Australian Capital Territory

Health Professionals (ACT Medical Board Standards Statements) Approval 2006 (No 1)*

Notifiable instrument NI2006–175

made under the

Health Professionals Regulation 2004, Section 134 (Standard's Statement)

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1. Name of instrument

This instrument is the *Health Professionals (ACT Medical Board Standards Statements) Approval 2006 (No 1)*.

2. Commencement

This instrument commences on the day after notification.

3. Standards Statements

In accordance with Regulation 134 (3) of the *Health Professionals Regulation 2004* the ACT Medical Board has approved the following Standards Statements.

Heather M Munro
President

16 May 2006

*Name amended under Legislation Act, s 60

ACT
MEDICAL BOARD

STANDARDS STATEMENTS

CONTENTS

Standards Statements issued by the Medical Board are designed to raise awareness of the standard of practice required from a registered medical practitioner to be competent to practise, or to help the practitioner improve his or her suitability to practice. The information contained in these statement are to be used as a guideline for medical practitioners to follow and reflects the interpretation of the *Health Professionals Act 2004* by the Board. Non-adherence or breach of the statements may be grounds for a finding of a breach of the Act.

Disclaimer

In the case of any conflict or discrepancy between this document and legislation, the legislation prevails.

PREFACE

The ACT Medical Board has developed a number of standards statements to guide practitioners on medical, legal and ethical issues. The Board believes that these standards reflect the high standards of care expected of practitioners in the ACT. The legislation governing practice in the Territory is the *Health Professionals Act 2004.* In the case of any conflict or discrepancy between the standards statements and Act, the Act prevails.

The Board has issued these papers in loose-leaf form and intends to review them regularly and add new policy statements as they are developed.

Comments about the policies would be welcomed and should be directed to the Board's Executive Officer.

Members of the Board hope you will find these statements useful.

ACT MEDICAL BOARD

STANDARDS STATEMENT

CODE OF CONDUCT

Introduction

1. The Board has developed this Code of Conduct to set out its view regarding proper standards and to provide clear principles for the determination of complaints against registered medical practitioners. This Code complements the *Health Professionals Act* 2004 but it is not a substitute for the legislative provisions contained in the Act.

2. The Board provides further guidance on specific issues and areas of practice in other standards statements it publishes from time to time.

General Principles

3. Patients must be able to trust registered medical practitioners (doctors) with their lives and wellbeing. To justify that trust, all doctors have a duty to maintain high standards of practice and respect for human life. As a doctor, you should:

- make the care of the patient your primary concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the right of patients to be fully involved in decisions about their care;
- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- respect and protect confidential information;
- make sure that personal beliefs do not prejudice your patients' care;
- act quickly to protect patients from risk if there is good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor;
- work with colleagues in the ways that best serve patients' interests;
- be honest and trustworthy; and
- maintain necessary medical indemnity cover.

4. All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are:

- clinical competence (possession of adequate knowledge and skill);
- observance of professional obligations;
- good relationships with colleagues; and
- integrity in the conduct of business and research.

Clinical Competence / Performance

5. Good clinical care includes:

- an adequate assessment of the patient's condition, based on the history, clinical signs and appropriate examination;
- providing or arranging appropriate investigations or treatment;
- communicating with patients respectfully and, when necessary, with the assistance of a skilled interpreter
- taking suitable and prompt action; and
- when indicated, referring the patient to another practitioner.

6. In providing care you should:

- recognise and work within the limits of your clinical competence when making diagnoses and when giving or arranging treatment;
- be willing to consult colleagues;
- keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatment prescribed;
- keep colleagues well informed when sharing the care of patients;
- pay due regard to effectiveness of care and the use of resources;
- prescribe only the treatment, drugs, or appliances that serve the needs of patients; and
- do your best to provide appropriate treatment in an emergency.

7. In order to maintain your competence (knowledge and skill) you must:

- participate in educational activities, relevant to your area of practice which develop and maintain your competence and performance throughout your working life; and
- observe and keep up to date with the laws and statutory codes of practice which affect your work.

8. In order to maintain your performance you should:

- ensure that you do not work excessive hours;
- work with colleagues to monitor and maintain your awareness of the quality of the care you provide;
- take part in regular and systematic medical and clinical audit, and record all data carefully and honestly;
- respond to the results of audit to improve your practice, for example, by undertaking further training;
- respond constructively to assessments and appraisals of your professional competence and performance; and
- ensure that you report to authorities where premises or equipment are inadequate.

Professional Obligations

9. In relation to education, teaching and training, you should;

- encourage members of the public to be aware of and understand health issues;
- contribute to the education and training of other doctors, medical students and colleagues;
- develop the skills, attitudes and practices of a competent teacher, especially if you have special responsibilities for teaching;

- ensure that students and junior colleagues under your supervision are properly supervised; and
- be honest and objective when assessing the performance of those you have supervised or trained. Remember that patients may be put at risk if you confirm the competence of someone who has not reached or maintained a satisfactory standard of practice.

References

10. When providing references for colleagues, your comments should be honest and include all relevant information which has a bearing on the colleague's competence, performance, reliability and conduct.

Maintaining Trust

11 Successful relationships between doctors and patients depend on trust. To establish and maintain trust you should:

- listen to patients and respect their views;
- treat patients politely and considerately;
- respect patients' privacy and dignity;
- treat information about patients as confidential. (There may be circumstances where the public interest requires that confidentiality be breached. You should seek appropriate advice in these circumstances.)
- give patients full information about their condition, treatment and prognosis in a way they can understand. This information should be provided to those who have legal responsibility for a patient when that situation applies.
- wherever possible, check that the patient, parent or guardian has understood the information given and the course of action proposed, and that they consent to it, before you provide treatment or investigate a patient's condition;
- respect the right of patients to be fully involved in all decisions about their care;
- respect the right of patients to decline treatment or decline to take part in teaching or research;
- respect the right of patients to a second opinion;
- observe professional boundaries with patients; and
- be readily accessible to patients and colleagues when you are on duty.

Putting Patients First

12. In dealing with the interests of patients, you should:

- give priority to the investigation and treatment of patients on the basis of clinical need;
- investigate or treat on the basis of your clinical judgment of the patient's needs;
- not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social, economic or insurance status to prejudice the treatment you provide or arrange;
- explain to the patient if you feel that your beliefs might affect the treatment you provide, tell them of their right to see another doctor, and where appropriate, refer them to another doctor;
- not refuse or delay treatment because you believe that a patient’s actions have contributed to the patient’s condition, or because you may be putting yourself at risk. If a patient poses a risk to your health or safety, you may take reasonable

steps to protect yourself before investigating the condition or providing treatment; and

- act in your patients' best interests when making referrals and providing or arranging treatment or care; and
- not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgment. You must not offer such inducements to colleagues.

