GOOD MEDICAL PRACTICE

Professionalism, Ethics and Law

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GOOD MEDICAL PRACTICE

Good Medical Practice: Professionalism, Ethics and Law brings together the information central to the professional, ethical and legal requirements of being a doctor. It covers a core curriculum for medical students, doctors in training and international medical graduates preparing for the Australian Medical Council examinations. It will also be useful for busy doctors looking for answers to issues that arise in practice, and for approaches that meet professional standards.

The book's central premise is that effective and compassionate practice depends not only upon sound medical knowledge and clinical competence, but also upon good communication skills, an empathetic attitude and respect for all patients, truthfulness, self-reflection and an awareness of the responsibilities arising under the law. *Good Medical Practice* encapsulates these attributes and includes practice management, inter-professional relationships, sexual misconduct, complaints processes, the Australian health care system and doctors' health within its broad and comprehensive purview. Complex perennial topics such as the allocation of resources, abortion and mental illness are also thoroughly explored.

Written by specialist practitioners representing both the medical and legal professions, each with vast teaching experience, this is a unique, timely and accessible text that reinforces and redefines a contemporary focus on professionalism in medical practice.

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FOREWORD

This imposing book has grown to full maturity, following its childhood and adolescence as two precursors published respectively in 1994 and 1997. The successive alterations in the title are a reflection of its maturation and growth. *Law and Ethics in Medicine for Doctors in Victoria*, published in 1994, grew from its conception as an innovative professional practice program, a short course to help young doctors in the transition from hospital training to independent medical practice, developed by three of the authors of the current book, Drs Breen, Cordner and Plueckhahn. It was a concise description of aspects of law and ethics that related to medical practice. They were presented as 'add ons' to be accessed and applied when they became necessary. *Ethics, Law and Medical Practice*, published in 1997, recognised by its title and its emphasis that ethics and law influenced many aspects of medicine and the book integrated these facets more comprehensively into the context of medical practice. The title of the current book, *Good Medical Practice: Professionalism, Ethics and Law*, gives a clue to its much more ambitious scope. It recognises that good medical practice requires the knowledge and application of law and ethics and that there is a range of additional components that have come to be depicted by the term 'professionalism'. It is also significant that a fourth author has been added to the three well-qualified authors of the two earlier volumes. Colin Thomson brings his extensive background as an academic lawyer with a particular expertise in the legal and ethical aspects of medical practice and health research to this edition. Like Kerry Breen he has been Chair of the Australian Health Ethics Committee of the National Health and Medical Research Council.

The change in title and scope of the book reflect four complementary developments.

The first is that the authors have quite heroically expanded the content of the book to include all aspects of medical practice that are additional to the knowledge of medical science and its application to the diagnosis and treatment of patients. Some of these components, such as communication skills and dealing with distressed or dying patients, overlap with skills that are normally taught in clinical education. Others, such as the complex ethical issues that often confront medical care and the expanding legal environment that provides the boundaries within which such care must be practised, are not usually addressed in medical texts but are central to good medical practice.

The second development is a change in medical practice itself over the last two decades, a change that has seen much greater emphasis paid to medico-legal issues, ethical judgments and respect for patient autonomy. No longer is it possible to practise medicine in a cosy, traditional, paternalistic two-way relationship between the doctor and the patient. Legal parameters set absolute boundaries, but professionalism demands a more sophisticated knowledge and practice, applying ethical principles in difficult situations calling upon wisdom and judgment. Moreover, the patient's right and frequent wish to be included in the decision-making process is now recognised and must be respected. This book deals extensively and sensitively with all these issues.

The third development is the much greater power of medicine to save or preserve life using sophisticated technology. While this has brought monumental benefits to people with acute illnesses often accompanied by multiple organ failure, it also raises ethical dilemmas in the management of people with chronic illnesses whose expectations of that technology may exceed the utility of even the most sophisticated interventions. Where does a patient's right to autonomy end and when do sound clinical judgment and common sense become more important? Is it appropriate to preserve the life of a very premature infant with a high risk of permanent disability? When does withholding or withdrawing life support differ in nature from euthanasia? Decisions like these that seek to balance the power and promise of medical technology, the heightened expectations of seriously ill patients and their families, and the ethical and legal constraints of good medical practice require an understanding of legal boundaries as well as a sound ethical framework to guide decision making.

The fourth factor is that, with the greater capability of medical technology together with the cost of that technology, the questions of distributive justice become more pressing. Who should have priority to what resources and on what grounds? How should the cost be fairly apportioned? These questions can be considered on many levels. For example, how much of our resources should be used for the acute care in hospitals of patients with low quality of life and with little prospect of real improvement, compared with preventive measures in the wider community? In an era where donor organs are becoming increasingly harder to access, what criteria do we use to decide who should receive one? What degree of 'queueing' is appropriate for chronic but not life-threatening conditions? The issue of distributive justice becomes even more troublesome when we look at the different health outcomes in different communities in our own country, especially among Aboriginal and Torres Strait Islander people. And since ethics is not confined by national boundaries, how should we respond when we see, in poor countries in our region and beyond, the terrible effects of diseases that are preventable, or easy to treat using resources we have in abundance?

The authors, with their extensive and diverse backgrounds, are ideally equipped to deal with these complex topics. They have created an important work that provides an invaluable guide to good medical practice for new medical graduates and established practitioners alike.

RICHARD LARKINS, AO
Vice-Chancellor and President
Monash University

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PREFACE

The primary purpose of this book is to provide in a single accessible format information central to the professional, ethical and legal requirements of being a doctor. It covers a core curriculum for medical students who must obtain a grounding in the elements of what constitutes being a medical professional [1–2]. The same material is essential for doctors in training and for international medical graduates coming to work in Australia. This book should be a useful and readily accessible starting point for busy doctors looking for answers to issues as they arise in practice. This edition brings together updated material generally not found in textbooks of clinical medicine. Although most doctors are now equipped to seek information electronically, this can take time as information is not accessed readily or integrated at a single source, may not be relevant to the local setting and may not be quality controlled.

Since the 1997 edition of our book [3] there have been significant developments in regard to the importance of professionalism. Medical boards here and overseas have focused attention on the breadth of professional skills needed for good medical practice; indeed the UK General Medical Council's primer for doctors is called just that, *Good Medical Practice* [4]. More recently, medical indemnity organisations and health-care institutions have been active in promoting good professional attitudes and behaviour, under the banner of 'risk management', to reduce the risk of adverse outcomes.

Australian medical colleges have agreed to have their education and training programs accredited by the Australian Medical Council (AMC) and this has resulted in a greater emphasis on professionalism and ethics for specialists in training. The AMC clinical examination for international medical graduates now specifically addresses professional attitudes.

At its core, medicine remains the delivery of care to people who are unwell and are seeking help. The effective and compassionate practice of medicine requires a combination of medical knowledge, clinical competence, and sound professional attitudes and skills. In the distant past, professional attitudes and skills were known as a 'good bedside manner' and were not taught formally. It was assumed that young doctors would somehow acquire such skills, perhaps by observation and experience. In Australia, since the 1988 *Doherty Report* [5], the medical profession, especially those sections responsible for the basic medical education, has identified professional skills as something that can and must be taught.

'Professionalism' is a convenient shorthand term to describe the professional attributes required (over and beyond simply having adequate knowledge of medicine and adequate procedural ability) for effective medical practice that the community can trust. Professionalism covers a wide range of elements, including good communication skills, an empathetic attitude, the virtues of self-reflection, truthfulness and dependability, cultural awareness in our multicultural society and awareness of responsibilities arising under relevant laws pertaining to medical practice. Above all it covers an assumption that a person wishing to practice medicine effectively will bring positive attitudes to all the roles involved in being a doctor. Used in this way, the term 'professionalism' is consistent with the focus of the Victorian Professional Practice Program, which in 1991 and 1992 was the basis of an early version of this book [6].

Many new influences have been brought to bear on the doctor–patient relationship, including community expectation of excellent outcomes of all interventions, a changing legal interpretation of medical negligence, the conundrums of infinite need versus finite resources, awareness of preventable adverse events, commercialisation and corporatisation of medicine, a patchwork of federal and state privacy laws, additional forms of accountability for doctors with closer scrutiny of professional performance, alertness to doctors' ill health leading to impairment, and demands for programs of maintenance of professional standards. Despite these influences, the practice of clinical medicine remains very rewarding. As this book unfolds, we hope the reader will recognise that meeting the professional, ethical and legal requirements of medical practice, while demanding, is consistent with approaches competent doctors have used to provide effective and appreciated service for patients over many years. Primary features of such practice remain respect for patients, the personal integrity of the doctor and good communication.

Our approach in this book remains essentially pragmatic. While the text necessarily explores the underpinning themes of ethical theory and medical law, and addresses topical issues such as euthanasia and abortion, it does not probe the ethical or legal detail. Our fundamental aim is to provide core information for medical students and doctors in training, and to guide medical practitioners who are faced in their daily work with practical problems in consultation with their patients. While every care has been taken to strive to be accurate and up to date, the reader should not rely on this book as a source of legal advice. There now exist in Australia several excellent texts on ethics in health care, and on medical law, which are recommended where relevant, and ample references and suggested additional reading are provided for readers who wish to explore any topic in more depth.

KJ BREEN
SM CORDNER
CJH THOMSON
VD PLUECKHAHN

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PREFACE TO THE 1997 EDITION

A smaller version of this book was published in 1994 as *Law and Ethics in Medicine for Doctors in Victoria* and was well received in that state. It was produced to help meet the need for doctors to be more informed of the ethical and legal obligations of medical practice. Since then, national debate on topics such as consent, compensating patients for adverse events in medical practice, sexual misconduct by doctors and euthanasia has reinforced this need. In addition there are changes occurring in the delivery of health services, in education for health-care providers and in the regulation of the medical profession about which practising doctors need to be informed. Parallel with these changes is the gradual increase in interest and understanding by the community of its health-care needs and rights. Associated with this is the community's determination to have an appropriate say in matters such as the utilisation of health-care resources and the determination of medical professional standards, and its desire for individuals to be adequately informed and involved in decisions regarding their own health. This book does not directly address all these changes, but much of its content is informed by them as reflected in chapters referring to the increasing involvement of community members in the regulatory processes of the medical profession, the development of more accessible patient complaint-handling mechanisms and changes that are occurring to medical education and the selection of medical students.

Against this background, and in response to interest expressed throughout Australia for this type of resource for doctors in other states, the authors embarked on a major rewrite of their original book. The present book is updated, expanded and reorganised to reflect as fully as possible the current legal and ethical obligations of daily medical practice. This update is intended to be pragmatic, accessible and informative and primarily directed to doctors in the making and doctors in practice.

The authors' opinions are that much of the material published in recent years on medical ethics and medical law is not readily accessible to doctors because of its abstract approach and legalistic language. In addition, many modern books on medical ethics have focused on bioethics, using the narrow sense of bioethics as referring predominantly to the ethics of biotechnology. While providing valuable contributions for discussion, these materials may have deflected the average practising doctor away from an understanding of, and meaningful debate and engagement with the community on, the ethical principles that underpin everyday interactions between patient and doctor.

The authors hope that the principles and practices described in this book will be congruent with the wider medical profession's understanding of these issues and, if they are not, that the differences will be the subject of contemplation, study and debate inside and outside the profession. The book contains considerable material relating to state and Commonwealth laws and their interpretation. While every care has been taken to strive for accuracy, the reader should not rely upon this book as a source of legal advice.

K. J. BREEN
V. D. PLEUCKHAHN
S. M. CORDNER
1 January 1997

ACKNOWLEDGMENTS

Much of the essential material in this edition is based on the content of the previous 1997 edition (published under the title of *Ethics, Law and Medical Practice*) and some has its basis in our 1994 book, *Law and Ethics in Medicine for Doctors in Victoria*. Thus we must first repeat the acknowledgments made in those two books to a very wide range of medical and other health professional colleagues, lawyers, academics, administrators and regulators, and others without whose help the project would never have been undertaken, let alone completed.

In revising and updating all the chapters of this edition, we have again been very generously assisted by a large number of colleagues. The following people critically examined draft revised chapters and provided advice and direction: Chapter 1 – Professor Wendy Rogers; Chapter 2 – Professor Brendan Crotty; Chapter 3 – Dr Paul Nisselle; Chapter 4 – Dr David Hart; Chapter 5 – Dr David Hart; Chapter 6 – Dr Paul Nisselle; Chapter 7 – Dr Hugh Aders; Chapter 8 – Dr Joanna Flynn, Mr Andrew Dix; Chapter 9 – Ms Beth Wilson, Dr Joanna Flynn; Chapter 10 – Dr Carolyn Quadrio; Chapter 11 – Dr Jenni Parsons; Chapter 12 – Dr Peter Greenberg; Chapter 13 – Associate Professor Bernadette Tobin; Chapter 14 – Professor Stephen Leeder; Chapter 15 – Dr Peter Greenberg; Chapter 16 – Dr Joanna Flynn; Chapter 17 – Professor John McNeil; Chapter 18 – Professor Greg Whelan; Chapter 19 – Ms Helen McKelvie; Chapter 20 – Professor Jock Findlay, Dr David Wells, Dr James King; Chapter 21 – Professor Roger Pepperell, Dr James King; Chapter 22 – Dr John Santamaria, Dr James Tibballs; Chapter 23 – Dr John Tiller; Chapter 24 – Ms Helen McKelvie; Chapter 25 – Professor John Cade; Chapter 26 – Dr David Wells. Other colleagues, including Mr Ian Frank, Dr Sandra Hacker, Dr David Hillis, Dr Katrina Watson and Dr Leanna Darvall, provided advice, or guided us to other sources of expertise and information.

The following organisations kindly gave permission to reproduce material: Australian Medical Association, Australian Medical Students Association, County Court of Victoria, Medical Board of Queensland, Medical Practitioners Board of Victoria, National Health and Medical Research Council, Pharmaceutical Society of Australia, Royal Australian College of General Practitioners and World Medical Association.

Ms Kerry Johannes, Medical Librarian at the Victorian Institute of Forensic Medicine, once again kindly tracked down innumerable hard-to-find articles and court reports, and obtained books we needed to read.

Ms Meg Heaslop of Biotext undertook the layout of the text and generously checked all the websites listed for their accuracy and currency.

Professor Richard Larkins, who was the key speaker on medical ethics at our first Professional Practice Program workshop nearly two decades ago, kindly agreed to write the foreword for this edition.

Finally, Ms Debbie Lee, Publishing Manager (Academic and Professional) at Cambridge University Press, was unstinting in her enthusiasm and support for this project.

ABOUT THE AUTHORS

Dr Kerry J Breen AM, MB BS, MD (Melb), FRACP is a Melbourne-based physician who has spent most of his career as a practising gastroenterologist. His interest in the professional, ethical and legal issues of everyday medical practice began when he was first appointed a member of the Medical Board of Victoria in 1981. He has served as President of the Medical Practitioners Board of Victoria (1994–2000), President of the Australian Medical Council (1997–2000) and Chairman of the Australian Health Ethics Committee of the National Health and Medical Research Council (NHMRC) (2000–06). He was a member of the joint Australian Law Reform Commission and NHMRC inquiry into the protection of human genetic information. He has published extensively in the areas of clinical medicine, clinical research, health ethics and medical professionalism. He is presently a part-time member of the federal Administrative Appeals Tribunal and Commissioner of Complaints of the NHMRC.

Professor Stephen M Cordner AM, MA (Lond), MB BS, B Med Sc, Dip Crim, DMJ, FRCPath, FRCPA is Professor of Forensic Medicine at Monash University and Director of the Victorian Institute of Forensic Medicine (VIFM). His department is responsible for providing the undergraduate teaching in law for medical students at Monash University, where there is an integrated tutorial-based program taught through the whole curriculum. He co-authored with Professor Plueckhahn the second edition of *Ethics, Legal Medicine and Forensic Pathology* (Melbourne University Press 1991). He has a particular interest in the interface of forensic pathology and human rights issues internationally.

Professor Colin JH Thomson LLB, BA, LLM (Syd) is Professor of Law at the University of Wollongong, where he is also the Academic Leader for Health Law and Ethics in the Graduate School of Medicine. He is presently Chair of the Australian Health Ethics Committee of the National Health and Medical Research Council and was a member of that committee from 1998 to 2002. Between 2002 and 2006, he was the Consultant on Health Ethics for the National Health and Medical Research Council. In 1983, he introduced the second Australian university course on law and medicine, at the Australian National University, and has published and spoken widely, nationally and internationally, on issues in health law and ethics. He has been Executive Officer and Chair of the Board of the Australian and New Zealand Institute of Health, Law and Ethics and Vice-President of the Australasian Bioethics Association and is an Associate Editor for the *Journal of Bioethical Inquiry*.

Vernon D Plueckhahn AM, OBE, ED, MD (Adel) Hon MD (Monash), FRACP, FRCPath, FRCPA, FAMA, FCAP, FAACB, MIAC is a retired Consultant Forensic Pathologist and Honorary Associate Professor in the Department of Forensic Medicine at Monash University. He was President of the AMA (Victoria) and also of the Royal College of Pathologists of Australasia. He is acknowledged internationally for his work in, and textbook on, *Ethics, Legal Medicine and Forensic Pathology* (Melbourne University Press, two editions) demonstrating an early appreciation of the importance of an understanding of medical law and ethics for good medical practice. He was the driving force in the establishment of the Victorian Institute of Forensic Medicine.

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1 ETHICAL PRINCIPLES FOR THE MEDICAL PROFESSION

This chapter sets out to define what is meant by the term 'ethics', briefly introduces the reader to current frameworks for ethical thinking, summarises the key ethical principles for good medical practice, and presents the codes of ethics that guide the medical profession. The chapter is intended to provide a foundation for the ethical dimensions of issues addressed in later chapters. Modern doctors are required to be cognisant of the needs and rights of the individual patient, aware of the rights of patients' relatives, carers and guardians, alert to issues such as cultural and language barriers, prudent in the use of health resources, familiar with complaints processes, and involved in maintenance of professional competence and their own health. As subsequent chapters will demonstrate, doctors who possess good communication skills, respect their patients, have a broad knowledge of ethics and the law relating to medical practice, and are willing to consult more experienced colleagues when needed will be well equipped to resolve most of the ethical dilemmas that they will encounter in the daily practice of their profession.

More detailed historical or theoretical studies of medical ethics or in-depth discussion of the application of medical ethics in specific subjects areas such as in-vitro fertilisation, human cloning, euthanasia and organ transplantation are beyond the scope of this book. A suggested reading list is provided at the end of this chapter for those seeking to commence a more detailed study of medical ethics.

1.1 SOME HISTORICAL CONTEXT

Codes or statements of ethical principles have existed to guide medical practitioners for almost 2500 years. The basis for the principles contained in the modern codes originated in Greece through what is usually termed the Hippocratic Oath. Hippocrates was born on the island of Kos in 460 BC and was responsible for the beginnings of a scientific approach to medicine through his teaching and practice of medicine in Greece. His teachings covered all branches of medicine and included the moral and ethical requirements of an

ideal physician, which were subsequently epitomised in the Hippocratic Oath. His writings are collected into the Corpus Hippocraticum, which comprises 70 books. It is probable that many of the 70 books were written by his disciples after his death [1].

While the Hippocratic Oath is frequently used as a starting point to introduce the topic of medical ethics, in its original form it would not serve modern society well nor would it effectively guide modern medicine or the medical profession [2]. Its continued mention relates more to the medical profession's pride in its origins, traditions and right of self-regulation than to its immediate relevance. It does identify some key issues that still underpin more modern ethical codes, including the concepts of 'first, do no harm', abuse of privilege, confidentiality, respect for life and awareness of one's limitations. As discussed below, many medical professional bodies, international and national, now publish ethical codes and more detailed guides to professional conduct [3–6]. Many medical schools in Australia [7] and abroad [8–9] have maintained or reintroduced the swearing of modernised 'Hippocratic' oaths for medical students at graduation ceremonies. However, medical education in Australia does not rely on this symbolic practice and instead concentrates on providing education in ethical, legal and professional development issues in an integrated manner through the entire medical student curricula and (to a lesser extent to date) through postgraduate curricula [10].

1.2 WHAT ARE ETHICS?

When we speak of ethics in a modern sense, we refer to a systematic approach to how we as individuals or as a society wish to live our lives, expressed as an 'ethos', meaning a way of life. Ethics and ethical codes can then be seen as 'an accumulation of values and principles that address questions of what are good or bad in human affairs. Ethics searches for reasons for acting or refraining from acting; for approving or not approving conduct; for believing or denying something about virtuous or vicious conduct or good or evil rules' [11].

As this book addresses both ethical and legal issues in the practice of medicine, it is important for doctors to appreciate that ethics and the law are quite different concepts, although in most areas of medical practice they may often seem to be closely aligned. When faced with clinical decisions involving ethical considerations, recourse to what the law says will generally be unhelpful. The law is in essence a system of rules developed by government on behalf of a community to regulate the interaction between individuals and the state, to which system the community agrees to be bound.

1.3 AN INTRODUCTION TO ETHICAL THINKING

Ethics is not only a set of principles or values; ethics also has characteristic modes of reasoning and justification. Traditionally, the two major schools of ethical

reasoning are the consequentialist and the deontological. When applied to medical ethical problems, these systems of reasoning can be regarded as procedures for making and justifying value judgments. Their usefulness in the study of medical ethics is to reveal who is making these judgments and how they are being justified – in starkest relief, are doctors applying only their own value judgments and ignoring those of patients or the community? More recently, as discussed below, there has been revived interest in applying what is termed 'virtue ethics' when considering the ethical qualities required of medical practitioners.

The best known consequentialist school of moral thinking is utilitarianism, measuring the good or bad of any action according to whether its results are good or bad. Utilitarianism was described by the English philosopher Jeremy Bentham towards the end of the eighteenth century. Bentham proposed that actions be evaluated by their ability to produce pleasure (moral good) or pain (moral evil). In its present form, utilitarianism finds expression in terms of an action's ability to best satisfy the needs of all those affected by the proposed action; it involves examining the results and effects of actions, and not the motives or thoughts of the actor.

Conversely the deontological approach centres on the standards or values to which the action conforms or to the motivation behind the action, according fixed moral values to actions. The ten commandments are a well-known deontological set of rules, albeit religiously founded, but other deontological codes that do not have a religious basis have been developed, for example that developed by the German philosopher Immanuel Kant in the eighteenth century. The deontological approach, based on fixed moral values, is almost certainly a common method of justifying many professional judgments. For example, seeking consent of a patient is more likely to be justified because of the ethical principle of respect for autonomy that it expresses than whether doing so will lead to a better outcome for the patient. A deontological approach is also a common basis for the personal moral judgments made by most doctors. When these personal values conflict with requests for treatments that are lawful, difficulties may arise, for example requests for sterilisation or abortion to a doctor who views such procedures as morally unacceptable.

While the consequentialist and deontological approaches to ethical justification are the best-known procedures for analysing medical ethical problems, modern thinking has produced or revived a number of other frameworks, including virtue-based theory, values-based medicine, narrative ethics, discussion or discourse ethics, professional ethics and critical ethics [12]. Despite this proliferation, doctors should not be deterred from engaging in debate and discussion of ethical issues in medicine simply through lack of familiarity with the language and frameworks used by moral philosophers and ethicists.

In practice, it seems most doctors pragmatically combine elements of both the deontological and utilitarian approaches to ethical decisions, often without articulating the processes involved or identifying and explicating the ethical component of a decision. Often, when they use a deontological approach only to

find that it is likely to produce undesirable outcomes, they will switch to utilitarian approach – providing an ethical justification for the value judgments that resolve difficult issues. There is nothing inherently wrong with this approach. However, if difficult ethical problems are to be debated frankly within the community, or even discussed between patient and doctor, it is enlightening for the doctor to understand how he or she has reached a position. Doing so also increases the likelihood that the values of the other party or parties will be appreciated.

1.4 A MODERN FRAMEWORK FOR DISCUSSING MEDICAL ETHICS

In recent times, many of those responsible for teaching ethics to medical students have adopted four generally agreed basic moral principles relevant to medical practice [13]. Three of these four principles, drawn largely but not exclusively from a deontological ethical philosophy, were first identified systematically in the US Belmont report [14] and were later extended to four and popularised by James Childress and Thomas Beauchamp, teachers from Georgetown University in that country (hence the colloquial reference to the 'Georgetown mantra') in their *Principles of Medical Ethics* first published in 1979 [13]. These four ethical principles are described as autonomy, beneficence, non-maleficence and justice:

1 *Autonomy*, or more accurately, respect for autonomy, in this context may be defined as the obligation of doctors to respect the right of individuals to make decisions on their own behalf. While most societies have long recognised a basic moral obligation to respect each person's autonomy, it is only relatively recently that this ethical principle has evolved to be of such central importance in the doctor–patient relationship. Respect for autonomy is a component of respect for human dignity, a principle embedded in international covenants.
2 *Beneficence* is defined as the duty to do the best for the individual patient or to act in the best interests of the patient. Although this is a relatively straightforward obligation, its application is often challenged by such questions as who is to decide what is best, an issue of autonomy, and the availability of the required resources, an issue of justice.
3 *Non-maleficence* is defined as the duty to do no harm. This also appears to be a relatively straightforward moral obligation and probably is the best understood and most widely adhered to ethical principle in clinical practice. However, as medical inventiveness yields new techniques and new diagnostic tests, subtle potential breaches of this obligation are not readily identified by enthusiastic innovators, as may be seen with the premature promotion of new tests for 'earlier' diagnosis or for population screening.
4 *Justice* is more difficult to define but incorporates notions of equity and fair distribution. While it may be tempting for doctors to shun this obligation,

leaving it to managers, administrators and government, this is neither realistic nor desirable. Increasingly, individual doctors are being made aware of the resource consequences of their decisions and prompted to reflect on how those decisions can effect equitable access to health care. This ethical principle emphasises that the doctors have a responsibility to the community at large as well as to individual patients (see Chapter 13).

These four ethical 'pillars' do not stand on their own, but are interpreted and applied as justifications for clinical decisions using systems of reasoning or thinking developed by moral philosophers as outlined above. Doctors trained in the scientific method, where hypothesis is refuted by factual observation, are often uncomfortable with the approaches of moral philosophers, although subconsciously or unknowingly they themselves use these approaches to problems.

An important consideration and shortcoming of an exclusive reliance on these four principles is that they can be deployed to justify opposite resolutions of the same ethical choice. Thus, a decision in favour of a treatment can be justified because it respects the patient autonomy principle but can be opposed on the ground that it will infringe the non-maleficence principle. This characteristic underlines the limits of adopting a narrow approach to the sources of ethical justification. In response to this shortcoming and in recognition that the above four principles tend to limit rather than enhance ethical debate, some observers have turned, or returned, to the alternative framework of virtue ethics, an approach that assesses the nature of professional behaviour by the way that it expresses desirable qualities or virtues [12].

1.5 QUALITIES OF AN 'ETHICAL' DOCTOR; VIRTUE ETHICS

1.5.1 Capacity for self-reflection

One of the long-standing distinguishing features of a learned profession has been said to be a capacity for self-regulation. In earlier times, this was taken to mean personal self-regulation (self-reflection). Society accepted this approach by the medical profession until the mid-nineteenth century when the registration and disciplinary processes of medical boards were first established (see Chapter 8). Gradually the concept of self-regulation came to be understood as the regulation of the profession by medical boards consisting solely of medical practitioners. The earlier notion of a key feature of being a professional meaning taking personal responsibility for maintaining professional standards and competence faded from view. This is unfortunate as the capacity for self-reflection remains a central element of professionalism. It encompasses such things as keeping one's knowledge and skills up to date, being aware of the nature of one's interactions with patients and colleagues, being capable of self-criticism, and taking responsibility for one's own health. Being a doctor is first a vocation, and secondly a profession. For those

who espouse this perspective, externally imposed regulation and codes of conduct should represent an affirmation of this professionalism rather than a burden.

In addition to this primary quality of the capacity for self-reflection, there are additional qualities that have been proposed as making the good or 'ethical' doctor. The qualities, or virtues, that have been proposed include [15]:

- fidelity to trust
- compassion
- phronesis – practical wisdom or prudence
- justice
- fortitude – courage
- temperance
- integrity
- self-effacement.

From our perspective, there are a more limited number of qualities that, if possessed and/or practised, would ensure that patients were secure in their trust and confidence in their doctor. These include veracity (truthfulness), maintenance of privacy and confidentiality, and fidelity.

1.5.2 Veracity (truthfulness)

The profession's recognition of the move away from paternalism and towards respect for autonomy should make it clear to doctors that they have an obligation to be truthful and that patients expect doctors to tell them the truth. It would be unusual for an 'ethical' doctor to deliberately lie to patients, but some doctors experience difficulty in discerning the difference between obfuscation and compassionate provision of information. This difficulty may be compounded in many parts of Australia, where doctors are dealing with patients and patients' families from many other cultures. Arguments against the virtue of veracity include the suggestions that 'benevolent deception' is warranted at times to reduce patient anxiety, that neither patients nor doctors can ever know 'the whole truth' and that some patients do not want the truth. While sincerely considered clinical examples can be gathered to support these arguments, they are not acceptable to the community and would be unlikely to be accepted by the doctor if the doctor became a patient. The existence of these arguments simply emphasises that effective medical practice has to combine veracity with compassion, patience, discernment and good communication skills.

Truthfulness, veracity and frankness can present challenges for doctors, including how to explain to patients that something has 'gone wrong' with an operation or procedure conducted by that doctor or another, or whether the doctor should notify the medical board regarding a colleague whose ability to practise may be impaired (see Chapter 8). In many such situations, these challenges are ethical dilemmas that arise because there may be no one best or correct answer to a problem. Such challenges are intrinsic to the nature of ethics and especially

professional ethics. Their resolution requires a sound knowledge of the competing ethical justifications and the wisdom to decide between them. Ethics has been criticised because it does not provide *the* resolution in such situations, but this misunderstands its role. Ethics clarifies the choices and the alternative justifications: it cannot, and should not, displace the individual professional judgment that is required.

1.5.3 Privacy and confidentiality

These concepts, which have both ethical and legal origins and applications, are discussed more fully in Chapter 5. The ethical concept of maintenance of confidentiality of information about patients was probably based in the need to earn the confidence of patients so that they would be willing to disclose all relevant personal information so that, in turn, accurate and beneficial judgments could be made about diagnosis and treatment. In ethical terms, this could have been described as fulfilling the principle of beneficence – ensuring that decisions are in the patient's best interests. It is now also based on the principle of respect for autonomy (so that a patient does not surrender the right to privacy and confidentiality by consulting a doctor and retains the right to control the disclosure of personal information). Even if a basis in ethical principle is not sought, confidentiality would remain pivotal, for the practical reason of the need for trust to underpin a satisfactory doctor–patient relationship.

There are legal and ethical conflicts with the maintenance of patient confidentiality, for example when a doctor possesses confidential information that, if released, might prevent harm or injury to others (see Chapter 5). In routine medical practice breaches of this duty do occur; their avoidance is important to the maintenance of trust which the duty serves. In daily practice, it is essential to be aware that sharing of information in hospitals with other staff or students breaches confidentiality if it is not necessary for the patient's treatment or care. Normally implied consent can be safely assured where it is necessary for that care. Confidentiality can also be breached thoughtlessly, systematically or deliberately. Thoughtlessly, many doctors breach confidentiality in public discussions with colleagues or at clinical conferences. Systematically, institutional procedures can breach confidentiality by, for example, not keeping records secure or by the ready visibility of operating and admission lists. Finally, some doctors breach confidentiality deliberately in seeking to learn more of the illness of colleagues or public figures not under their care.

1.5.4 Fidelity/trustworthiness/integrity

It is not possible to adhere to the basic ethical principles of autonomy, beneficence and non-maleficence without demonstrating fidelity (dependability), trustworthiness or integrity, and reliability. These qualities explain why doctors cannot

abandon their patients without making or allowing time for other arrangements; why doctors must never use the doctor–patient relationship for sexual or improper purposes; why they must leave their family or friends when on call or called to an emergency; and why the profession has long claimed that 'the patient's interests must always come first'.

