no statutory obligation to report such concerns to the licensing authority. However, the Board's Code of Professional Conduct: Good Medical Practice states that:

- there may be circumstances where the public interest requires that confidentiality be breached. You should seek appropriate advice in these circumstances.

The RTA publication 'Assessing Fitness to Drive' September 2003 guidelines states:

- National uniform law requires a patient to advise their own Driver Licensing Authority of any permanent or long-term injury or illness that affects his or her safe driving ability. This law can impose penalties for failure to report. NSW Road Transport (Driver Licensing) Regulation 1999 30 (5) states that 'the holder of a driver licence, must, as soon as practicable, notify the Authority of any permanent or long term injury or illness that may impair his or her ability to drive safely.
- With respect to assessing and reporting fitness to drive, the duty to maintain confidentiality is qualified in certain circumstances in order to protect public safety.

If driving continues despite appropriate counselling and is likely to endanger the public, the health professional should consider reporting directly to the Driver Licensing Authority (DLA). The *Road Transport (General) Act* provides that people, including health professionals, who make such reports to the DLA in good faith, are protected from civil and criminal liability.

When the Board's Code of Conduct, RTA guidelines and the *Road Transport (General) Act* are considered in conjunction, it is clear that medical practitioners are expected to report their concerns when there is a risk to public safety and have statutory protection in doing so.

DOCTORS ANONYMITY – PROTECTED WHEN REPORTING CHILD ABUSE AND NEGLECT CONCERNS

Medical practitioners have a statutory duty, as mandated reporters under Section 27 of the NSW Children and Young Persons (Care and Protection) Act 1998, to report a child or young person to the Department of Community Services (DoCS) if they have reasonable grounds to suspect that a child is at risk of harm. The failure to report can incur a $22,000 penalty.

The legislation prohibits the disclosure of the identity of anyone who makes a report to the Department of Community Services, except if that person gives consent. In addition, Section 29 of the NSW Children and Young Persons (Care and Protection) Act 1998 provides protection for mandated reporters who report concerns "in good faith".

In summary, these protections mean that certain matters cannot be deemed to be:

- a breach of professional etiquette, ethics or conduct
- defamatory
- grounds for civil proceedings for malicious prosecution or for conspiracy, or
- the subject of information which a person can be compelled to provide in evidence in Court proceedings.

If you are concerned for the safety, welfare or wellbeing of a child or young person, please contact the DoCS Helpline on 13 3627 (13 DoCS).

The DoCS Helpline can assist medical practitioners who may be uncertain about their obligations to report, or who wish to clarify information about child protection concerns.

The Helpline is the centralised intake system for child protection reports in New South Wales. It operates 24 hours a day, 7 days a week, every day of the year. All calls to the Helpline are answered by experienced and trained child protection staff.

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