If Things Go Wrong

13. Patients who complain about the care or treatment they have received have a right to expect a prompt and appropriate response. You have a professional responsibility to:

- deal with complaints constructively and honestly;
- co-operate with any complaints procedure which applies to your practice;
- ensure that a patient's complaint does not prejudice the care or treatment you provide or arrange for that patient. It may sometimes be wise to arrange an appropriate referral to another doctor.
- act immediately to put matters right, if that is possible, should a patient under your care suffer serious harm, through misadventure or for any other reason. You should explain fully to the patient what has happened and the likely short and long-term effects. When appropriate, you should offer an apology. If the patient is cognitively impaired or lacks the maturity to understand what has happened, you should explain the situation to the patient's parents, guardian or carer;
- co-operate fully with any formal inquiry into the treatment of a patient, subject to appropriate advice from your medical defence organisation. You should not withhold relevant information; and
- assist the Coroner when an inquest or inquiry is held into a patient's death;

14. When a patient dies, you should explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility, the patient's partner or next of kin.

15. If the doctor / patient relationship deteriorates, you should:

- attempt to re-establish and maintain a relationship of trust with the patient;
- in circumstances in which you find it necessary to end a professional relationship with a patient, tell the patient why you have made the decision;
- assist the patient to make prompt arrangements for their continuing care; and
- transfer records or other information to the patient's new doctor on request.

Abuse of your professional position

16. You must not abuse your patients' trust. You must not:

- use your position to establish improper personal relationships with patients or their close relatives;
- put pressure on your patients to give or lend money or to provide other benefits to you or other people;
- improperly disclose or misuse confidential information about patients;
- give patients, or recommend to them, an investigation or treatment which you know is not in their best interests;

- deliberately withhold appropriate investigation, treatment or referral;
- put pressure on patients regarding their insurance status; and
- allow anyone who is not a registered doctor to carry out tasks which require the knowledge and skills of a doctor.

Protection of Patients

17. In order to protect your patients and the public, you should:

- be vigilant in identifying doctors or other colleagues whose health, conduct or performance is a threat to the public; and
- report adverse events which reflect on the professional performance or conduct of colleagues to a hospital Chief Executive or the Medical Board.

Own Health and Patients

18. If you have a serious condition which you could pass on to patients, or if your judgment or performance could be significantly affected by a condition or illness, you should;

- consult and follow the advice of a suitably qualified doctor on the necessary tests, treatment and modifications to your clinical practice; and
- not rely on your own assessment of the risks to the patient.

Providing information about your services

19. If you publish or broadcast information about services you provide, you must:

- ensure that the information is factual and verifiable;
- provide information in a way that conforms with legislation;
- ensure that the information does not create an unjustified expectation of beneficial treatment or promote the unnecessary or inappropriate use of medical services;
- avoid making claims about the quality of your services particularly by comparison with those of your colleagues; and
- not offer guarantees of cures, nor exploit a patient's vulnerability or lack of medical knowledge.

Working with colleagues

20. You must:

- always treat your colleagues fairly;
- ensure that students or practitioners under supervision are not abused or harassed;
- respect the views of other colleagues even if they differ from your own;
- not allow your views of a colleague's lifestyle, culture, beliefs, race, colour, gender, sexuality, or age prejudice your professional relationship with him/her; and
- not make any patient doubt the knowledge or skills of colleagues by making unnecessary or unsustainable comments about them.

Working in teams

21. Health care is increasingly provided by multi-disciplinary teams, although you remain accountable for your professional conduct and the care you provide. You should:

- work constructively and respect the skills and contributions of all team members;
- ensure optimal communication with other members of the team; and
- endeavour to resolve disagreement within the team. If you believe that the decision would harm the patient, tell someone who can take action. If necessary, and as a last resort take action yourself to protect the patient's safety or health.

22. If you are a team leader, you should:

- take responsibility for ensuring that the team provides care which is safe, effective and efficient;
- do your best to make sure that the whole team understands the need to provide a polite, responsive and accessible service and to treat patient information as confidential;
- make sure that colleagues understand their role and responsibilities in the team; and
- work to improve your skills as a team leader.

Arranging Cover

23. When you need to arrange cover, 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; and
- satisfy yourself that doctors who stand in for you have the qualifications, experience, knowledge and skills to perform the duties for which they will be responsible.

Coordinating a Patient's Care

24. It is in a patient's best interests for one doctor, usually a general practitioner, to be fully informed about and responsible for maintaining continuity of medical care. The doctor undertaking this role should:

- be aware of the range of specialist services available; and
- actively co-ordinate the patient's care, or make certain that this task is being undertaken by another medical practitioner.

Delegation and Referral

25. Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate or refer care or treatment you should:

- be sure that the person to whom you delegate or refer is competent to carry out the procedure or provide the therapy involved; and

- unless the patient objects, pass on all relevant information about the patient's history and current condition.

Probity in professional practice

26. You must be honest in financial and commercial matters relating to your work. You should:

- inform patients about your fees, particularly non-rebatable fees;
- avoid financial involvement, such as loans and investment schemes, with patients;
- not allow your financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies to affect the way you prescribe for, treat or refer patients;
- inform patients if you have a financial or commercial interest in an organisation or hospital to which you plan to refer a patient for treatment or investigation:
- not ask for or accept any material gifts or loans from companies that sell or market drugs or appliances; and
- not accept fees for agreeing to meet sales representatives.

Certificates

27. When signing certificates and other documents, you must:

- take reasonable steps to verify any statement before you sign; and
- not sign any document which you believe to be false or misleading.

Research

28. If you take part in clinical drug trials or other research involving patients or volunteers, you should:

- ensure that the research protocol has been approved by a properly constituted research ethics committee;
- conduct all research with honesty and integrity;
- ensure that the individual has given informed, written consent to take part in the trial;
- ensure that the research is not contrary to the individual's interests;
- seek advice where your research involves children or adults who are not able to make decisions for themselves.
- follow all aspects of the research protocol;
- accept only those payments approved by a research ethics committee; and
- report evidence of fraud or misconduct in research to an appropriate person or authority.

