NEW SOUTH WALES Medical Board

Board News

JULY 2009

National registration - more work to be done

The long-awaited legislation to underpin the national registration scheme was released for a short consultation period ending 17 July 2009.

The exposure draft of Health Practitioner Regulation National Law 2009 (also known as 'Bill B') sets out the legal framework for the national scheme, including registration and complaints functions and powers (available at www.nhwt.gov.au/natreg.asp).

The legislation broadly covers all the elements of a regulatory system. However, the Bill has taken a very different approach to the Conduct, Health and Performance structure that is familiar in NSW and would, in the Board's view, represent a significant step backwards for the NSW medical regulatory system.

In the Board's view the proposed complaints system is inadequate and in particular it fails to give due recognition to the significance of the Health and Performance programs, which it treats as lesser forms of professional misconduct.

It is anticipated that the NSW Government will opt out of these provisions, as foreshadowed in the Australian Health Workforce Ministerial Council communiqué of 9 May and confirmed in the Frequently Asked Questions released with the exposure draft and in discussions with NSW Health.

Since the Council of Australian Governments first agreed in 2006 to establish a national registration scheme for health professionals, the NSW Medical Board has emphasised the need to safeguard public protection and medical standards. The Board has been particularly concerned that a 'one size fits all' model does not end up being a system based on the lowest common denominator and which abandons the initiatives of the largest and most complex jurisdictions.

The draft Bill B may provide some improvements to regulatory schemes for other jurisdictions, but as it stands it will diminish the effectiveness of medical regulation in NSW.

At the time of writing, the NSW Medical Board was finalising its submission on the Bill in which it will continue to make the positive case for the introduction of a robust and coherent national scheme across all jurisdictions. The National Registration and Accreditation Implementation Project secretariat has been receptive to constructive criticisms, but it remains to be seen whether the significant changes which the Board considers necessary can be effected at this stage.

There are a number of other aspects of the Bill which in the Board's view will require amendment, including the mandatory reporting provisions, which appear to broaden the scope of the provisions currently operating in NSW.

This edition of *Board News* includes details of the Board submission on draft Bill B *(see page 4)*, as well as updates on the implementation of last year's legislative changes to NSW registration and disciplinary systems, and other current professional conduct and registration matters.

Associate Professor Peter Procopis
President, NSW Medical Board

Professional Standards Committees

Legal representation

Legislative amendments to allow doctors and the Health Care Complaints Commission to have legal representation before a Professional Standards Committee were passed by Parliament in May.

However, the amendments will not take effect until guidelines regarding the use of legal practitioners before PSC proceedings are developed. At the time of writing, these were still in development by NSW Health in conjunction with the Board, the HCCC and representatives of the profession.

Under section 177 of the existing *Medical Practice Act*, neither the complainant (being the HCCC) or the medical practitioner the subject of the complaint may be represented by a legal practitioner at an inquiry, although a legal practitioner is entitled to be present at the inquiry and may advise the practitioner. The HCCC is generally represented by a person who has legal training but is not a legal practitioner.

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NEW SOUTH WALES
Medical Board

Professional Standards Committees (continued from page 1)

The recent amendments will allow a practitioner or complainant before a PSC to be represented by a legal practitioner, in line with the section of the Act which allows a practitioner or complainant to be legally represented in proceedings before the Medical Tribunal.

The changes follow the 2008 amendments to the Act, which among other things, require hearings of a PSC constituted after 1 October 2008 to be held in public and decisions of a committee to be published (unless a committee forms the view that it is not in the public interest to do so).

The Government has stated it is 'keen to ensure that proceedings before the professional standards committee do not become overly legalistic and process driven. Therefore, the amendments will commence on proclamation, rather than assent, to allow time for a code of conduct regarding the use of legal practitioners in proceedings before the professional standards committee to be developed.'

The recent legislative changes also included a number of procedural amendments to the *Health Care Complaints Act*. Full copies of NSW legislation can be viewed at www.legislation.nsw.gov.au

Public hearings and decisions

The first public hearing of a PSC was held in May following last year's amendments to the *Medical Practice Act* which required hearings of a PSC constituted after 1 October 2008 to be held in public, except where the Committee otherwise directs.

Information about PSC hearings, listings and attendance is published in the 'Hearings and decisions' section of the Board's website www.nswmb.org.au.

Under the Act, a PSC must provide its written statement of a decision to the complainant, the practitioner and to the Medical Board. Following last year's amendments, the Board publishes statements of decision which have been handed down since 1 October 2008 if the complaint has been proved or admitted in whole or in part, unless the Committee has ordered otherwise.