Conflicts of interest that greatly try the virtue of fidelity do arise. In the grey zone of conflict between self-interest and patient interest, these conflicts are frequently not recognised, or certainly not openly admitted, for example where additional medical services will increase the doctor's income, where the completion of a clinical trial competes with a patient's desire to withdraw or where attendance upon a patient is deferred until the next morning. Conflicts of interest in relation to selected aspects of medical practice, including the conduct of clinical research and interactions with the pharmaceutical and medical devices industries, are considered in more detail in Chapters 17 and 18.

1.6 OTHER DESIRABLE QUALITIES

While less pivotal for the satisfactory completion of any doctor–patient interaction, there are two other characteristics that we believe assist most doctors in developing and maintaining effective relationships with their patients and also assist in finding means acceptable to all parties to avoid potential breaches of ethical responsibilities. These are compassion and discernment.

Compassion in the context of medical practice encompasses empathy, perceptivity and sensitivity to the needs of the patient, kindness and humaneness [16]. It is a quality that helps separate the giving of medical care from mere application of technology. The converse of compassion includes thoughtlessness, rudeness, abruptness and insensitivity. Although these negative characteristics are sometimes excused on the grounds of efficiency and effectiveness, this does not lessen their likely negative impact on the patient–doctor relationship.

Discernment or *judgment* can be defined in two ways. Most medical students learn of the term 'clinical judgment' in the setting of making a diagnosis from a list of possibilities, weighing the clinical evidence or choosing between treatment options. However, discernment in good medical practice takes this considerably further and implies (whether by intuition, insight, good communication, experience or other reasons) that the doctor is able to discern the real need of the patient, the hidden concerns of the family, even the true reason for the patient presenting on a particular day. Another way of expressing discernment is to separate knowledge from wisdom; knowledge derived from information tells the doctor what can be done while wisdom derived from experience informs what should be done. Discernment is a quality more readily developed by some doctors than others and will never be developed if no effort is applied. Of course, judgment and discernment can never be perfected. Even the most experienced and caring of

doctors will occasionally get it wrong – misunderstandings, particularly based on cultural differences or personality, can always arise [17–19].

Finally, an important additional quality expected of doctors is a *commitment to teaching*, expressed in the code of ethics of the Australian Medical Association (AMA) as 'Honour your obligation to pass on your professional knowledge and skills to colleagues and students'. Teaching brings its own professional responsibilities; these are discussed in Chapter 2.

1.7 MODERN CODES OF MEDICAL ETHICS

Most professions have developed their own ethical codes of behaviour. These are guides to proper conduct for their members whose particular obligations to society are, because of the nature of their training and responsibilities, different from those of the community as a whole. The codes are derived from and reflect moral principles already generally agreed upon by the community, but are often more restrictive than the norm because their function is to define the conduct that is required of a member of the profession. While the standards they set can be quite demanding, they are not absolute and vary between different communities and professions, and change with time as the attitudes and values of a society change. They act as standards by which people, within and without a particular profession, may judge or measure what is considered proper behaviour for people in that profession at that particular time and in that particular society. Most professional codes set standards of integrity and competency, with the primary aim of ensuring the trust and respect of the community. Most also contain reference to standards of intra-professional behaviour (professional etiquette).

For the medical profession, the best known and most influential code is the *Declaration of Geneva*, adopted by the World Medical Association (WMA) at its First Assembly in Geneva in 1948 and amended from time to time, most recently in 2006 [3]. It is regarded as the modern version of the Hippocratic Oath and reads as follows:

> *AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:*
>
> *I SOLEMNLY PLEDGE* to consecrate my life to the service of humanity;
>
> *I WILL GIVE* to my teachers the respect and gratitude that is their due;
>
> *I WILL PRACTISE* my profession with conscience and dignity;
>
> *THE HEALTH OF MY PATIENT* will be my first consideration;
>
> *I WILL RESPECT* the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour.

The most recent revision of the code of ethics of the Australian Medical Association [4] was published in 2004 and revised in a minor way in 2006. It is reproduced in full as Appendix 1. Medical colleges have also issued codes of ethics that include principles specific to the relevant field of practice. National bodies such as the National Health and Medical Research Council, the medical colleges and professional associations from time to time issue ethical statements specific to topical issues; examples of these are referred to in other chapters.

1.8 THE RIGHTS OF PATIENTS

Fundamental to any meaningful 'doctor–patient relationship', and essential for good patient care, is that the relationship is based on mutual respect, trust and confidence between doctor and patient. The reciprocal nature of this relationship is emphasised by increasing reference to it being a partnership. The relationship includes respect for the competent adult patient's right to decide what will happen. This emphasis on patient autonomy and partnership does not diminish the fundamental ethical responsibilities of the doctor doing good and not doing harm to the patient. This change in emphasis of ethical principles (towards patients' rights and away from earlier codes that now appear too paternalistic in approach) is not a particularly new trend. In September 1981, the 34th Assembly of the WMA met in Lisbon and approved the following statement on the rights of the patient. It was referred to as the *Declaration of Lisbon* and stated:

> Recognising that there may be practical, ethical or legal difficulties, a physician should always act according to his/her conscience and always in the best interest of the patient. The following Declaration represents some of the principal rights which the medical profession seeks to provide to patients. Whenever legislation

> or government action denies these rights of the patient, physicians should seek by appropriate means to assure or to restore them.
> (a) The patient has the right to choose his physician freely.
> (b) The patient has the right to be cared for by a physician who is free to make clinical and ethical judgments without any outside interference.
> (c) The patient has the right to accept or to refuse treatment after receiving adequate information.
> (d) The patient has the right to expect that his physician will respect the confidential nature of his medical and personal details.
> (e) The patient has the right to die in dignity.
> (f) The patient has the right to receive or to decline spiritual and moral comfort, including the help of a minister of an appropriate religion. [20]

The declaration was revised, updated and extended in 2005. Now entitled *World Medical Association Declaration on the Rights of the Patient*, it continues to emphasise patient autonomy with the following introduction:

> The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them. [20]

In 2008, the Australian Commission on Safety and Quality in Health Care issued the *Australian Charter on Healthcare Rights*, a document that covers access, safety, respect, communication, participation, privacy and comment (complaints) [21]. The charter is complemented by more detailed advice on its application and use. In most spheres of life, those who have rights are usually deemed to carry matching responsibilities. It is becoming more frequent that statements of patients' rights also include patients' responsibilities, as is seen from one Australian hospital [22]. The Australian Charter obliquely identifies similar responsibilities for patients. Doctors should also be aware of the advice given to patients by consumer advocate groups [23]. Most of this advice can only enhance the doctor–patient relationship, as it strives to make patients more aware of their role in the relationship.

1.9 UPHOLDING ETHICAL CODES OF CONDUCT

Doctors who breach ethical codes are open to possible action on several levels according to the seriousness of the breach. Disciplinary actions may be taken by colleagues, employers or professional associations, but generally do not carry legal or statutory sanctions. Medical registration boards' sanctions range from reprimand to deregistration; the allegations faced by the doctor at a medical board or tribunal will be specific instances of unprofessional conduct as provided for under the relevant legislation (see Chapter 8) rather than breaches of ethical codes. Some conduct that constitutes a breach may also lead to criminal charges (for example, sexual assault, if the alleged assault occurred in the setting of clinical practice). Other breaches may be the basis of civil claims for damages.

Speaking generally, criminal law sets the minimum standards for conduct in a society by prohibiting behaviour that is offensive to the community and unacceptable in any circumstances, using state agencies to enforce those prohibitions. Civil law, by contrast, enables citizens to enforce rights that the society grants by, most commonly, seeking compensation for harm caused when those rights are ignored by others. Administrative law sets standards for the agencies of the state and governs the relationship between them and citizens. Legislation that establishes medical boards and tribunals reflects a blend of elements of all of these types of law by fixing and empowering the enforcement of standards for professional conduct and enabling citizens to enforce their rights to that level of performance. The medical profession itself, relying on the processes of undergraduate, postgraduate and continuing education, and quality assurance programs, promotes standards of professional excellence that are designed to exceed, and thus ensure conformity with, the levels of performance that the community is entitled to expect. Medical codes of ethics play a central role in articulating and promoting those standards of excellence throughout the course of that education.

1.10 THE MUTABILITY OF MEDICAL ETHICS

The similarity of some of the key tenets of the Hippocratic Oath to modern codes of medical ethics has already been remarked upon. However, codes of ethics are designed to guide and inform professional conduct and each ethical principle is intended to be interpreted in the light of prevailing circumstances and should not be followed rigidly, without thought about the real issues involved. Further, the codes are responsive to broader social shifts on ethical and moral issues. For example, two principles stand out as differences between the Hippocratic Oath and modern ethical concepts – namely the modern emphasis on patient autonomy and the concept of distributive justice.

A more mundane example of changing ethical views has been the evolution of the controls on advertising by doctors that occurred during the last 25 years. Previously, ethical codes had strictly limited advertising by doctors on the somewhat

paternalistic basis that people who were ill and seeking medical attention were vulnerable to misleading advertisements that promised more than medicine could offer. This limitation was gradually replaced by the principle of a community's right to information (advertising), and to the exercise of their free, autonomous and informed choice. Experience of potential and even real harm, especially in the area of advertising of non-essential cosmetic surgery [24], has since provoked some communities, via their parliament, to revisit the controls placed on advertising by doctors (see Chapter 8).

1.11 THE LAW AND MEDICAL ETHICS IN CONFLICT

Conflicts between specific ethical principles, or conflict between the conscience of the individual doctor and a lawful request for medical services that are morally unacceptable to that doctor, are dilemmas with which the medical profession is familiar. In the latter type of situation, the doctor should recognise and disclose the personal ethical conflict and advise the patient to consult another doctor. Doctors must refrain from imposing their personal moral judgments onto patients, who are fully entitled to make choices according with their own moral values.

As society through its parliament and its courts increasingly wishes to use the law to regulate aspects of medical practice, situations will arise where the law appears to be in direct conflict with the generally agreed approach of the profession. This was seen in the *Rights of the Terminally Ill Act 1995* of the Northern Territory, which legalised euthanasia, an initiative subsequently overruled by federal parliament.

Parliament, as the democratic expression of the society, can create new laws limiting the scope of professional conduct when it perceives that patients could suffer harm should doctors not voluntarily recognise or accept the ethical obligations and the privileged position they occupy. Such laws generally set the outermost limits within which doctors must function in any given circumstance. Past examples include laws about the use of certain surgical treatments of the mentally ill.

1.12 CONFLICTS BETWEEN ETHICAL PRINCIPLES

1.12.1 Autonomy versus beneficence

The Hippocratic tradition emphasised beneficence in a way that the community would now regard as unacceptably paternalistic. In the space of a generation, respect for autonomy has supplanted beneficence as the overriding principle guiding medical practice. (Incidentally, the term 'generation' conceals the fact that learning to be a doctor and practising as a doctor is a continuum. The doctor nearing retirement and the young doctor entering practice are a generation or more apart, but are still practising medicine in the same community. The community probably expects similar ethical values from both, but human nature

assures us that this is unlikely, a fact which itself can create ethical conflict.) The pre-eminence which society now places on autonomy has been the basis for widespread discussion of the issue of informed consent or informed decision making (see Chapter 4). Autonomy may also conflict with the principle of justice, in relation to the allocation of medical resources (see Chapter 13).

The principle of respect for autonomy is increasingly being supported by or incorporated into legislation. Most Australian states have legislated for the right of patients to refuse medical treatment. For example, in Victoria, the *Medical Treatment Act 1988* prescribes that patients can refuse medical treatment that may preserve or sustain their lives.

1.12.2 Autonomy versus non-maleficence

An example of this conflict is whether a patient should be informed of a diagnosis of terminal malignancy when the opinion of an attending doctor and that of his or her relatives is that such knowledge would be psychologically harmful to the patient. The principle of respect for autonomy would say that patients should be told everything they wish to know about their condition so that they may make properly informed decisions about their future. However, in certain situations the principles of non-maleficence and beneficence might be given more weight. Such an outcome should only follow a discussion with the patient to establish the patient's capacity to manage bad news and to ascertain the patient's attitude to the involvement of relatives in decision making. It may also require cautious discussion with those closest to the patient, normally the relatives. This latter discussion faces the criticism that it is a breach of autonomy and of confidentiality if the patient has not given informed consent to discuss the diagnosis with others. The response to such criticism is that, in the circumstances, the principle of beneficence is a preferred justification or, drawing on a utilitarian approach, that such discussion is most likely to have the best outcomes. Again, ethics helps to clarify the choices and justification available, but does not replace the judgment that must be made. As the values of patients are greatly influenced by their cultural heritage, this example remains very real in multicultural Australia, despite all that has been written and said in the Western world about the pre-eminence of autonomy.

1.13 ETHICS BEYOND THE DOCTOR–PATIENT RELATIONSHIP

The traditional one-to-one doctor–patient relationship is increasingly altered or strained by various changes in the practice of medicine and in its financing. An increasing number of doctors, including specialists, practise in groups or in hospital teams. Modern patterns of medical practice as well as specialisation have

meant that for many encounters, more than one doctor is involved in the care of the patient. The term 'health-care team' is an abbreviation for the various professional groups who may need to assist in patient care; this team includes specialist nurses, physiotherapists, social workers, psychologists and others.

Various strategies to monitor or control the cost of health care introduced by government and applied by third parties (such as financial agreements between private hospitals and medical insurers) may also affect the doctor–patient relationship to such an extent that patients' rights or the doctor's ethical duties are seriously challenged (see Chapter 13).

Where the other health-care professional is present at the request of the doctor and is instituting care at the direction of the doctor, the prime responsibility for the overall care of the patient remains with the attending doctor. Other health-care professionals have their own codes of ethics and are usually subject to disciplinary oversight by a registration body. The experience, expertise and ethical codes of the other members of the health-care team should be respected by the doctor. Ethical conflicts do arise from time to time, with many being explained by misunderstanding or poor communication (see Chapter 3).

1.14 ETHICS AND LIMITED RESOURCES

While respect for autonomy has dominated the ethical debates and been the focus of community attention in the past 25 years, the ethical principle of justice is likely to become the dominant influence over the next twenty-five. There is an obligation on doctors to provide the best possible care to their patients. When resources are limited, a decision may have to be made about the benefit of a treatment to one patient versus another (for example, the young versus the old, the curable versus the incurable) or made about one form of treatment versus another (for example, does the patient 'need' liver transplantation or should supportive 'treatment' be advised?). An obligation to practise cost-effective medicine will clash with the other obligations of the doctor. This increasingly important subject is discussed more fully in Chapter 13.

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2 ETHICAL AND LEGAL RESPONSIBILITIES OF MEDICAL STUDENTS

There are legal and ethical considerations even for students planning to enrol in medical school. After enrolment, from the point of first contact with patients in year 1 in many medical courses, many of the ethical and legal responsibilities of doctors also apply to medical students. Most of this book is thus of relevance to medical students, relevance that increases progressively as clinical training and patient contact increase. The curricula of all Australian medical schools provide information about these ethical and legal responsibilities and the schools aim to develop appropriate attitudes in students [1]. Some Australian medical schools have adopted the practice of medical students taking an oath of ethical commitment at the time of graduating [2]. There is new evidence that behavioural attitudes at medical school can strongly predict subsequent professional conduct that has been the subject of disciplinary actions by medical boards against practising doctors. This evidence adds emphasis to the need for early introduction of education in regard to expected professional standards [3]. Stressful ethical issues peculiar to the life of medical students are also discussed in this chapter, together with a new code of ethics developed by the Australian Medical Students Association (AMSA) [4] and issues around medical student health. Career choices in medicine are discussed in Chapter 16.

2.1 CONSIDERATIONS BEFORE ENROLMENT

Australian medical courses leading to the degree of Bachelor of Medicine and Bachelor of Surgery (MB BS), or its equivalent, are designed to prepare graduates with the knowledge, skills and attitudes required for the provisional registration year (also known as the intern year or postgraduate year 1). Students who are contemplating a career in medicine need to be aware of the academic criteria for admission to the course and to consider the following issues:

- A medical course is long and demanding and students need to be confident that they have the motivation, dedication, and financial and emotional support to complete it.
- The practice of medicine is essentially about helping people and requires a positive non-judgmental attitude to other members of society, a desire to serve, good communication and interpersonal skills, and a sensible balance of altruism and self-respect.
- To be a medical student and a doctor implies an informed willingness to accept the risks entailed, most obviously the risks of contracting infectious diseases from patients [5–6].
- Medical students also need to be able to cope with the emotional and psychological impact of confronting serious illness and death.
- Acceptance into medical school may require compliance with immunisation schedules and consultation with an infectious diseases physician to arrange hepatitis B immunisation and to discuss testing for HIV, hepatitis C and tuberculosis.
- Upon completion of the MB BS degree, provisional registration by the medical registration board may be denied for the following reasons
  - being not of good character
  - having been convicted of serious crime
  - being ill or impaired in a manner that may put the community at risk
  - being alcohol or drug dependent
  - having a physical or mental impairment that significantly impairs the ability of the applicant to practise medicine.

Before being provisionally registered, the new medical graduate may be required to sign a statutory declaration attesting to the absence of any of the above factors. The term 'illness or impairment' includes the carriage of asymptomatic infectious diseases like human immunodeficiency virus (HIV), hepatitis B and hepatitis C. To assist potential and enrolled medical students in what can be a difficult and emotive area, most medical schools provide written information and access to counselling and independent infectious diseases specialists. Students who carry such diseases are not excluded from the medical course, but they will require advice as to whether any restrictions will be placed upon them in regard to their practical experience, for example in obstetrics, emergency departments or surgical electives. As their ability to undertake the intern year fully or to undertake certain areas of clinical practice may be subject to limitations, early counselling is essential.

2.2 CRITERIA FOR ENROLMENT: SELECTION PROCEDURES

Places in medical schools are keenly sought and an essential criterion for acceptance is academic ability, as evidenced by high school performance or performance in another tertiary course (either for 'lateral entry' to undergraduate entry

courses or for entry to graduate-entry courses). Some medical schools identify success in prerequisite subjects including English and chemistry, and may also include biology, physics and mathematics, as part of the academic criteria. Some medical schools use assessment by a structured personal interview (or series of interviews) to help select students. The interview panels, which usually include a non-medically qualified community member, assess personal attributes considered appropriate to a career in medicine.

Entry to graduate courses requires success in the Graduate Australian Medical Schools Admission Test (GAMSAT) while the undergraduate courses (with the exception of James Cook Medical School) use the Undergraduate Medicine and Health Sciences Admissions Test (UMAT). Information about GAMSAT and selection processes into graduate entry medical courses can be found at http://www.gamsat.edu.au/. Information about UMAT and processes for selection into undergraduate entry medical courses can be found at http://umatweb.acer.edu.au/. Information regarding selection processes is also available from the faculties of medicine at each of the eighteen Australian universities that have medical schools. There are links to each medical school at the Medical Deans of Australia and New Zealand website at http://www.medicaldeans.org.au. A very helpful guide to Australia's medical schools, covering entry requirements and information regarding course structure, fees, support and accommodation, is available on the website of AMSA (http://www.amsa.org.au/publications-medicalschoolguide.php). Twelve of Australia's medical schools now offer the medical course as a graduate-entry program, including some that offer mixed graduate and undergraduate entry, while six medical schools continue solely as undergraduate courses of 5 or 6 years' duration.

2.3 REGISTRATION OF MEDICAL STUDENTS

In Victoria, NSW and SA, medical students entering clinical placements must be registered with the medical board. This registration is free but must be renewed annually. Registration has the effect of making medical students subject to the registration legislation in their state (see Chapter 8), particularly the disciplinary and impairment provisions. In addition to contributing to the education of students by alerting them to their developing professional responsibilities, this provides a means of protecting and assisting students who are unwell because of psychiatric illness or drug dependence, as well as protecting patients from impaired students. Registration is not required in other states. Medical students in these states are subject to the disciplinary provisions of their university and to any other processes of the university or in teaching hospitals for students assessed as being incapable of continuing their studies by virtue of illness, impairment or drug dependence. At the time of writing it is proposed that the new national registration scheme will require all medical students to be registered at some point in their training (see Chapter 8).

2.4 OBJECTIVES OF THE MEDICAL COURSE

Australian medical courses remain primarily vocational and aim to prepare students to have the necessary knowledge, skills, professional attitudes and behaviour to undertake the provisional registration year. The aims, design and content of each medical course have always been subject to review and change. A landmark national review of medical education published in 1988 [7], known as the *Doherty Report*, reaffirmed the basic principles of the undergraduate medical course while highlighting the need for medical schools to prepare their graduates to meet future challenges and to overcome deficiencies perceived by the community. At around the same time, the Australian Medical Council (AMC) was established (see Chapter 8). One of its key tasks is to accredit medical schools on behalf of the state and territory medical boards. Medical schools have responded to the Doherty Report and to the accreditation standards established by the AMC [8] and are increasingly concentrating on educational outcomes, beyond the acquisition of knowledge and skills. These outcomes include:

- better communication and interpersonal skills
- greater awareness of ethical and legal issues in medical practice
- better skills in problem identification and resolution
- the commitment and skills required for lifelong professional education and continuing education
- increased awareness of the social, economic, environmental and cultural dimensions of medicine and health
- the ability to critically evaluate the evidence on which medical decisions are based, and
- a willingness to participate in and where necessary lead a coordinated team approach to the delivery of health care.

2.5 PROFESSIONAL ETHICS FOR STUDENTS

In addition to the specific ethical obligations of medical students described below, there are ethical requirements general to all university courses, including not to cheat and not to plagiarise the work of others [9–10]. These obligations and the penalties applied by universities can be found in their student handbooks.

2.5.1 Contact with patients and learning from patients

In most medical schools, students are introduced to people as patients as early as is practicable in the course. Closer patient contact in terms of taking a detailed medical history and conducting a physical examination may also commence early in the undergraduate entry course. In the 4-year graduate-entry courses, this contact with patients usually occurs in year 1. This places students in a privileged and responsible position, and they need to be aware of this and of

their dependence upon the cooperation of patients for their learning. Access to patients and their cooperation is a privilege that must not be taken for granted. Patients must always be treated with courtesy, consideration and respect. They are ill and are often anxious and vulnerable, particularly when in hospital for assessment and treatment, regardless of the impression created by their outward demeanour.

Before approaching any patient, students should generally first seek permission from those responsible for the immediate care of the patient. This is usually the nurse in charge of the ward, but permission should also be sought from medical staff if they are present in the ward.

Most patients are aware or rapidly become aware that medical students are present in teaching hospitals and may even have been informed of this upon admission. Many positively welcome medical students, for reasons which range from a sense of duty to help to a desire to see better doctors graduate.

Medical students should always introduce themselves by name, should explain that they are students and must always seek and gain consent to take a history or perform a physical examination. For patients who are children, consent from a parent must be sought. Patients have the right to refuse and sometimes do, particularly if they have already seen many students. Students should ask patients how they prefer to be addressed (by first name or more formally as Ms, Mrs or Mr). Patients may expect students to be more informed than they are and to have more authority than students actually do. This misunderstanding must not be exploited.

2.5.2 Consideration and respect

Patients regard illness as a serious matter and rightly expect health professionals to adopt a serious approach to their problems. This extends to the physical appearance of health professionals, including students, and is especially important with the older patients who make up most of the general hospital population. Medical students need to dress and groom themselves professionally and adhere to the standards required by the hospital, health centre, medical practice or other institution in which they are placed.

Students must always respect the religious and moral views of patients and should not engage in debate or comment, or question their beliefs. It is usually inappropriate for students to attempt to assume a role of patient advocate, confidante or adviser.

In large hospitals, it may be difficult at times to provide adequate privacy for patients. Nevertheless, students must strive to provide patient privacy when interviewing and examining patients. This includes such matters as not asking potentially embarrassing or personal questions within earshot of other patients, ensuring that the patient is adequately screened and gowned when conducting a

physical examination and only exposing the part of the body relevant for each phase of the examination. When conducting a physical examination, particularly of patients of the opposite sex, a nurse or medical student of the same sex as the patient should be present. Under no circumstances should medical students conduct sexually intrusive examinations, including breast, genital or rectal examination, without supervision or an accompanying nurse. Students need to be aware of the medical school policy in regard to sexually intrusive examinations [11].

At the completion of seeing a patient, the student should thank the patient for their time and assistance and when relevant offer to help the patient to dress and return to their allocated bed or place.

2.5.3 Confidentiality

From the day of first contact with people as patients, medical students are bound by the same rules of confidentiality as doctors (see Chapter 5). This covers information obtained from the patient, family or friends, the patient's medical records or from hospital staff. Students must take care to ensure that notes taken during an interview and examination are kept secure and, if used for education or training purpose, destroyed when no longer needed. Confidentiality also prohibits disclosure to other people that an individual has been admitted to hospital or has been seen by a student in the patient–student contact. Consent to release such information must not be sought by a medical student.

2.5.4 Recognition of the limitations of knowledge

Being granted access to patients and undertaking minor procedures may give some students a misplaced sense of authority and competence. Medical students must recognise that their knowledge and experience are limited and that they are not authorised to provide medical advice to patients. This necessitates taking great care in answering the questions of patients so as to avoid answers that imply advice on diagnosis, prognosis or the like. Despite this restriction, students should spend as much time talking with patients as possible to improve communication skills (see Chapter 3) and to learn how to establish rapport with people from different social and cultural backgrounds or who are of a different age group. Students must refrain from criticising or appearing to criticise a patient's medical management in front of the patient. As students often spend more time with patients in hospital than do doctors, establishment of rapport may lead to patients having the confidence to reveal to medical students information crucial to diagnosis, management or understanding of the implications of their illness. Where information is clearly relevant, patients should be encouraged by students to raise these issues directly with their doctor or nurse. In some instances, the patient may ask that the student pass on the information; this is appropriate so long as consent has been

clearly given. In this way, students can learn much more from their experience of clinical clerking and can gain a greater sense of what it means to belong to a health-care team.

As the medical student's knowledge and experience grows, the student will be requested to do more and will be given opportunities to perform procedures under supervision and to assist in other ways. In some medical courses, the final year includes a pre-internship term, where students work with interns, registrars and senior doctors as part of a medical team. In all these situations, it is important to understand that the final responsibility for the students' actions rests with the doctor supervising the student. The degree of supervision will vary according to the procedure, the student's experience and skills and the regulations of the hospital. Students should not perform any procedure if they feel that they have not been appropriately trained or feel inadequately supervised. If students do incur personal liability while on approved and supervised clinical or field placements, they will be covered by indemnity arrangements made by the university.

The responsibilities of medical students are also addressed in the code of ethics developed by the Australian Medical Students Association and issued first in 2003 [4]. It provides the following eight principles of conduct to which are added more detailed annotations, where medical students should:

- respect the needs, values and culture of patients they encounter during their training
- never exploit patients or their families
- hold clinical information in confidence
- obtain informed consent from patients before involving them in any aspect of training
- appreciate the limits of their role in the clinical setting and in the community
- respect the staff who teach and assist them in their clinical training
- adhere to the ethical principles in the appropriate national and international guidelines, if involved in clinical research
- maintain their personal integrity and wellbeing.

2.5.5 Infection control

Medical students on clinical placements must be instructed in appropriate infection control measures, for their own protection and for the protection of patients. Patients may be put at risk by medical students transferring infection (usually bacterial) from patient to patient. To prevent this, students must adhere to standards for hand-washing or the use of antiseptic applications before and after examining patients. In higher risk situations, they must observe directions regarding the use of gloves, mask or gown.

Patients may also be put at risk where a student is a carrier of an airborne virus, such as the documented spread of measles and rubella [12]. Medical students should also be mindful of the possibility of exposing elderly or immunocompromised patients to influenza and other upper respiratory infections and have free annual influenza vaccination. Patients may also be at risk if a student is a carrier of an agent transmissible by direct contact of the student's blood with patient tissues (HIV, hepatitis B and hepatitis C). Students may themselves be at risk of being infected by such transmissible agents from contact with a patient's blood or body fluids. To overcome or reduce these risks to patients and medical students, students must be immunised against a range of illnesses (see below) and must be instructed in the use of preventive measures termed 'universal precautions'.

2.5.6 Infectious diseases

To reduce the risk to patients and to students, medical schools have policies in regard to infectious diseases, including the use of universal precautions. These policies cover advice and counselling before enrolment and include a requirement that students are immunised against (or are immune through past exposure to) infectious diseases including diphtheria, tetanus, polio, pertussis, measles, mumps, rubella and hepatitis B. Many medical schools also require students to be immunised against hepatitis A and to receive annual influenza vaccination.

In some medical schools there is also a requirement that students consult an independent infectious diseases physician early in the course to discuss immunity, infection control and the desirability of knowing their HIV, hepatitis B and/or hepatitis C status. To protect patients they are in contact with, students should be aware of their infectious disease and immunity status [13]. Those who are infected with HIV, hepatitis B or hepatitis C are not excluded from the medical course, but are required to avoid exposure-prone procedures and must seek counselling and advice on restrictions on training and career opportunities, and on measures to prevent patients or fellow workers being placed at risk. Australian and overseas experience shows that medical students are involved in needle-stick and other injuries that place them at risk of being infected by blood-borne viruses and that these incidents are underreported [14–15]. All hospitals have protocols in place when needle-stick injuries or similar incidents occur and students are advised to report the incidents and follow the protocol, for the benefit of both the student and future patients.

2.5.7 Sexual boundaries

One of the most important ethical principles in medical practice is that the trust of patients be respected. This principle means that doctors must not engage in

behaviour designed to provide sexual gratification. Such behaviour exists in a continuum beginning with inappropriate remarks about a patient's appearance or the use of sexually suggestive language, through to the use of the doctor–patient relationship to establish an improper emotional or sexual relationship, to sexual assault and/or rape.

It is important that students appreciate that subconscious influences and psychological impairment of the doctor can increase the likelihood that some doctors will breach these boundaries and will abuse the doctor–patient relationship to create opportunities to live out the doctor's sexual fantasies. When the doctor–patient relationship is exploited for sexual ends, the trust in doctors of patients and of the community at large is destroyed or undermined. Even more importantly, experience shows that such violations always damage the victim emotionally, even in those situations where doctors try to absolve themselves by claiming that the patient was a willing participant [16]. This subject is discussed more fully in Chapter 10.

2.6 THE STUDENT AND THE HEALTH-CARE TEAM

The doctor's role in health care is progressively changing in response to a range of influences including health-funding alterations, patient and community expectations, increasing complexity of illnesses and their treatment, and the need for a team approach so that patients have access to the special skills of other health-care professionals. In both hospital and ambulatory settings, medical students have a great opportunity to learn about the role played by other health professionals and by pastoral care workers and chaplains, including the skills they bring to patient care.

Changes in models of health-care delivery can be very challenging for doctors. In some instances, these changes have led to tensions between professional groups and have contributed to professional dissatisfaction. Other doctors have risen to the challenge and have gained greater respect from the other professions by being willing participants in multidisciplinary teams [17]. While doctors generally retain primary medico-legal responsibility for patients, effective collaboration with other health professionals is now expected of all doctors.

Most people when ill still expect doctors to be competent to take charge of serious or life-threatening illness, yet can be ambivalent about the power they thus cede to doctors. This also applies to other health professionals who become ill. Medical students need to be aware of these tensions and challenges, which should be addressed during their training, allowing them to develop a clear understanding of the roles and capabilities of other health professionals, a respect for other health professionals, a positive approach to team work, an understanding of leadership roles and enhanced communication skills.

These issues are covered more fully in Chapter 15, which emphasises the professional responsibilities of doctors to work collaboratively and respectfully with other health-care professionals. Medical courses now strive to encourage students to develop positive attitudes to these responsibilities.

2.7 STUDENT HEALTH

As the health problems facing doctors may also affect medical students, this section should be read in conjunction with Chapter 11. Many health problems have their origin in the student years.