Acknowledgement

These guidelines have been adapted with permission from the General Medical Council's publication "Good Medical Practice" and the New South Wales Medical Board's Code of Professional Practice.

ACT MEDICAL BOARD

STANDARDS STATEMENT

MEDICAL CERTIFICATES

General

1 Medical practitioners are able to issue medical certificates to patients under a range of legislation and workplace awards. The information required on the certificate and the information provided by the practitioner will vary according to the requirement.

2 Medical practitioners should be aware of the legal consequences of medical certificates.

3 A certificate is a written document attesting to the knowledge of the person providing the certificate. "Certify" means to "attest formally." A certificate is not a sworn document, but its contents should be given the same careful consideration as sworn testimony.

Absences from Work

4 The most common certificate requested by patients is one for absences from work due to illness. The purpose of the certificate is to confirm to the employer that the employee was absent from work on a particular day or days because illness prevented the person from attending their place of work.

5 The medical practitioner should be careful to provide such a certificate only if it is his/her opinion that the patient is unable to attend work because of illness. The practitioner needs to consider the nature of the patient's work as well as the effects of the illness.

6 Problems may arise when the practitioner is consulted after an illness has abated. Patients may request a certificate late in the evening of the day they have not attended work or on a subsequent day. This may place the practitioner in a difficult position, particularly when there is no longer clinical evidence of illness. In such instances the practitioner may:

a. issue a certificate;
b. decline to issue a certificate;
c. issue a modified certificate or letter stating that the patient has reported that they were unable to attend work on a certain day because of illness. Further qualifying clauses may be added;
   - that the illness could not be independently verified and/or
   - that there was no reason to dispute this claim.

Dates

7 A certificate should show at least two dates which may or may not be the same, namely:

a. the date on which the patient was examined; and
b. the date on which the certificate was issued.

8 Certificates may require the dates of full or partial incapacity for work. The practitioner should exercise caution when providing a certificate where the date from which incapacity is certified is not the same as the date of examination. This applies whether the certificate is certifying incapacity commencing prior to or after the date of examination. Backdating of medical certificates can seldom be done without the practitioner certifying matters which are outside his/her personal knowledge and requests for backdating certificates which cannot be substantiated by examination or clinical records, should always be denied.

9 Where a disease or injury has been present for a long period and/or is expected to last for a protracted period, the practitioner should not issue continuing certificates without being satisfied that the incapacity still exists.

Diagnosis

10 Some certificates, notably those where a worker's compensation claim has been made, seek a specific diagnosis from the practitioner. Caution should be exercised in this regard. Imprecise diagnoses should be avoided.

Causation of Illness or Injury

11 Worker's compensation certificates commonly require some indication of the cause of the condition for which compensation is sought. Practitioners should be careful not to exceed the bounds of their knowledge when certifying the cause of the condition. If the practitioner is relying solely on information provided by the patient and not on personal knowledge, this should be made clear on the certificate. It may be preferable in some instances to word the certificate in terms of:

"Patient X is suffering from (condition) which he/she states is due to (cause)".

Conclusion

12 The medical practitioner has responsibility for the investigation and management of a patient's illness or injury, and should be careful, particularly in worker's compensation matters, to remain objective. The practitioner should not put his or her name to a document which might be used to mislead or defraud an employer.

13 To issue a certificate that is not true in every detail or is misleading, fraudulent or otherwise improper will create a *prima facie* impression that the practitioner has breached the required standards of practice in terms of R 147 of the *Health Professionals Regulation 2004*. Practitioners should not under any circumstances, allow themselves to be persuaded by a patient or any other party to write such a certificate.

ACT MEDICAL BOARD

STANDARDS STATEMENTS

DEATH CERTIFICATES

General

1 Under the *Births, Deaths and Marriages Registration Act* 1997 medical practitioners are required to issue death certificates.

Legislation

2 Sub section 35(1) of the *Births Deaths and Marriages Registration Act* 1997 states that a doctor who was responsible for a deceased person's medical care immediately before death, or who examines the body of a deceased person after death, shall, within 48 hours after the death notify the Registrar-General (of Births Deaths and Marriages) of the death and of the cause of death in a form approved by the Registrar-General. In the ACT, certificates may be obtained by telephoning the Registrar General's Office on 6207 0460.

Certificates

3 Practitioners should always keep in mind that a death certificate is a legal document. The written certificate is a statement having official status concerning matters within the knowledge of the practitioner providing the certificate. "Certify" means to "attest formally" and although a certificate is not a sworn document, its contents should be given the same careful consideration as sworn testimony.

4 Death certificate diagnoses may be extensively analysed. Wording them with care may contribute to the advancement of medicine, public health and epidemiology. The information contained in a death certificate is usually of great importance to the family of the deceased.

5 The Australian Bureau of Statistics booklet 'Cause of Death Certification Australia' provides an excellent reference for practitioners completing medical certificates of cause of death. Assistance can be obtained by telephoning 1800 620 963.

Who Should Issue the Certificate

6 The best person to issue the certificate is the doctor who has recent full knowledge of the patient's condition. In most instances this will be the doctor who usually attended the patient.

7 Only in extreme circumstances should practitioners sign a death certificate for a family member or close family friend.

8 Practitioners must not sign a certificate unless they are confident death was from natural causes. If practitioners are unsure whether it was from natural causes, the case must be referred to the Coroner.

9 The Coroner's pathologists welcome enquiries and can help when practitioners may be having difficulty with the wording of a certificate. They will also advise practitioners whether a case needs to be referred to the Coroner.

10 Deaths must always be handled sensitively and respectfully. Courtesy is essential. If the practitioner cannot in all conscience satisfactorily complete a medical certificate of cause of death, he/she should inform the family that the matter will need to be referred to the Coroner.

Coronial Matters

11 S 13(1) of the *Coroner's Act 1997* (ACT) (Coroner's Act), states:

"A coroner shall hold an inquest into the manner and cause of death of a person who-

(a) is killed; or
(b) is found drowned; or
(c) dies, or is suspected to have died, a sudden death the cause of which is unknown; or
(d) dies under suspicious circumstances; or
(e) dies during or within 72 hours after, or as a result of-
    (i) an operation of a medical, surgical, dental or like nature; or
    (ii) an invasive medical or diagnostic procedure; other than an operation or procedure that is specified in the regulations to be an operation or procedure to which this paragraph does not apply; or
(f) dies and a medical practitioner has not given a certificate as to the cause of death;
(g) dies not having been attended by a medical practitioner at any time within the period commencing 3 months prior to the death; or
(h) dies after an accident where the cause of death appears to be directly attributable to the accident; or
(i) dies, or is suspected to have died in circumstances that, in the opinion of the Attorney-General, should be better ascertained; or
(j) dies in custody."