A Committee retains the power to direct that hearings be closed or that decisions not be published on the basis that it is not in the public interest for reasons connected with the subject matter, the inquiry, or the nature of the evidence to be given.

Snapshot: Disciplinary hearings

Disciplinary complaints against medical practitioners are prosecuted by the Health Care Complaints Commission before the Medical Tribunal or a Professional Standards Committee.

The Tribunal and PSCs are independent statutory bodies established by the *Medical Practice Act*. These bodies and their proceedings are independent of the Medical Board.

Both bodies comprise two medical practitioners and one non-medical person. The Tribunal – the only body that can order the de-registration of a doctor – is chaired by a District Court judge. A PSC is chaired by a legally qualified person.

Seventeen PSC proceedings were finalised in 2007-08 resulting in 12 doctors having unsatisfactory professional conduct findings made against them, of whom eight were also reprimanded and had conditions imposed on their registration. One matter was referred to the Medical Tribunal, and in three matters the complaint was dismissed or no orders were made.

In 2007-08, the Medical Tribunal handed down determinations in relation to complaints against six doctors which resulted in all six being found guilty of unsatisfactory professional conduct and/or professional misconduct. Four doctors were de-registered and two had conditions imposed on their registration, as well as their reprimanded and fined.

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Mandatory reporting of misconduct

Issues around individual responsibility for making a mandatory report about misconduct that may be known to a number of medical colleagues have been highlighted by matters recently brought to the Board.

In particular, the Board is aware of the potential difficulties for junior doctors reporting on the conduct of senior colleagues in the hierarchical structures of institutions or organisations.

In a recent matter a junior practitioner made a report to the Board about a colleague's impairment. It emerged that the doctor had also raised the issue with senior colleagues, but they were of the belief that under the mandatory reporting requirements only the junior doctor was able to make the report to the Board, despite his/her reservation about doing so in a junior position.

In the Board's view, there is nothing to prevent senior practitioners reporting information passed on from junior colleagues, whether as a mandatory report of misconduct or other complaint or notification.

The obligation under the reportable misconduct provisions is on any registered medical practitioner who believes or ought reasonably to believe that reportable misconduct has been committed to report the conduct to the Board as soon as practicable.

The legislation provides that a report made in good faith is not of itself a breach of professional ethics or departure from acceptable standards.

The Board has published 'Reportable misconduct: Guidelines for practitioners' on its website. These expand on the term 'reasonable belief' as follows:

'A reasonable belief requires a stronger level of knowledge than a mere suspicion. For example, you should not be reporting mere speculation, rumours, gossip or innuendo. A report should be based on personal knowledge of facts or circumstances that are reasonably trustworthy and that would justify a person of average caution, acting in good faith, to believe that reportable misconduct has occurred. You do not need conclusive proof that reportable misconduct has occurred. Your own professional background, experience and expertise will also be relevant in forming a reasonable belief.'

The Medical Board has received approximately 20 reports of misconduct since the mandatory reporting laws came into effect on 1 October 2008.

About half of those have met the requirements for reportable misconduct, which focus on three specific areas:

- practising medicine while intoxicated by drugs or alcohol
- practising in a manner that constitutes a flagrant departure from accepted standards of practice or competence and risks harm to another person
- engaging in sexual misconduct in connection with the practice of medicine.

Though not all of the received reports have not met the specific requirements for mandatory reporting, they have still been worthwhile and constructive notifications to the Board regarding conduct, performance and health matters.

* *The Australian Health Workforce Ministerial Council announced in May that mandatory reporting requirements will be an obligation on all health registrants under the national registration scheme.* *For more national updates, see page 4.*

Evidence of indemnity at renewal

The Board is exploring options to simplify the requirements for documentary evidence of professional indemnity insurance (PII) status at the time of registration renewal.

From 1 October 2008, as a result of amendments to the *Medical Practice Act*, all registered doctors in NSW have been required to provide documentary evidence of their PII status with their Annual Renewal.

Before 1 October 2008, the Board accepted a declaration regarding their PII status in their Annual Return.

Regrettably, the legislative requirements were complex and the Board worked closely with insurers, public health organisations and employers to try to make their introduction as simple and practical as possible.

The Board is currently exploring options to improve and simplify the PII reporting procedures in the year ahead. Any changes will be communicated to registrants in their Annual Renewal papers, on the Board's website and in future editions of *Board News.*

From July 2010 doctors will be registered under the new national scheme. The recently released draft legislation to underpin the national scheme suggests doctors will be required to make a declaration regarding their PII status when renewing annually, but it does not detail documentary evidence requirements.