2.7.1 Stress and psychological difficulties

Many medical students find their experiences stressful. Stress can be experienced in patient contacts, examinations, excessive workloads, personal difficulties and financial concerns. Studies from Australia and New Zealand in the 1960s reported neurotic symptoms and a need for psychiatric counselling in 13 per cent of medical students [18]. A more recent Australian study quoted students reporting constant anxiety (13 per cent) and having experienced three or more recent stressful events (30 per cent) [19]. Similar experience has been reported from the UK and USA [20–22]. Studies also suggest that personality traits can be used to predict those students more likely to find the medical course very stressful, especially a combination of neuroticism and conscientiousness [23]. Most students who seek help usually need counselling only for very brief periods. However, some students experience serious depression requiring intervention, while others may manifest a psychotic illness for the first time. Certain developmental and personality factors may be present in students at risk of eventual impairment through psychological difficulties. These factors include introversion, masochism, trait anxiety, non-joining behaviour or the experience of adverse early life events or adverse parental factors [24]. Fellow students should not hesitate to encourage colleagues to seek help from the university health service, a general practitioner or the clinical dean or equivalent person. Some medical schools have identified an academic staff member who can be approached in confidence. In Victoria, medical students also have access to the Victorian Doctors Health Program.

2.7.2 Drug and alcohol abuse

Overseas studies indicate that at entry to medical school student use of alcohol and drugs is no different from that of their peers [25–28]. A UK study reported that 25 per cent of medical students were using alcohol at levels above those regarded as low risk, 50 per cent had used cannabis and 22 per cent had tried other

illicit drugs [29]. During the medical course, possibly in response to the stresses mentioned above, some students do establish dangerous patterns of alcohol or drug use. These patterns should be regarded seriously as they are harbingers of greater difficulties after graduation.

2.7.3 Other disabilities

Medical schools do not discriminate against disabled students who are able to meet admission/selection criteria and who are able to satisfactorily complete the essential components of the course. Medical schools are required to take reasonable steps to adapt teaching and assessment methods so as to accommodate the needs of disabled students. However, to be registered fully as a doctor, all graduates must complete an accredited intern year. Students with a disability that may prevent a graduate from meeting all the requirements of the intern year should discuss the effect of their disability with medical school staff at entry or as soon as the disability becomes apparent. Disabled students can also seek advice from a medical board.

2.7.4 Lifestyle

The demands and competitive pressures of a medical course lead some students to adopt an unbalanced approach to study, rest, exercise, outside interests and maintenance of friendships. Unfortunately, this approach may be encouraged by observing the lifestyle of some highly successful medical mentors. Eventually students will become aware that life is short and will regret not having pursued other interests or maintained friendships. Striking a reasonable balance as medical students and supporting each other in this regard should help establish good habits that can be carried over to achieving a balance between professional, family and personal needs after graduation [30].

2.8 RESPONSIBILITIES OF AND PROFESSIONAL ETHICS FOR MEDICAL TEACHERS AND SUPERVISORS

The Hippocratic Oath in part reads as follows:

> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art – if they desire to learn it – without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

The modern World Medical Association version of this oath (Chapter 1) omits reference to teaching students but states: 'I will give to my teachers the respect and gratitude which is their due'. The code of ethics of the Australian Medical Association (see Appendix 1) states the following in regard to clinical teaching:

- Honour your obligation to pass on your professional knowledge and skills to colleagues and students.
- Before embarking on any clinical teaching involving patients, ensure that patients are fully informed and have consented to participate.
- Respect the patient's right to refuse or withdraw from participating in clinical teaching at any time without compromising the doctor–patient relationship or appropriate treatment and care.
- Avoid compromising patient care in any teaching exercise. Ensure that your patient is managed according to the best-proven diagnostic and therapeutic methods and that your patient's comfort and dignity are maintained at all times.
- Where relevant to clinical care, ensure that it is the treating doctor who imparts feedback to the patient.
- Refrain from exploiting students or colleagues under your supervision in any way.

The universities also provide for their teaching staff ethical codes of conduct, which cover such issues as sexual impropriety, sexual harassment and other inappropriate behaviour towards students. Medical teachers engaged by the university are bound by these rules as well as by the ethical codes of the medical profession.

Whether aware of these codes or not, most doctors after graduating remain grateful to their past teachers and are enthusiastic in their desire to assist medical students. Unfortunately this is not true of all doctors and even enthusiastic teachers breach ethical codes. Student surveys report instances of verbal abuse, humiliation, belittlement, sexual harassment, sexual advances and even threat of physical harm [31–32]. More subtle abuse may involve exposing students to unnecessary risks [33], for example by not advising them sufficiently in order to reduce the risk of infection [12]. It is also apparent that some doctors are imperfect role models for medical students, particularly in regard to such matters as paternalistic attitude to patients, lack of respect for patient autonomy or inadequate communication skills. These abuses and failings, referred to as the 'hidden curriculum', create real dilemmas for medical students, who are naturally reluctant to confront their teachers or to report their teachers to relevant authorities [33].

Sometimes, students may be confused as to whether the role model observed is appropriate, particularly where the teacher has a powerful personality or highly regarded skills in other areas of practice. There is no single best response to these dilemmas [34]. Where the issue is one of sexual harassment, universities and hospitals provide formal reporting and counselling processes. For other issues, options

to be seriously considered include discussing concerns with fellow students, other teachers or the student dean, or raising the issues in relevant segments of the course devoted to ethics. The last of these options can be used without having to identify the individual concerned. In raising concerns with those in authority, there is no requirement to identify the particular teacher initially. Students will often be pleasantly surprised to find that their concerns have been expressed by others, but disappointed that the medical profession has yet to develop effective methods of dealing with inappropriate role models whose behaviour falls short of warranting disciplinary action.

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3 COMMUNICATION SKILLS

Chapter 1 emphasised how respect for patient autonomy has become more central to the doctor–patient relationship while beneficence has been diminished in importance because of its paternalistic overtones. Effective communication strengthens patient autonomy by enhancing understanding and is essential for good medical practice. It is the means of history taking, obtaining consent for examinations and procedures, and explaining diagnoses and treatment. Effective communicators are able to establish rapport, trust and confidence with patients more easily than ineffective communicators, thereby enhancing the flow of crucial information and increasing the likelihood that advice will be heeded. Effective communication decreases the likelihood of complaints [1], acrimony or legal action if adverse events occur [2–3]. Good communication skills alone are not sufficient for professional medical practice and must be accompanied by clinical competence, empathy and ethical behaviour [4]. Good communication skills are also a necessary prerequisite if the doctor is to provide effective leadership of the 'health-care team'.

Effective communication also improves the quality of health care [5–6] and can have a very positive effect on the satisfaction gained from a consultation by both doctor and patient. Breakdowns in communication are the most common basis of patient dissatisfaction. Surveys show that dissatisfied patients criticise their doctor for not listening, for not providing adequate explanations or for appearing disinterested. Satisfied patients perceive their doctor to demonstrate humaneness, understanding, ability to listen without hurrying the patient, and the skill of involving the patient in decision making [7–9]. Poor performance in communication skills as assessed at licensing examinations in Canada predict complaints to medical boards [1], a finding consistent with the fact that failure of communication underlies the majority of complaints made against doctors (see Chapters 7 and 8). The opportunity for a patient to exercise his or her autonomy is undermined when a doctor is a poor communicator or appears to be unapproachable or unwilling to respond to the questions or concerns of patients. A large proportion of problems of a medico-legal

nature which arise in clinical practice are generally precipitated by the latter factors [10]. Even the tone of the surgeon's voice has been shown to correlate with malpractice claims [11].

A traditional perception has been that the possession of good communication skills ('a good bedside manner') was innate, but it is now well accepted that effective communication is a clinical skill that can be taught and practised [7–8, 12–13]. Doctors who graduated prior to the provision of teaching in these skills had to learn their communication skills 'on the job' and from good role models. Role models remain an important influence on students and young doctors, although negative effects may also result [14]. Workshops in communication skills for doctors in practice are available from a variety of sources.

This chapter highlights obstacles to communication, describes key skills for effective communication and provides advice in regard to such matters as the use of interpreters, how to respond when patients are angry or when things have gone wrong and how to approach sensitive issues such as discussing sexuality. The chapter briefly mentions the importance of good written communication but Chapter 6, on medical record keeping, should also be consulted.

3.1 OBSTACLES TO EFFECTIVE COMMUNICATION

Obstacles to good communication may relate to a lack of skills and/or to a poor attitude of the doctor, to factors in the clinical practice setting, or to the patient's own communication issues. These matters are well outlined in a 2004 publication of the National Health and Medical Research Council entitled *Communicating with Patients: Advice for Medical Practitioners* [15].

3.1.1 Doctor-related obstacles

The reasons why some doctors are poor communicators include:

- lack of training in communication skills
- inadequate role models during training
- lack of insight into communication deficiencies
- lack of time in clinical practice
- misapprehensions or subconscious anxieties (for example, the anxiety not to create patient dependence, or discomfort at the inability to cope with information that might arise when a patient has the confidence to be frank) – these anxieties can translate into curtness, professional detachment or authoritarianism
- lack of attention to emotional content in the consultation
- unresolved emotional and psychological problems of the doctors themselves

- upbringing and obtaining initial medical education in a culture different from that of the patient, combined with insensitivity to or lack of awareness to cultural differences
- inadequate attention to practice administration.

In addition, the doctor's own emotions can interfere with communication [16] while the purpose of the examination (for example, clinical care as a treating doctor versus medico-legal assessment as an independent medical examiner) can also influence the effectiveness of communication.

A common doctor-related reason for communication failure observed by medical boards and health complaints agencies is lack of insight; that is, doctors are unaware or deny that their style of communication is negatively perceived by their patients. Lack of insight has been shown also in a study of medical students where students' confidence in their communication skills was negatively correlated with their actual skills independently assessed via videotaped interviews with simulated patients [17].

Another reason for communication difficulty is a mismatch between the patient's expectations and the doctor's communication style. Many doctors assume that patients prefer a doctor who is confidently in control of the consultation (paternalistic in style), whereas many patients anticipate a more equal patient–doctor interaction. Such patients will respect doctors for their expert knowledge, but in return expect the doctor to respect their autonomy and right to make their own informed decisions about their health care [9]. Determining the patient's expectations in this regard, early in a consultation, is an important communication skill. Judgment in responding to those expectations is an important additional professional skill.

3.1.2 Obstacles in the clinical setting

The adequacy of the waiting area, the attitude of reception staff to the patient and the physical surroundings of the consulting room may affect the subsequent communication between patient and doctor. Good communication may be impeded by failure to ensure a comfortable and secure environment that meets the need for privacy. The consulting room should be soundproof and staff instructed to knock before entering.

Some doctors consider that a desk between patient and doctor is a barrier to communication, but individual practitioners need to decide what is comfortable and appropriate for the nature of their practice. Computer use can also be a barrier to effective communication. Use should be limited to what is essential within the consultation. If the patient cannot see the computer screen, an explanation of what the doctor is viewing may be appropriate. Some interruption to take essential telephone calls about clinical matters is unavoidable for most doctors, but every

attempt should be made to minimise this. When calls are taken, an explanation or apology should be made to the patient who is with you and consideration given to the need to move to another telephone. As described later, time constraints, real or anticipated by the patient, can also interfere with communication.

3.1.3 Patient-related obstacles

Readily recognisable factors include differences between doctor and patient in age, gender, social class, level of education, ethnic background, language barriers and variations in patients' attitudes and emotional responses to their illness. Other factors include the effects of illness or medication, embarrassment, intimidation related to the setting and difference in status between patient and doctor, the use of medical jargon, reluctance to ask questions and patient concern over time pressure for the doctor [15]. These barriers can be reduced by the doctor by such steps as asking questions designed to elicit a patient's understanding and by taking care to explain the doctor's understanding of the health issue at hand.

3.2 THE USE OF COMMUNICATION SKILLS IN MEDICAL PRACTICE

Most doctor–patient interactions occur within the consultation. Of the several separate skills used during the consultation, all except one are critically dependent on effective communication. These skills are the:

- clinical skill of history taking and physical examination
- diagnostic skill of formulating an hypothesis and pursuing it effectively
- skills involved in explaining the diagnosis and proposed management, including obtaining consent (see also Chapter 4)
- skill of patient education
- skill of effective prescribing
- skill of counselling in some clinical settings.

All of the above skills are capable of being learned and improved. They are skills that need to be accompanied by perceptiveness and an attitude that conveys to the patient respect, sensitivity and empathy.

3.2.1 Starting a consultation: putting the patient at ease

The technique used will vary according to the setting and the clinical problem. An essential first step is to ensure that the patient is aware that the doctor has seen and acknowledged him or her as a whole person before the doctor tackles the clinical problem the patient presents. The introduction should make the patient feel welcome and as comfortable as possible. Doctors should introduce themselves by name, but should be aware of unconscious signals of power imbalance even

at this stage; 'Hello Mary, I'm Dr Smith' sends a different message from 'Hello Mrs Jones, I'm Dr Smith'.

Pre-reading existing records or a letter of referral before the patient is brought into the consultation room allows the conversation to begin immediately, permits maintenance of eye contact at a crucial time, shows respect for the patient and avoids the impression for review patients that the doctor may have totally forgotten them. A helpful open introductory question such as 'Perhaps you can tell me in your own words what brings you to see me today' or 'How can I help you?' or 'How have you been since I last saw you?' should be used to open the consultation. A broad opening question is more inviting and ultimately more productive than a closed question.

Having commenced the consultation, it is important to avoid premature control of the flow of spontaneous information by the use of direct and closed questions. Studies have shown that doctors interrupt patients on average within twenty seconds of the start of the consultation. The same studies have demonstrated that patients are able to convey their issues adequately if the doctor permits them to express themselves in an uninterrupted fashion for 90–120 seconds. Such listening improves patient satisfaction and improves the quality of the communication [18–19]. Premature interruption of this phase of the consultation is likely to prevent the expression of the patient's real concerns and may lead to the doctor focusing on irrelevant matters. In addition, early interruption reduces the chances of establishing good rapport and trust. There are exceptions to this general advice, as one's approach needs to be modified for garrulous or demented patients and in emergencies.

3.2.2 Active listening

An active listener is able to learn more than just what is contained in the spoken words [15–20]. Active listeners maintain eye contact and ask open-ended questions. They are attuned to tone of voice, demeanour, vocabulary, gestures, linguistic pattern and non-verbal messages. It has been estimated that more than half the information communicated in a consultation is by non-verbal means. Body language is a major element of non-verbal communication. Doctors need to be aware also of their own body language (posture, eye contact, fiddling and other actions). For those who have computerised their medical records, this must include taking care that the patient and not the computer screen is the focus of attention.

An active listener also conveys to the patient that the patient is being seen, heard and understood. This may require verbal acknowledgement when distress is apparent (for example, 'I see this distresses you'). Silence with maintained eye contact or a simple nod of the head will also convey empathy. Limited verbal encouragement such as 'Uh-huh' or 'Yes' assures the patient you are listening and

wish them to continue. Summarising briefly back to the patient also reassures the patient that the doctor has listened effectively, as well as providing the patient with the opportunity to correct any misunderstanding.

3.2.3 Lack of time

Most patients are aware of time constraints on doctors. The duration of a consultation alone is virtually never the cause for complaint; it is the perception of being rushed. Patients perceive the consultation to be rushed if they are not listened to, are frequently interrupted, or observe body language that suggests the doctor is anxious to be elsewhere. Complex problems that clearly require more listening time are best addressed by a frank explanation and an offer of another appointment when sufficient time will be available.

In the hospital setting, the doctor who stands at the end of the bed when communicating may send the following message to a patient: 'I have no time to sit and listen and I want to stay near the door so that I may move off quickly'. Conversely where the doctor takes a chair by the side of the bed or, with the patient's permission, sits on the edge of the bed clearly sends a warmer message, which is, 'What you have to say is important to me and I will take the time to listen'. This may take no longer and will enhance communication with the patient [21].

3.3 APPRECIATING PSYCHO-SOCIAL FACTORS IN PATIENTS WHO SEEK MEDICAL HELP

The primary emphasis of the science-driven, disease-based Western medical model is on establishing a diagnosis and treating that disorder or relieving its symptoms. This is appropriate and effective for many physical illnesses but has severe limitations when a doctor is faced with a person whose symptoms are probably secondary to personal, psychological or social pressures and difficulties. In addition, physical illness is often accompanied by psychological distress and social consequences. In many spheres of practice more than half the patients presenting to doctors will not have a physical illness and can be recognised as suffering from tension, anxiety, depression or functional or somatoform disorders. The strongest material that will assist doctors in recognising these presentations and the most effective means of helping relieve their distress is to put greater effort into communication to find out more about the patient and the personal environment that has set the scene for the development of these symptoms. Studies have shown that many doctors avoid engaging in the social and psychological dimensions of patient's problems but that, where they do so engage, better outcomes are achieved [22]. Doctors who feel that this approach to communication and history taking should be the province of psychiatrists and psychologists would be well advised to read the original work of Balint [23] or enlightening

books by Hislop, an Australian physician [24], and Barbour, an American physician [25].

3.4 THE PHYSICAL EXAMINATION

Communication skills are also an essential element of this part of the consultation. Medical students and new graduates soon become inured to the breach of privacy involved in physical examinations such that patient anxiety and vulnerability may be overlooked. All new patients and most review patients should be interviewed before being asked to undress. When a proper examination requires that the patient undress, the need for this should be explained and the doctor should leave the room or direct the patient to an adequately screened area. A gown and/or a cover sheet should be provided, depending upon the examination to be undertaken. There are certain situations when even greater care must be taken in explaining the need for and nature of the examination, obtaining consent and providing for privacy (and sometimes a chaperone). These include any intimate examinations (for example, breast, vaginal or rectal examinations), especially where the patient is young or may never have experienced such an examination or where the patient is new to your practice. It also includes the examination of some patients from different cultural backgrounds (see also Chapter 4 on consent).

To reduce the anxiety experienced by patients during examination, it may be useful to engage the patient in conversation, for example by completing elements of history taking in regard to family, past medical or social history. Alertness to non-verbal communication is also a skill to be valued during the examination (for example, the first evidence that an area of the abdomen is tender when palpated may come from the patient's facial expression, not from any comment or response to a question).

3.5 TRANSCULTURAL ISSUES AND THE USE OF INTERPRETERS

Living in multicultural Australia means that most doctors will encounter patients with different backgrounds from their own. While these patients will not expect the doctor to have a great knowledge of or understanding of their language and culture, the doctor–patient relationship will be enhanced if the doctor clearly shows respect for these differences. This can be demonstrated in small ways such as by asking questions of their country and its heritage, by indicating knowledge of their country of origin, or by taking additional trouble to ensure that the patient is fully understood.

As a medical consultation involves the exchange of complex and subtle information, the barrier of language needs to be reduced by the use of interpreters, especially when obtaining consent for treatment (see also Chapter 4). Ideally the interpreter should be properly trained and, if requested by the patient, of the

same sex as the patient. Family members or other hospital staff should not be used to interpret medical information. Where in an emergency this is unavoidable, a qualified interpreter should be called as soon as practicable after the event to ensure that accurate information has been obtained. Contact details for access to telephone interpreters are provided in Chapter 15.

Using an interpreter appropriately is a skill that needs to be learnt. Medical interpreters undertake formal training of which doctors should be aware (see Chapter 15). Problems may arise if the language of the patient has not been correctly identified and if the interpreter has not been arranged in a timely manner. It may be appropriate to provide the interpreter with some background information about the patient and the purpose of the consultation. The interpreter should be introduced by name to the patient and his or her role explained. When using an interpreter, the questions and eye contact should be directed at the patient, not at the interpreter. Questions should be brief or, where this is not possible, care should be taken to break up the passages to be interpreted. In addition, the doctor should be alert to signals from the interpreter that he or she is being overloaded and to any hint that the patient is not comfortable with the interpreter [26–28].

For doctors working in areas where a large proportion of their patients are Aboriginal or Torres Strait Islander, or are drawn from cultural groups new to Australia, information about their culture and beliefs, especially as this might pertain to issues around health and health-care practices, should be regarded as essential. Several helpful articles and books on these topics relating to Aboriginal or Torres Strait Islander and immigrant Australians are listed at the end of this chapter.

3.6 CONCLUDING THE CONSULTATION

This aspect of the consultation is especially important if there is not to be ongoing regular contact with the patient or when new and serious diagnostic information is being provided. This information needs to be conveyed slowly in simple terms and, if possible, the doctor should ensure that the patient has understood. Note taking and/or the presence of a relative or close friend should be encouraged. Where medical jargon is unavoidable, it needs to be explained, or written down such that the patient can look up the meaning again later. A wise doctor presumes no prior knowledge at this point even when the patient is another doctor or health professional. Encourage and be responsive to any questions asked by the patient or any accompanying person at this point in the consultation. Not every question in medicine can be answered and it is reasonable to say ‘I don’t know’; patients are usually able to tolerate a degree of uncertainty. Doctors also need to be aware that the manner in which the uncertainty is conveyed may be unsettling to patients [29].

It is human nature to be optimistic, but optimism without discernment in the consulting room is misplaced. Thus care must be taken not to imply or promise outcomes that cannot be delivered. It is also human nature to transfer one's own feelings to others and assume that the person would feel as you would in their situation; doctors must avoid judging or criticising the actions or behaviour of patients according to their own personal standards or beliefs. It is wise to anticipate that patients will not recall or will only selectively recall what you tell them, particularly if the information is unexpected or distressing. If the information is critical, then taking the trouble to write it down and arranging to see the patient again, or ensuring that a relative or friend is present, is strongly advised. This will assist the patient to assimilate information that was not immediately taken in because of emotional distress. If appropriate, conclude the consultation with an anticipation of the outcome of the illness and clear instructions in regard to follow-up.

3.7 COMMUNICATING WHEN THINGS GO WRONG

Special attention to communication is needed when an unexpected or adverse outcome or event transpires in medical practice. It is essential in such situations to be open and frank in communicating with patients and their families. This should involve telling the patient as early as possible that something untoward has occurred. In so doing it is important to acknowledge any patient distress and to express concern and regret, without admitting any wrongdoing or liability. The latter advice is based on the requirements of indemnity insurers as well as the fact that the doctor is not in a position to make such a judgment, especially 'in the heat of the moment' [30–33].

Changes to medical negligence laws reinforce this concept of 'open disclosure' (see Chapter 7).

3.8 COPING WITH ANGRY PATIENTS

One of the most challenging situations even for experienced doctors is dealing with angry patients, especially those angered because their complaints have been ignored or badly handled. As Niselle has wisely written, in such situations 'the patient is allowed to be irrational, illogical, emotional and accusatory, but the doctor is meant at all times to be fair, reasonable, dispassionate, measured, and above all, professional' [34]. Key elements in responding include making time available as early as possible to meet with the patient, acknowledging the person's distress, making genuine attempts to respond positively to the complaint (which may include referring the person to the relevant complaints agency if you are unable to conciliate the issues) and giving the patient some power in the resolution of the complaint [30–31, 35].

3.9 MEDICO-LEGAL EXAMINATIONS

Proportionately more complaints to medical boards and health complaints agencies arise from this field of practice than any other. The reasons include the absence of the usual patient–doctor relationship, the need for the doctor to provide a detailed report to a third party and the underlying concern of the patient that the report may be not favourable. This topic is discussed in more detail in Chapter 25.

3.10 TOUCHING PATIENTS

Physical touching is another form of human communication. Touching a patient without consent is an assault (or more precisely in legal terms 'battery'), yet touching is a very human means of conveying concern and warmth and is very much part of the healing role of doctors, nurses and other health professionals. During any physical examination, touching is permitted because the patient has given consent, usually implied, for the examination to occur (hence the advice above to explain such examinations before conducting them). However, there are other times during a consultation when touching may be appropriate and helpful, for example if a patient is distressed by receiving bad news. There is no way in which specific advice can be given as to when touching, for example holding a hand or placing an arm around a shoulder, is safe or appropriate. It is more likely to be safe and appropriately interpreted if a third party is present, if the patient is clearly distressed, if the patient is well known to you and if it is timely yet brief. Doctors also need to be alert to the patient's reactions to being touched, especially if negative, or inappropriately positive. A very helpful discussion concerning touching as an aspect of communication is given by Myerscough [36].

3.11 TALKING ABOUT SEX AND SEXUALITY

As sexual difficulties can themselves bring patients to doctors or can complicate other illnesses, the need for doctors to be competent in seeking information in this sensitive area is self-evident. While it is not necessary nor justified to include questions about sexual function in every medical interview, doctors should be alert to clinical situations where sexual difficulties are more likely, including patients presenting with gynaecological problems, with symptoms suggesting a sexually transmitted disease, with marital problems, with certain disorders associated with sexual dysfunction and after certain types of surgery (such as mastectomy, colostomy or ileostomy). Introducing questions of this nature should not be done until rapport has been established and should always be preceded by a simple explanation as to why the questions are regarded as necessary. This simple

explanation will prepare the patient and at the same time make it clear that the doctor is comfortable in having such a discussion.

3.12 TALKING WITH THE DYING

Most doctors will at some time in their careers have the task of conveying information about serious illness to patients. A smaller proportion will be involved in the ongoing care of the terminally ill. The development of oncology and palliative care services and the hospice movement may have suggested that only specialists need training in communication in these areas. However, all doctors in clinical practice should be able to convey information about serious illnesses to patients with sensitivity and with awareness of the needs of patients with fatal illnesses [37–38].

The task of conveying bad news has already been touched on above where it was emphasised that adequate time must be made for this, privacy must be assured, the patient should be encouraged to have a relative or friend present and an early follow-up appointment offered [15]. On receipt of bad news, patients typically respond over time with a sequence of denial, anger, bargaining, depression and then acceptance [39], a sequence of reactions that may vary in its pace of evolution, and with overlap of the reaction phases. Very rarely, denial dominates the entire final illness [39]. Denial is to be appreciated as an important mechanism whereby patients cope with the news of their mortality. Doctors who deny their own eventual mortality may have the greatest difficulty in coping effectively in communication in this area [39].

In this clinical setting, doctors must be sensitive to the stage each patient is at and not try to provide information until the patient wishes it. As stated by Charlton, 'the most important issue is not what most patients or doctors think, but what the particular patient in the particular circumstance wants at the time' [38]. Kubler-Ross has also emphasised the critical importance of always leaving some room for hope, making clear the doctor's willingness to listen, avoiding mention of a prognosis in terms of a specific time period, and assuring the patient that he or she will not be abandoned. Her work also demonstrated that most patients are aware of their diagnosis, but readily collude when the health-care team tries to protect them from such bad news. Although the prognosis of many of the illnesses has changed considerably since the original work in this field by Dr Kubler-Ross, her 1969 short book, *On Death and Dying* [39], remains an outstanding and very relevant source of guidance on this topic.

After the death of a patient, doctors also can play a valuable role in assisting the relatives of the deceased to cope with their grief by making themselves available to answer questions about the death. At times, grief will be manifested as anger, which may be directed at others, including the doctor [40].

3.13 DOCTORS AND OTHER HEALTH-CARE PROFESSIONALS AS PATIENTS

The particular difficulties for doctors in regard to seeking care for their own health are addressed in Chapter 11. It is well recognised that doctors caring for other doctors or other health professionals can make dangerous assumptions about their patients' understanding of their illness, proposed investigations, procedures or treatment, and with compliance. It is appropriate not to make any such assumption of knowledge but to impart information at the appropriate level for that patient, having established their level of understanding and the need for information, as with any patient. Good communication skills will ensure that even where the patient happens to be well informed, no offence will be taken and the patient will have greater confidence in the doctor's ability to provide good care.

3.14 THE IMPORTANCE OF WRITTEN COMMUNICATION

The written record needs to be clear, to contain all relevant information (this will often mean information regarding the patient's knowledge of their illness and their emotional state) and to be signed by the person who wrote it. It is usually not relevant to include critical, judgmental or emotive descriptors and these can cause substantial embarrassment if the record is read by the patient or read out in court. Abbreviations should be limited to those used widely throughout the health-care system. Medical record keeping is discussed in depth in Chapter 6.

In undergraduate medical education, much importance is attached to the student being able to elicit and then record systematically a detailed history and physical examination. In the early postgraduate phase, attention is also paid to the adequacy of progress notes and discharge summaries. Later the emphasis shifts to record keeping for defensive reasons (would your medical records stand up to the scrutiny of the court?). While this is a powerful incentive to keep clear contemporaneous records, there are many other reasons why written communication, whether in hospital progress notes, in clinic cards or in letters to doctors and others, should be carefully and conscientiously attended to [15]. Not the least of these reasons are the increasing size of the medical team caring for patients and the shorter hours worked by doctors.

3.15 INTRA- AND INTER-PROFESSIONAL COMMUNICATION AND RELATIONSHIPS

The good communication practices outlined above apply also to communication between doctors and to communication between doctors and other professionals involved in the care of the patient, in order that patients receive optimal care.

Patient care may be compromised when there is poor communication between health-care professionals. As medical practice and health care frequently involve cooperative teamwork, and as care has become more specialised and at times compartmentalised, with multiple professionals involved concurrently and at different times during the course of patients' illnesses, the risk of communication failure has increased.

Doctors need to be alert to this risk and to openly share relevant information with other professionals, with the patient being informed and involved, when this is possible. This applies especially to the information provided in referrals for consultation and in the responses to these, to the documentation of progress and of changes in treatment, and when health care is transferred to other individuals or teams. For example, when many doctors are involved, each with expertise essentially confined to some but not all of the body systems, and each with the capacity to change medications, it is essential that all relevant professional colleagues are involved in, or informed of, decisions about changes before they are implemented.

Providing relevant information for other health-care providers implies that doctors must understand and respect the potential contribution of others. Chapter 15 is devoted to the roles played by other health professionals. Appropriate respect on the part of doctors for these non-medical professional roles is demonstrated by open and effective oral and/or written communication.

A closely related issue is the importance of protecting patients from unjustifiable direct or implied criticism of another doctor or health-care professional. One problem is that any criticism might be ill-informed, especially if based on incomplete information. Apart from being disrespectful to other health professionals and having the potential to destabilise patient confidence, this behaviour can also be a factor leading to unwarranted civil litigation by a patient (see also Chapter 7). In many clinical instances, robust evidence for specific interventions is lacking, meaning that there are likely to exist well-meant and appropriate variations in professional opinions. In such situations, discussion and resolution of differences of opinion by the professionals involved, before options are presented to patients, represents good medical practice.

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4 CONSENT AND INFORMED DECISION MAKING

There are ethical and legal reasons why doctors must adequately inform patients about proposed treatments or procedures, especially in regard to risks and dangers, and be satisfied that patients understand and consent to such measures. Ethically, this arises principally out of respect for the autonomy of the patient. The two-way information exchange required in order to bring patients to a position from which they can provide meaningful consent (an exchange referred to as 'shared decision making') is an essential component of good medical practice. Doctors who fail to adequately inform their patients about their condition, treatment options or material risks of treatment may be sued on the grounds of negligence (see Chapter 7). Exceptions to the requirement for consent are uncommon but include genuine emergencies and situations where treatment has been authorised by a court. In addition, if a doctor undertakes any procedure that involves touching the patient without consent, the doctor is guilty of an assault or, more precisely in legal terms, a battery, and an action in trespass may be brought against the doctor in a civil or a criminal court.

Just as there are both ethical and legal reasons for seeking informed consent, so too there are ethical and legal paths to understanding the principles involved in seeking informed consent. The legal pathway involves a detailed appreciation of what the courts in Australia and elsewhere have said about consent [1]. The ethical or professional pathway involves seeking good communication with the patient, as has been outlined in the previous chapter. The present chapter refers briefly to the relevant legal cases where appropriate, but in general adopts the ethical pathway as this is more likely to be readily understood, assimilated and applied by medical trainees and medical practitioners and is as likely to conform to legal obligations. The Australian High Court has suggested that the term 'duty to disclose' might be preferable to 'informed consent' [2]. Others have suggested the use of terms such as 'shared and/or informed decision making'. We have retained the term 'informed consent' as it remains in widespread use and appears to be well understood. Although the

term 'informed consent' has become enshrined in law in the USA, this is not the case in Australia.

While the ethical and legal requirements of obtaining informed consent are accepted and broadly understood by doctors, difficulties in obtaining a patient's consent still arise, particularly in regard to what and how much information needs to be disclosed, what constitutes a material risk, what to do when dealing with minors, or adults who may not be competent to give consent, what constitutes implied consent and whether 'therapeutic privilege' can be claimed. This chapter provides advice in regard to these difficulties and identifies recent professional and legal developments that have helped clarify how doctors should meet these difficulties.