The specified operations and procedures referred to in (e) above are listed in Regulation 5 (2) of the Coroners Regulations-

(a) the giving of an intravenous injection;
(b) the giving of an intramuscular injection;
(c) intravenous therapy;
(d) the insertion of a line or cannula;
(e) artificial ventilation;
(f) cardiac resuscitation: and
(g) urethral catheterisation.

12 Regulation 5 (1) states that an "operation or procedure specified for this section is not an operation or procedure for the Act, section (1) (e) if the doctor responsible for carrying it out gives a certificate stating that the death has not happened as a result of that operation or procedure".

13 S 77 of the Coroners Act states that a person shall report a death to a Coroner or a police officer if the person has reasonable grounds for believing that the death is one, in respect of which a Coroner would have jurisdiction to hold an inquest. Failure by a registered medical practitioner to make such a report may be grounds for the Board to reach a finding of unsatisfactory professional conduct.

14 Practitioners should also note that s 83 of the Coroner's Act states that if a post mortem examination is likely to be ordered, or an inquest held, it is an offence to interfere with, or remove, the body with intent to avoid the post mortem or inquest.

ACT MEDICAL BOARD

STANDARDS STATEMENT

EXAMINATIONS ON BEHALF OF A THIRD PARTY

Definition

1 Section 2.1 of Schedule 2 to the *Health Professionals Regulation 2004* provides that the practice of medicine includes the "examination or assessment for medico-legal purposes".

Issues

2 Examinations on behalf of a third party are usually single consultations and therefore particular care should be taken with explanation of the practitioner's role. It is important that the practitioner is understood to be offering an impartial professional opinion and that the nature and purpose of these examinations are different from that of an examination for the purpose of medical treatment.

3 Practitioners should remember that patients may feel very vulnerable because of the perceived implications to their future life-style, occupation and financial well being.

Role of the Practitioner

4 The role of the practitioner conducting these examinations is to provide to the third party a professional opinion based on objective evidence. This role, however, does not absolve the practitioner from his or her duty of care towards the patient.

5 The practitioner should do everything within his or her power to ensure that the patient is treated fairly and justly and with care and courtesy. The practitioner must ensure that no action by him or her, clinical or otherwise, jeopardises the recovery of the patient.

6 Practitioners should provide opinions only in their field of expertise and the report should contain a description of the expertise which qualifies the practitioner to make such comments.

Advice to the Patient

7 At the commencement of the examination, the practitioner should explain his/her role fully to the patient. The patient should be made aware that the practitioner:

a. is providing evidence to a third party relating to the condition under consideration;
b. is assessing and not treating or advising the patient;
c. will explain the reason behind asking questions or conducting physical tests; and
d. will be writing a fair and objective report to the third party.

The Examination

8 Any examination, investigation or procedure should be undertaken with the informed consent of the patient or guardian.

9 The practitioner should conduct any physical examination with due care and without unnecessary force and should ensure that no harm is caused by the examination. Failure of the patient to consent to any aspect of the assessment should result in that part of the assessment being omitted and this should be documented in the report to the third party.

10 Should a practitioner find a previously undiagnosed but significant condition, he/she has a duty of care to make the patient aware of the condition and its possible consequences.

Presence of an Observer

11 Because of the potentially legal nature of the examination, many patients request that an observer be present during the examination and/or that they be allowed to tape record the consultation.

12 The Board supports this practice as it may assist the patient and provide protection for the practitioner. Practitioners are encouraged to comply with requests for the presence of an observer of the patient's choice except where this would undermine the reliability of the opinion. The practitioner should ensure that any observer present is treated with due courtesy and not unnecessarily excluded from any elements of the consultation.

The Report

13 The opinion must be based on, and supported by, the testable evidence available. The practitioner must give due consideration and weight to all documented evidence provided including information provided by the patient's regular treating practitioner.

14 The report generated from the examination should only contain information relevant to the matter under consideration.

15 Practitioners should remain aware of the Court's Code of Conduct with respect to expert witnesses.

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MEDICAL PRACTITIONERS AND SEXUAL MISCONDUCT

General

1 This paper aims to ensure medical practitioners are aware of their responsibilities in instances where there might be sexual attraction between a practitioner and his or her patient, including former patients.

Expectations of the Public

2 It is the responsibility of the practitioner to behave responsibly at all times and to maintain professional boundaries with patients. Any exploitation of the relationship between the patient and the practitioner must be considered as a violation of the public's trust.

Definitions

3 Sexual misconduct is behaviour that exploits the physician-patient relationship in a sexual way. This behaviour is non-diagnostic and non-therapeutic, may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that may be construed by a patient as sexual.

4 There are primarily two levels of sexual misconduct: sexual violation and sexual impropriety. Practitioners should note that expectations of patients have altered during recent years and practices that were acceptable at the time of their training may need to be reviewed.

5 **Sexual violation** may include practitioner-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to:

a. sexual intercourse, genital to genital contact;
b. oral to genital contact;
c. oral to anal contact, genital to anal contact;
d. kissing in a romantic or sexual manner;
e. touching breasts or genitals other than appropriate examination or treatment, or
f. where the patient has refused or has withdrawn consent;
g. encouraging the patient to masturbate in the presence of the practitioner or masturbation by the practitioner while the patient is present;
h. offering to provide practice-related services, such as drugs, in exchange for sexual favours.

6 **Sexual impropriety** may comprise behaviour, gestures, or expressions that are seductive, sexually suggestive, or demeaning to a patient, including but not limited to:

a. disrobing or draping practices that reflect a lack of respect for the patient's privacy, deliberately watching a patient dress or undress;
b. subjecting a patient to an intimate examination in the presence of medical students or other parties without the explicit consent of the patient or when consent has been withdrawn;

c. examination or touching of genitals without the use of gloves;
d. inappropriate comments about or to the patient, including but not limited to making sexual comments about a patient's body or underclothing, making sexualised or sexually demeaning comments to a patient, criticising the patient's sexual orientation (homosexual, heterosexual or bisexual), making comments about potential sexual performance during an examination or consultation except when the examination or consultation is pertinent to the issue of sexual function or dysfunction, requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation;
e. using the practitioner-patient relationship to solicit an inappropriate relationship;
f. initiation by the practitioner of conversation regarding the sexual problems, preferences or fantasies of the practitioner;
g. examining the patient intimately without consent.