All doctors practising medicine in NSW must hold approved insurance, or fit within an exempt category. Any person practising medicine without approved insurance, or who is not within an exempt category, will be deemed to be guilty of unsatisfactory professional conduct.

The Board recently prosecuted a doctor for practising medicine without insurance and making false representations to the Board about the nature and currency of his insurance. The Medical Tribunal found the doctor guilty of professional misconduct and ordered he be de-registered (NSW Medical Board v Dr Rajesh Dinakar, 24 June 2009).

It was the view of the Tribunal that the doctor, by his failure to comply with the PII regime, *'has shown callous disregard for the requirements of the profession and has shown disdain for his obligations as a practitioner. He has compounded this by his dishonesty in his dealings with the authorities. In the Tribunal's view, such behaviour undermines the maintenance of public confidence in the medical profession and calls for relief that will act as a deterrent to him and to others.'*

Medical Board submission on draft national registration law

The exposure draft of the Health Practitioner Regulation National Law 2009 – the legislation setting out the legal framework for the new registration national scheme - was recently released for consultation.

The NSW Medical Board's submission on the draft Bill is available on its website (www.nswmb.org.au). Below is the introduction to the Board's submission, together with an extract from the Joint Medical Boards Advisory Committee submission

NSWMB Introduction

The New South Wales Medical Board (NSWMB) has supported the introduction of a system of national registration of medical practitioners and has actively contributed to the debate.

The NSWMB considers that Bill B as it currently stands has touched on most of the major elements required of a system of professional regulation, but it has significant shortcomings in some areas, and without major amendment it will be inadequate for the purposes for which it is intended, and possibly unworkable. The Bill is overly prescriptive in some areas, while others where a degree of detail is necessary are very short on detail.

The Bill is particularly unsatisfactory in its approach to the critical matters of Conduct, Performance and Health, apparently misunderstanding the relationship between these major aspects of a NSWMB's work, and proposing a system that is at the same time both cumbersome and inadequate.

The NSWMB notes that the NSW Government has indicated that it is likely to opt out of the Complaints provisions, and to the extent that this occurs, the NSWMB's concerns regarding these provisions may not be relevant. However the NSWMB believes that insofar as it is possible, the legislation should represent best practice, and if it is amended to reflect this, there is a greater chance of NSW reversing the decision to opt out. Also, with movement of practitioners, the NSWMB will have to deal with the consequences of poor decisions made under inadequate provisions if Bill B is not rectified.

The NSWMB has made its views clear at the various forums at which an opportunity has been given to comment on Bill B, and it also notes in this regard that its concerns regarding the complaints handling system have been echoed by all other Medical Boards and apparently by a substantial number of other professional Boards as well.

Finally, the NSWMB is pleased to note that its concerns about Bill B have been listened to carefully by the NRAIP staff responsible for developing the next version, and it is hopeful that many of the issues raised by it and other bodies during the consultation process will be understood and taken into account in the next version.

NRAIP has indicated that there will be no further public consultation when the next draft of the legislation is developed. The NSWMB believes that in a matter as critical as this where legislation is being developed that will set the course for the regulation of health professions in Australia into the future, it is vital that more time is taken to get it right, rather than adhering to deadlines set several years ago which are becoming increasingly unrealistic. Serious consideration must be given to allowing a further round of consultation so that the new system gets off to a sound start, with the commitment of those who will be participating in it strengthened by the knowledge that it is a good system, rather than one that has been finalised in haste to meet artificially imposed deadlines.

Extracts from Joint Medical Boards Advisory Committee submission

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2. The complaints/ performance/health provisions

2.1 Extensive regulatory experience of Medical Boards

Medicine is not the largest profession covered by the Bill, but regulation of the medical profession constitutes about 70-80% of the workload for existing regulatory bodies. This is reflected in the complexity of legislation governing medical practitioners, which has been developed over many years to meet the growing requirements of transparency and accountability, and the primary goal of public protection. Doctors who fail to measure up to proper standards are in a position to do substantial harm to health care consumers in many professional / clinical situations. Additionally, doctors are well resourced to resist attempts at regulatory action, and will often test the limits of a medical board's powers to exercise their functions. The experience of boards in dealing with this legal environment is reflected in the construct of the various state Medical Acts, but much of the important detail which has enabled medical boards to function effectively in the face of these challenges has not been clearly reproduced, or has been omitted from the Bill.