4.1 ELEMENTS OF VALID CONSENT

For consent to be valid, it needs to:

- be freely given; this includes avoiding pressuring patients through failure to provide sufficient time for the patient to consider matters or failing to recognise other pressures (for example, from family)
- involve disclosure by the doctor of sufficient information including material risks (see page 53)
- be specific for the proposed procedures – the catch-all phrase 'any other procedures that may be deemed necessary' should only be relied on to undertake unforeseen and urgent procedures and, if the phrase is used, a note should be made of the matters discussed under it
- be given by a person who is competent to consent – this will ordinarily be the patient unless the patient is believed to be not competent
- involve some assessment or indication that the patient has an understanding of the proposed procedure or treatment.

No guidance exists in relation to how long consent, once given, remains valid. If significant time has elapsed between obtaining consent and the commencement of treatment, the existence of valid consent should be confirmed.

4.2 IMPLIED, ORAL OR WRITTEN CONSENT

Consent may be given orally, given in writing or be implied. The more major the proposed treatment, such as a surgical procedure, an invasive investigation or medical treatment with potentially serious side effects, the greater the need is that the patient be fully informed and the greater the desirability that the patient's consent be attested to in writing. However, the recommendation that consent be in writing is not a legal requirement. The existence of a signed consent form does not constitute conclusive evidence of adequately informing patients; consent forms are more usefully regarded as an important reminder that sufficient information be given for the consent to be valid and as prima facie evidence that the

discussion took place. Traditionally, written consent has not been obtained when medications are prescribed, but nevertheless the duty to warn patients of significant side effects must not be overlooked. Depending upon each clinical situation, doctors may be wise to make a note of any discussion held of the possible serious side effects of drug treatments and diagnostic procedures. The documentation of consent for more major procedures, especially surgical, is outlined below.

In everyday medical practice, for example when patients attend for consultations, accept prescriptions or proffer an arm for blood pressure measurement, venesection or injection, consent is either implied or verbal. Depending upon any pre-existing doctor–patient relationship that provides a basis for mutual understanding, the nature of the clinical problem, and the patient's attitude and capacity to understand, more or less time may need to be devoted to communication specifically directed towards consent. It is not possible to provide advice that predictably or fully covers every eventuality. The following list of situations where special consideration in regard to oral or implied consent should be given is neither exclusive nor ranked in any order of importance. This list does not contain reference to major surgery or more serious therapeutic procedures, as consent for these should be documented and must fulfil the requirements of valid consent noted above. Consent to surgical or other major invasive procedures is discussed in more detail below.

- *History taking*, in regard to sexual or personal questions, where the link with the patient's reason for attending may not be immediately apparent to the patient
- *Physical examination*, for any intimate or invasive examination, especially where the patient is young or inexperienced as a patient or where there are any reasons to anticipate communication difficulties, such as undue anxiety, cultural differences or language barriers
- *Laboratory investigations*, in situations where the outcomes may be of special significance as in testing for HIV and in genetic testing. In both of these examples consent needs to be accompanied by counselling. Pre-test counselling may be a legal requirement in certain situations. For example in both Victoria and Tasmania, it is a legal requirement to counsel patients before seeking consent for HIV testing (see also Chapter 26). Other investigations that may be precursors to major interventions, such as screening tests for cancer, should be looked at in a similar light.
- *Minor procedures*, such as certain injections and inoculations, which carry real and serious although rare complications
- *Prescribing medications*, especially when prescribing a medication for the first time and where the medication carries known serious or predictable side effects
- *Diagnostic procedures*, especially where there has been no prior discussion of risks inherent in procedures such as invasive radiology, endoscopy and organ biopsy. For these procedures, most hospitals insist on written documentation of consent.

- *Release of information to other parties*, especially if this does not fall within the usual expectation of the patient (see also Chapter 7 on confidentiality and privacy)
- *Participation in medical research*: there are additional ethical considerations involved in seeking such consent and these are covered in Chapter 17.

If at any point in undertaking an examination, treatment or procedure, a patient should resist the attention or withdraw consent, the doctor should not continue even if discontinuation is likely to see the patient's condition deteriorate. Even where a doctor believes that a patient will certainly die without treatment, a request by that patient to be left alone must be heeded. Every attempt should be made to advise the patient of consequences of his or her decision. Such situations arise infrequently. Where they do, the doctor will be wise to seek a second opinion and/or take advice from a medical indemnity assurer or a clinical ethics committee. Refusal of treatment is discussed in more detail on page 66 and in Chapter 22.

4.3 CONSENT FOR SURGICAL OR OTHER MAJOR INVASIVE PROCEDURES

Most case law and most ethical advice regarding obtaining informed consent is directed towards major procedures that carry significant risks. Based on a combination of case law, inquiries by government agencies, guidelines developed by statutory bodies and professional organisations such as the colleges and medical indemnity organisations, as well as in legislation in a small number of states (Queensland and Tasmania), there now exists reasonably clear advice as to how doctors should approach the matter of consent. Although the advice is clear, there are many aspects that will regularly require careful judgment. Mechanical application of such guidelines, without considering the personality, temperament, cultural background, level of education and other characteristics of the patient at hand, will not represent good clinical practice and may do more harm than good. While the guidelines at first reading may appear daunting, the doctor who communicates effectively with his or her patients and listens and responds to his or her patient's questions is likely to conform to the guidelines and most unlikely to encounter legal difficulties.

In 1993 the National Health and Medical Research Council (NHMRC) published *General Guidelines for Medical Practitioners on Providing Information to Patients* [3]. This publication, which was reviewed and reissued unchanged in 2004, can be regarded as an authoritative guide to the extent and nature of information a doctor should communicate to a patient to assist the patient in making an informed decision. When reissued in 2004, these guidelines were accompanied by complementary guidelines entitled *Communicating with Patients: Advice for Medical Practitioners* [3]. This publication expands upon the material to be

discussed with patients and provides practical advice about achieving effective communication. The following advice is drawn directly from the latter guidelines:

> Patients seek many types of information and advice from doctors. To enable them to participate meaningfully in decisions affecting their health care, patients need relevant information presented in a way they can understand. It is not possible, however, to provide information about every detail of all intervention* options, potential benefits or harms, and all possible outcomes. It is also not possible to assess risks with complete certainty, and this uncertainty should be communicated to patients.
>
> Where possible, information about the benefits and risks of interventions should be framed in ways which assist the patient to best understand his or her situation (for example using absolute, rather than relative, risk data) and to understand the nature of the risk. The patient should be advised of material risks, as described by the High Court in *Rogers v Whitaker* in 1992 [2]. Material risks are those to which a reasonable person in the patient's position is likely to attach significance, or those to which the doctor knows or ought to know the particular patient is likely to attach significance.
>
> Known risks that reasonable people would regard as significant should be disclosed, whether an adverse outcome is common and the detriment slight, or whether an adverse event is severe though its occurrence is rare.
>
> The communication process described in this Advice should enable a doctor to become aware of risks that a particular patient would treat as significant.
>
> **6.5 Providing information about diagnosis**
>
> When discussing the diagnosis, the following should be considered:
>
> - the possible or likely nature of the illness or condition
> - the degree of uncertainty of any diagnosis
> - the possible need for referral for diagnostic confirmation or refutation
> - the extent and soundness of medical knowledge about the specific condition
> - the status of the patient's illness, whether temporary, chronic or terminal
> - the involvement of the patient in the formulation of the ongoing care
> - patient's request for information
> - sensitivity to the patient's wishes for information, and
> - alternative sources of reliable information.

* The NHMRC advice explains the term 'intervention' thus: 'The general term "Intervention" is intended to cover diagnostic procedures and tests, and all forms of treatment (pharmaceutical, surgical etc). The principles involved in providing information for decision making may extend to other interventions including counselling and screening for diseases (eg genetic screening tests) wherever the intervention brings with it risks be they physical, emotional, financial or other.'

Section 6.7 [not reproduced] addresses additional considerations that should be taken into account if the doctor needs to communicate bad news to the patient.

6.6 Providing information about interventions

When discussing what proposed intervention involves with the patient, the following information should be conveyed in plain language:

- a description of the intervention
- what will happen to the patient
- whether the proposed intervention is critical, essential, elective or discretionary
- whether the proposed intervention represents current accepted medical practice
- whether the proposed intervention is conventional, experimental or innovative
- whether the proposed intervention is part of a clinical trial or other research project
- the degree of uncertainty about the benefit(s) of the proposed intervention
- how quickly a decision about the proposed intervention needs to be made
- who will undertake the proposed intervention, including their status and the extent of their experience, and that of the supervising doctor, where this information is known
- how long the proposed intervention will take
- how long until the results of the intervention will be available
- how long will be needed for recuperation and/or rehabilitation
- what the estimated costs are (where known), including out-of-pocket costs, and
- what, if any, conflicts of interest the doctor might have, including financial ones.

The potential consequences of any proposed intervention should be conveyed including:

- the expected benefits
- common side effects, common complications, contraindications and possible harms, including their likelihood and degree
- uncommon side effects to which the particular patient may be exposed, or that are of concern to that patient
- any outcomes that may require further intervention, and
- any significant long-term adverse outcomes (physical, emotional, mental, social, sexual, financial or other).

The patient should be advised of alternative options including:

- what those options are
- their availability and potential consequences, and

- likely short- and long-term consequences that may arise if they choose not to proceed with the proposed intervention or with any intervention at all.

The patient should be advised of proposed follow-up arrangements including:

- clearly stated arrangements for providing the results of the intervention (usually an investigation), and where relevant
- feasibility and costs of the follow-up arrangements.

Complex interventions usually require the provision of detailed information, as do treatments where the patient has no physical illness, for example cosmetic surgery.

Among many issues to be covered in explaining proposed procedures to a patient is the possible personal financial cost for the patient (what is needed is 'informed financial consent'). The Australian Medical Association issued a position statement on this topic in 2006 [4]. Other than in Queensland and Tasmania, there are no legal requirements for obtaining informed consent, although the standard of care in giving advice is a matter of statute in other states. Section 21 of the Queensland *Civil Liability Act 2003* provides that doctors must give (a) 'information that a reasonable person in the patient's position would, in the circumstances, require to enable the person to make a reasonably informed decision about whether to undergo the treatment or follow the advice' and (b) 'information that the doctor knows or ought reasonably to know the patient wants to be given before making the decision to undergo the treatment or follow the advice'. Section 21 of the Tasmanian *Civil Liability Act 2002* has almost identical provisions. The legislation in these two states thus embodies the principles laid down by the High Court in *Rogers v Whitaker* [2].

Informed consent is essentially an issue of good communication. Doctors should indicate to patients that they are willing to answer any further questions they may have and should provide time for these to be answered. As good clinical practice, and to provide evidence should complaints or claims of negligence arise, doctors are strongly advised to document in the patient's record what has been discussed, especially the risks canvassed. Where a patient refuses to consent to more extensive surgery this needs to be recorded. In the ideal situation, the doctor who is to undertake the procedure should obtain consent and document it, but this requirement may be modified in situations as may apply in large teaching hospitals, so long as the delegated doctor is equipped to provide all the relevant information. Doctors should familiarise themselves with the policies of the hospitals in which they work.

In relation to the subject of communication with patients, particularly in the problematic area of perceptions of risks and benefits of health-care interventions, the NHMRC has issued a detailed handbook entitled, *Making Decisions about Tests and Treatments: Principles for Better Communication between Healthcare Consumers and Healthcare Providers* [5].

4.4 THERAPEUTIC PRIVILEGE AND WITHHOLDING INFORMATION

Therapeutic privilege refers to the concept that a doctor may choose to withhold information regarding the risks of a proposed treatment or procedure, or information regarding diagnosis and prognosis, if, in the doctor's opinion, disclosure may harm the patient. This approach was once more widely followed and was based upon the ethical principles of beneficence and non-maleficence. It is now increasingly seen as paternalistic and not in accord with the principle of respect for patient autonomy. Patients wish, and need to be invited wherever possible, to participate in a more open, shared decision-making process and expect to be given all relevant information. The possibility that a doctor may withhold information may be a source of anxiety for, or increase the anxiety of, patients. Nevertheless the courts have indicated that therapeutic privilege is still acceptable as a reason for failing to disclose information. In *Rogers v Whitaker*, the High Court confirmed this, when referring to a doctor's duty to warn patients of material risks inherent in proposed treatments, by saying, 'This duty is subject to therapeutic privilege' [2]. Great caution should be used in claiming therapeutic privilege, as in the same High Court case, in a dissenting opinion, Gaudron J made the following remarks:

> Leaving aside cases involving a medical emergency or a situation where the circumstances of the individual require special consideration, I see no basis for treating the doctor's duty to warn of risks (whether involved in the treatment or procedures proposed or otherwise attending the patient's condition or circumstances) as different in nature or degree from any other duty to warn of real or foreseeable risks. And as at present advised, I see no basis for any exception or 'therapeutic privilege' which is not based in a medical emergency. [2]

To withhold information on this basis is likely to be strictly interpreted by the courts. Doctors need to be able to show that they believed on reasonable grounds that giving the patient the information would impose a significant risk of serious harm to the patient's physical or mental health. It is not enough that the patient might be alarmed or distressed or might not give consent to a procedure recommended by the doctor. Occasionally a doctor is faced with the opposite situation, where the patient expressly indicates that information is not desired. While doctors must respect patient autonomy in this situation, such an attitude may reflect intense denial by the patient, and alert the doctor to the need for a more sensitive and discerning approach to communication [3].

Another variant of this difficulty is where a doctor is asked by family members to withhold potentially distressing information from a patient. This needs to

be handled sensitively and with respect for the cultural background that is producing the difficulty. With time, most families can appreciate that withholding information completely is virtually impossible and that the patient's confidence in the doctor will be seriously undermined if the doctor is not free to respond to questions and impart crucial information. The distress that family members are expressing in this situation is often their own and not that of the patient. Placed theoretically in the patient's position, they can usually accept the need for open communication; acceptance is made easier if they perceive the doctor to be compassionate and tactful.

4.5 PATIENTS WHO MAY NOT BE LEGALLY ABLE TO CONSENT

Adults (18 years of age or over) are presumed to be legally competent to give consent, a presumption that can be rebutted by evidence that shows a lack of competence. Such patients must also have cognitive capacity to understand the medical condition, the options for treatment, what the doctor is recommending, any material risk and what may happen if no treatment is given. We examine first the issues surrounding consent from people who are not yet adults and thus presumed not to be competent to give consent. Whether the question of competence to consent arises in adults or children, the treating doctor is responsible for assessing in each case whether the patient is competent to understand [6]. The test for competence involves determining whether a person is capable of understanding the general nature and effect of the proposed treatment or procedure. A higher level of understanding is required for more complex or risky procedures.

The issues that need to be addressed when assessing competence or decision-making capacity include the patient's ability to communicate a choice, to understand relevant information, to appreciate his or her situation and its possible consequences, and to reason about treatment options. While there will be times where the assistance of experts such as psychogeriatricians or the application of formal cognitive testing is appropriate, all doctors are capable of making such assessments using a series of relatively simple questions (see Table 4.1), reinforced as needed by information from those who know the patient well, such as the general practitioner and close family members [7–8].

4.6 CONSENT OF CHILDREN AND TEENAGERS

People under the age of 18 in Australia are regarded in law as minors (they reach the age of majority at 18 years, when they can exercise all normal civil rights). Teenagers are not recognised in law, but in New South Wales and Tasmania there is legislation recognising a 'young person' at ages 16 and 17 (*Children and Young Persons (Care and Protection) Act 1998* (NSW); *Children, Young Persons and*

Table 4.1 Approach to assessing decision-making capacity*

Capacity: Questions for clinical assessment
Communicating a choice: Have you decided whether to follow my advice about treatment? Can you tell me what your decision is?
Understanding relevant information: Please tell me in your own words what I have told you about your health problem, recommended treatment, and benefits, risks or discomfort of the proposed treatment, any other options and the risks and benefits of no treatment.
Appreciating the situation and its consequences: Please tell me what you believe is wrong with your health now, whether you believe you need treatment, what the treatment will do for you and what you think will happen if you have no treatment.
Reasoning about treatment options: How did you decide to accept or reject the recommended treatment? What makes this choice better than another option?

* Table modified from [7–8].

Their Families Act 1997 (Tas)), while in the Australian Capital Territory a young person is defined as aged 12 to 17 years. There is no uniform age of consent for medical treatment but South Australia and New South Wales have legislation covering the rights of children to consent to treatment (see below).

Parents can generally consent to medical procedures for their children provided that the proposed procedure is in the child's 'best interests'. However, doctors should not proceed without the additional consent of the child if the child is aged 14 or older.

In common law, the starting point is that a minor does not have the competence to consent to medical treatment, unless it is demonstrated that the minor is competent via 'achieving a sufficient understanding and intelligence to enable him or her to understand fully what is proposed' [9]. Where a proposed procedure is relatively minor, older children can provide consent themselves. For more serious procedures or operations, a doctor will need to very carefully assess the competence of the young patient and generally should also seek the consent of a parent or guardian, other than in true emergencies. In New South Wales, the *Minors (Property and Contracts) Act 1970* allows minors over 14 years of age to give consent for medical and dental treatment. Despite this provision, doctors should proceed cautiously if any treatment is opposed by the parents. The same Act provides protection from liability for assault when a doctor treats a minor under 16 years of age with the consent of a parent or guardian. Where the parents are requesting that a procedure be done but a competent child aged over 14 years old is opposed to the treatment, the refusal of the minor should be respected and independent advice sought. Such conflicts between parent and child might best be resolved by a court order. In South Australia, under the *Consent to Medical*

Treatment and Palliative Care Act 1995, doctors can accept the consent of a child, provided the child is capable of understanding what is proposed, the treatment is in the child's best interests, and a second doctor has assessed the child and has concurred in writing.

A frequently faced problem is the request from a sexually active teenage girl for advice on contraception, where the teenager makes it clear that her parents are not to be informed of her attendance. Each case should be judged on its merits, but for practical purposes it is generally permissible for doctors to treat teenagers who are 16 years or over, provided they are mature and appear to understand the proposed treatment. If they meet these criteria, they are also entitled to have their medical information kept confidential from their parents. When the teenager is under 16 or where doubt exists as to the maturity of a teenager over 16 years, greater care must be taken and the doctor should endeavour to explain to the teenager the need to obtain the consent of the parent or guardian as well, unless the minor clearly objects. The doctor is not necessarily obliged to provide treatment to such a minor, other than in an emergency.

Another practical difficulty that may emerge is where parents are separated or divorced and the custody of the child is at issue. In the absence of a court order, both parents remain responsible for the care of children under 18 years and either parent is entitled to provide consent. Nevertheless, other than in an emergency, doctors should take care to accurately establish the social and legal situation with regard to which parent is able to consent on behalf of the child, especially when procedures carrying risks are proposed. The situation can be made more complex if the separated parents are not communicating well, or if one parent has custody but the other is responsible for medical expenses.

Where a child is temporarily in the care of a teacher, babysitter, relative, sports coach or the like, again care should be taken to obtain consent from a parent for medical treatment other than for first aid or in an emergency. Legal protection for certain emergency procedures on children exists in some states. Thus in Victoria, Queensland, Western Australia, Tasmania and the Australian Capital Territory, blood transfusions may be given in a life-threatening emergency without the consent of the parents. In Northern Territory, the *Emergency Medical Operations Act 1973* permits emergency surgery without the consent of parents, while in South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* places an obligation on the doctor to seek the consent of the parent or guardian. In both the Northern Territory and South Australia, there are requirements for a second medical opinion. In New South Wales, the *Children and Young Persons (Care and Protection) 1998* provides for emergency treatment without consent 'in order to save his or her life or to prevent serious damage to his or her health'.

Special rules apply for non-therapeutic procedures such as sterilisation, or treatment or surgery that may incidentally lead to permanent infertility. In New

South Wales, the *Children and Young Persons (Care and Protection) Act 1998* provides that such special medical treatment on a child is permitted in matters of urgency or where authorised by the Guardianship Tribunal.

Most states have similar specific legislation covering such issues. In addition, the *Family Law Act 1975* also provides the Family Court with the power to authorise such procedures. Order 23B of the *Family Law Rules* 'applies to applications for a declaration that a person is authorised to consent to a medical or surgical procedure for a child'. Such applications may be made by:

- a parent, guardian or custodian of the child
- any other person who has an interest in the welfare of the child
- if a parent, guardian or custodian is not the applicant, he or she must be joined as a respondent to the applicant.

Applications are made on a special form and the applicant must lodge with the application affidavits, which include relevant medical and psychological reports. These must set out the exact nature and purpose of the proposed medical or surgical procedure and the likely long-term effects of the procedure on the child. In addition the following information must also be provided:

- that alternative and less invasive procedures or treatments would be, or have proved to be, inadequate
- that the procedure proposed is necessary for the welfare of the child
- that the child is incapable of making his or her own decision about undergoing the procedure
- that the child is unlikely to develop sufficiently to be able to make an informed judgment about undergoing the procedure within the time in which the procedure should be carried out, or within the foreseeable future
- that there are any other reasons for granting the application.

4.7 CHILDREN WHO ARE INTELLECTUALLY DISABLED

For intellectually disabled people under 18 years, the power to give consent generally resides with the parents, other than for non-therapeutic procedures, particularly treatments designed to affect reproductive capacity. The law in regard to sterilisation procedures is clear. In New South Wales and South Australia, this is covered by the legislation previously referred to, via the *Children and Young Persons (Care and Protection) Act 1998* in New South Wales and the *Guardianship and Administration Act 1993* in South Australia. The Family Court (a federal court) also has powers under the *Family Law Act 1975* to authorise such procedures. These powers were reinforced in a decision of the High Court when a ruling by the Family Court in 1992 was appealed by the Northern Territory Department of Health and Community Services [10]. Thus no parents or guardians can make these decisions in relation to sterilisation procedures.

4.8 SUBSTITUTE DECISION MAKERS

In clinical practice, particularly in hospitals and other institutions that care for the elderly, doctors are frequently faced with patients who are temporarily or permanently lacking the capacity to give their consent for treatment and procedures. Medical decisions in these situations are sometimes made after consulting relatives and/or carers. There is no authority in common law to authorise this practice but most jurisdictions have put in place, or are in the process of putting in place, guardianship legislation to guide doctors and to authorise substitute decision makers, without the need to appoint official guardians [11].

When managing a patient assessed as incompetent to give consent, the doctor should first seek to establish whether the patient has signed an advance care directive (see Chapter 22) or if there is already a guardian appointed who is authorised to make medical decisions on behalf of the patient. If neither is the case then, other than for minor treatments (see below), the guardianship legislation must be followed. The relevant titles of this legislation, the websites and the contact telephone numbers for the Guardianship Board, Public Guardian or Public Advocate are given in Table 4.2 (p. 62).

The legislative framework and its details vary considerably between the jurisdictions. In New South Wales, Tasmania and Victoria, the legislation identifies a hierarchy of 'persons responsible'. The most detailed hierarchy, in priority order, is provided in the Victoria legislation as follows [12]:

1. an agent – appointed by the patient under enduring power of attorney (medical treatment)
2. a person – appointed by VCAT to make decisions about the proposed treatment
3. a guardian – appointed by VCAT with health-care powers
4. an enduring guardian – appointed by the patient with health care powers
5. a person – appointed by the patient in writing to make decisions about medical and dental treatment including the proposed treatment
6. the patient's spouse or domestic partner
7. the patient's primary carer, including carers in receipt of a Centrelink Carer's payment but excluding paid carers or service providers
8. the patient's nearest relative over the age of 18 years, which means (in order of preference):
   (a) son or daughter
   (b) father or mother
   (c) brother or sister (including adopted people and 'step' relationships)
   (d) grandfather or grandmother
   (e) grandson or granddaughter
   (f) uncle or aunt
   (g) nephew or niece.

Table 4.2 Guardianship legislation and guardianship boards/tribunals

State	Act	Telephone
New South Wales	*Guardianship Act 1987*	Guardianship Tribunal Tel: (02) 9555 8500 Toll free: 1 800 463928 http://www.gt.nsw.gov.au
Victoria	*Guardianship and Administration Act 1986*	Office of the Public Advocate Tel: (03) 9603 9500 Toll free: 1 300 309 337 http://www.publicadvocate.vic.gov.au
Queensland	*Guardianship and Administration Act 2000*	Guardianship and Administration Tribunal Tel: (07) 3234 0666 Toll free: 1300 780 666 http://www.justice.qld.gov.au/473.htm
South Australia	*Guardianship and Administration Act 1993*	Guardianship Board and Public Advocate Tel: (08) 8269 7515 Toll free: 1 800 800501 http://www.opa.sa.gov.au
Western Australia	*Guardianship and Administration Act 1990*	Guardianship and Administration Board Tel: (09) 9219 3111 Toll free:1 300 306 017 http://www.publicadvocate.wa.gov.au/
Tasmania	*Guardianship and Administration Act 1995*	Guardianship and Administration Board Tel: (03) 6233 3085 http://www.guardianship.tas.gov.au
Northern Territory	*Adult Guardianship Act 1988*	Office of Adult Guardianship Tel: (08) 8922 7343 http://www.health.nt.gov.au/Aged_and_Disability/Adult_Guardianship/index.aspx
Australian Capital Territory	*Guardianship and Management of Property Act 1991*	Guardianship and Management of Property Tribunal Tel: (06) 257 4281 and Public Advocate Tel: (06) 207 0707 http://www.publicadvocate.act.gov.au/

Where there are two relatives in the same position (for example, a brother and sister) the elder will be the person responsible.

When a relative or carer accepts the role of person responsible, there are obligations and restrictions. Decisions must be made in the best interests of the patient and efforts must be made to determine the wishes of the patient and the patient's

family. There are restrictions in the Victorian legislation as to the decisions a person responsible may take. For example, if the patient is likely to be able to consent within a reasonable period of time, the person responsible can consent to treatment only where the failure to treat would result in a significant deterioration in the patient's condition. In addition, a person responsible cannot consent to 'special procedures' – procedures likely to lead to infertility, termination of pregnancy and removal of tissue for transplant. In these situations in Victoria, the person responsible must apply to the Victorian Civil and Administrative Tribunal, which has the power to authorise such treatments. Similar provisions apply in other jurisdictions (see the section on special procedures below).

In South Australia, in the absence of an appointed guardian, the nearest relative is deemed under section 59 of the *Guardianship and Administration Act 1993* to have 'appropriate authority' to make decisions on behalf of an incompetent adult. In South Australia, a 'relative' is defined to include a spouse or domestic partner, a parent, a person who acts *in loco parentis* (a carer), a brother or sister 18 years or older, and a son or daughter 18 years or older. In Queensland, via sections 62 and 63 of the *Powers of Attorney Act 1998*, a similar list of relatives and carers (in order, commencing with spouse) are authorised to act as 'statutory health attorneys'. In Western Australia, the *Guardianship and Administration Act 1990* has been amended by the *Acts Amendment (Consent to Medical Treatment) Act 2008,* bringing provisions similar to those of Victoria, but the amendment had not been promulgated at time of writing, while in the Australian Capital Territory a discussion paper on the topic has been issued, and in Northern Territory there is no legislation. In these three jurisdictions, 'consent could be given informally by relatives and carers or by a guardianship body or court' [11].

4.9 CONSENT FOR SPECIAL PROCEDURES

In most jurisdictions, there are provisions in the legislation for people not competent to give consent where consent is required for sterilisation, termination of pregnancy, and other procedures termed 'special' or 'prescribed'. Such procedures cannot be authorised by substitute decision makers other than a court or tribunal. The focus is generally on procedures that lead to infertility, but may include other medical or surgical treatments and clinical research. The most extensive list of special procedures is contained in the New South Wales legislation and includes treatments intended or likely to render a person permanently infertile, new treatments not yet supported by a 'substantial number' of doctors, treatments declared under the regulations to be special, the long-term use of drugs of addiction for non-cancerous conditions, treatments involving aversive stimuli, the administration of drugs affecting the central nervous system in doses or combination outside accepted modes of treatment, and the use of androgens for behavioural control. Such procedures can be authorised only by the New South Wales Guardianship

Tribunal. As each jurisdiction has slightly different definitions and requirements, and as in some jurisdictions the regulations may change, the reader is advised to check local legislative requirements for specific information (see Table 4.2).

4.10 TREATMENT WITHOUT CONSENT

4.10.1 Emergencies when the patient is unable to consent

Genuine emergencies are the principal exception to the general rule that a doctor who goes outside the scope of authority expressly or implicitly conferred by a patient risks liability in trespass. The exception presumes that the patient is temporarily incapable of giving consent, that immediate treatment is required to save the patient's life or prevent serious damage to their health and that there is no substitute decision maker immediately available. This exception does not absolve the doctor from adhering to appropriate standards of care in the circumstances of the emergency. As soon as the patient's condition is sufficiently improved or stabilised, consent for ongoing treatment must be obtained.

In all states and territories with the exception of the Australian Capital Territory, there is legislation that covers the subject of emergency treatment without consent. For New South Wales, Victoria, Queensland, Western Australia and Tasmania, this is the relevant guardianship legislation. In South Australia, emergency treatment is covered by the *Consent to Medical Treatment and Palliative Care Act 1995*; the legislation calls for a second doctor to personally examine the patient and provide written support for the treatment plan, unless such a second opinion is not practicable. In Northern Territory, section 3 of the *Emergency Medical Operations Act 1992* permits emergency treatment for children and adults.

4.10.2 Non-urgent but necessary treatment in incompetent patients

In this area, there are considerable differences between jurisdictions. In New South Wales, the legislation distinguishes between major and minor treatment. Minor treatment is any treatment that is neither major nor special. In New South Wales, section 33(1)(d)–(f) of the guardianship legislation identifies as examples of minor treatment non-intrusive physical examinations, first aid, the administration of usual medication, and treatment that is not major or special or part of a clinical trial. The New South Wales Guardianship Tribunal advises that minor treatment also includes general anaesthesia for the management of fractures or for endoscopy and the single use of certain prescription drugs [13]. In New South Wales, where such minor treatment is deemed necessary and neither a guardian nor a person responsible can be located, the doctor may proceed but is obliged to note in the

record that treatment will promote the patient's health and wellbeing and that the patient is not objecting. Where major treatment is proposed and a person responsible cannot be identified, the New South Wales Guardianship Tribunal must be approached.

In Victoria, the legislation does not differentiate between major and minor treatment but permits a doctor to carry out non-urgent treatment (other than special procedures – see above) without consent if there has been failure to locate a person responsible, and where the proposed treatment is in the best interests of the person, the doctor gives notice in writing to the Public Advocate ahead of the treatment, and the Office of the Public Advocate confirms by phone that the legislation is being complied with. In Queensland, similar provisions apply but only to treatment that is 'minor and uncontroversial', while in Tasmania section 41 of the Act states that, where a person responsible is not available, the doctor may proceed if the treatment is deemed necessary, is to be provided in the form that 'will most successfully' promote the person's health and wellbeing, the person does not object and the doctor documents all the above in the person's medical record.

4.10.3 Minor procedures in incompetent patients

In some jurisdictions, public guardians have advised that minor procedures may be undertaken without consent (and presumably without going through the process of seeking and not finding a person responsible). However, 'minor procedures' are indeed minor. Thus, in Victoria, the Public Advocate has provided as examples of minor treatment 'a visual examination of the patient's mouth, providing first aid, or the administration of a prescribed drug within recommended dosages' [14]. The Guardianship and Administration Board in Tasmania gives the same examples [15].

Other than in an emergency, when considering undertaking treatment without consent, it is clear that doctors must make judgments about exactly what is covered by the legislation in their jurisdiction in this regard. If in any doubt, and especially where relatives or carers are expressing any concern or where an apparently simple procedure could have serious implications or complications, doctors should seek the advice of the state guardianship office or equivalent (see Table 4.2).

4.11 CONSENT AND THE MENTALLY ILL

The foregoing sections on consent to treatment for the incompetent person do not apply to the mentally ill in most jurisdictions. The laws relating to the care of the mentally ill and to consent for specific treatments are discussed in Chapter 23. When obtaining consent, the diagnosis of a mental illness does not necessarily preclude the capacity to consent and the doctor's first action should be to assess

the patient's capacity to give consent. Only if this capacity is lacking is it necessary to refer to the relevant state legislation.