Disciplinary Options

7 A finding of sexual violation is usually flagrant enough to warrant the finding of a breach of the Act leading to cancellation or suspension of registration.

8 A finding of sexual impropriety may result in a finding of a breach of the Act which may attract less severe sanctions.

9 The Board offers the following suggestions when dealing with patients:

a. before proceeding, explain to the patient what is to occur in a medical examination and ensure that the patient agrees and consents to the procedure;
b. do not request or encourage irrelevant or unnecessary details of a patient's sexual history, sexual performance or sexual preference;
c. allow the presence of a chaperone during an intimate physical examination;
d. allow a patient to dress and undress in private;
e. offer the patient a suitable covering to use during the examination;
f. use gloves when conducting internal examinations or invasive procedures;
g. do not make unnecessary comments about a patient's body or clothing or make other sexually suggestive comments by way of sexual innuendo or jokes;
h. treat patients respectfully regardless of their sexual orientation;
i. do not under any circumstances discuss your own sexual problems, preferences or fantasies;
j. do not make comments about a patient's sexual performance unless this is necessary for treatment and you have previously explained why it is relevant;
k. if medical students are to be present during an examination, request the patient's permission beforehand.

Warning Signals

11 Practitioners are advised that there are certain behaviours in themselves which should warn that a violation of boundaries may occur. These include:

a. intrusive thoughts of the patient;
b. feelings of falling in love with the patient;
c. arranging appointments with the patient when other staff have left the office;
d. thoughts of meeting the patient outside the office;
e. according special 'treatment' to the patient;
f. increasingly irrelevant self-disclosure to the patient; or
g. any activities you would not like colleagues to know about.

Reports to the Board

12 A medical practitioner who believes that another practitioner has behaved improperly and unprofessionally by engaging in sexual exploitation or abusive behaviour towards a patient or former patient, should report the matter to the Medical Board.

13 The Board believes that if a medical practitioner is informed by a patient that another practitioner may have been involved in sexually exploitative or abusive behaviour, he/she has an obligation to encourage the patient to make a complaint to the Community and Heath Services Complaints Commissioner or to the Board.

Reference: Report on Sexual Boundary Issues by the Ad Hoc Committee on Physician Impairment of The Federation of State Medical Boards of the United States, Inc.

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STANDARDS STATEMENT

TREATMENT OF SELF AND RELATIVES BY MEDICAL PRACTITIONERS

1 The Board considers that medical practitioners should not treat themselves, family members or close friends unless there is no practical alternative. The reasons for this are:

a. professional objectivity may be compromised and judgement influenced by the personal nature of the relationship with the patient;
b. the patient may feel uncomfortable disclosing sensitive information or undergoing a physical examination;
c. the practitioner may fail to investigate fully when taking a medical history or fail to undertake an appropriate physical examination;
d. informed consent may be compromised when there is a close personal relationship between patient and practitioner.

2 Medical practitioners should not damage the confidence that members of their families have in their own independent general practitioner by undermining the advice and treatment that they have been given.

Treating General Practitioners

3 Practitioners have an ethical duty to themselves and to their patients to ensure that their own health problems are effectively managed.

4 All registered medical practitioners should be treated by their own, independent general practitioner. He/she should not be a relative, or another member of the practitioner's practice.

5 Practitioners need to be aware that they become the patient in a doctor-patient relationship.

Principles

6 The Board endorses the following:

a. medical practitioners should not initiate treatment, including prescribing and referral to specialists, for themselves, family members or close friends;
b. in emergency situations, where there is no other help available, medical practitioners may treat themselves or family members until another medical practitioner is available;
c. it is not advisable for medical practitioners to issue certificates for themselves or members of their family;
d. only in extreme circumstances, should a practitioner issue a death certificate for family members or close friends; and
e. a medical practitioner should never prescribe a drug of addiction for themself, a family member or close friend, except in an extreme emergency, when it should be on a one-off basis.

Acknowledgement

The Board acknowledges guidelines published by the Medical Practitioners Board of Victoria, the NSW Medical Board and the BMA

ACT MEDICAL BOARD

STANDARDS STATEMENT

MEDICAL PRACTITIONERS WITH COMMUNICABLE DISEASES

General

1 The Board is concerned to ensure that medical practitioners registered in the ACT who carry infectious diseases are aware of their responsibilities towards their patients.

Terms

2 The term 'blood borne virus' is used throughout this paper and refers particularly to HIV, Hepatitis B and C.

General Points

3 Medical practitioners have a wide range of professional, ethical and legal responsibilities towards their patients, the public and their colleagues. The emergence of infections such as HIV, Hepatitis B and Hepatitis C has focussed attention on the role and responsibility of practitioners. The Board considers that the general principles that govern the management of other communicable diseases should be applied to infection with these blood borne viruses.

Transmission

4 Practitioners are responsible to ensure that basic infection control procedures are used whenever patients are examined and treated. Any medical practitioner who undertakes or could reasonably be anticipated to undertake exposure-prone procedures has a professional responsibility to take appropriate steps to be aware of his or her infective status in relation to these blood borne viruses.

Indicators of Infective Status

5 Indicators of infective status used as the basis for the practitioner's refraining from the practice of exposure prone procedures include a positive HIV antibody test, a positive HBe antigen or HBV DNA test.

6 Practitioners who are HCV antibody positive should undergo expert clinical assessment, including HCV PCR testing. A HCV PCR positive test is at present the best marker of the potential to transmit HCV infection.

7 Practitioners performing exposure-prone procedures should be tested on at least a twelve monthly basis to detect change in status and more frequently in the event that the practitioner has reason to believe that he or she may have been exposed to any of these blood borne diseases.

Breach of Standards of Practice

8 A medical practitioner who is aware that he or she is infected with a blood borne virus should not undertake exposure prone procedures. To do so, the Board believes would *prima facie* constitute a breach of the standards of practice.

Reporting

9 Mandatory reporting to the Board of a medical practitioner infected with one of these blood borne viruses is not required.

10 However, if a practitioner is aware that a colleague is experiencing physical or mental difficulties following a positive diagnosis, he or she is obliged to encourage the impaired practitioner to seek medical help. In such cases, practitioners should note the Board's Doctors' Health Program is available for peer support, education and counselling.

11 If a practitioner becomes aware that a colleague is engaged in behaviour that could place the public at risk, such as undertaking exposure-prone procedures while infected, he/she has a professional responsibility to advise the Board. The Board considers that failure to report such behaviour may constitute unsatisfactory professional conduct.