JMBAC recognises that the Bill aims to provide a framework for all the professions covered by AHPRA, from the largest to the smallest, and is well aware of the fact that smaller professions may well not need to have the level of

detail that is required for the effective regulation of the larger professions. It may be that the Bill, as drafted, will lead to a raising of standards for the majority of professions by introducing provisions that they do not currently have. However, the desire to not over-complicate matters and processes must not lead to a diminution of the effectiveness of the professions which operate in a more complex and litigious environment. Smaller boards may have no need to invoke some of the provisions which are of paramount importance for larger boards, but if these are left out, both the public and the health professionals will suffer.

2.2 Disciplinary and non-disciplinary provisions

Disciplinary provisions are an essential feature of professional regulation, but of equal importance are the mechanisms for dealing with practitioners who are not deliberately or recklessly engaging in misconduct, but who are impaired, or whose standards have fallen below an acceptable level. The Bill purports to cover Impairment and Performance, but does so in a way that does not recognise nor understand the difference between these pathways and the Disciplinary pathway, and how they relate to each other. The Bill is couched in terms of 'complaints', failing to recognise the non-disciplinary nature of the Impairment and Performance processes which is essential to their successful implementation. Allowance should be made for the use of the word 'notifications' which do not have the disciplinary overtone of complaints.

2.3 The role of Performance Assessment in regulation

A critical definitional and conceptual failure of the Bill is the characterisation of unsatisfactory performance as a subset of unsatisfactory conduct. While there will be individual cases where this is appropriate (the practitioner who recklessly or wilfully undertakes procedures for which he/she is not trained), in the vast majority it is not. To define performance in this way significantly detracts from its remedial and non-punitive approach, reflecting the worldwide regulatory movement towards assessment and enhancement of professional skills, with punitive measures reserved for 'bad' conduct.

Australia is at the forefront in the development of performance assessment programs, and is regarded by the International Performance Assessment Coalition, a group of a dozen or more jurisdictions from all the countries where performance assessment is seen as a vital tool of professional regulation, as a world leader. The performance provisions in the current Bill (which JMBAC believes to be misconceived and seriously inadequate) will undo over ten years work in this area, leading to a corresponding diminution in the Board's ability to meet its public protection charter.

2.4 Flexibility of assessment and assignment of matters

All notifications should be initially assessed with a view to establishing whether they are to be treated as conduct, performance or impairment, and regardless of whether they have come to the Board's notice as a patient notification/complaint, a self referral, a notification by an employer etc. Once initial assessment has been made, and the matter assigned to the relevant pathway, there must be the power to reassess and reassign at any time, or to deal with a practitioner in two pathways simultaneously if appropriate. The Bill appears to require a matter, once assigned to a particular pathway, to go through the entire process of that pathway before reassignment is possible.

2.5 Definition of Complaint

The language of complaint used in the Bill fails to recognise the significant amount of regulatory activity undertaken by Boards which should not be characterised as disciplinary. The term 'notification' was originally used during the consultation process, and this should be reinstated. Complaints should be viewed as a subset of notifications, and the source of the information should be viewed as secondary to the characterisation as Conduct, Performance or Health once assessment has been undertaken.

The language of the Bill should not add to the current level of confusion regarding the role played by HCEs in conciliation of consumer complaints.

The title of Part 8 should be amended to reflect this, and the interactions between conduct, performance and health.

2.6 Health Panel Procedures

The Bill indicates that practitioners will have a right of legal representation before Health Panels. While there is no debate that health proceedings and the practitioner will almost invariably benefit from the practitioner being assisted by a sympathetic and understanding adviser, JMBAC considers that providing for a right of legal representation will promote an adversarial culture. This is clearly not in the best interests of the public or the impaired doctors.

The Bill provides that the notifier / complainant has a right to make a submission to a Health Panel. While this information may be useful in providing evidence to the Panel relating to behaviour, this should be a matter solely for the Panel to determine and on a case-by-case basis.

It is difficult to see the rationale for requiring the publication of the decisions of Health Panels (and Performance Panels) and we suggest that this be reviewed.

The provisions regarding self-referral appear to contemplate that the first step after receiving the referral will be to enter into an agreement with the practitioner. It is difficult to see this being possible in most circumstances, without first obtaining a health assessment.

2.7 Status of Undertakings

Undertakings can provide a useful means of resolving relatively low level matters in a consensual atmosphere, but if they are used, they must be transparent and binding.