Under the relevant Mental Health Act (or similar title), provisions are made to ensure that consent for most treatments, other than electroconvulsive therapy or psychosurgery, can be obtained from an authorised person. In New South Wales, Victoria, South Australia and the Australian Capital Territory, specific and stricter provisions apply when electroconvulsive therapy or psychosurgery is being contemplated. The *Mental Health Act 1996* in Western Australia leaves decisions in the hands of the treating psychiatrist, while the *Mental Health Act 2000* in Queensland has different requirements according to whether the patient has been admitted voluntarily or involuntarily or whether the treatment is required urgently.

4.12 REFUSAL OF TREATMENT

This topic is covered more fully in Chapter 22 where preservation or prolongation of life is discussed. A competent patient at all times may refuse treatment or withdraw previously given consent to treatment, even where that treatment is regarded by the doctor as life-saving. Difficulties arise where an illness renders a previously competent person incompetent and decisions need to be made as to whether treatment should be continued. Some doctors have expressed concern as to their legal position if they withdraw treatment in this situation. In Victoria, this problem has been addressed by the *Medical Treatment Act 1988*, which allows patients to complete a refusal of treatment certificate in advance of their becoming incompetent. It also allows patients to appoint someone to make decisions on their behalf should they become incompetent. Similar powers for patients to give advance directives regarding life-prolonging measures exist under legislation in South Australia in the *Consent to Medical Treatment and Palliative Care Act 1995*, in Northern Territory in the *Natural Death Act 1988*, in Queensland in the *Powers of Attorney Act 1998* and in the Australian Capital Territory in the *Medical Treatment (Health Directions) Act 2006*. In 2004, the New South Wales Health Department issued guidelines on advanced care directives [16] and in 2005 issued updated guidelines on end-of-life care and decision making [17].

4.13 REFUSAL OF BLOOD TRANSFUSION

Because of the beliefs of some religious groups, doctors not infrequently encounter patients and their families who refuse blood transfusion. As a starting point, the first consideration should be whether there are safe alternatives to blood transfusion. However, the refusal of transfusion by a competent adult must be respected. Where parents refuse life-saving blood transfusion for a child, all jurisdictions have legislation that enables doctors to provide blood transfusion in an emergency [18].

This legislation does not cover non-emergency treatment and, for those situations involving children, advice should be sought from the Guardianship Board.

4.14 INFORMED CONSENT AND THE PERFORMANCE RECORD OF THE DOCTOR

Traditionally consent follows when patient and doctor have adequately communicated about the options, risks, benefits and costs of a proposed treatment or procedure. However, barriers beyond those of poor communication do exist and can prevent valid informed consent. From the patient's perspective, it is argued by some that information regarding a doctor's past record in relation to such things as complication rates, malpractice claims or health status should be available and that a doctor's HIV status should be known [19]. These arguments have generally not been supported in Australia, where information regarding doctors is limited to that available in the medical register of any state or territory, known personally by the referring general practitioner or acquired by the patient in direct contact with the doctor concerned. However, the above does not absolve the treating doctor of the ethical responsibility to consider his or her capacity to safely carry out any proposed treatment. The obligations on doctors who carry HIV infection are discussed in Chapter 11.

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5 CONFIDENTIALITY, PRIVACY AND DISCLOSURE

Fundamental to a proper doctor–patient relationship is the assurance that information provided by the patient to the treating doctor will remain strictly confidential. Doctors must be free to ask their patients any questions necessary for diagnosis and treatment, and patients must be willing to trust doctors by giving full answers. Maintaining such trust has a wider social benefit of ensuring that medical practice serves to promote and maintain the health of the community. The basis of this trust lies in one of the oldest ethical principles of medical practice stated in the Hippocratic Oath as:

> whatsoever I shall see or hear in the course of my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. [1]

This same obligation has since been repeated in the World Medical Association *Declaration of Geneva* as 'I will respect the secrets confided in me, even after the patient has died' [2].

This ethical requirement for confidentiality, well understood by doctors, has been overlaid in Australia in recent years by the progressive introduction of privacy legislation at the federal level and in some states, which for doctors covers very much the same territory as this ethical requirement.* As a result, doctors now need to understand the ethical and legal bases of their professional obligations in this regard. In this chapter, both bases are described and explained. However, it is the authors' view that doctors who conscientiously adhere to the ethical principles involved in maintaining patient confidentiality, and who communicate effectively with their patients, are very unlikely to be in breach of the complex mix of privacy law. This complex mix includes not only different legislation at federal and state levels, but also between the public and private sectors. In some states, the privacy law is contained within

* The Australian Law Reform Commission has conducted a detailed review of Australia's privacy laws, including health privacy, and in August 2008 issued its final report entitled *For Your Information: Australian Privacy Law and Practice*, available at http://www.alrc.gov.au

legislation that covers medical record keeping. Thus this chapter needs to be read with Chapter 6 in mind.

5.1 CONFIDENTIALITY DISTINGUISHED FROM PRIVACY

While at times the words 'privacy' and 'confidentiality' are used interchangeably, they are not the same thing, especially when considering privacy in its legal context. One big difference is that privacy law covers not only the issue of disclosure but also issues of patients' access to their records, security of those records and maintenance of accurate and up-to-date records. The extension of federal privacy law to private medical practice in 2001 initially caused some concern because of its effect on everyday medical practice, for example the taking of a family history. This example serves to demonstrate important differences between confidentiality and privacy.

Taking a family medical history has long been routine in medical practice and the information collected has been protected by professional duties of confidentiality. Privacy law gave to family members a right to be informed when information personal to them was collected by a doctor from another family member or to consent to that collection if it was health information. A determination of the Federal Privacy Commissioner authorised such history taking [3] by releasing the doctor from the necessity of notifying family members about or seeking their consent to the collection of their health information.

More general concerns have been allayed with experience and the passage of time. Now it could be said that adjusting to the new laws has served the medical profession and the community well, as doctors have become more alert to having appropriate policies and processes in place to protect patient privacy and maintain patient confidentiality.

5.2 THE ETHICAL BASIS OF CONFIDENTIALITY

The professional obligation of confidentiality has been seen to be a cornerstone of ethical medical practice for over 2000 years. It is covered in the Australian Medical Association's code of ethics 2006 as follows:

> Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests. [4]

In addition, the centrality of confidentiality is emphasised in guides to good medical practice adopted by state and territory medical boards. For example, the Medical Practitioners Board of Victoria guide, under the heading 'Maintaining trust with and providing information to patients', states:

> Treat information about patients as confidential. The law recognises a number of important exceptions to confidentiality, including circumstances in which the law, the public interest or the patient's best interests authorise the disclosure of patient information (for example, in some cases to a patient's carer). You should seek appropriate advice in these circumstances. [5]

Allegations of unjustified breaches of confidentiality are handled as possible professional misconduct by medical boards.

5.3 CONFIDENTIALITY IN THE DOCTOR'S SURGERY

The general rule is that doctors may not, without the consent of their patients, disclose to any third party information acquired in the course of their professional relationship. This rule of confidentiality extends also to disclosure to family members. Strictly interpreted, a doctor may not disclose a husband's condition to his wife without his consent or vice versa, and children of sufficient maturity are also entitled to this confidentiality [6]. (The matter of judging the competence and maturity of older children is discussed in Chapter 4.) The presence of husband and wife together at a consultation usually implies that they both agree to share information. However, a wise doctor would not take this for granted, especially when the consultation has revealed an unexpected finding, or where the doctor is aware of other special circumstances. Releasing information to relatives, although often a necessary and quite normal function, should not be done without reasonable confidence that the patient expects and approves of this. If in doubt, information should not be released without the consent of the patient.

The duty of confidentiality is owed to the patient, who can release the doctor from that duty. Accordingly, doctors should not obstruct the release of medical information when requested to do so by the patient. At times, it may be desirable that the doctor explain to the patient the medical or other significance of releasing the information. The duty of confidentiality thus forms part of those ethical duties of doctors that include acting and deciding in a patient's best interests. These duties together go beyond the right of privacy. They include the duty to a patient to ensure that the information provided will be used only for the purpose for which it was given; that it will not be subject to unauthorised access or disclosure; and that records of it will be kept correct, current and not altered improperly.

The duty of confidentiality of medical information and medical records persists after a patient dies, with the right of granting release from that duty passing to the legal representative of the deceased, usually the executor appointed in the deceased's will or the administrator of the estate of the deceased.

When employing receptionists, secretaries and other staff who have access to patient records, doctors must take particular care to instruct such staff in the essentials of patient confidentiality and the possible harms from breaches of

such confidentiality. Staff must be made aware that all such information, whether gathered by casual conversation, telephone or perusal of patient records, is confidential. Doctors must give appropriate instructions to all their staff regarding the release of information over the telephone and regarding access to files and computer-held data. Staff also need to be advised to take care in regard to where records are placed, how computer screens are to be protected and about conversations in the reception and waiting areas, whether in person or by telephone, which may be overheard by others.

The day-to-day work of caring for patients would come to a standstill if absolute confidentiality were adhered to. Common sense needs to be used when other doctors (or their staff) request information, as frequently happens when specialist opinions are sought or a patient is referred to a hospital. Requests for information about a patient whose care is shared, from a doctor personally known to you, especially where the information requested has no apparent sensitivity, should be responded to promptly and cooperatively. However, if there is any reason to doubt the identity or bona fides of the caller and the situation is not an emergency, the doctor is wise to request a telephone number to which a return call can be made, or to request written consent for the release of the information.

5.4 CONFIDENTIALITY AND MEDICAL REPORTS AND CERTIFICATES

Very frequently employers ask for reports from treating doctors on the medical condition of absent or sick employees, insurance companies may seek particulars of the medical history of present or prospective policy holders, and solicitors may request information for use in threatened or actual legal proceedings. In all these cases the general rule holds good, and a doctor should never give information without the written consent of the patient concerned, or of the executor or authorised next of kin in the case of deceased people. Issues occasionally arise as to whether a written consent provided to a doctor with a request for release of medical information is valid. Doctors should be cautious of accepting photocopies of a signed general release. Ideally, the consent to release information should be an original letter addressed to a named doctor, giving a clear indication of the material to be released and carrying a recent signature of the patient. Doctors need also to consider whether the consent given is sufficiently informed, particularly when dealing with patients whose language skills or intellect may limit their understanding of how the information to be released may be used.

Providing medical certificates about patients who are employees for employers can create threats to patient confidentiality. Employers can be cynical in regard to some employees and some doctors, and may be reluctant to accept that patients are entitled to confidentiality in regard to their personal affairs. The legitimate practice

of full disclosure of the details of illness and injury covered by workers compensation payments to employers has perhaps contributed to the misapprehension that all certificates must be similarly detailed. Medical boards are frequently invited by employers to consider the reliability of medical certificates, and in many instances the certificates are found to be proper (the doctor has behaved professionally by declining to reveal confidential medical information). As it remains in the patient's power to determine how much of his or her information is disclosed, most doctors take the trouble to assist patients in this regard by asking the patient if a specific diagnosis should be written on a medical certificate and advising patients when this diagnosis might have personal, social or employment implications. If a patient requests that the diagnosis not be included, the term 'on medical grounds' or a similar phrase should be used.

Employers and doctors are sometimes in conflict with each other, even when they are both genuinely attempting to guide injured workers back to work. Some doctors create difficulties for themselves by rigidly adhering to the principle of patient confidentiality, even to the extent of refusing to accept telephone calls from employers. When a patient who has a work-related illness or injury is seeking compensation or salary maintenance, or is being encouraged to enter a work-based rehabilitation program, it is usually possible by simple explanation to the patient and, by the sensible release of sufficient information, to assist both the patient and the employer. There are exceptions to this and these include where a patient exhibits psychological distress or is accused of malingering. The doctor should avoid the temptation to take over the role of the workers compensation tribunal or similar agency to adjudicate such difficult impasses and should take great care that medical reports are objective and that the patient's confidentiality is respected. At times, this may result in unfair criticism by employers who do not appreciate the doctor's ethical position or the rights of patients.

A simple means of seeking to assure the confidentiality of material released by way of certificate, report or letter is to hand the document concerned directly to the patient, who is then free to pass the information on to whomsoever he or she chooses. This action is not free of ethical problems, as the information contained therein may be expressed in terms not understood by the patient and the patient may be naively unaware of the consequences of releasing the information. The doctor should be aware of these problems and explain them to the patient if necessary.

5.5 SHARING INFORMATION IN THE HEALTH-CARE TEAM

In many health-care situations, consent for sharing confidential information between members of the 'health-care team' is implied and it is presumed that patients know and accept that this will happen. This implied consent is also the basis of the ready and often rapid sharing of information between and among

doctors involved in the care of a patient. This presumption may not be safe where the 'health-care team' is extended to include multidisciplinary clinics attended by clinicians who may never meet the patient; in this situation hospitals should have policies in place such that patients are made aware of how their information will be used. Even where it can be safely presumed that the patient is aware, doctors should exercise caution in recording highly personal information in a patient record and, in some situations, should expressly seek the patient's permission. Once again, discretion may need to be exercised regarding highly personal information, especially where it is not essential that the other doctors involved in the care of the patient need to know that information.

5.6 EXCEPTIONS TO THE DUTY OF CONFIDENTIALITY

There are well-recognised exceptions to the doctor's ethical duty to protect patients' entitlement to complete confidentiality. The first exception is when a patient gives consent to disclosure. In this situation, doctors must take care that the patient is capable of giving consent and understands what is being disclosed and to whom and what consequences may follow. Other exceptions are matters of law or matters of the greater community good, whereas some involve consideration of the best interests of the patient. In ethical terms, all of these situations involve an interest of ethical significance that competes with that of the patient's interest in the confidentiality of his or her information. Accordingly, these exceptions can involve the treating doctor in difficult judgments, even those called for by law, such that seeking independent advice from agencies such as a medical indemnity organisation, a professional association or other source should be considered. A similar range of exceptions are provided for in privacy legislation (see below).

5.6.1 Exceptions established by law

These include the notification of infectious diseases, births and deaths, and deaths reportable to the coroner. In some states, doctors are obliged to notify the relevant registration authority if a health-care professional who is a patient is ill and the community is believed to be at risk; this exception is backed by immunity from civil action (see also the sections on disclosure below).

5.6.2 Exceptions in the community interest

These include for example where a psychiatrist believes a patient is a serious threat to others or where a doctor believes an HIV-infected person is irresponsibly placing other people at risk.

5.6.3 Exceptions in the patient's best interests

One example is where a patient is seriously mentally ill and a danger to him- or herself and a crisis assessment team or the police need to be notified (see also Chapter 23).

5.7 THE LEGAL BASIS OF CONFIDENTIALITY

Common law (see Chapter 24) has substantially recognised the ethical origins of confidentiality in the health-care context. The principles about confidentiality that apply to a wide range of situations beyond doctor–patient relationships are found in three areas of common law:

1. *Contract*. There is usually an implied contract in the doctor–patient relationship. This contract is based on the promise that patients impliedly make to pay a fee for professional services. Services provided in public hospitals would present an obvious problem in identifying a contractual relationship with an individual doctor [7]. It can be argued that a term of this implied contract is that the doctor promises to protect the confidentiality of the patient's information.
2. *Tort*. A doctor's duty of care that arises from the doctor–patient relationship includes a duty not to give to any third party any information about a patient that may result in any loss or damage to the patient [6].
3. *Equity*. The principles of equity originated in upholding duties of conscience and recognised the duty of confidentiality inherent in the doctor–patient relationship. These principles can support remedies of restraining a threatened breach of the duty as well as limited compensation (see also Chapter 24).

Even if a doctor fails to protect a patient's confidentiality, the patient may not find redress in the court. If the patient sued in contract or in tort, the patient would need to prove that the breach of confidentiality caused some physical or financial harm to the patient. Embarrassment or wounded feelings would not generally be compensable. Equity may provide a remedy to restrain disclosure that would breach confidentiality, but the circumstances in which equity may found a claim for compensation are very limited.

5.8 STATUTORY AUTHORISATION OF DISCLOSURE

Statutes law define the circumstances in which information gained in the treatment of a patient must be disclosed. These include the reporting of 'notifiable diseases'; the notification of sexually transmitted diseases, including acquired immune deficiency disease; the stating of the underlying causes of death and associated conditions in death certificates; the notifying of births and deaths; varying provisions

related to the consumption of alcohol and road traffic offences; the fitness to be granted a driver's licence; varying requirements concerning disclosure related to cancer, to alcoholic and drug-dependent people, to child abuse and suspected child abuse; the reporting of various categories of death to a coroner; and furnishing the coroner with any medical information concerning such reportable deaths. These matters are covered more fully in Chapters 19, 20 and 26.

In all states there is a statutory duty for doctors to notify the relevant authority of patients infected with HIV (see Chapter 26). In Victoria and the Australian Capital Territory, the doctor must not disclose the full name of the patient, but must provide sufficient information such that the doctor can again identify the patient if the relevant authority requests further epidemiological data. In New South Wales, doctors are prohibited from disclosing the name and address of patients other than via submitting a request for a test for HIV status. Any other disclosure must be by court order or with the consent of the patient. In Tasmania, the *HIV/AIDS Preventive Measures Act 1993* provides doctors with the authority to notify sexual contacts of an infected patient if the patient is continuing to place contacts at risk. The Tasmanian Act also provides statutory protection when an HIV-infected patient requests a doctor to disclose the patient's HIV status to the patient's partner.

5.9 DISCLOSURE IN COURT

At common law there is no privilege that entitles doctors to refuse to answer questions on the grounds of keeping a professional confidence. Courts may compel a doctor to divulge such information in answer to questions, and doctors cannot claim privilege any more than the ordinary citizen. Where information is sought by subpoena, especially the production of documents (such as medical records), the scope of subpoenas must be confined to information relevant to the issues in the court proceedings. Responses to subpoenas are to the court and not to the parties in the proceedings. Submissions can be made to the court that only medical information relevant to the issues be disclosed, thereby protecting other material in a patient's record from disclosure.

A doctor may be summoned to give evidence in civil or criminal cases and may be guilty of contempt of court if he or she does not attend. If, while giving evidence, doctors are asked questions that they consider embarrassing to their patient or regard as confidential they may seek the protection of the judge and ask whether it is necessary to answer such questions. Judges, by virtue of their overriding discretion to control their court, can, if they think fit, tell doctors that they need not answer the question. Whether or not a judge would take that line depends largely on the importance of the potential answer to the issues being tried.

In Tasmania, statute establishes an exception in certain kinds of cases in civil courts to this duty of disclosure. Section 127A of the *Evidence Act 2001* prescribes:

> (1) A medical practitioner, without the consent of his or her patient, must not divulge in any civil proceeding any communication made to him or her in a professional capacity by the patient that was necessary to prescribe or act for the patient unless the sanity of the patient is the matter in dispute.
> (2) A person who has possession, custody or control of any communication referred to in subsection (1) or of any record of such a communication made to a medical practitioner by a patient, without the consent of the patient, must not divulge that communication or record in any civil proceeding unless the sanity of the patient is the matter in dispute.
> (3) This section does not:
> (a) protect any communication made for any criminal purpose; or
> (b) prejudice the right to give in evidence any statement or representation made at any time to or by a medical practitioner in or about the effecting by any person of an insurance on the life of that person or any other person.

Doctor–patient communications are not similarly privileged elsewhere. The privilege does not, however, extend to civil proceedings in which the sanity of the patient is an issue or from disclosing facts that would be observable by others, such as the day a patient was admitted to hospital. The provisions operate only with respect to information necessarily acquired in the doctor–patient relationship, and which would not have been available to the doctor in any other capacity.

The following guidelines may assist doctors from whom information may be sought about a patient either before the commencement of court proceedings or during a court action:

- There is no general privilege to withhold information on the ground that it is confidential. Where statute creates this privilege, it belongs to the patient and not to the doctor.
- Where information is sought by parties to proceedings, it may be released, provided the patient has given valid consent.
- Where information is sought by a court order or subpoena, it should be provided, subject to the right to request that only relevant information be disclosed.
- Information should not be given to lawyers before a court hearing, without the patient's consent.
- In civil courts, if in doubt about disclosing confidential information when answering questions, the doctor should ask for, and then follow, the direction of the judge or magistrate.
- Questions can be safely answered in a criminal court, but again, if in doubt, the doctor should seek and follow the advice given by the judge.

- Confidentiality applies even when the patient has died.
- Doctors who fail to attend court when properly served with a subpoena, or who, when called as a witness in court, decline to answer questions on the grounds of protecting confidentiality, may be charged with contempt of court.

5.10 PUBLIC INTEREST AND DISCLOSURE

In addition to statutory disclosure and disclosure in court, there are situations where the law accepts that public interest justifies the disclosure. The scope of public interest exception to the duty of confidentiality is uncertain. However, a substantial risk of serious avoidable harm to another party appears to be one such situation, although such disclosure should be preceded by the doctor making every effort to persuade the patient to agree to disclosure. If patients do not agree, doctors are then in the difficult position of having to decide whether their duty to the community outweighs that to their patient. Advice from experienced colleagues may assist in such decisions. There are provisions in various state and territory Acts that will indemnify doctors against patients taking civil action for certain disclosures. As an example, there are provisions in the state legislation for doctors to advise the police of any patient whom they believe, on health grounds, should not be driving a motor vehicle. The legislation indemnifies the doctor against the patient taking civil action for such disclosure (see Chapter 26).

5.11 DISCLOSURE TO THE POLICE

Where summary offences (less serious offences normally dealt with in the Magistrates' Court) are concerned, the attending doctor is generally under no duty to disclose information to the police. A somewhat different problem may arise when a doctor becomes aware from a patient that a serious criminal offence has been committed. Patients may disclose that their condition has arisen as a result of the crime, or police may seek information from a doctor concerning a patient whose condition they believe may have resulted from a criminal attack. If the consent of the patient to disclose such information is not obtainable, doctors must use their own judgment as to what course to take. The common law as well as the ethical principle of confidentiality supports the notion that doctors should not provide medical information to police when approached informally, unless it is clear that one of the legal exceptions apply. The most likely applicable exception is that there is a serious or imminent threat to the life, health, safety or welfare of an individual. Even if this seems likely to be the case, doctors would be wise to politely delay helping the police and seek advice before revealing confidential medical information.

5.12 THE LEGAL BASIS OF PRIVACY

The concept of privacy is difficult to define because it can include the domains of information privacy, bodily privacy, privacy of communications and territorial privacy. In Australian statutory privacy law, the meaning is confined to information privacy. The central legislative change was the federal government's 2001 amendment of the *Privacy Act 1988* to extend it from Commonwealth agencies to private sector organisations throughout Australia and to the collection, use and disclosure of health information in private medical practice. This came into force in December 2001 and in the following years some states have enacted complementary legislation that, with minor differences, mirrors the federal law. The legislation is said to bring new obligations to protect patient privacy, to give patients some control over how their information is handled and access to the information held. It also means that doctors are expected to be more open about providing the information [8]. Of these changes, the one of most significance is the provision to patients of a right of access to their medical records (see also Chapter 6).

The structure of Australian federal and state privacy legislation is broadly similar. It defines the information to which it applies and the organisations on which obligations about that information are imposed, and uses principles to describe those obligations. The legislation applies to 'personal information', which is defined in the *Privacy Act 1988* as:

> information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.*

Within this category of personal information is sensitive information, of which one kind is health information, which includes information about a patient obtained by a doctor during the course of providing a health service or an opinion formed by a doctor about a patient. It also includes the patient's name, address and contact details, medical history, Medicare number, social circumstances, the health service requested or provided and wishes expressed about future provision of health services.

The legislation applies to agencies and organisations. Agencies are Commonwealth authorities and organisations are private sector entities. The Commonwealth Act does not apply to 'authorities', which are state or territory government entities. Doctors are included in organisations because of their involvement with health information.

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* The ALRC report on the review of privacy has recommended a change in this definition.

5.12.1 The national privacy principles

In its application to the private sector, the federal privacy legislation contains ten national privacy principles (NPPs), which set out obligations concerning the collection, use and disclosure of health information. Using these principles as headings is a convenient means of explaining how the law applies to medical practice. The Act requires that doctors, being people who hold health information about individuals, comply with the NPPs. What follows is an abbreviated version of the NPPs and a brief statement of how each principle affects medical practice. A very useful summary, by way of a table which compares the provisions of federal, state and territory privacy laws, has been published [9]. In addition the websites of the federal, state and territory privacy commissioners are given in Table 5.1.

NPP1: the collection of information; and NPP10: the collection of sensitive information

NPP1 establishes the basic requirements for collection of any personal information and NPP 10 adds specific requirements for collection of sensitive, including health, information. The basic requirements are that:

- organisations must collect only personal information that is necessary for their functions and only by lawful and fair means
- if reasonable and practicable, organisations should collect personal information from the individual to whom it relates
- at or before collection, organisations must take steps to ensure individuals are aware of who the organisation is, why the information has been collected and to whom the organisation usually discloses it, any laws that require the collection, that there is access to the information and any consequences of not collecting the information.

NPP10 provides that sensitive information can be collected only with consent or where required by law or, if certain conditions are met, following guidelines and ethics committee approval. In a usual patient consultation, consent to take a patient's history can be implied so long as it is clear to the patient what information is being recorded and why. In certain situations, for example in regard to sexual health, sexually transmitted diseases, suspected domestic violence or other sensitive matters, more attention should be paid to explaining why certain questions need to be asked and to obtaining consent to record information. In health-care team situations, it may be necessary to inform patients about how other members of the team will have access to information; this will give the patient the opportunity to request that certain information not be recorded. As a Federal Privacy Commissioner once stated, 'Good privacy involves no surprises' [10].

Table 5.1 Health privacy legislation and websites

Government	Legislation and responsible body	Website
Commonwealth	Federal Privacy Commissioner – *Privacy Act 1988*	http://www.privacy.gov.au
New South Wales	Privacy Commissioner – *Health Records and Information Privacy Act 2002*	http://www.lawlink.nsw.gov.au/privacynsw
Victoria	Health Services Commissioner – *Health Records Act 2001*	http://www.health.vic.gov.au/hsc/
Australian Capital Territory	Human Rights Commission – *Health Records (Privacy and Access) Act 1997*	http://www.legislation.act.gov.sa au/a/1997–125/default.asp
Queensland	Health Quality and Complaints Commissioner – *Information Privacy for the Queensland Department of Health 2001*	http://www.privacy.qld.gov.au/
Western Australia	Legislation (Information Privacy Bill 2007) is before parliament	
South Australia	Privacy Committee – *Code of Fair Information Practice*	http://www.archives.sa.gov.au/privacy/committee.html
Tasmania	Ombudsman – *Personal Information and Protection Act 2004*	http://www.ombudsman.tas.gov.au/
Northern Territory	Information Commissioner – *Information Act 2002*	http://www.privacy.nt.gov.au/

Note: The Federal Privacy Commission website provides a helpful summary of the legislation and oversight of privacy in the states and territories at http://www.privacy.gov.au/privacy_rights/laws/index.html#4.

NPP2: the use and disclosure of information once it has been collected

Health information can be used or disclosed for the primary purpose for which it was collected. In routine medical practice, that primary purpose is for the assessment, diagnosis and treatment of the patient. From the perspective of a treating doctor, this purpose would include not only the care delivered by the doctor but also usual medical practice elements such as referral to specialists or referral for investigation. Making sure that patients know the purpose of collection and routine disclosure practices, for example, to specialists, is an obligation that arises under NPP1 when collecting health information. However, consulting or

showing X-rays to colleagues for advice, accessing previous test results by computer where the tests were requested by a different doctor or giving all members, including locums, of a group practice access to patients' health information may not appear, to patients, as clearly within that primary purpose [11]. Problems may also arise when a patient's name is placed on a recall register (other than registers authorised by law) without informing the patient and obtaining consent. Leaving information for a patient on a telephone answering service may also be hazardous unless prior arrangements have been agreed. Where patients may have this view, and have doubts that their privacy is being protected, it will be important to tell patients that such use and disclosure directly relates to their treatment and are practices that they should reasonably expect. Doing so conforms to the NPP2, which permits such use and disclosure for 'a directly related secondary purpose that falls within the reasonable expectations of the individual'.

NPP3: data quality

This provides an obligation to take reasonable steps to ensure that health information is accurate, complete and up-to-date. Good medical practice that keeps accurate records of all attendances and services provided will ensure compliance.

NPP4: data security and retention

This imposes an obligation to take reasonable steps to ensure that health information is protected from unauthorised access, modification or disclosure and from misuse or loss. For information on the appropriate care of medical records that will meet this obligation, and when and how medical records may be disposed of, see Chapter 6.

NPP5: openness

This requires that medical practices have a document available to patients that clearly sets out the privacy policy of the practice.

NPP6: access and correction

This principle makes it clear that patients are entitled to access to their records and patients do not have to give reasons for asking for access, subject to exceptions outlined below. Medical practices need to develop a policy on handling such requests. Access can be provided in a number of ways, including allowing the patient to read his or her record (and take notes), talking the patient through his or her records or providing a copy of the requested information. The person requesting access may agree to accept an accurate summary, especially where the original records are extensive. Access requests should be handled by the treating doctor and delays should be avoided as access should normally be provided within 30 days. Fees may be charged but patients need to be informed of their options (such as photocopying as opposed to going through the record with the

doctor) and informed ahead of time of the costs likely to be incurred. There is no legal requirement to charge a fee and patients cannot be charged for lodging a request for access. Patients can be charged for the administrative costs of providing access, with fees being set in some jurisdictions (for example, Victoria). Where a patient opts to see the doctor to go through the record with the doctor, a consultation fee commensurate with an ordinary consultation of that length may be charged. However, the patient may not claim reimbursement from Medicare and the account must include GST.

This principle provides for exceptions to patient access to their records. These include where:

- the health information contained would pose a serious threat to anyone's life or would have an unreasonable impact on someone else's privacy
- the information relates to an existing or anticipated legal proceeding and the information is subject to legal professional privilege
- the request is frivolous or vexatious
- access might prejudice an investigation of possible unlawful activity.

NPP7: the use of identifiers

It is not permitted to adopt, use or disclose identifiers such as Medicare numbers.

NPP8: anonymity

This principle provides that, where it is lawful and practicable, people have the option of not identifying themselves when entering transactions with organisations that have their personal information. Although this principle seems designed primarily for non-health situations and is unlikely to be encountered in medical practice, it may be necessary to point out to patients the difficulty anonymity might create for providing adequate medical care and that the patient would be denied access to Medicare, pharmaceutical benefits and private health-care benefits.

NPP9: transborder data flow

This principle requires that if information is to be transferred to someone in a foreign country, the patient must give consent or the disclosing doctor must believe that there is comparable protection legislation in that country. It is unlikely that this principle will be relevant to most medical practices.

5.12.2 Other legal requirements

A medical practice is obliged under the federal *Privacy Act 1988* to have in place a privacy policy that demonstrates compliance with the Act and to display a notice to this effect. A number of professional bodies, most notably the Australian

Medical Association, have provided model privacy policies and public notices readily adaptable for this purpose [8].

5.13 ENFORCEMENT PROVISIONS

Privacy regulation in Australia uses a complaints-based system. On receipt of a complaint, the Federal Privacy Commissioner will normally attempt conciliation but does have powers to investigate and, if a breach is found to have occurred, can make an enforceable determination (1) that the conduct is not to be repeated, (2) that the doctor do any reasonable act to redress loss or damage suffered, and (3) that a specific amount of compensation be paid.

5.14 OTHER CONSIDERATIONS

5.14.1 Medico-legal and specialist reports

A medico-legal report, if retained by a doctor, continues to be health information about the patient and is generally accessible by the patient under privacy law. However, when a report has been commissioned from a doctor who is not the treating doctor by a third party such as the insurer to a defendant in a legal proceeding, and the report is subject to legal privilege, then access can be denied under the *Privacy Act 1988*. Where a specialist's report to the referring doctor carries a proviso about non-release to third parties, this proviso may be ignored if the patient requests access to his or her records, as the specialist's report is deemed in law to be part of the medical record. However, the access principle may prompt doctors to consider whether access could be denied if it poses a serious and imminent threat to the patient's life or health.

5.14.2 Recording family histories

As noted above, taking a family, social or medical history about a third party where necessary for a patient's medical care has been authorised by a public interest determination (PID) made by the Federal Privacy Commissioner [3]. When the PID was renewed in 2007, the Privacy Commissioner made it clear that an amendment to the Privacy Act was needed and that she anticipated that the current review of the Act by the Australian Law Reform Commission would recommend such an amendment. The PID also extended the notion of family history to non-family members where the information related to the patient's relevant interpersonal relationships [8].