12 A medical practitioner infected with one of these blood borne viruses who is not otherwise impaired may continue to practise medicine that does not involve exposure prone procedures.

Exposure prone procedures

13 Examples of exposure prone procedures include:

a. caesarean section
b. vaginal hysterectomy and repair
c. abdominal hysterectomy
d. intercostal catheter insertion
e. all procedures performed in the mouth
f. all prosthetic joint replacements
g. major abdominal surgery, and
h. coronary artery bypass surgery.

14 Procedures where the hands and fingertips of the health care worker are visible and outside the patient's body at all times and internal examinations that do not require the use of sharp instruments are not considered to be exposure prone.

The Board endorses the ACT Department of Health and Community Care policy paper *Management of Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus, Infected Health Care Workers*. The Board particularly supports the recommendations in the policy paper regarding immunisation of practitioners.

ACT MEDICAL BOARD

STANDARDS STATEMENT

ANABOLIC - ANDROGEN STEROIDS

General

1 The Medical Board is always concerned about unnecessary, excessive and indiscriminate prescription of drugs by registered medical practitioners. Prescription of anabolic-androgenic steroids requires extra vigilance on the part of practitioners.

Usage of the Drugs

2 The use of anabolic-androgenic steroids to enhance sporting performance or physical appearance may be classified as drug abuse. There is a strong risk of side effects. Women of any age and young men are at special risk.

Risk of Abuse

3 Practitioners should realise that those people intent on using anabolic steroids for bodybuilding or enhanced physical performance are unlikely to recognise the need for dose compliance or to submit to the requisite medical monitoring. Illegal distribution is facilitated by prescription of these drugs in quantities greater than would meet the needs of the patient.

Drugs in Sport

4 World-wide, professional and sporting groups consider that use of these drugs in sport is unethical. The risk-to-benefit ratio is too high and side effects are more likely because athletes often use different agents simultaneously or sequentially in doses which substantially exceed those used for approved therapeutic indications. Side effects include psychological alterations (aggression, mood swings, sleep disturbances) altered libido, acne, gynaecomastia, male pattern baldness, lipid abnormalities, hepatic tumours, peliosis, hepatic cholestasis, pre-diabetes and cerebro-vascular accidents.

5 Women are liable to masculinising effects including hirsutism, deepening of the voice and clitoromegaly. Adolescents are at risk of precocious puberty and premature epiphyseal closure.

Responsibility of Practitioners

6 Medical practitioners have a clear responsibility to ensure that prescriptions of anabolic steroids, like those for all other drugs, must be for a specific identifiable and justifiable clinical purpose. Practitioners should ensure that anabolic steroids are not prescribed for non-therapeutic or performance- enhancing purposes. Failure to do so will leave the practitioner subject to the provisions of the legislation.

Acknowledgment

The Medical Board thanks the Medical Board of South Australia for the clinical information provided in this paper.

ACT MEDICAL BOARD

STANDARDS STATEMENT

PRESCRIBING OF BENZODIAZEPINES

General

1 Inappropriate prescribing of any drug may contravene this standards statement and thus breach R 139 to the *Health Professionals Regulation 2004*.

2 The Board would be concerned if a medical practitioner:

a. knowingly prescribed any drug not for the use of the person for whom it is prescribed, i.e. the *bona fide* patient of the practitioner;
b. prescribed a drug which is not required for the medical treatment of a person;
c. knowingly prescribed a drug to a person who has a Voluntary Undertaking in existence with another practitioner in respect of that drug or class of drugs.

Usage of benzodiazepines

3 Benzodiazepines are a group of drugs most commonly prescribed for insomnia and anxiety symptoms. Other perceived medical indications for prescribing benzodiazepines include panic disorders, epilepsy, muscle relaxation, manic episodes, movement disorders, alcohol withdrawal, sedation and anaesthesia.

4 There is strong evidence to suggest that some patients use benzodiazepines for non-medical indications, often in an unsafe and uncontrolled manner.

5 Information regarding the prevalence and problems associated with the use of benzodiazepines is attached as Appendix 1 to this Paper.

Risk of Abuse

6 Practitioners are advised that patients may abuse benzodiazepines for the purposes of:

a. increasing the effect of heroin;
b. boosting or prolonging the intoxicating effect of methadone;
c. becoming ‘high’ by combining benzodiazepines with large quantities of alcohol;
d. strengthening the sensation of well being, reducing anxiety and withdrawal symptoms.

7 Knowingly prescribing these drugs in quantities greater than would meet the treatment needs of the patient facilitates illegal distribution.

Responsibility of Practitioners

8 The Board considers that medical practitioners have a clear responsibility to ensure that prescriptions of benzodiazepines must be for a specific identifiable and justifiable clinical purpose.

9 Practitioners are advised to ensure that all prescriptions for benzodiazepines clearly show the amount prescribed in both figures and words.

10 Practitioners should ensure that benzodiazepines are not prescribed for non-therapeutic purposes. Failure to do so will leave the practitioner subject to the provisions of the Act as described in paragraph 1 above.

Voluntary Undertakings

11 ACT Health has instituted a strategy of Voluntary Undertakings between patients and their treating practitioners.

12 Such undertakings are an agreement entered into by a patient with their doctor whereby the patient agrees:

a. to attend only one identified medical practitioner to receive their prescriptions for benzodiazepines;
b. to attend only one identified pharmacy to have their prescriptions for benzodiazepines dispensed.

13 Given the terms of such undertakings, the prescribing of a drug by a practitioner to a person whom that practitioner knows or should reasonably know has a Voluntary Undertaking with another practitioner at the time of writing the prescription, may lead to a finding of unsatisfactory professional conduct by the Board.