2.8 How will it work?

The view of the CEOs/Registrars of the Medical Boards, based on their collective experience across all the jurisdictions, is that aspects of Bill B, especially the Complaints components as currently proposed, will be very difficult to implement or to operate effectively.

Attempts at modelling how a typical complaint would flow through the system have led to a variety of different interpretations, with the common threads being that the system is cumbersome, circular, and inadequate.

Do I need registration for medico-legal work?

Doctors working as medico-legal consultants are reminded that they **are** practising medicine and therefore must be registered and insured to do so. They should also be staying up to date with medical knowledge and practice in their areas of expertise.

The Board continues to receive inquiries from practitioners about the type of registration required when solely working in a medico-legal capacity.

Doctors who have left or retired from clinical practice may seek to register in the Non-Practising or the Limited Prescribing and Referral categories, depending on their individual circumstances.

However, doctors who undertake medico-legal assessments are practising medicine and these categories of registration do not apply.

In a medico-legal consultation the practitioner is not in a therapeutic relationship with the patient, but the same level of professional skill is required as in a therapeutic setting.

Accordingly, doctors working as medico-legal consultants are considered to be in medical practice and are subject to the provisions of the *Medical Practice Act* regarding their registration, conduct, health and performance. The Board's 'Medico-Legal Guidelines' are available on its website www.nswmb.org.au.

Short-term registration of overseas 'experts'

Visiting medical practitioners must be registered to participate in or demonstrate techniques and procedures on patients in NSW.

With the consent of patients, unregistered doctors can observe medical consultations and procedures, but they must not consult with, advise, or treat patients, operate or assist with procedures.

The Board is aware of two recent cases where well-intentioned local doctors invited unregistered visiting doctors to assist them at surgery, even though they were aware that registration was required.

There were no adverse consequences or complaints made in relation to the visiting doctors, but these cases provide a salutary reminder that registration is required if a visiting practitioner intends to consult with or treat patients in NSW.

Registration can be sought under the 'Temporary Registration in the Public Interest' category. The Board's requirements for temporary registration are based on the principle that patients have the right to expect that appropriate treatment and follow up care will be provided by qualified, registered and competent practitioners (*Board News,* July 2008).

Visiting practitioners who consult with or treat patients without registration in NSW risk prosecution for holding themselves out to be registered medical practitioners. In these circumstances, registered practitioners who are involved in the organisation of workshops or seminars to demonstrate procedures also risk disciplinary action being taken against them.

More information on registration in NSW – including temporary registration in the public interest - is available on the Board's website www.nswmb.org.au

Registered address reminder

Doctors are reminded of the importance of keeping their registered address up to date to ensure they receive information that may affect their registration.

The Board has become aware of a number of out of date addresses following recent mail outs to all registrants.

Failure to notify such a change may result in non-receipt of the annual registration notice and removal from the Register for non-payment of the fee.

An out-of-date address may also result in non-receipt of information related to the range of legislative changes occurring at a state and federal level which may affect medical registration and professional duties now and in the future.

The *Medical Practice Act* requires practitioners to notify the Board in writing of any change to their registered address within three months after the change occurs.

If you wish to change your registered address, please complete the 'Request form to change address' located in the Registration section of the Board's website www.nswmb.org.au

Can doctors with conditional registration provide emergency medical care?

Changes to the legal definition of emergency medical care and the obligations of registered doctors to appropriately render such care have been recommended by the NSW Law Reform Commission (NSWLRC).

The NSWLRC recommendations are contained in its recent report on the question of whether doctors whose right to practise is restricted by conditions on their registration should, contrary to those conditions, provide medical care to a person in need of urgent attention.

The terms of reference for the NSWLRC report arose from the recommendations of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (the Garling Report).

The NSWLRC examined the potential conflict in section 36 of the *Medical Practice Act* due to the interaction of provisions that unsatisfactory professional conduct of a registered medical practitioner includes:

(c) 'Any contravention by the practitioner (whether by act or omission) of a condition to which his or her registration is subject'

(l) 'Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another registered medical practitioner attends instead within a reasonable time.'

In a report released in April 2009, the Commission recommended the Act be amended by:

- substituting 'in need of emergency medical attention' for 'in need of urgent medical attention'. 'Emergency medical attention' should be defined as medical attention that is required as a matter of urgency and is necessary to save a person's life or prevent serious damage to his or her health.
- adding a section to the effect that a registered medical practitioner is not guilty of unsatisfactory professional conduct described in s 36(1) if the practitioner renders emergency medical attention to a person in need of it unless:
  - any condition to which his or her registration is subject excludes the rendering of emergency medical attention; or
  - any condition to which his or her registration is subject excludes the rendering of emergency medical attention of a particular kind or in particular circumstances and the medical attention rendered is of that kind or is rendered in those circumstances.
- making it clear that the practitioner does not have to be 'requested' to act, but will be expected to act (subject to the other requirements of the provision) simply when an emergency situation presents itself.