5.14.3 Disclosure of genetic information to at-risk relatives

In its original form, NPP2 authorised use or disclosure of health information to a third party if there was a serious and imminent threat to an individual's

life, health or safety. In their 2003 report *Essentially Yours: The Protection of Genetic Information*, the Australian Law Reform Commission and the National Health and Medical Research Commission (NHMRC) recognised that genetic information was rarely associated with 'imminent' risk to others. Following their recommendation, the legislation was amended in 2006 to permit disclosure of genetic information if necessary to lessen or prevent a serious threat, whether imminent or not, to someone's life, health or safety to genetic (blood) relatives. Disclosure is required to be in accordance with guidelines issued by the NHMRC and approved by the Federal Privacy Commissioner [12]. The NHMRC guidelines have yet to be issued.

5.14.4 Disclosure for research

Health information can be used or disclosed for research where the patient has consented or, where seeking consent is impracticable, in accordance with guidelines issued by the NHMRC and approved by the Privacy Commissioner (see Chapter 17).

5.14.5 Differences between the federal and state privacy laws

In Victoria, the *Health Records Act 2001* has additional health privacy principles covering transfer of records, closing of a practice and making information available to another doctor. The Act extends privacy protection to health information of deceased individuals for 30 years after death. In Victoria, requests for access are to be in writing and time limits apply. Where access is denied on the grounds of risk to the patient, arrangements are to be made to provide the information via another doctor.

In New South Wales privacy in health matters in both the public and private sectors is covered by the *Health Records and Information Privacy Act 2002*, which became applicable in September 2004. In the Australian Capital Territory, both the *Health Records (Privacy and Access) Act 1997* and the federal *Privacy Act 1988* apply. Queensland, South Australia and Western Australia do not have state legislation on privacy but have standards or codes consistent with the federal legislation.

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6 MEDICAL RECORDS, REPORTS AND CERTIFICATES

6.1 THE IMPORTANCE OF MEDICAL RECORDS

Accurate and sufficiently detailed medical records are an essential component of good patient care. Their main purpose is to store clinical data for use in patient management and as a means of communication with other doctors and health-care professionals. Thus, the medical record of any patient should contain sufficient information to enable another doctor to carry on the management of the patient. This need is particularly obvious in situations such as in public hospitals where resident medical cover and nursing cover are arranged in shifts; in group practices where patients may see different doctors; and in after-hours deputising locum services where the only communication between the locum and the treating doctor is in writing.

Medical records are an important repository of personal information. They include records held in private doctors' surgeries, in private and public hospitals, in medical clinics in industry and in community health centres. Medical or health information is also held in a variety of state and federal government departments including those of Health, Veterans Affairs, Education and Defence, and Medicare Australia.

Medical records can also be important for clinical and epidemiological research, teaching and health administration, and in litigation. Requests for information about patients come not only from other doctors but also from insurers, employers, police, lawyers and government agencies for legal, financial or other reasons and can be properly complied with only via recourse to accurate medical records.

A professional responsibility closely related to the keeping of good records is the need to keep medical records confidential, a requirement based originally on ethics and the common law, and now reinforced by privacy legislation. Doctors make daily decisions in relation to the release of confidential information and should appreciate the ethical principles and laws related to the release of any information from medical records.

6.2 WHAT IS A MEDICAL RECORD?

A patient's medical record includes information recorded about the medical history, findings on physical examination, possible diagnoses, results of investigations, treatment provided, and follow-up advice. The record also includes correspondence from other doctors. Information usually kept separately, such as images from X-rays, ultrasounds or other techniques, and clinical photographs, also form part of the medical record.

While the words 'medical record' remain a convenient term that includes all the information about a patient to which the doctor's ethical and legal duties of confidentiality apply, neither the concept nor the term is used in privacy law, where the key terms are 'personal information' and 'health information'. In some states and territories, privacy legislation uses a definition of 'health information', which indicates what a medical record would normally contain. For example, in Victoria under the *Health Records Act 2001*, 'health information' is defined as:

> (a) information or an opinion about—
> (i) the physical, mental or psychological health (at any time) of an individual; or
> (ii) a disability (at any time) of an individual; or
> (iii) an individual's expressed wishes about the future provision of health services to him or her; or
> (iv) a health service provided, or to be provided, to an individual– that is also personal information; or
> (b) other personal information collected to provide, or in providing, a health service; or
> (c) other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances; or
> (d) other personal information that is genetic information about an individual in a form which is or could be predictive of the health (at any time) of the individual or any of his or her descendants . . .

Normally, copies of medico-legal reports, for example those requested by and provided to lawyers, insurers and the like, are held within the patient's medical record. It is important to note that such reports are the property of the agency that requested them. Where they have been prepared in contemplation of litigation, their release will be restricted and they should not be released without the permission of the owner. (See also Chapters 5 and 25.)

6.3 WHAT SHOULD BE RECORDED?

Apart from New South Wales, there are no state regulations that cover in detail what should be recorded in a patient's medical record. The approach taken by

medical boards generally has been to emphasise that the records need to be clear, accurate and legible, and contain clinical findings, decisions made, information given to patients, drugs prescribed and investigations requested, and sufficient information to enable another doctor to readily assume the care of the patient.

In New South Wales under the *Medical Practice Regulation 2003*, made pursuant to the New South Wales *Medical Practice Act 1992*, a more prescriptive approach is taken as follows:

Schedule 2 – records relating to patients (clause 5)

I Information to be included in record

1. A record must contain sufficient information to identify the patient to whom it relates.
2. A record must include:
   (a) any information known to the registered medical practitioner who provides the medical treatment or other medical services to the patient that is relevant to his or her diagnosis or treatment (for example, information concerning the patient's medical history, the results of any physical examination of the patient, information obtained concerning the patient's mental state, the results of any tests performed on the patient and information concerning allergies or other factors that may require special consideration when treating the patient), and
   (b) particulars of any clinical opinion reached by the registered medical practitioner, and
   (c) any plan of treatment for the patient, and
   (d) particulars of any medication prescribed for the patient.
3. The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the registered medical practitioner who is treating the patient.
4. A record must include the following particulars of any medical treatment (including any medical or surgical procedure) that is given to or performed on the patient by the registered medical practitioner who is treating the patient
   (a) the date of the treatment,
   (b) the nature of the treatment,
   (c) the name of any person who gave or performed the treatment,
   (d) the type of anaesthetic given to the patient (if any),
   (e) the tissues (if any) sent to pathology,
   (f) the results or findings made in relation to the treatment.

Any written consent given by a patient to any medical treatment (including any medical or surgical procedure) proposed by the registered medical practitioner who treats the patient must be kept as part of the record relating to that patient.

II General requirements as to content

1. In general, the level of detail contained in a record must be appropriate to the patient's case and to the medical practice concerned.
2. A record must include sufficient information concerning the patient's case to allow another registered medical practitioner to continue management of the patient's case.
3. All entries in the record must be accurate statements of fact or statements of clinical judgment.

III Form of records

1. Abbreviations and short hand expressions may be used in a record only if they are generally understood in the medical profession in the context of the patient's case or generally understood in the broader medical community.
2. Each entry in a record must be dated and must identify clearly the person who made the entry.
3. A record may be made and kept in the form of a computer database or other electronic form, but only if it is capable of being printed on paper.

IV Alteration and correction of records

A registered medical practitioner or medical corporation must not alter a record, or cause or permit another person to alter a record, in such a manner as to obliterate, obscure or render illegible information that is already contained in the record.

V Delegation

If a person is provided with medical treatment or other medical services by a registered medical practitioner in a hospital, the function of making and keeping a record in respect of the patient may be delegated to a person other than the registered medical practitioner, but only if:

(a) the record is made and kept in accordance with the rules and protocols of the hospital, and
(b) the registered medical practitioner ensures that the record is made and kept in accordance with this Schedule.

Even this prescriptive list does not include all those elements of a patient's medical record which would be regarded as part of holistic care. For example, the Royal Australian College of General Practitioners (RACGP) standards for general practice accreditation emphasise that patient demographic information needs to include the full name of the patient, date of birth, gender and contact details, and encourage doctors to also record the contact information of the person the patient wishes to be notified in an emergency, and to seek self-identification of people of Aboriginal or Torres Strait Islander origin [1]. The RACGP standards also describe what should be recorded at times of consultation as follows:

1. Our patient health records document consultations – including consultations outside normal opening hours, home or other visits, telephone or electronic consultations where clinically significant – comprising:
   - date of consultation
   - patient reason for consultation
   - relevant clinical findings
   - diagnosis
   - recommended management plan and where appropriate expected process of review
   - any prescribed medicine (including medicine name, strength, directions for use/dose frequency, number of repeats, and date medicine started/ceased/changed)
   - any relevant preventive care undertaken
   - documentation of any referral to other health-care providers or health services
   - any special advice or other instructions
   - identification of who conducted the consultation (eg by initial in the notes, or audit trail in electronic record – health records review).
2. Our patient health records show evidence that problems raised in previous consultations are followed up (health records review).
3. The documentation of our patient health records includes:
   - name and contact details of the patient's usual GP/general practice
   - time of consultation.

6.4 GUIDELINES FOR MAKING MEDICAL RECORDS

There are some additional practical points that are important for doctors in the making of medical records:

- Create records contemporaneously with the consultation, although it is recognised that in emergency and some other situations this may not be practicable. Nevertheless, the sooner after an event an entry is made, the more likely it is that the entry will be accurate.
- When not using computerised records, write legibly and clearly. Avoid the use of non-standard abbreviations.
- Make each entry sufficiently comprehensive and comprehensible such that another doctor could readily assume care of the patient.
- Patients are entitled to request that sensitive information about them not be recorded and it is good practice for you to be proactive in this regard.
- Note date and time of each entry. If they are different from the date and time of the consultation, note this.
- Write the notes yourself and sign them.
- Never sign an entry on behalf of another staff member.

- Be objective in your recorded observations. Avoid recording subjective and personalised critical comments about the appearance, behaviour and disposition of patients.
- Do not edit the records, even for legibility.
- If errors occur, cross out the inaccuracies and initial and date them. Enter a marginal note as to the reason for the correction. Then enter the corrections in proper chronological order. Note that information must not be altered or deleted in this process.
- Do not record thoughtless or unnecessary and disparaging remarks about colleagues or their treatment. Such remarks may prompt litigation.
- Take great care when transcribing treatment orders or reports from an original order or report.

Medicare Australia has also issued advice about the need to maintain adequate and contemporaneous records in relation to the payment of Medicare benefits to patients and has defined its meaning of 'adequate' and 'contemporaneous'. This advice is contained in the Medicare Benefits Schedule available online at http://www.health.gov.au/mbsonline.

6.5 MEDICAL RECORDS AND THE COMPUTER

There has been a progressive increase in computer-based medical record keeping by general practitioners and some specialists, despite ongoing concerns about reliability, cost of maintenance and security [2]. Such use is usually combined with computer-based prescribing. In many clinical situations it has so far been either too difficult or prohibitively expensive to move to a solely computer-based record, thereby creating an additional medico-legal hazard if crucial information is overlooked because it is held on paper and not on computer (or vice versa).

The foregoing advice in regard to keeping records applies equally to computer entries. Thus it is essential that the system used provides for identification of the doctor who makes an entry and a means of showing where errors have been corrected.

Computer-based record systems theoretically create greater chances of accidental or deliberate breaches of privacy than the traditional paper-based record. Despite this risk and despite the poor record of doctors who fail to log out at any computer terminal, there does not appear to have been a flood of complaints about such breaches. This may reflect lack of awareness on the part of the patient rather than satisfactory monitoring. While 'the benefits of electronic data storage and retrieval are undeniable, such databases should be less vulnerable than a filing cabinet, not more' [3].

6.6 SAFETY AND SECURITY OF RECORDS

Privacy law demands that reasonable steps be taken to protect personal information from misuse, loss, unauthorised access, modification or disclosure. In practice

this means that records not in actual use should not be accessible to anyone other than practice personnel in office hours, while records in use need to be kept away from public view. Access by practice staff beyond that required in the course of their duties is a breach of privacy law and this should be explicitly stated in employment contracts. In addition, the practice needs to be adequately secured after hours. The RACGP has produced a document, *Handbook for the Management of Health Information in Private Medical Practice*, which covers these matters in more detail [4].

Computer-based records have separate and additional security issues, including the need for a policy on levels of access by staff, the use of personal passwords that are kept secure, regular back-up, provision of off-site storage of the backed-up records, and an adequate 'information disaster recovery plan' in the event of an emergency such as a power failure. Where confidential information is sent or received electronically, firewalls, antiviral programs and encryption will also be essential [5].

In all medical practices, computerised or not, attention also needs to be paid to how printed material emanating from facsimile (fax) machines and printers is protected. One of the serious drawbacks of using fax machines in medical practice is their lack of privacy. When messages are printed out on the receiving end, the sender loses control over who has access to them. Confidential reports and requests are accessible to anyone who walks by the fax machine. This can be circumvented by the use of a 'mailbox', which allows a confidential message to be stored electronically in the receiving fax machine's memory until an assigned password is entered. Covering transmission sheets are essential for good records of faxed information. In litigation, the absence of such detail can be critical. Doctors should not assume that material sent by fax is effective to achieve the intended purpose and can later be relied on to establish that that purpose has been achieved. Prescriptions for controlled drugs, some certificates and other documentation are not acceptable in a fax format; the regulations may require that the original document be also sent by post. Any requirements in legislation and regulations should be followed.

6.7 OWNERSHIP OF MEDICAL RECORDS

Ownership of the medical record is a separate matter from access to the information contained in the record. Medical records were originally regarded as aide-mémoires for treating doctors – hence the notion that the records and the information they contain belonged to the doctor and not to the patient. The issue of ownership of medical records was clarified in Australia by the High Court decision in *Breen v Williams* [6]. In this important test case, the six judges were unanimous in their judgment, delivered in September 1996, that the law as it then stood in Australia was that the person who created the record was the owner of

the record and patients did not have a common law right of access to their medical records.

While finding that the doctor in question owned the record, several of the judges drew attention to the issue of patient access to information held in a record and agreed that such a right would need to be created by legislation. Although the law on ownership of medical records has not changed, the Commonwealth *Privacy Act 1988* was amended in 2001 to confer on patients the rights of access to information held in medical records, including X-ray and other images, specialists' reports, pathology reports and the like. The Commonwealth legislation applies to all private medical practice throughout Australia. Similar complementary legislation covering patient access to the information held in the medical record now exists in Australian Capital Territory, New South Wales, Victoria and Tasmania.

6.8 ACCESS TO MEDICAL RECORDS

The right of access to their medical records by patients is a central element in the changes to federal and state privacy laws introduced in recent years as described more fully below. As described in Chapter 5, there are many clinical situations where health professionals other than doctors are entitled to access the records of patients who come under their care. Such health professionals have their own codes of ethical conduct (see Chapter 15) and are bound by privacy law. Nevertheless, all health professionals need to recognise that such access can generally be had only with the consent of the patient. Medical practices, hospitals and the like must ensure that their privacy policy covers such access and that staff are adequately instructed in that policy (see Chapter 5).

In hospitals, patient care invariably involves a number of doctors and the handling and exchange of confidential information between them, nursing staff, technicians, dietitians, physiotherapists, social workers and others who need access to the information to provide appropriate care and treatment for the patient. These staff are authorised, but shielding medical records of sick patients in hospitals from all unauthorised eyes is virtually impossible. Others without authorisation, such as administrative staff, filing clerks and hospital porters, are in a position to read such records if they are so inclined. In teaching hospitals, students of various health disciplines also have access to medical records. Most patients nowadays who are treated in hospitals realise that any information given to an attending doctor will be seen by other doctors and health professionals involved in their care, and consent by patients for such access is usually implied. Thought should be given to the detail to be recorded and the security of the record when patients reveal particularly sensitive information to their doctors. In addition, clinics and hospitals must have appropriate privacy policies supplemented by staff instruction, backed by disciplinary procedures to reduce the risk of breaches of confidentiality.

Doctors also need to be aware that it is unethical, and unlawful in the sense that it breaches confidentiality and probably privacy, for a doctor to access the records of a patient in whose care he or she is not involved. If detected, such access would be dealt with as unprofessional conduct. For guidance in regard to access to records for permitted purposes such as for medical research and quality assurance, see Chapter 17.

6.9 MEDICAL RECORDS AND PRIVACY LEGISLATION

Privacy legislation now covers the issues of the privacy and confidentiality of medical records, the right of patients to access their own records, and the safe keeping, storage and destruction of the records. The legislation and the associated privacy principles are discussed in greater detail in Chapter 5. The following represents a distillation of how doctors need to address issues around access to, storage of and destruction of records in a manner that does not breach federal or state privacy and/or health records legislation.

6.10 PATIENT ACCESS UNDER PRIVACY LAW

Since December 2001, patients throughout Australia have been entitled to access to health information concerning them kept in medical records. This right extends to the patient's authorised representative should the patient be incompetent or incapable of exercising his or her right. Normally a request for access should be in writing. Legal representatives also have a right of access to the records of a deceased person. However, this and several other aspects of the legislation vary in those jurisdictions (New South Wales, Victoria, Tasmania and Australian Capital Territory) that have legislation so doctors should become familiar with local requirements. A list of websites where federal and state legislation and guidelines may be accessed is provided in Table 5.1 in Chapter 5.

When a request for access is received, it should be acknowledged promptly. A patient does not have to give a reason for his or her request but it is permissible to attempt to clarify the needs of the patient. Such clarification, including an explanation of the options under privacy law as to how the request may best be met, is likely to make the process a better experience for both the patient and the doctor. The legislation is intended to encourage openness and transparency.

The legislation also stipulates the means by which the right of access can be exercised, including:

- attending to inspect the records and take notes
- to be given a copy or print-out
- to view the records in the presence of the doctor and have the record explained
- by agreement, to receive a detailed summary.

Fees may be charged; these are regulated in Victoria. In New South Wales, fees can be charged for copying or for inspection of records and further guidance is anticipated. If the doctor sits with a patient to explain a record, a consultation fee may be charged but a Medicare rebate is not payable.

There are exceptions to an unfettered right of access. Before arranging access, the doctor should go through the record to check that there is no material relating to another person (which might breach that person's privacy) and to consider whether there is information that if released might cause a serious threat to the life or health of the patient or another person. In the latter case, consideration should be given to the options available under the relevant privacy regime to release the information to a third party, such as another doctor of the patient's choice [4]. In Victoria there are authorised grounds of exception: viz (1) if access is believed on reasonable grounds to create a threat to the life or health of the individual or another person and (2) where information in the record has been given in confidence by another person. In New South Wales, Queensland, South Australia, Western Australia, Tasmania and the Northern Territory, there are additional exceptions including where legal proceedings are in progress or anticipated, where access might prejudice an investigation of possible illegal activities, and where the request is deemed vexatious or frivolous. As denial of access may be a difficult decision, and be associated with distress on the part of the applicant, doctors are advised to first seek advice from their medical indemnity organisation or from the relevant health privacy office (see Table 5.1 in Chapter 5).

6.11 RETENTION AND DESTRUCTION OF MEDICAL RECORDS

Federal privacy law states that medical records must be kept for as long as they may still be required for use or disclosure in accordance with the *Privacy Act 1988*. This is generally deemed to be a minimum of 7 years after the last attendance by the patient or, in the case of minors, for 7 years after the minor reaches the age of 18 years [4] as provided for in New South Wales, Victoria, Tasmania and Australian Capital Territory legislation. It should also be noted that the records of deceased patients are covered by the relevant privacy legislation. Doctors should not adopt a policy of automatically destroying records when the above minimum time limits are met. Medical defence organisations usually advise doctors to keep records where there has been an adverse event, a complaint or a threat of legal action. In Victoria, these time limits do not apply to the records held by a doctor who has retired. Nevertheless, retired doctors would be well advised to follow both the privacy laws and the advice of their medical defence organisation.

When medical records are destroyed, a record of the destruction must be kept. The relevant legislation stipulates that a record is to be kept of the name of the

individual to whom the health information relates, the period covered by that record and the date on which it was destroyed. The method of destruction should be secure. Mere shredding may not meet this requirement so it may be safer to use the services of a professional document disposal company.

Most states have subordinate legislation or guidelines concerning the disposal of medical records in public facilities and these laws and guidelines must be followed.

6.12 RETENTION OF MEDICAL RECORDS WHEN A DOCTOR RETIRES OR DIES

Minimum requirements for the handling of medical records when a practice is to be closed or transferred or when a doctor dies are provided for in privacy legislation. These requirements vary slightly between jurisdictions. For example in Victoria, the *Health Records Act 2001* provides that where a practice is to be sold, transferred or closed, a notice must be published in a newspaper circulating in the locality stating the details of the proposed sale, transfer or closure and the manner in which the doctor proposes to deal with the medical records. In addition guidelines issued by the Health Service Commissioner under the Victorian legislation cover matters relating to publishing a notice for non-English-speaking patients, the placement of a notice within the practice at least 2 months ahead of the proposed sale transfer or closure, and individually notifying patients regarded as currently receiving a program of care.

In a group practice or partnership, the medical records of a deceased or retired doctor are usually taken over by his or her colleagues. In this situation, the spirit of the legislation should be followed – that is, existing patients should be notified of what is proposed and should be given the opportunity to have a copy of their records (or a detailed summary) transferred to a doctor of their choice.

When a solo medical practitioner dies, the patient's records become the property of the estate. The legal representatives of the deceased doctor have the same responsibilities under the privacy legislation as outlined above. Should the executor be able to sell the practice to another doctor, the care and retention of those records become the responsibility of the purchaser, who must also assume responsibility to meet the requirements of the privacy laws. Where the practice is not sold, the executor will need to take steps to care for the records because, leaving aside the interests of the patients, the estate may need the protection of those records should claims arising from the practice be made against the estate. Among the steps that may be taken by the executor are:

- obtaining the assistance of another doctor who agrees to take care of the records and notifying the patients by letter of this arrangement
- inviting patients, within a reasonable period of time, to accept their own records and make use of them

- inviting patients to nominate another doctor to whom the records may be forwarded.

Other issues, separate from the care of medical records, that relate to retirement from medical practice, including the notification of a range of organisations and statutory bodies, are covered in Chapter 16.

6.13 MEDICAL RECORDS AND THE COURTS

The important role of adequate medical records in protecting a doctor against unfounded allegations or complaints cannot be overstressed. Where the recollected evidence of two parties is in conflict, a clear contemporaneous record made by the doctor of the history, clinical findings and treatment or advice given carries great weight in court.

The availability of detailed medical records is most important in medical negligence litigation. A persistent theme in advice given to doctors by medical defence associations is the importance of keeping thorough, accurate and contemporaneous clinical notes. The courts will always, other things being equal, prefer oral evidence that is reinforced by contemporaneous notes to evidence that relies on unaided recollection of distant events. If the notes are made reasonably soon after the events to which they refer – and reasonably soon should be a matter of hours, not days – the court will allow witnesses who made such notes to refresh their memories from them when giving evidence. All or part of a patient's medical record may become court exhibits. Poorly kept records can very easily be used in court to throw doubt on a doctor's professional ability, competence, responsibility and dedication. The key to the defensibility of at least 40 per cent of all medical malpractice claims rests with the quality of the medical records, according to the United Kingdom-based Medical Defence Union [7]. In like manner, if a doctor is called upon to respond to a complaint to a medical board, or to appear before a medical disciplinary tribunal, the quality of the doctor's medical records will be a significant factor in the outcome of the matter.

6.14 MEDICAL RECORDS AND RESEARCH

Using medical records for research whether or not the records contain identifying information about the participants, without their consent, is open to legal and ethical objections. In ethics and law, these objections arise from duties of confidentiality, while in ethics additional objections are based upon principles of respect for autonomy (and its expression in the need for consent), justice and beneficence. Where the records used contain identifying information, their use in research is covered by federal privacy legislation and in some state privacy regimes (for example, Victoria). More details are provided in Chapter 17.

6.15 MEDICAL REPORTS

The provision, for a reasonable fee, of a factual report of the history, clinical and physical findings, treatment, diagnosis and progress of the patient is a proper part of the doctor's responsibility, provided always that the report is issued with the patient's knowledge and consent. Medical reports should be provided promptly. The most common complaint in regard to medical reports is doctor tardiness. In seeking entitlements in relation to disability support pensions, life insurance, workers compensation, accident compensation and superannuation, members of the community depend upon the prompt assistance of doctors in providing relevant and accurate certificates and medical reports. The acceptance of this responsibility is implied whenever a doctor–patient relationship is established.

Failure to accept this will disadvantage patients in securing their legal entitlements, and will also diminish the reputation of the medical profession. Most complaints come from lawyers, insurance companies and managers of superannuation funds. The patience that has been shown by some complainants is quite remarkable. It is often only after repeated written requests for medical reports have remained unanswered that such delays are brought to the attention of medical boards. Should such tardiness result in a patient being denied entitlements to compensation or the like, the doctor may be disciplined by the medical board. If a doctor signs or provides a medical report that is untrue, misleading or improper, whether written with gross carelessness or as a deliberate fraud, this may amount to serious professional misconduct.

Where a doctor is requested by a solicitor, insurer or other third party to prepare a medico-legal report on other than his or her own patient, no additional authority is required from the person examined or reported upon. The decision to prepare and provide such a report is for the doctor to make, while the purposes and details of the report are matters determined by agreement between the doctor and solicitor or other party requesting the report. As the patient is not attending for care, additional attention must be paid to communication. Doctors should make their roles clear at the start of the consultation, inform patients of the nature of such examinations and should observe the normal courtesies. In preparing reports, they should be objective and clear and express with reasons their genuinely held opinions. The preparation of medico-legal reports is discussed in more detail in Chapter 25.

6.16 MEDICAL CERTIFICATES

All of the examples of medical certificates covered below illustrate an important aspect of the relationship between the medical profession and Australian society. Society trusts doctors to give these certificates as professionals – truthfully and objectively according to the best judgment of matters within their knowledge and

expertise. In fulfilling this professional responsibility, doctors contribute to the maintenance of the trust the community has in them. When doctors fail in this responsibility, they risk eroding that trust. They also risk disciplinary action by medical boards (see Chapter 8).

6.16.1 Medical certificates of fitness to work

Although medical students have impressed upon them the serious legal implications of signing medical certificates, ignorance, simple mistakes, acceptance of pressure from patients, misguided assistance to patients, carelessness, and sometimes deliberate fraud continue to bring doctors to the attention of medical boards [8]. As with medical reports, a doctor who signs or gives any such certificate that is untrue, misleading or improper, whether written with gross carelessness or as a deliberate fraud, may be open to a charge of serious professional misconduct.

A certificate certifying illness may be issued where a patient has a medical condition that requires time away from work. Most commonly this is because that person is too ill to work but on occasion (for example, an infectious disease) it may be because the person should not be at work because of risks to others. The normal requirements for a medical certificate regarding fitness for work are that it should provide the following information:

- the name and address of the doctor
- the name of the patient
- the date on which the certificate was issued
- the period (with dates) of unfitness for work
- supplementary remarks to explain any apparent inconsistencies in the information provided (see below).

The issuing of a certificate must be based on an adequate history and physical examination accurately recorded. When the purpose of the certificate is to provide a benefit to the patient, the diagnosis may be given. Increasingly employers expect to be provided with a diagnosis, but this should be done only with the consent of the patient (see Chapter 5). Problems sometimes arise concerning the date of issue of a certificate and the period between specified dates during which the patient will be unfit for work. It is quite common for a patient to present to a doctor 2 or 3 days after an injury or the onset of an illness because initially the patient thought that medical consultation was unnecessary and had expected recovery in 24 to 48 hours. Appropriate supplementary remarks on the certificate should resolve this problem. A certificate in which the first date of incapacity specified is after the date of issue might indicate an elective operation or investigation, but this should also be clarified on the certificate. In situations where the patient attends late in the course of an illness and the doctor feels unable to certify an illness, it is acceptable and may be of assistance to the patient to provide a note or letter of support [9].

The foregoing advice applies to the most common form of certificate, the sickness certificate. Where certification of illness or fitness/unfitness to work is requested under workers compensation, accident compensation or other legislated schemes, the regulations of the relevant scheme apply.

6.16.2 Medical certificates of fitness to travel

Doctors from time to time are asked by insurers to certify whether people are fit to travel, especially by air. This may require expert assessment and doctors need to be careful to separate their respect for their patient's desires and plans from the objective medical risks. If in doubt in any instance, discussion with, or referral to, a relevant specialist or contact with a medical indemnifier is appropriate [10].

6.16.3 Certificates for carer leave

The federal legislation governing the workplace (*Workplace Relations Act 1996*) was amended in 2006 to incorporate an entitlement to personal/carer leave. The term 'personal leave' is synonymous with sick leave and requests for medical certificates for this purpose have been outlined above. 'Carer leave' refers to a situation where a member of an employee's family or household is ill and the employee is required to care for that person. Doctors may issue a certificate to this effect, but care must be taken to ensure that the patient (who is not the employee and may not be a patient of the doctor providing the certificate) consents to the certificate being issued. Additional care should be taken to ensure that confidential and sensitive health information is not released [9].

6.16.4 Other certificates

There are a number of legislated schemes that place obligations on treating doctors to provide other forms of certificates. Relatively uncommonly a patient may request a certificate for early release of superannuation benefits to fund medical or dental treatment that is not readily available via the public health system and is necessary to treat a life-threatening illness or injury. Such a release of funds has to be approved by the Australian Prudential Regulation Authority, and the Authority has provided an example of the type of certification required as follows: '{patient's name} is suffering from a life threatening illness and requires treatment which is not readily available through the public health system' [9].

Certification of births and deaths is covered in Chapters 19 and 20. Chapter 26 covers the notification of infectious diseases and certification of fitness to drive. Doctors are in certain cases bound by law to give certificates, notifications, reports and similar documents for use either in courts of justice or for administrative purposes.

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7 NEGLIGENCE, PROFESSIONAL LIABILITY AND ADVERSE EVENTS

The discomfit the medical profession has with the legal concept of negligence was succinctly expressed by Justice Michael Kirby in 1995 when he wrote:

> Medical practitioners tend to see malpractice cases as involving a moral blight or stigma upon the practitioner concerned. From the point of view of the patient (and most lawyers) however, the issue is usually much more basic. It is whether a person who has suffered in some way as a result of medical or hospital procedures will be cast upon the genteel poverty of the social security system or be entitled to recover compensatory damages from the medical practitioner's insurance. [1]

He went on to add:

> To gain insurance the practitioner must pay premiums. These premiums become part of the costs of medical practice. In this way, all patients bear the cost of, and contribute to, the fund from which are paid damages when things go wrong. [1]

Many have argued that the current system of the use of civil action by way of claims for negligence should be replaced by a no-fault compensation scheme [2–4] as exists in New Zealand and some Scandinavian countries [5]. Others have pointed out how fraught is the concept of independent experts judging the cause of a poor or unexpected outcome after the event and have decried the gradual change in the notion of what represents negligent conduct [6–7]. These issues are not addressed in this chapter. Instead the chapter is designed to assist doctors to more fully understand our current legal system for handling claims for damages and the closely associated system of professional medical indemnity (both of which have been the subject of considerable change in recent years). In addition, the chapter addresses the topics of adverse events, risk management and prevention, and the concept of open disclosure. Receipt of a notice of action for negligence is a very stressful experience for doctors and

the chapter also provides information on sources of support to help handle this stress.