ATTACHMENT 1

PROBLEMS ASSOCIATED WITH BENZODIAZEPINE USE

Dependence and withdrawal

Benzodiazepines were first synthesised in 1933, although it was not until the 1980s that benzodiazepine dependence and associated withdrawal became recognised (Ashton, 1991). Benzodiazepine dependence has been demonstrated in several studies following therapeutic doses for a period of three months or longer (Boixet, Batlle & Bolibar, 1996). A risk of dependence has also been established for shorter periods of regular benzodiazepine use, of four-six weeks (Tyrer, P, 1988). Development of tolerance may result in some patients experiencing withdrawal symptoms while they are still taking Benzodiazepines (National Health and Medical Research Council, 1991). Withdrawal symptoms include insomnia, anxiety, depression, restlessness, tremor, dizziness, hyperacusis, muscle pains, fatigue, depersonalisation, derealisation and abnormal perception or sensation of movement (Mant & Raoul, 1997). Focal or generalised seizures may also occur in withdrawal (National Health and Medical Research Council, 1991)

Adverse effects on sleep, moods and behaviour

Benzodiazepine use can inadvertently worsen the symptoms for which it is originally prescribed. It is known to produce and complicate depressive symptoms (Ancill et al in Findlayson, 1995 and Meir, 1994). It may disrupt sleeping patterns, causing disturbed and broken sleep, nightmares, aggravated hypoxia in respiratory patients and rebound insomnia (Mant & Raoul, 1997). Some people experience paradoxical effects with increased anxiety, irritability, hostility, aggressive behaviour and disinhibition (Salzman in National Health and Medical Research Council, 1991). Benzodiazepines are also the most common drug involved in self-poisonings presenting to Australian hospitals (National Drug Abuse Data System, in Mant & Rauol, 1997).

Oversedation and psychomotor impairment

Oversedation and psychomotor impairment may occur with benzodiazepine use, particularly in older people. Difficulties with concentration and memory, mental confusion, incoordination, ataxia, dysarthria and diplopia may occur. (Ashton in National Health and Medical Research Council, 1991). In addition benzodiazepines, especially those which are long acting, are reported as being the most common cause of drug-related cognitive impairment in older people (Finlayson, 1995).

Increased risks of accidents

Benzodiazepine use increases the risk of accidental injury. In older people benzodiazepine use substantially increases the risk of falls and fractures (Ray, Griffen, Schaffer et al, 1987). People taking benzodiazepines are also up to four times more likely to be involved in a motor vehicle accident resulting in injury or death than those not taking benzodiazepines (Skegg in National Health and Medical Research Council, 1991).

Interaction with alcohol

The use of benzodiazepines with alcohol or other central nervous system depressants can potentiate the adverse side effects on cognitive and psychomotor performance (Sellers & Busto, and Hill et al in National Health and Medical Research Council, 1991). Patients with a history of excessive alcohol use have also been shown to:

- have an increased desire to drink for up to two hours following ingestion of a benzodiazepine (Ciraulo in Sellers et al, 1993);
- have higher rates of 'euphoria' and 'drug liking' of benzodiazepines than patients with no history of alcohol abuse (Sellers et al, 1993) and therefore may be more at risk of developing a dependency.

Interaction with opiates

Benzodiazepines are common drugs of abuse, particularly among those who may also be using other illicit drugs (Pereka, et al in National Health and Medical Research Council, 1991) . Simultaneous consumption of benzodiazepines with heroin is a potential risk factor of heroin overdose (Guitierrel-Ceibollada, de la Torre, Ortuno et al, 1994). An Australian study of non-fatal heroin overdoses, noted that 26% of heroin users had consumed benzodiazepines at the time of their overdose (Darke, Ross & Hall, 1991). This is consistent with a NSW investigation of coronial files from 1992. Benzodiazepines were found in 26% of heroin-related deaths (Zador, Sunjic & Darke, 1996).

In the ACT, toxicological results from the 20 opiate-related deaths over a two and a half year period indicated the presence of benzodiazepines in 50% of cases. In three of the 10 cases where benzodiazepines were identified, benzodiazepine levels were significantly above therapeutic or normal concentrations (ACT Department of Health and Community Care, 1997a).

Intravenous use

Benzodiazepines, including tablet formulations, are used intravenously. In an Australian study of 210 heroin users who used benzodiazepines 48% had injected them (Darke, Ross & Hall, 1995). The injection of benzodiazepines is a practice which may be associated with arterial and venous thrombosis. This is particularly true with the use of 'gel filled' temazepam capsules, the injection of which in Britain was found to cause serious morbidity including gangrenous limb loss (Chief Medical Officer, UK, 1995). In the ACT there is evidence of at least one loss of a limb associated with injecting a benzodiazepine (ACT Department of Health & Community Care, 1997b). There is also anecdotal evidence of additional cases where limb damage has been sustained as a result of the intravenous use of benzodiazepines (Mazengarb, 1997).

Increased harm among injecting drug users

The use of Benzodiazepines among injecting drug users, either orally or intravenously has been associated with greater levels of risk-taking behaviour and psychosocial dysfunction (Darke, Ross & Cohen, 1994 and Darke, Hall & Ross et al 1992). As a resulting injecting drug users who also abuse benzodiazepines are a more difficult group to treat and represent a subgroup of injecting drug users with multiple problems.

Injecting drug users using benzodiazepines compared with other injecting drug users;

- inject more frequently, share injecting equipment more frequently and share needles with more people (Darke, Ross & Cohen, 1994 and Darke, Hall & Ross et al 1992), thus increasing their exposure to HIV, Hepatitis C and other infectious diseases;
- report more polydrug use (Darke, 1994);
- are more likely to have been paid for sex (Darke, Hall & Ross et al, 1992);
- are less likely to use condoms (Caplehorn & Saunders, 1993);
- are more likely to be unemployed, not to have completed high school, to have been imprisoned and to be currently involved in crime (Darke, Ross & Cohen, 1994);
- have higher levels of psychopathology and poorer health (Darke, Ross & Cohen, 1994);
- are more likely to have alcohol-related problems and higher alcohol consumption rates (Reidenberg, 1991);
- are recognised as a more dysfunctional subgroup of injecting drug users (Darke, Hall & Ross et al, 1992).

Reduced response to methadone treatment

The use of benzodiazepines by methadone-maintenance clients reduces the effectiveness of methadone treatment. Methadone-maintenance clients who have concurrent benzodiazepine use compared with those who do not use benzodiazepines:

- show higher levels of personal distress, anxiety and depression (Darke, Swift & Hall, 1994);
- have increased rates of injecting and more frequent borrowing and lending of injecting equipment (Darke Swift, Hall et al, 1993);
- represent a subgroup of methadone-maintenance clients who do not respond as well to treatment (Darke Swift, Hall et al, 1993);
- may have unexpectedly low levels of serum methadone suggesting that some benzodiazepines may affect the metabolism of methadone (Bell, Bowran, Lewis et al, 1990).

Abuse Potential of Different Benzodiazepines

Different benzodiazepines have different abuse potential (Darke, Ross & Hall, 1995). The more rapid the increase in the plasma level following ingestion, the greater the intoxicating effect and the more open to abuse the drug becomes. The speed of onset of action of a particular benzodiazepine correlates well with the 'popularity' of that drug for abuse.