The NSWLRC report can be viewed on its website at http://www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/pages/LRC_index

Updated pathology guidelines

Updated guidelines on the Pathology Request-Test-Report Cycle were recently published by the Royal College of Pathologists of Australasia.

The guidelines have been developed for use by medical practitioners when requesting pathology tests and by pathology providers operating in both public and private practice.

The guidelines and contact details for the College are available at www.rcpa.edu.au

Immunisation practices

Doctors are reminded of keeping their immunisation knowledge and practice up to date to ensure patient safety and peace of mind.

The Board has recently been made aware of several instances where doctors made mistakes in relation to the doses and timing of childhood vaccinations and communicated poorly with parents. In these cases there were no adverse outcomes and appropriate follow-up ensued, however the risk of harm and the parental confusion and distress could have been avoided if the doctors concerned were up-to-date and confident in their immunisation practices.

The Immunise Australia website includes links to the Australian Immunisation Handbook 9th edition, the National Immunisation Program (NIP) Schedule, and state and territory information contacts:

http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/nips

Registration renewals - national transition

As readers would be aware, a national registration scheme is expected to be introduced on 1 July 2010.

To ensure a smooth transition to the new scheme, doctors whose due date for annual renewal of registration in NSW falls between now and September 2009 will be registered for a period greater than 12 months, ending on 30 September 2010.

Accordingly, the fee for doctors due to renew registration before 30 September 2009 is calculated as follows:

- current annual renewal fee applicable to category of registration

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- pro rata current annual renewal fee to 30 September 2010.

Details of these arrangements are also included in the Annual Renewal papers sent out to individual doctors affected by these arrangements.

The registration renewals for the period 1/10/2010 – 30/9/2011 will be managed by the new national organisation and doctors will be advised about the arrangements in due course.

Poor medical records compound complaints

The Medical Board, defence unions and others seem to write articles ad nauseum about the importance of medical records.

The Board is doing this once again, as a number of recent complaints considered by the Board have been compounded by the inadequacy of medical records.

In such complaints, allegations of unsatisfactory conduct are made, the doctor may offer a reasonable explanation in response, but the records are illegible or non-existent.

The Board and various disciplinary bodies cannot be expected to give the doctor the benefit of the doubt every time that a case is put that he or she did the right thing but there are no records to back this up.

These situations highlight the difficulties and complications caused by poor records in the management of complaints against doctors, but such instances also raise broader concerns about inadequate record-keeping in the context of the individual patient care.

Good record-keeping is required by law under the *Medical Practice Regulation*, which details general requirements as to the content and the form of records. The Regulations are available from the Board's website www.nswmb.org.au

Attention: Fiji-registered medical practitioners

Doctors who are presently, or have ever been, registered in Part II (General registration) of the register of the Fiji Medical Council, are advised to consult the Notice published in the Ministry of Health website,

www.health.gov.fj/Medical Council/medicalcouncil.html, for information concerning their Fiji registration.

The Fiji Medical Council is engaged in a major rationalization exercise. The names of listed doctors who do not respond to this notice before 30.09.09 will be removed to an Archival register.

Doctors who are unsure of their status may apply for information by email to medical.council@health.gov.fj

Doctors wishing to ensure they are retained in the Active register should obtain application forms from the website, and lodge them with Council before 01.10.09.

You are reminded that it is your duty to inform Fiji Medical Council of your current address.

Secretary, Fiji Medical Council

Corporate appointments – advertising and records

When a corporation is engaged in the provision of medical services, the *Medical Practice Act* requires it to appoint a registered medical practitioner to be responsible for medical record keeping and the advertising of medical services.

These appointments must be in force at all times, otherwise the corporation is guilty of an offence.

Details of the relevant legislative provisions and forms to nominate a practitioner are available from the Board's website (www.nswmb.org.au) under 'Advertising – Act and Regulations' and 'Medical Records – Act and Regulations'.

If a corporation contravenes the record keeping or advertising requirements imposed by regulations, the nominated practitioner is taken to have contravened the requirements.

Under the Act, any contravention of regulations by a registered practitioner is unsatisfactory professional conduct.