7.1 CAUSES OF ACTION AGAINST DOCTORS

The four most usual causes of action that a dissatisfied patient may take against a doctor are the following:

1 *Negligence*. Negligence actions often arise from matters of diagnosis or subsequent procedures or management. The failure to obtain consent may also result in actions in negligence (see also Chapter 4). Negligence is discussed in more detail below. A failure to fully inform will be fought in negligence.
2 *Trespass*. Should a doctor undertake medical treatment involving touching a patient without the consent of the patient, the doctor is guilty of an assault (or more precisely in legal terms, a battery) and for which an action in trespass to the person may be brought. Examples of such treatments are not common because of the recognition of the need for consent. However, if systemic mistakes occur in the identity or needs of a patient so that a procedure is conducted on the wrong patient or at the wrong site, that patient would not have consented to the procedure and so could make such a claim. Once the patient is informed of the broad nature of what was proposed, no action for trespass remains. Developments in law relating to consent now focus on the duty of doctors to inform their patients fully about the nature and risks of any proposed treatment or procedure and to obtain their consent. These are fully discussed in Chapter 4.
3 *Breach of contract*. By itself, this action is uncommon but it is often combined with actions in negligence. The basis of such a claim is that, between a doctor and patient, there is a contract, essentially an agreement between two people, supported by a consideration – that is, the exchange of money or something else of value. A breach of contract claim alleges that the defendant has failed to fulfil an obligation that the contract required. Between a patient and a doctor, a claim might be that the doctor failed to provide the treatment at the promised standard.
4 *Breach of fiduciary duty*. This is an unusual cause of action and is a duty claimed to arise from the special relationship that exists between doctor and patient, the word 'fiduciary' signifying a relationship of 'utmost good faith'. In *Breen v Williams* [8], the High Court concluded that although the doctor–patient relationship is not a fiduciary relationship, it can include fiduciary duties, such as maintaining confidentiality and avoiding conflicts of interest, such as accepting gifts from patients.

In addition, actions arising out of the doctor–patient relationship less commonly may relate to breach of duty of confidence (Chapter 5), breach of equal opportunity or discrimination legislation, breach of statutory duty, or claims arising from the unsafe state of the doctor's surgery. The present chapter is

concerned with the most common cause for action by patients against doctors: negligence.

7.2 ACTIONS FOR NEGLIGENCE

A patient who suffers an injury through health care may have a right, recognised by law, to seek damages from those responsible. In law, a claim for negligence can succeed only if the defendant owes a duty of care to the claimant, if the defendant has breached the required standard of care and if it is proved that that breach caused the injury. Patients are required to prove negligence before they can obtain compensation. Compensation may also be agreed upon by negotiation between the claimant's solicitors and the doctor's medical indemnifier, and in some jurisdictions compensation may be agreed upon via a legislated conciliation process (see Chapter 9).

Once a doctor has responsibility for a patient, a legal relationship comes into existence and obliges the doctor to exercise a reasonable degree of skill and care. Failure to exercise such a degree of skill and care that leads to injury or harm to a patient leaves a doctor open to an action in negligence by the injured patient. This is a civil action in which the aggrieved patient (plaintiff) sues the doctor (defendant) for damages for an alleged injury resulting from the treatment given or from an omission of treatment or advice and where the injury caused loss that is assessable monetarily. The standard of proof in such civil cases is 'on the balance of probabilities' (see Chapter 24).

If negligence is established, compensation is payable, the payment being calculated by reference to general damages for the injury suffered, and special damages to place the plaintiff in the position in which he or she would have been in if the injury had not occurred. The recent Australian statutory modifications of recoverable damages (see 7.9 'The medical indemnity crisis and its outcomes') has significantly limited the damages that can be recovered, broadly to the most serious cases, and confined the actions that can be brought to those in which there will be recoverable damages. The damages in general have nothing to do with punishing the doctor, although in exceptional cases a court may award punitive damages. The principle of damages is solely to compensate for pain and suffering and to restore the plaintiff, as far as money can. Although the elements of a successful negligence claim are well established, they must be shown to exist in the facts of each situation giving rise to a claim.

Negligence has been established in relation to virtually every aspect of medical practice: failure to disclose risks; failure to diagnose; failure to attend; failure to provide advice; failure to refer and/or arrange appointment; lack of knowledge; lack of reasonable care; and breach of confidentiality. More recently, claims have been made to recover damages where negligence had led to 'wrongful life' or 'wrongful birth' (where negligence related to reproduction or to the birth of a child with disabilities). Claims have been successful in enforcing a duty of care to the

partner of a patient with HIV, and recovering damages for loss of opportunity of timely intervention and treatment. Actions for negligence may also arise through a failure to provide sufficient information as to the material risks of a procedure when seeking the consent of a patient. In relation to giving sufficient information, the standard of care is determined by reference to the information needs of the patient and not, as with diagnosis and treatment, by reference to the usual practice of doctors in the same field (see also Chapter 4).

Australian courts have made it clear that it is the court which will finally judge whether a doctor has fallen short of the standard of care and skill required, although the court will be influenced by the evidence it hears from professional peers. In the changes to the law resulting from the 'medical indemnity crisis' (see below), in most jurisdictions the standard of care required of doctors is now defined by statute.

For an action in negligence to succeed, the patient (the plaintiff) must establish, in the specific circumstances and on the balance of probabilities (that is, that it is more probable than not), that:

- a duty of care was owed by the doctor (defendant)
- the defendant's conduct fell below the required standard of care
- the breach of the duty of care caused, or materially contributed to, the damage suffered – be it physical or mental
- the loss or damage suffered was reasonably foreseeable
- the loss or damage is assessable monetarily.

Where a patient relies upon a claim of not being adequately warned of a particular risk, the patient also has to establish that he or she would not have proceeded with the treatment if so warned. The onus is on the plaintiff to prove these elements and not on the defendant to disprove them.

7.3 THE DOCTOR'S DUTY OF CARE

A doctor who undertakes to care for a patient has a duty to exercise reasonable care and skill in treating and advising the patient so as to avoid injury. The High Court of Australia, in *Rogers v Whitaker* in 1992, stated this duty in the following terms:

> The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement'; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case . . . [The] standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill, in

this case the skill of an ophthalmic surgeon specialising in corneal and anterior segment surgery. [9]

7.3.1 When does the duty arise?

Duties of care arise from relationships, such as that between a doctor and patient. It is usually clear when that relationship has arisen but it is important to recognise that it can arise even before a consultation. In *Albrighton v. Royal Prince Alfred Hospital* [10], a specialist was held to have a duty to a patient at a time when the specialist had reviewed the referral and had agreed to see the patient 'later in the week'.

7.3.2 Duty of care to third parties

Although the doctor–patient relationship involves a duty of care, one recent case indicates that duties may arise in relationships with people who are not patients. The matter of whether a doctor owes a duty of care to a third party was the subject of *BT v Oei* 1999 NSWSC 1082 [11]. The claimant was the wife of a man who died of HIV. She had contracted HIV from her husband and alleged that her late husband's general practitioner had been negligent on two grounds: (1) failing to diagnose that her husband had HIV and (2) failure to adequately counsel her husband on the need to undergo an HIV test. The case was argued primarily on the basis that the claimant was not a patient of the doctor and thus the doctor did not owe her a duty of care. The court found that the doctor did owe such a duty. The relevant standard of care was to 'exercise the reasonable care and skill of a general practitioner in 1992' and that, in the light of the history of the husband's viral illness, such a general practitioner would have considered a diagnosis of HIV and counselled the need for an HIV test. The judge found that if the general practitioner had made the diagnosis of HIV and had appropriately counselled his patient, the husband would have taken steps to prevent his wife being infected. The court awarded damages to the claimant for past economic loss and care and for future economic loss and care.

7.3.3 Duty of care in an emergency

From a strictly legal point of view there is no obligation to undertake the care of any particular person. However, in an emergency there is an ethical responsibility to provide emergency care to the level to which one is trained and experienced. The AMA code of ethics refers to this situation as follows: 'Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one' [12]. The UK General Medical Council (GMC) has advised 'in an emergency, wherever it arises,

you must offer assistance, taking account of your own safety, your competence, and the availability of other options for care' [13]. Some Australian medical boards have adapted the GMC guide in this regard. For example, the Queensland Medical Board document *Good Medical Practice* advises 'in emergency situations, offer your patients or members of the public any treatment that you could be reasonably expected to provide' [14].

Some doctors have been reluctant to render emergency assistance in the case of accidents for fear of being sued if their attempts to assist are unsuccessful. However, as part of the legislative changes brought about by the 'indemnity crisis' (see below), in all jurisdictions other than Tasmania, protection from civil liability is now assured where help has been provided in an emergency without expectation of financial reward.

In New South Wales, the *Medical Practice Act 1992* provides as one category of 'unsatisfactory professional misconduct' under section 36(1)(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.

This section was relevant to the outcome in *Lowns v Woods*. This case involved a claim of negligence against a general practitioner for allegedly refusing to attend a child who was fitting. The New South Wales Court of Appeal accepted the following general principle stated by Badgery Parker, J in the initial trial. Badgery Parker, J stated:

> In general the common law does not impose a duty to assist a person in peril even where it is foreseeable that the consequence of a failure to assist will be the injury or death of the person imperilled. Something other than the foreseeability of harm is required before the law imposes a duty to intervene. It has been held in other common law jurisdictions that a doctor is under no duty to attend upon a person who is sick, even in an emergency, if that person is one whom the doctor is not and has never been in a professional relationship of doctor and patient. [15]

However, while those words may give comfort to doctors, in the case in question the doctor was found negligent. The circumstances that influenced this conclusion were that the doctor was physically very close to the child (about 300 metres away); there was a direct request to the doctor for help; and there was nothing to prevent the doctor responding. A section of an earlier Medical Act

equivalent to section 36(1)(l) of the New South Wales *Medical Practice Act 1992* (as quoted above) also influenced the outcome of this case.

7.4 THE REQUIRED STANDARD OF CARE

The legal definition of the standard of care required of doctors by the Australian courts has been altered as a result of reforms introduced by the federal government in May 2003 in response to what was called either a 'litigation crisis' or a 'medical indemnity crisis' (see below). Historically, the standard of care required was that of 'reasonable care' or the care that a 'competent practitioner' would have taken in the circumstances, allowing for the special skills and knowledge possessed by that person. Lord Nathan in 1957 expressed this standard as:

> He will not be judged by the standards of the least qualified member of his class, nor those of the most highly qualified, but by the standard of the ordinary careful and competent practitioner of that class. [16]

In the same year, Justice McNair instructed the jury in the famous case of *Bolam v Friern Hospital Management Committee* in the following terms:

> [The doctor] is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art . . . [Putting] it the other way around, a man is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion which would take a contrary view. [17]

This definition became known as the 'Bolam test' and, although an English decision, was generally accepted for three decades in Australia. During the 1990s its application in all situations was questioned and its authority in Australia was diminished by other decisions, most importantly in *Rogers v Whitaker* [9].

With the introduction of legislation progressively in all states, but not yet the Australian Capital Territory or Northern Territory, in response to the 'medical indemnity crisis', courts dealing with cases of alleged medical negligence in treatment are now obliged to follow what has been termed the 'modified Bolam' test. For example, the New South Wales *Civil Liability Act 2002*, in section 5O headed 'Standard of care for professionals', states:

> (1) A person practising a profession ('a professional') does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.
> (2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.
(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

In nearly all jurisdictions, similar new civil liability legislation provisions apply. In Victoria the term 'unreasonable' replaces 'irrational' in regard to the peer opinion, while in Western Australia the notion is expanded by the words 'so unreasonable that no reasonable health professional in the health professional's position could have acted or omitted to do something in accordance with that practice'. It should be noted that in some Acts, and as recommended by the Ipp review (see below), the legislation explicitly states that this standard does *not* apply to the giving of information for the purpose of obtaining consent. For example section 60 of the *Wrongs Act 1958* in Victoria limits section 59 (which covers the standard of care generally) in the following way:

60. Duty to warn of risk
Section 59 does not apply to a liability arising in connection with the giving of (or the failure to give) a warning or other information in respect of a risk or other matter to a person if the giving of the warning or information is associated with the provision by a professional of a professional service.

These provisions recognise the developments in the law relating to the disclosure of risks; this is addressed in the next section of this chapter.

7.5 THE CIRCUMSTANCES OF NEGLIGENCE

The following summaries of some important and influential cases may assist readers to understand the various circumstances in which claims for negligence are pursued.

7.5.1 Failure to disclose risks

The sentinel case covering this topic is *Rogers v Whitaker*, which was decided by the High Court of Australia in 1992 [9]. A patient sued an ophthalmic surgeon for failing to warn her of the risk of sympathetic ophthalmia in her good eye when proposing surgery to improve the appearance of and possibly correct blindness due to an old injury in the other eye. The High Court decision expressly rejected the Bolam test in relation to the provision of information by doctors, discounting the weight of evidence of a group of ophthalmic surgeons who would not have warned of this risk. The High Court also rejected the conclusion of a UK case (*Sidaway v Bethlehem Royal Hospital Governors & Ors*), which had held that information provided to a patient was a matter of medical judgment [18]. The

High Court instead accepted the approach taken in South Australia in 1983 by King CJ, which reserved for the court the power to determine the standards of care in regard to disclosure, having regard for evidence of acceptable medical practice as a useful guide [19]. The High Court said:

> There is a fundamental difference between, on the one hand, diagnosis and treatment and, on the other hand, the provision of advice or information to a patient. In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it . . . But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession . . . whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment . . . is not a question the answer to which depends upon medical standards or practices. [9]

The High Court decision recognised that respect for patient autonomy is relevant in regard to decisions about accepting whether or not to undergo treatment. The doctor has a duty to disclose matters that might influence a 'reasonable' person in the position of the patient about whether to proceed with the proposed treatment, and such matters included any 'material risk' of the treatment. A material risk was identified as either one to which a reasonable person in the patient's position was likely to attach significance or one to which the doctor ought to have been aware that the particular patient would have attached significance to the risk.

In the later case of *Rosenberg v Percival* [20], the two contexts of material risks were helpfully distinguished by explaining that, under the Rogers test, a risk is material if:

1. in the circumstances of the case, a reasonable person in the patient's position would be likely to attach significance to it ('the objective limb')
2. the medical practitioner was, or should have been, aware that the particular patient would be likely to attach significance to it ('the subjective limb').

In *Rogers v Whitaker*, Mrs Whitaker repeatedly sought information from Dr Rogers regarding any risks associated with the surgery and in particular the risks to her good eye. In other words, she successfully relied on the 'subjective' limb of the test for material risk disclosure. The National Health and Medical Research Council (NHMRC) *General Guidelines for Medical Practitioners on Providing*

Information to Patients, first issued in 1993 and reissued in 2004 (see Chapter 3), are consistent with this judgment.

In addition to clarifying the material risk test, *Rosenberg v Percival* 2001 canvassed many of the other matters arising from *Rogers v Whitaker* but is of particular interest as the case was decided primarily on the credibility of the patient's claim that she would not have proceeded with treatment if she had been warned of a particular risk [20]. For a successful claim in negligence, the plaintiff must establish that the defendant's negligence caused or materially contributed to the injury. In cases about risk disclosure, an essential issue is: did the failure to disclose the risk cause the injury? This has been answered by asking whether the plaintiff would have proceeded with the procedure even if the risk had been disclosed. In *Rosenberg v Percival,* the patient, an experienced health professional, sued for damages in relation to chronic pain that followed surgery to realign a fractured jaw. Her claim failed initially before the Western Australia District Court because the trial judge did not accept her evidence that she would not have had the surgery if she had been warned of this possible outcome. On appeal to the Western Australia Supreme Court, the decision was overturned. The matter was then appealed to the High Court of Australia where the original decision in favour of the doctor was restored.

The five justices of the High Court, although unanimous in their decision, wrote separate judgments that are very usefully analysed by Gottlieb and Linden [21]. The pertinent issue here was the difficulty the patient faced in establishing 'causation' (that she would not have proceeded if forewarned). Chief Justice Gleeson wrote as follows:

> The more remote a contingency which a doctor is required to bring to the notice of a patient, the more difficult it may be for the patient to convince a court that the existence of the contingency would have caused the patient to decide against surgery.

The issue of causation also arose in an earlier case before the High Court in 1998: *Chappel v Hart* [22]. There the patient claimed that she would not have proceeded with elective surgery for a pharyngeal diverticulum if she had known that postoperative infection could lead to loss of her voice. In this case, the High Court decided by a 3–2 majority in favour of the patient. The case also raised issues of interest, including the question (not decided in this case) of whether the surgeon should have canvassed with the patient his experience or lack thereof with the planned operation.

7.5.2 Therapeutic privilege

The judgment in *Rogers v Whitaker* also recognised that the duty to disclose was subject to the longstanding concept of 'therapeutic privilege'. This privilege

entitles a doctor to withhold information if the doctor believes disclosure might be harmful to the patient. Reliance on the privilege is rare and, if not carefully applied, may easily be construed as paternalistic and interfering with the ability of the patient to act autonomously. In the one known Australian example, a doctor was held, by a 2–1 majority, to have been entitled to withhold telling a patient that there was a risk of blindness from prolonged treatment for her severe mental illness [23].

7.5.3 Failure to diagnose

Many actions for negligence are commenced under this heading and frequently relate to allegations of delayed diagnosis of cancer. In 1994, a case before the New South Wales Supreme Court (*O'Shea v Sullivan*) attracted much attention [24]. A 24-year-old patient attended a general practitioner complaining of post-coital bleeding. The general practitioner diagnosed breakthrough bleeding and undertook a pap smear, which was reported as negative, a result that was later proven to be incorrect. Further investigations by the general practitioner were deferred and by the time cervical cancer was diagnosed, the disease was incurable.

The court found that the pathology laboratory had failed to exercise reasonable care in examining and reporting the pap smear. It also found that the general practitioner had failed to exercise reasonable skill and care in the initial assessment of the patient's complaint and in her failure, in the light of all the patient's symptoms, to refer the patient to a specialist gynaecologist for investigation. The findings in this case have caused alarm in several quarters. Doctors need to be aware that pap smears, whether undertaken for screening or for diagnosis, have a predictable error rate and they, for patients who are symptomatic, should not be relied upon solely to exclude a diagnosis of cervical cancer. While the general practitioner was held to be negligent in failing to refer the patient for timely gynaecological assessment, her error may be best described as one of judgment, rather than carelessness – doctors every day have to weigh up possibilities and decide when to further investigate or when to refer to a specialist. However, in the circumstances of this case, the general practitioner's judgment was held to fall below the relevant standard of reasonable professional care. The legislative definitions of that standard would now apply.

7.5.4 Failure to provide sufficient advice

Negligence was alleged against a general practitioner who failed to attend a child suffering status epilepticus and against a paediatric neurologist for failing to advise the child's parents regarding the administration of rectal diazepam in such an emergency [15]. The Supreme Court of New South Wales found negligence proven in both instances, but in an appeal to the New South Wales Court of

Appeal, Justices Kirby, Mahoney and Cole did not uphold the finding against the paediatric neurologist. The judgment handed down by the Court of Appeal is noteworthy for several reasons. It relied upon the definition of the duty of care stated by the High Court in *Rogers v Whitaker* and the role that that decision gave to the court in relation to normal medical practice:

> The ultimate question . . . is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the courts and the duty of deciding it cannot be delegated to any profession or group in the community. [15]

In carefully reviewing the evidence, the Court of Appeal noted extensive evidence from Australia, USA and UK that rectal diazepam was not advised in this situation and noted the strength of the arguments against its use. The Court of Appeal rejected the evidence to the contrary that had been provided by one London-based paediatric neurologist. The following excerpts of the judgment by Mahoney JA are useful:

> A judge can substitute his own judgement of what a medical risk involves for that of the treating doctor. *Rogers v Whitaker* makes that clear. But, at least in the case of a clinical judgement, there must be reasons in the nature of the factual material warranting such a factual decision . . . [Having] regard to what was said in *Rogers v Whitaker* in the High Court of Australia and in this Court, I am conscious that, in the end, this Court may substitute its conclusion as to what a duty requires for that of the medical profession. It is right that it be able to do so. But as I have suggested, the Court should have regard to the nature of the judgement made in the instant case. In my respectful opinion the courts should be slow to intervene where what is involved is the weighing up of advantages and disadvantages, medical necessities and the like by the profession . . . [There must be] strong reasons why a clinical judgement properly arrived at is to be put aside as wrong and, a fortiori, as negligent. [15]

7.6 ASSESSMENT OF DAMAGES

Actions for negligence allege and can succeed only if the plaintiff has suffered damage. The courts accept that damage may be physical or mental ('nervous shock') or involve economic loss. The award of damages is related to the degree of harm or loss and not to the degree of negligence. The compensation is intended to restore the plaintiff to the position that he or she would have been in if negligence had not occurred. Damages are assessed and awarded in regard to:

- general damages for pain, suffering and loss of enjoyment of life (now capped in most jurisdictions)
- specific damages for actual financial losses and expenses (loss of income and superannuation, medical and hospital expenses)
- future losses and expenses arising from the negligence (including care, medical expenses, home modification and maintenance, and therapeutic and physical aids).

7.7 STATUTES OF LIMITATIONS

Statutes of limitations define the period of time within which a claim for negligence may be brought after an event. This period is now 3 years in New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania and the Northern Territory. However, it is open to a litigant to seek a court-ordered extension of this period of time, most usually because an injury has not become apparent within the stated period or because the litigant was unaware of any connection between the injury and previous medical intervention.

7.8 VICARIOUS LIABILITY

Vicarious liability means that a person or organisation can be liable for the negligence of another person, without any direct personal fault being attached to the person or organisation sued. An employer thus may be held responsible for the negligence of an employee, but for this to be established it is necessary to demonstrate that the wrong was committed by a person who was an employee, and was committed by the employee during the course of his or her employment and within the scope of his or her employment.

Injured people may sue the employee, the employer or both. Hospitals and similar institutions are employers and are vicariously responsible for the acts or omissions of their staff, who can be regarded as part of their organisation. The scope of such liability was confirmed in *Albrighton*'s case in concluding that the hospital was vicariously liable for the negligent conduct of both the staff and the specialist practitioners. The court also found that the hospital itself had a duty of care to the plaintiff [10]. Each staff member can be held liable for his or her own negligent actions. When an employing authority, such as a hospital board, is sued for alleged negligence of its medical staff, the negligent staff member is not exonerated. The employer can claim to be indemnified by the employee (fully, or pro rata if other parties are involved). Although all hospitals carry indemnity insurance to cover claims for negligence and this insurance would usually extend to staff members acting in good faith, this cannot be guaranteed. Accordingly, all

doctors, including junior doctors, employed by hospitals and institutions should carry their own medical indemnity insurance.

7.9 THE MEDICAL INDEMNITY CRISIS AND ITS OUTCOMES

There is no agreement as to what constituted or what caused a 'crisis' that led to major changes in medical negligence laws and to the medical indemnity system that had been in place for at least 100 years. However, in the late 1990s and early 2000s, the medical profession, politicians and the general community became concerned over a number of threats to the system. The medical profession was concerned about the rising costs of medical indemnity and the profession's concerns were heightened when a major medical indemnity/defence organisation (MDO) appeared to be on the brink of collapse. The profession and the community were understandably concerned that MDOs were free to withdraw indemnity from members in certain situations. MDOs reported increased notification of claims and increased size of settlements. The causes of this increase have been the focus of conjecture and not all commentators accept that there had been a steady increase. Politicians began to take notice of the issues, not only in relation to medical indemnity but also in regard to insurance cover costs for sporting and other voluntary groups. At the same time, the public became aware of reports of a high incidence of adverse events in health care. There was also community concern in regard to a perceived arbitrariness of civil court compensation for medical and other injury.

In response to these concerns, the federal government established an eminent persons panel chaired by Justice David Ipp to conduct a review of the law of negligence, and a report was published in 2002, which became known as the Ipp report [25]. The report recommended a number of changes including:

- changing the standard of care applied to medical practitioners accused of negligence
- a reduction in limitation periods in which a claim for negligence can be commenced
- caps on various heads of damage and thresholds under which claims cannot be brought.

The recommendations of Justice Ipp were accepted by government and in 2003 the relevant federal minister announced a range of actions that were to be taken to address 'two fundamental problems in the provision of medical indemnity insurance, viz (a) the financial viability of the providers of medical indemnity insurance and (b) the ongoing affordability of cover for doctors' [26]. The actions to be taken included:

- premium subsidies to assist doctors in high-risk specialties
- a scheme to subsidise medical indemnity insurers for payouts over $2 million
- tort law reform to change the laws governing liability for negligence

- an extension of financial support for a threatened insurer
- a scheme to fund incurred but not reported claims that some MDOs had not adequately funded in the past
- prudential and product regulation to strengthen the medical indemnity industry.

The impact of these reforms is not addressed in this book, although doctors in practice at the time will be well aware of them. For our purposes, the most important changes related to 'tort law reform', including legislation reducing the statute of limitations to 3 years, defining the required standard of care, placing a cap on damages paid for pain and suffering and loss of enjoyment of life, limiting negligence claims to 'significant injuries' as either specified or above a set threshold, and protection for 'good Samaritans'.

7.10 ADVERSE EVENTS AND THEIR PREVENTION

While the Ipp report might seem to be an isolated event, concerns about medical indemnity had existed for several years before that time. A federal government-funded professional indemnity review (the Tito review) was completed in 1995 and its final report released in 1996 [27]. As part of this review, a major study of the incidence of adverse events in private and public hospitals in two Australian states was undertaken [28]. The study concluded that the rate of adverse events in Australian hospitals was 13 per cent, which contrasted unfavourably with a rate of 3.7 per cent for a similar study from the USA [29]. Independent experts assessed the value of the study as indicating that 'among a randomly selected series of hospital records examined by experienced doctors a substantial number were judged to display substandard care that resulted in injury to patients' [30]. The Australian study has had a mixed impact on medical and hospital practice. Governments, both federal and state, have established committees tasked with pursuing means of reducing adverse events, most notably the federally funded former Australian Council on Safety and Quality in Health Care (ACSQHC). Its activities have focused especially on system-related adverse events such as medication errors, operations on the wrong body part, in-hospital falls and the like. The Council has also contributed to the 'open disclosure' developments [1]. More recently the governance arrangements of ACSQHC have been altered and it is now known as the Australian Commission on Safety and Quality in Health Care. The organisation has continued to collect and publish data on serious adverse events in Australian hospitals [32].

MDOs have reinforced their efforts to educate doctors about preventable causes of legal action (see below). In some sections of the profession, for example in surgery, much greater emphasis is placed on simple measures such as procedures in the operating room to ensure correct identification of the patient and the body part to be operated on. Hospitals also have taken a range of steps to reduce

adverse events. However, some members of the medical profession remain sceptical about the preventability of many events identified as adverse, believing that interventions, especially in older patients with multiple morbidities, will always carry a risk of complications. There is published research supporting both sides of this argument [33] and there has emerged a general consensus that between 30 per cent and 50 per cent of adverse events are preventable. More adverse events are associated with surgery but overall these are less preventable, while a third of events are in medicine, frequently being preventable medication errors. Politicians and journalists prefer to portray all adverse events as preventable and ignore the fact that preventability is a post hoc assessment. Merry and McCall Smith have written an enlightening analysis of the preventability of medical mistakes [6].

7.11 PREVENTING CLAIMS FOR NEGLIGENCE/RISK MANAGEMENT

Among the reasons for the increasing numbers of claims made to MDOs are:

- breakdowns in communication
- increased scope of therapy and increased use of services
- increased expectations of patients, which fail to be met
- advertising by lawyers regarding negligence claims
- media coverage of negligence actions and the importance of early diagnosis of cancer
- a demystification of the 'art of medicine'
- increased community awareness of patients' rights
- decreased importance of the patient–doctor relationship through bulk-billing and third-party reimbursement for the cost of medical services.

MDOs focus much attention on 'risk reduction' strategies involving educating their membership in behaviour and practices that may reduce the incidence of claims. To create incentives to change the attitude of doctors, MDOs conduct risk management training and provide tools for risk assessment in medical practices, with reduction in indemnity premiums for those doctors who participate. Much of the advice given in this regard is very similar to that given in Chapter 9 to reduce complaints against doctors and revolves around improved communication and maintaining high standards of care. It now also includes risk assessment of the physical environment (for example, disposal of sharps), good record keeping, follow-up of laboratory results and the like. Particular care should be taken when giving medical advice by telephone [34]. Advice is also directed at avoiding problems that may arise if a doctor does not pay attention to good communication, is not reasonably available and is not seen to be caring and sympathetic. Unrealistic patient expectations in regard to outcome of treatment, especially in such areas as cosmetic surgery, should not be fostered. Fully informed consent is crucial and if untoward complications develop, communication must again be given priority.

MDOs also give specific advice, based on their experience of recurring problems, which includes:

- avoiding making gratuitous and often ill-informed remarks to patients about treatment provided by other doctors
- keeping clear, contemporaneous records
- carefully eliciting and recording any history of allergies
- for surgeons, avoiding errors in relation to the operative site, instrument and pack count, instructions regarding plaster casts, and so on
- taking great care with diathermy equipment
- having a fail-safe system of reading and filing investigation reports
- being aware of the regulations and alert to the problems of drug-dependent patients
- ensuring that an adequate authority has been received before the release of confidential patient information
- taking special care with the adequacy of consent for 'open access' procedures such as colonoscopy.

It is also worth noting that only a relatively small percentage of patients who suffer unexpected outcomes will sue their doctors. Surveys have shown that the reasons patients sue include a failure of the doctor to communicate, especially to warn regarding potential complications, a feeling that the doctor has ignored them or will not adequately discuss matters when something goes wrong, feelings of anger and humiliation combined with a need for the doctor to indicate recognition of the patient's problem, a wish that doctors should be accountable and, last and of least importance, because of significant financial loss. Indeed it has been claimed that 'people don't sue doctors they like' [35]. When something unexpected and undesired happens following treatment, some doctors naturally may react by a 'head in the sand' approach. This quite clearly will only aggravate the problem; what must occur is an open and frank discussion with the patient, including with any friends or relatives the patient wishes to be involved. This good professional practice is now known as 'open disclosure' (see below). Encouraging discussion of the facts without attributing blame does not represent an admission of liability. If a doctor is uncertain that this is the correct approach in certain circumstances, advice should be sought urgently from the doctor's MDO.

7.12 OPEN DISCLOSURE

'Open disclosure involves saying sorry and giving a factual explanation of what happened, the consequences of the adverse event and steps required to manage the event and prevent reoccurrence' [36]. Most MDOs have advised the use of this approach for several years. Many doctors seemed to find difficulty in this changed approach, claiming that there is a fine line between expressing regret and admitting liability. As part of the responses to the Ipp report into the law of

negligence, all jurisdictions now have legislation to ensure that apologies given when something has gone wrong cannot form part of a case for negligence. For example, in Victoria, section 14J of the *Wrongs Act 1958* states that:

> An apology does not constitute (a) an admission of liability for the death or injury; or (b) an admission of unprofessional conduct, carelessness, incompetence or unsatisfactory professional performance, however expressed, for the purposes of any Act regulating the practice or conduct of a profession or occupation.

The ACSQHC has developed a national standard for open disclosure and has funded research into how it can be introduced as well as into its effectiveness [37]. The standard has been designed in the first instance for application in hospitals and includes detailed advice about investigating adverse events. In addition, good medical practice guidelines issued by several medical boards also expect open disclosure when things go wrong. For example, the *Good Medical Practice* document issued in 2006 by the Medical Practitioners Board of Victoria states under the heading of 'If things go wrong':

> If a patient under your care suffers harm, whether as a result of medical misadventure or otherwise, that patient has a right to expect a prompt and appropriate response. You have a professional responsibility to:
> - act immediately to do what is possible to put matters right, if a patient under your care has suffered serious harm. Explain fully to the patient what has happened and the likely short- and long-term effects. When appropriate, express regret. If the patient cannot understand what has happened, explain the situation honestly to those with parental or guardianship responsibility
> - deal with complaints constructively and honestly
> - ensure that information is available to patients about how to make a complaint (for example to a hospital, the Board or the Health Services Commissioner)
> - co-operate with any complaints procedure which applies to your practice
> - review adverse events and implement changes to reduce the risk of recurrence
> - 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 a referral to another doctor.