Darke, Ross & Hall found that flunitrazepam rated significantly higher than the next most liked drug, diazepam. The two most common reasons for this preference were that it was the 'strongest' and that it gave a good 'high'. The next 'most liked' benzodiazepines in descending order were oxazepam, clonazepam, and temazepam. Anecdotal evidence from the ACT Alcohol and Drug Program indicates a similar order of benzodiazepine popularity in the ACT.

Sources of Benzodiazepines

Benzodiazepines, used in an uncontrolled manner, have *usually been obtained by prescriptions*. The prescription may have been made out directly to the person using them. Many people go 'doctor shopping' i.e. visit many different doctors/emergency departments with different, often convincing stories. Data from the Health Insurance Commission indicates that in the calendar year of 1996, in the ACT, 221 people saw more than 15 different doctors, one seeing 105 different doctors. The number of times they saw a doctor ranged from 17-303 visits during the year, 33 patients visiting a doctor more than 100 times.

The benzodiazepine may have been prescribed for a family member or friend of the drug user, and may be used with or without that person's knowledge. A study in Norway of young people aged between 13 and 18 found that over the course of one year 10% had taken benzodiazepines. Most of this use was not prescribed and while some gave a therapeutic reason as a motive, for many, intoxication had been the aim. Parents, especially the mothers, were the most important suppliers (Pederson & Lavik, 1991).

Dealers or people who use other drugs may obtain benzodiazepine prescriptions to sell either part or all of their tablets in exchange for other drugs or money. Correspondence with Chief Health Officers in New South Wales, Northern Territory, Western Australia and South Australia shows that there is anecdotal evidence to suggest that the selling of prescribed benzodiazepines for other drugs and/or money may be a widespread practice.

Finally there may be some theft or 'leakage' from pharmacies. The main sources identified in one study, were pharmacists dispensing fake prescriptions either knowingly or unknowingly and providing patients with benzodiazepines without a prescription (Sellers et al, 1993).

Why Doctors Prescribe Benzodiazepines

Most misuse of benzodiazepines comes from a limited number of doctors who prescribe for the following reasons:

a. Inadequate knowledge;
failure to keep abreast of current prescribing practices (Colvin, 1995),
unaware of current drug abuse patterns (Colvin, 1995) or the abuse potential of benzodiazepines,
unprepared by training to diagnose and treat an individual with, or at risk from, addiction (Colvin, 1995),

b. Duped/deceived;
failure to detect deception by the dishonest patient (Colvin, 1995),
unaware that the patient was 'doctor shopping',

c. Inappropriate prescribing;
prescribing a benzodiazepine without first establishing a primary indication for its use (Sellers et al, 1993),
believing that benzodiazepines help with drug withdrawal problems,
prescribing a benzodiazepine when alternative medication/treatment could have been used,

d. Fear of a known addict/trafficker;

may write a script, out of exasperation, to get rid of a demanding patient (Colvin, 1995),
may fear retribution from the patient,

e. Impairment;
prescribes as a result of their own impairment - mental illness or misuse of medications (Colvin, 1995)

f. Dishonesty;
using their medical licence to deal in drugs (Colvin, 1995).

ACT MEDICAL BOARD

STANDARDS STATEMENT

ADVERTISING BY MEDICAL PRACTITIONERS

Legislation

1 Section 149 of the Health Professionals Regulations 2004 states that "A registered health professional must not advertise a health service in a way that is misleading".

Medical Board Policy on Advertising

2 An advertisement shall be taken by the Board to be misleading if it:

a. contains material misrepresentation of fact; or

b. is likely to create an unjustified expectation of beneficial treatment.

3 In addition, the Medical Board believes that medical practitioners should not advertise services in a manner that is likely to breach standards of practice including advertisements that:

a. denigrate the services provided by other practitioners;

b. claim or imply that any particular medical practitioner is superior to any other medical practitioner;

c. contain testimonials or other endorsements of a particular practitioner;

d. are vulgar or sensational; or

e. indicate that a practitioner practices at a place, unless the practitioner regularly attends that place in the course of his/her practice.

ACT MEDICAL BOARD

STANDARDS STATEMENT

ALTERATION OF PRACTICE SPECIALTY

The Health Professionals Act

1 R 118 of the *Health Professionals Regulation 2004* (the Regulation) provides:

118 Specialist Area Registration

(1) This section applies if the schedule for a health profession includes requirements relating to admission to a specialist area of the health profession.

(2) A person may only practise in the specialist area if the person is registered to practise in the area.

3 Section 2.3 of Schedule 2 to the Regulation provides the following suitability to practise definition:

To practise medicine a person must have-

(a) adequate physical capacity, mental capacity and skill to practise medicine; and

(b) communication skills that allow the person to practise medicine effectively without endangering patients.

4 Section 2.4 of Schedule 2 to the Regulation contains provisions regarding specialist registration.

Changing Specialties

5 The Board believes that in the age of increasing specialisation, skills are often confined to a specialty and do not translate well into other areas. It further believes that should a practitioner wish to change their specialty, at any time, he/she should undertake further appropriate training in a position approved by an entity accredited by the Australian Medical Council and the Board.

Failure to Undertake Retraining

6 The Board believes that to change specialty without undertaking relevant retraining may constitute a breach of the required standards of practise of the Act.

ACT MEDICAL BOARD

STANDARDS STATEMENT

TECHNOLOGY-BASED PATIENT CONSULTATIONS

Introduction

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 *Health Professionals Act 2004* and in the Board's Code of Conduct policy apply.

2. Medical practitioners who advise or treat patients in technology-based consultations:

a. should be particularly aware of paragraph 4 of the Board's Code of Conduct 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 paragraph 5 of the Code of Conduct which states that in providing care, doctors should keep colleagues well informed when sharing the care of patients;

b. 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;

c. must give an explanation to the patient of the particular process involved in the technology-based consultation;

d. must make their identity known to the patient;

e. must ensure that they communicate with the patient to;

   (1) establish the patient's current medical conditions and history and concurrent or recent use of medications including non-prescription medicines,

   (2) identify the likely cause of the patient's condition,

   (3) ensure that there is sufficient clinical justification for the proposed treatment, and

   (4) 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 access to their medical records.

f. 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;

g. 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;

h. must make a clear, accurate and legible record of the consultation;

i. 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.

Acknowledgement
This policy has been adapted with the permission of the New South Wales Medical Board.