7.13 THE ROLE OF MEDICAL INDEMNITY ORGANISATIONS

Medical indemnity or medical defence organisations (MDOs) have existed for over 100 years and had as their initial charter the protection of the character

and interests of medical practice, to promote good medical practice and to assist and advise doctors when facing proceedings [38]. Until the changes introduced by the federal government following the Ipp reforms, membership of MDOs operating in Australia was by annual subscription and MDOs were not regulated as insurance companies. Furthermore, until recently subscription was voluntary but in several jurisdictions including New South Wales, Victoria, South Australia, the Australian Capital Territory and Tasmania it has become a prerequisite for annual registration that the medical practitioner provide evidence of having medical indemnity cover. Not only does medical indemnity cover provide protection against medical negligence claims, but 'membership' also provides doctors with prompt access to practical medico-legal advice. The charter of MDOs includes the following aims:

- to represent the members' interests
- to improve standards of medical care by identifying and avoiding problems
- to educate members in regard to risk management and risk reduction
- to provide fair compensation to patients who are harmed by doctors whose actions have been agreed or proven to be negligent

7.13.1 Support and counselling

Many doctors have written accounts of the stress involved when negligence is claimed against them [39–40]. Doctors should not ignore this aspect as stress that is not dealt with may adversely affect the doctor's ongoing professional performance and the wellbeing of those around them [41]. MDOs are a very important source of support for doctors facing actions for negligence, although this is not their primary role. Other sources of support include peer support programs offered by professional associations and medical colleges and by organisations concerned with doctors' health (see Chapter 11).

7.13.2 Medical defence organisations in Australia

The RACGP website at http://www.racgp.org.au/gpissues/indemnity provides the names and contact details of MDOs operating in Australia.

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8 THE REGULATION OF THE MEDICAL PROFESSION

To practise medicine in Australia doctors are required by law to be registered with the relevant state or territory medical board. For convenience, in this chapter the term 'medical board' will be used for all the states and the territories, although the name of the first registration body established in Australia, in 1837, is the Medical Council of Tasmania. Also, in this chapter the term 'state' will apply to both states and the territories. The addresses and websites of the medical boards are provided in Table 8.1.

The requirements for registration are practically identical in each state. Via the process of 'mutual recognition' (explained later in this chapter), a doctor who is registered in one state has an automatic right to be registered in any other state, subject to completing certain procedural requirements and paying the relevant fee. Any conditions or limitations that apply to the registration in the original state will also apply in the second state.*

The main purpose of registration is to protect the public. This is achieved through the powers granted to medical boards to:

- determine that applicants for registration possess recognised medical qualifications and are of good character
- investigate allegations of unprofessional conduct and discipline doctors found guilty
- suspend or place conditions upon the registration of doctors whose capacity to practise is impaired by illness, and
- in some states, place conditions upon the registration of doctors whose practice performance (competence) is found to be unsatisfactory.

* At the time of writing, the Council of Australian Governments (COAG) has agreed to establish a single national process of medical registration, along with the registration of other health professionals, due to be in place by mid-2010. It is assumed that the broad principles of regulation as outlined in this chapter will be maintained in the new national framework. The implementation project team has established a website to provide information about the new national process at http://www.nhwt.gov.au/natreg.asp.

Table 8.1 Contact details of state and territory medical boards, the Australian Medical Council and the Confederation of Postgraduate Medical Education Councils

Name of board	Title of Act establishing it	Address details
New South Wales Medical Board	*Medical Practice Act 1992*	PO Box 104 Gladesville NSW 2111 http://www.nswmb.org.au Tel (02) 9879 6799 Fax (02) 9816 5307
Medical Practitioners Board of Victoria	*Health Professions Registration Act 2005*	PO Box 773H Melbourne Vic 3001 http://www.medicalboardvic.org.au Tel (03) 9655 0500 Fax (03) 9655 0580
Medical Board of Queensland	*Medical Practitioners Registration Act 2001*	GPO Box 1667 Brisbane Qld 4001 http://www.medicalboard.qld.gov.au Tel (07) 3234 0176 Fax (07) 3225 2522
Medical Board of South Australia	*Medical Practice Act 2004*	PO Box 791 North Adelaide SA 5006 http://www.medicalboardsa.asn.au Tel (08) 8219 9800 Fax (08) 8361 9422
Medical Board of Western Australia	*Medical Act 1894* (amended 1994) *Medical Practitioners Act 2008*	PO Box 1437 Subiaco WA 6008 http://www.medicalboard.com.au Tel (08) 6380 3500 Fax (08) 9321 1744
Medical Council of Tasmania	*Medical Practitioners Registration Act 1996*	PO Box 8 South Hobart Tas 7004 http://www.medicalcounciltas.com.au Tel (03) 6233 5499 Fax (03) 6233 7986
Medical Board of Northern Territory	*Health Practitioners Act 2007*	GPO Box 4221 Darwin NT 0801 http://www.health.nt.gov.au/Health_Professions_Licensing_Authority_HPLA/Health_Registration_Boards/Medical_Board/index.aspx Tel (08) 8999 4157 Fax (08) 8999 4196

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Table 8.1 (*cont.*)

Name of board	Title of Act establishing it	Address details
Medical Board of the Australian Capital Territory	*Health Professions Act 2004* Health Professions Regulations 2004	Scala House, 11 Torrens St, Braddon ACT 2612 http://www.medicalboard.act.gov.au Tel (02) 6205 1600 Fax (02) 6205 1602
Australian Medical Council		PO Box 4810 Kingston ACT 2604 http://www.amc.org.au Tel (02) 6270 9777 Fax (02) 6270 9799
Confederation of Postgraduate Medical Education Councils		c/o Postgraduate Medical Council of Victoria, PO Box 2900 St Vincent's Hospital Fitzroy 3065 http://www.cpmec.org.au Tel (03) 9419 1217 Fax (03) 9419 1261

These powers are mostly identical between the states, although some structural and procedural differences exist and there is considerable variation in how complaints made against doctors are handled (see also Chapter 9).

This chapter summarises the powers of medical boards and explains their processes. It defines unprofessional conduct, outlines the means by which possibly impaired doctors are assessed and describes the more recently introduced powers of assessing alleged poor professional performance by doctors.

8.1 HISTORICAL BACKGROUND

The identification and registration of people with qualifications entitling them to be 'legally qualified medical practitioners' was first set in place in the colonies of Van Diemen's Land and New South Wales in 1837 and 1838, respectively. Thus, the Medical Council of Tasmania predates the General Medical Council of the United Kingdom by 21 years. Initially the medical boards' functions were limited to registering doctors; additional functions, such as powers to discipline doctors, investigate complaints from the public and respond to ill or impaired doctors, were added later.

8.2 THE ESTABLISHMENT AND MEMBERSHIP OF BOARDS

The medical profession remains essentially self-regulating in that medical boards are mostly made up of practising members of the profession. Most boards also have members from the general community and members with legal qualifications. Each state medical board is a 'statutory body' set up under a state Act of Parliament. The titles of these Acts are given in Table 8.1. The size, composition and method of appointment of the boards varies but, essentially, medical practitioner members of boards cover a range of medical disciplines while the community and legal members are usually people of distinction who commonly have had experience with tribunals, health care, health-consumer issues or health administration. Board members are appointed by the Governor-in-Council in most states for fixed terms, although in the ACT a proportion of members are elected by the profession. The members are usually reappointed for more than one term, to ensure continuity and experience.

The regulation process provided by medical boards is funded by annual registration fees. In all states these fees are paid to the medical board, which is established as a body corporate with strict controls as to how this income may be used. Boards are required to provide annual reports to parliament, including audited financial statements. Examination of these statements shows that the main expenses incurred in the work of medical boards relate to paying for staff and for the conduct of disciplinary investigations and hearings.

As statutory bodies, the medical boards report to the parliament via the state Minister for Health. Medical boards are independent of the state health departments and the state branches of the Australian Medical Association. The roles of organisations and institutions other than medical boards, the Australian Medical Council and the Confederation of Postgraduate Medical Education Councils, are described in Chapter 14 on the Australian health-care system.

8.3 FUNCTIONS OF MEDICAL BOARDS

The key functions of medical boards are the assessment of:

- qualifications and maintenance of the register of medical practitioners (medical registration)
- professional conduct of medical practitioners brought to their attention, most often via complaints (complaints and disciplinary inquiries)
- fitness to practise, where a doctor's health is of concern (the impaired practitioner).

Subsidiary functions, not completely uniform between the states, include registration of medical students, pathways for the assessment of alleged poor performance, regulation of advertising by doctors, oversight of the intern year, and

registering of incorporated medical practices. In addition, amendments to the legislation in most states have linked registration renewal to documentation of adequate indemnity insurance, participation in continuing education, and self-reporting of health status and of criminal and civil court actions. Medical registration legislation also provides that it is an offence for an unqualified person to hold themselves out to be a medical practitioner, and alleged offences are usually prosecuted by the police in a Magistrates' Court.

8.4 THE AUSTRALIAN MEDICAL COUNCIL

The Australian Medical Council (AMC) was established in 1986. One of the key functions of the AMC and its initial *raison d'etre* is the accreditation of Australian medical schools, assuming a role previously played by the General Medical Council of the United Kingdom. The AMC is a company limited by guarantee and based in Canberra. Its membership includes one nominee of each state medical board, two nominees of the Australian Vice-Chancellors' Committee, two nominees of the Committee of Presidents of Australian Medical Colleges, two nominees of the Australian Health Ministers' Advisory Council, two people with a background in and knowledge of health-consumer issues, and one nominee from the Federal Council of the Australian Medical Association. In addition, the chairs of the standing committees of the AMC (the Accreditation of Medical Schools Committee, the Specialist Education Accreditation Committee, the Recognition of Medical Specialties Advisory Committee and the Examinations Committee) are members of the AMC. The Council is funded from examination and accreditation fees, and by contributions from the state medical boards and the federal government. The contact details for the AMC are given in Table 8.1.

The AMC has no statutory power of its own and its accreditation and examination powers are derived from relevant sections of state medical registration legislation. These Acts provide or infer that full (general) registration may be granted to people who are graduates of medical schools accredited by the AMC, or who are holders of a certificate attesting they have passed the AMC examination for overseas graduates, providing that they have completed an intern or equivalent year of supervised practice in Australia. The medical school accreditation process involves a site visit of 4–6 days by an external review committee every 5 or 10 years. The accredited medical schools are required also to notify the AMC of any major changes to the curriculum or to the provision of teaching that they may propose during a period of accreditation.

A second function of the AMC is to conduct written and clinical examinations for international medical graduates who come to Australia permanently and whose original degrees are not recognised by the state medical boards. The only overseas undergraduate medical training now recognised in the Australian states

is that of New Zealand and this is dependent upon New Zealand medical schools participating in the AMC accreditation process. International medical graduates whose medical education and internship was completed in jurisdictions deemed by the AMC to meet 'competent authority' criteria may apply to the AMC for advanced standing and, if granted, will be excused the AMC examinations but will have to complete 12 months' workplace-based assessment, working under supervision.

Via these functions, the AMC is a national standards body for the recognition of medical training. However, it is not directly involved in the registration of medical practitioners and thus differs in this way from counterparts such as the General Medical Council in the United Kingdom and the New Zealand Medical Council, both of which administer a single national system of medical registration.

In response to a request from the Minister for Health and Ageing in 1998, and after extensive consultation, the AMC assumed two additional related roles: the accreditation of existing specialist medical colleges and the assessment of applications from new specialist medical colleges for recognition. It established two additional standing committees for these tasks: the Recognition of Medical Specialties Advisory Committee and the Specialist Education Accreditation Committee. The first committee assumes the role previously played by the National Specialist Qualifications Advisory Committee, namely to advise the Commonwealth Minister for Health and Ageing on the recognition of new medical specialties. The second committee advises the AMC on the accreditation of existing and new providers of specialist medical education (including the two colleges responsible for training in general practice). This accreditation process is designed to be collegial and based on self and peer assessment, bringing benefits of transparency, accountability and improvement in education and training programs. When included with the accreditation of medical schools and the state-based processes for the accreditation of the intern year, the entire spectrum of medical education is now independently evaluated on a regular basis and is able to be more responsive to community and professional needs.

Other functions of the AMC include promoting uniformity of medical registration and disciplinary processes between the Australian states and coordinating the National Compendium of Medical Registers, which facilitates the flow of registration information between the state medical boards [1].

8.5 MEDICAL REGISTRATION

The categories of registration available via each state medical board are reasonably uniform, although the terminology used between states varies slightly. These categories are listed below.

8.5.1 Provisional registration

Provisional registration refers to the form of registration granted to new medical graduates for the 12 months during which they are gaining experience in medical practice under supervision (the intern year, now also known as postgraduate year 1 or hospital medical officer year 1). The category is also applicable to overseas graduates who have passed the AMC examination and are undertaking 12 months supervised experience in the Australian health-care system. In Western Australia, interns are registered 'conditionally', as provisional registration in that state refers to a form of interim registration.

Supervision, training standards and assessment processes for provisionally registered doctors are delegated by the medical boards to state-based postgraduate education councils. These councils accredit training positions in hospitals for years 1 and 2 and collaborate closely in regard to national supervision and training requirements through their membership of the Confederation of Postgraduate Medical Education Councils, the contact details of which are given in Table 8.1. Doctors who have completed the intern year satisfactorily, as attested by supervisors' reports, may be granted general registration. While the powers are rarely required, it should be noted that applicants may be denied provisional registration if they are not of good character, have been convicted of serious crime, are not competent in English, or are health-impaired in a way that puts the public at risk. In most states, applicants have to sign a statutory declaration that attests to the absence of impediments such as conviction for a serious crime.

8.5.2 General registration

General, full or unrestricted registration is granted after satisfactory completion of 12 months' provisional registration. Once granted, the registrant is able to renew this registration by the payment of an annual registration (or license to practise) fee, subject in most jurisdictions to the applicant for renewal declaring that he or she has medical indemnity insurance, is participating in ongoing education, is not impaired and has not been convicted of a serious crime. Registration lapses if the fee is not paid within a stipulated period. The commonest reason for 'deregistration' in Australia is the failure of doctors to renew their registration, usually because of failure to notify a change of address. Several state medical or health professions Acts therefore now also impose a fine for failure to notify the board of a change of address.

While general registration implies that the holders of such registration can undertake any type of medical practice that they may choose, their freedom of choice is constrained by the following imperatives:

- the ethical imperative that any doctor be adequately trained to undertake his or her selected form of practice

- a financial imperative in that the Australian health-care system (see Chapter 14) provides different levels of rebates to patients according to their doctor's specialist, consultant or family practitioner status
- a medico-legal imperative in that a doctor's medical indemnity cover (see Chapter 7) may be at risk if a doctor practises beyond his/her level of competence. Such doctors may also risk medical board sanctions.

8.5.3 Other categories of registration

The terminology of the medical registration legislation varies with references to specific, limited, restricted, conditional and temporary registration. Registration that is neither provisional nor general may be granted in all states of Australia to overseas medical graduates for the following limited purposes:

- to undertake supervised postgraduate training, study or research
- to fill a teaching or research position
- to fill a position in an identified 'area of need'
- to practise as a specialist, where the specialist qualifications are recognised by, or deemed equivalent to, the relevant Australian specialist college.

The last category allows indefinite renewal, while the former three may be restricted in duration by federal government immigration regulations or by regulations or practices of the particular state medical board. In addition, the following narrower categories of registration are available in some states:

- to undertake further specialist training prior to qualifications being recognised by the relevant Australian specialist college
- in the public interest
- for the purpose of practice exchange.

Most states have a 'non-practising' category of registration, designed to permit retired doctors to retain their courtesy title. The legislation varies and in some states this allows limited rights such as prescribing and referral. Most states also have a form of registration that permits a doctor to practise briefly in another state with appropriate protection, for example to retrieve donor organs. All states are able to grant interim registration in appropriate circumstances, pending formal approval by the medical board.

Requirements for registration of international medical graduates coming to work in Australia on a temporary basis are complex. They involve meeting stipulated requirements from the federal Department of Immigration and Ethnic Affairs before the relevant visa is issued, as well as providing to the medical board certified copies of the original medical degree certificate, a certificate of good standing from the medical registration authority in the doctor's country of origin, evidence of competence in English, and the relevant completed application forms. There may also be need for contact with the state health department, a relevant specialist college, and in some instances the Australian Medical Council.

Sponsoring institutions are strongly advised to leave ample time for this process.

Requirements for registration for international medical graduates seeking permanent resident or immigrant status are different, as these doctors usually seek general (unrestricted) registration or registration as a specialist. There are now uniform pathways to such registration agreed among the states. The pathways include the 'competent authority pathway', the longer standing AMC examination pathway, which requires the international medical graduate to pass both an occupational English test and the written and clinical examinations of the AMC, and the specialist pathway, which involves assessment of the international medical graduate by the relevant specialist medical college. Assessment of the training and experience of this last category of international medical graduates is coordinated by the AMC and conducted by the relevant Australian specialist colleges, on behalf of the state medical boards. Further details regarding general or specialist registration of overseas-trained doctors is provided by the AMC (http://www.amc.org.au/index.php/img).

8.6 REGISTRATION/RECOGNITION AS A SPECIALIST

Doctors with postgraduate specialist qualifications need to be recognised by Medicare Australia in order that their patients may receive the designated benefits for their services under the National Health Scheme (see Chapter 14). This process is conducted according to the Commonwealth *Health Insurance Act 1973*. Until 1997, the recognition of new medical specialties was based on the advice of the National Specialist Qualification Advisory Committee, but this function has been transferred to the AMC as noted above.

Application for specialist recognition under the *Health Insurance Act 1973* by individual doctors should be made to the CEO of Medicare Australia (formerly known as the Health Insurance Commission), PO Box 9822 in any state capital city. *Guidelines for the Recognition of Medical Practitioners as Specialists or Consultant Physicians for Medicare Purposes under the Health Insurance Act 1973* and the application form are available at http://www.medicareaustralia.gov.au.

In addition, the medical boards of Queensland, South Australia and the Australian Capital Territory maintain specialist registers, and some other boards have the power to endorse registration by listing specialist qualifications as recognised by the AMC.

8.7 MUTUAL RECOGNITION OF REGISTRATION

Mutual recognition legislation, passed initially by the Commonwealth Government as the *Mutual Recognition Act 1992* and followed by complementary legislation in all states, now allows for transfer of medical registration from state to

state. Under this legislation, a doctor who is registered in one Australian state is entitled to the same registration in any other state; this can be achieved by lodging the relevant notice with the medical board of the other state and paying the required fee. The application must contain certain information, including details of any disciplinary investigation in progress, or existing conditions on practice or suspension from practice. In lodging the application, the doctor also consents to the exchange of information by medical boards regarding the doctor's professional activities and conduct. Under mutual recognition legislation, if a doctor's registration is suspended or cancelled or has conditions placed upon it in one state, the same sanctions will be applied automatically in any other state in which the doctor is registered.

8.8 REGISTRATION OF MEDICAL STUDENTS

When first in contact with people as patients, medical students should be fully instructed by their teachers about appropriate conduct and ethical behaviour (see Chapter 2). The contact of students with patients is generally closely supervised, but problems may arise, especially when a medical student becomes impaired through illness. To enable the community to be more clearly protected, and because university medical schools have not had the appropriate statutory powers to act in these situations, medical students in their clinical years are now required to be registered in New South Wales, Victoria and South Australia. This has been the case in other countries (such as South Africa) for many years and is likely to become the norm in the other Australian states. There is no fee applicable to medical student registration in New South Wales, Victoria or South Australia, but registration has to be renewed annually. For medical students, the powers of the medical board are restricted to dealing with alleged impairment.

8.9 COMPLAINTS AND DISCIPLINARY HEARINGS

The monitoring of possible unprofessional conduct or substandard practice by doctors depends primarily on a responsive patient complaints system. In New South Wales, the *Medical Practice Act* was amended in 2008 to introduce the concept of 'reportable misconduct' such that a medical practitioner 'who believes, or ought reasonably to believe, that some other registered medical practitioner has committed reportable misconduct must, as soon as practicable, report the conduct to the [Medical] Board'. The legislation refers to 'flagrant departure from accepted standards' and the New South Wales Medical Board has issued guidelines to assist doctors to meet this new responsibility. Monitoring and reporting occurs also through other avenues such as the Coroner's Courts, drugs of dependence, surveillance, employers, other doctors, the police and medical negligence actions. The process by which complaints against doctors are investigated to the point at

which allegations of unprofessional conduct require a hearing varies considerably from state to state, but once this point is reached, the powers of the medical boards and medical tribunals to discipline doctors and the range of determinations (penalties) they can apply are very similar.

8.10 COMPLAINT-HANDLING PROCESSES

The processes for handling complaints against doctors from patients or their representatives have gradually become more uniform among the states, with the establishment in all states of a health complaints 'ombudsman', whose office has the power to investigate complaints, refer complaints to the medical board (or directly to the medical tribunal in New South Wales) and conciliate complaints. Such health complaints agencies are now a requirement of the Medicare funding agreements between the federal and state governments. This pathway sits beside the longer established pathway of complaints being lodged with the medical board. Complaints now may be lodged with either organisation and the organisations are obliged to 'share' the complaints. The terminology and powers differ considerably between the states. In New South Wales all investigation of complaints against doctors is conducted by the Health Care Complaints Commission, and that office refers allegations of unprofessional conduct or substandard practice to a professional standards committee established under the New South Wales *Medical Practice Act 1992* or to the Medical Tribunal (in the case of more serious matters) for hearing. In contrast, in Victoria, the Health Services Commissioner and the Medical Practitioners Board are both able to receive complaints and, under the respective legislation, must share the complaints and agree whether the complaint is suitable for conciliation or whether it raises issues of possible unprofessional conduct. In the latter case, the complaint is subjected to a preliminary investigation by the Board. The complaints process, especially with reference to conciliation and alternate dispute resolution, is discussed more fully in Chapter 9.

8.11 THE INVESTIGATION OF COMPLAINTS

The steps involved in investigating complaints are common to all states in that the nature of the allegations made are first clarified with the complainant and usually then put to the doctor for comment or explanation. Depending upon the doctor's response and the acceptability of the explanation to the board or the health complaints body, the matter may then be closed or, alternatively, further investigated with a view to a disciplinary hearing. In some more serious allegations, the doctor may not be informed of the matter until a notice of a formal hearing before a disciplinary tribunal is delivered, particularly if the welfare of complainants may be put at risk or if evidence could be interfered with.

8.12 DISCIPLINARY HEARINGS

Most states have a two- or three-tiered hearing structure, with the lowest level designed to deal with allegations of unprofessional conduct that are not of a serious nature (those that, if substantiated, are unlikely to warrant more than a caution, reprimand or counselling). Such lower-level hearings are structured to be informal, efficient and inexpensive, and are held in camera. At this level of hearing, the doctor is not entitled to legal representation and evidence is not taken on oath. The panel or committee conducting the hearing may exercise its judgment as to whether the complainant or other witnesses are interviewed. The doctor is adequately forewarned of the nature of the allegations to be investigated. The title, constitution, powers and range of determinations vary between the states but intent is similar, with 'penalties' at this level of hearing restricted to reprimand, caution or counselling. Although the registration and livelihood of the doctor is not in jeopardy in an informal hearing, one possible outcome of such a hearing is the referral of the matter to a higher level or formal hearing, during or at the conclusion of the informal hearing. In most states, it is also possible for a doctor who is dissatisfied with the outcome of an informal hearing to appeal by way of requesting a formal hearing. Such appeals are rarely made because of the possibility of more significant penalties.

Traditionally, it has not been possible for complainants to appeal decisions made at medical hearings as the process was about judging professional standards and the complainant had no standing other than that of bringing the matter to the attention of the medical board. This situation has been changed in Victoria under the *Health Professions Registration Act 2005*, with section 60 of the Act providing that a complainant ('notifier') may apply for review of a decision of the medical board by an investigation review panel.

For those states with three tiers, the next level up is usually termed a professional standards panel or committee. Such procedures are usually not open to the public, although this changed in New South Wales for all matters commenced after 1 October 2008. Whether the doctor is entitled to be accompanied by, or represented by, a lawyer is related to the powers of the panel (if the panel has powers that, if applied, would affect the doctor's livelihood, then legal representation is provided for in the legislation). At this level, panels generally do not have the power to suspend the registration or deregister a doctor but can place conditions on the doctor's practice, including orders for further training or to alter the nature of practice, and in some states may be able to fine the doctor.

8.13 FORMAL HEARINGS

Formal hearings are reserved for determining allegations of serious unprofessional conduct. In all states, these hearings are now conducted by medical tribunals

chaired by judges or lawyers and otherwise composed primarily of medical practitioners. The doctor is served with a formal notice of the allegations and is informed of the right of legal representation. Only very unwise doctors would not avail themselves of this right, the cost of which is usually met by the doctor's medical indemnifier. Formal hearings are open to the public, other than when certain types of evidence are being heard.

When conducting formal hearings, tribunals are generally not bound by the rules of evidence but are obliged to observe natural justice. In practice, such hearings are conducted in a manner very similar to that of the courts. Witnesses are sworn in and examined by the barrister appearing to assist the tribunal ('prosecute' the case) and cross-examined by the barrister appearing for the doctor. In addition to penalties available at informal hearings (caution, reprimand, counsel and, in New South Wales, fine and place conditions), the formal hearing tribunal may impose conditions or restrictions, fine, suspend the registration or cancel the registration, if the allegations of unprofessional conduct are proven.

The determinations of any formal hearing tribunal in most states are published in the *Government Gazette* and the Board's *Report to Parliament* and notified to other relevant bodies such as Medicare, other state medical boards and employers. The doctor is entitled to written reasons for the tribunal's decision and may appeal the decision to a higher authority, usually the state Supreme Court.

In addition to the foregoing deliberative processes, medical boards also have powers to take action urgently where it is deemed necessary to protect the public, via suspension or placing of conditions upon registration.

8.14 WHAT CONSTITUTES UNPROFESSIONAL CONDUCT?

Medical/health practitioner registration legislation usually defines categories of unacceptable conduct under headings including unsatisfactory professional conduct or professional misconduct (see below). These categories retain an older distinction between serious misconduct, for which a doctor's registration could be suspended or cancelled, and less serious misconduct, for which lesser penalties could be imposed. The previous term for serious misconduct, namely 'infamous conduct in a professional respect', is no longer used. However, it is informative to trace the history of the interpretation of these various terms in a little detail, particularly since Australian courts respect English court precedents.

The term 'infamous conduct in a professional respect' was first used in the *Medical Act 1858* in England and later in all medical registration legislation in Australia. It was considered by Lord Justice Lopes in 1894 to mean the following:

> If it is shown that a medical man in the pursuit of his profession has done something with regard to it which would be reasonably regarded as disgraceful

> or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council to say that he has been guilty of infamous conduct in a professional respect. [2]

In 1930 Lord Justice Scrutton commented that 'the phrase means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession' [3]. In 1941, in an appeal against a decision of the Victorian Medical Board, Mr Justice O'Bryan of the Supreme Court lent support to these definitions when he stated that the expression 'included conduct in the pursuit of a profession which men of good repute and competency in the profession would reasonably regard as disgraceful or dishonourable' [4]. The previous Tasmanian *Medical Act 1959* and the earlier Victorian *Medical Practitioners Act 1970* both had sections that had the effect that if a doctor was found guilty of infamous conduct in a professional respect the doctor's name had to be removed from the register. Thus the term came to be reserved for the most serious offences committed by doctors. The situation in Australia has, however, changed somewhat since then. The New South Wales *Medical Practice Act 1992* no longer uses the term 'infamous conduct in a professional respect', and the legislation introduced in other states since then has followed suit.

The most quoted recent decision related to 'misconduct in a professional respect' and was given by Mr Justice Kirby, then of the New South Wales Supreme Court, in *Pillai v Messiter* in 1989 [5]. The case related to an inadvertent drug dose transcription error that led to the death of a patient. Mr Justice Kirby stated:

> No purpose would be served, to achieve the objective of this statute of protecting the public, to remove the appellant from the register to prevent an error of transcription of medical dosage . . . [This] is not in the slightest to condone wilful harm to patients, indifference to their care or misuse of the privilege of professional practice. None of those defaults can be suggested in the case of the appellant. Nor is it to condone serious and rudimentary acts of negligence which demonstrate an unfitness to remain on the register with the great public trust which attaches to that privilege. It is simply to acknowledge that mistakes can happen to the most conscientious professional person. And in evaluating whether those mistakes amount to 'misconduct in a professional respect', it is necessary to demonstrate something more than mere negligence by the civil standard. It is that additional component which was missing in this case. I therefore agree with the orders which are proposed by Samuels JA.

In *Pillai v Messiter*, Mr Justice Samuels made the following remarks:

> Unacceptable practice does not make a case of misconduct. In my opinion there was no evidence before the Tribunal capable of supporting a finding of misconduct in a professional respect. The tribunal made findings about the appellant's conduct, which, of course, it had ample power to do. But it

> was not entitled to substitute its own view of the response which the appellant's professional colleagues would have made to his conduct. However, I do not think that the Tribunal made any such endeavour. Indeed, its judgement is remarkable for the omission of any reference to the principles which regulate the translation of professional negligence into professional misconduct (or misconduct in a professional respect). It seems as if the Tribunal treated the matter as if it were an action for professional negligence rather than a charge of misconduct. The Tribunal found that the appellant's conduct demonstrated a gross departure from 'the standard of care and competence of a medical practitioner' . . . [it] is not every departure – even if gross – from proper standards which amounts to misconduct, and in the absence of the necessary evidence no such inference can be made. In my view the appeal must be allowed.

The above interpretation of 'misconduct in a professional respect' may not be applicable to all the current medical registration legislation, as most now provide a broader range of categories of unacceptable practice under the rubric of either 'professional misconduct' (more serious misconduct for which loss of registration may be imposed) and/or 'unsatisfactory professional conduct' (less serious misconduct for which lesser penalties apply).

The most comprehensive list of conduct that might be unsatisfactory professional conduct is found in section 36 of the New South Wales *Medical Practice Act 1992* and includes:

- any conduct that demonstrates that the knowledge, skill or judgement possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience
- any contravention of a provision of the Act or the regulations
- any contravention of a condition to which the practitioner's registration is subject
- any conduct that results in the practitioner being convicted of or being made the subject of a criminal finding under six other pieces of legislation, including the *Mental Health Act 1990* (NSW), the *Guardianship Act 1987* and the *Health Insurance Act 1973* (Commonwealth)
- a contravention of section 34A(4) (Power of Commission to obtain information, records, and evidence) of the *Health Care Complaints Act 1993*.

In addition paras (e) to (k) of section 36 define as unsatisfactory professional conduct various aspects of professional behaviour including accepting inducements, referral of patients for pecuniary reasons, overservicing, and using or working with unskilled assistants or unregistered people. Para (l) covers refusing or failing to assist in an emergency and para (m) is a catch-all: 'any other improper or unethical conduct relating to the practice or purported practice of medicine'.

The New South Wales legislation defines 'professional misconduct' as 'unsatisfactory professional conduct of a sufficiently serious nature as to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register'. The Victorian *Health Professions Registration Act 2005* provides similar definitions of unprofessional conduct and professional misconduct.

While higher court precedent must have some impact on formal disciplinary hearings, the hearings remain essentially peer review, where allegations of unprofessional conduct are judged by a tribunal composed predominantly of experienced and respected medical practitioners and each case is judged on its merits.

The standard of proof required for findings by a tribunal or formal hearing panel has been determined to be the civil standard (the balance of probabilities), but weighted for the serious consequences of the finding for the medical practitioner, thus requiring a degree of certainty in the minds of the members beyond the balance of probabilities. This has been described as partway between the civil standard and the criminal standard of proof beyond reasonable doubt. The authority for this view is a 1938 decision of the High Court of Australia [6], which has been reinforced repeatedly in appeals to state courts.

8.15 CODES OF CONDUCT

In addition to the above statutory definitions of what might constitute poor professional practice, all medical boards now publish codes or guidelines as to what constitutes good medical practice. In New South Wales, the code forms part of the regulatory framework. Doctors should be familiar with the code in their jurisdiction as breaches of the code or guidelines may be grounds for disciplinary action. In 2008, the Australian Medical Council, on behalf of the state and territory medical boards, issued *Good Medical Practice: A Draft Code of Professional Conduct* for public consultation (http://goodmedicalpractice.org.au). When finalised, it is anticipated that this code will be adopted by the proposed new national medical board.

8.16 NATURE OF COMPLAINTS SUBJECT TO FORMAL HEARINGS

An indication of the range of complaints made against doctors is provided in the annual reports of the medical boards and the health complaints commissions (see Chapter 9). Matters that are regarded seriously by all medical boards and that are likely to be subject to a formal hearing include:

- sexual misconduct
- gross negligence or gross incompetence
- issue of fraudulent certificates

- conviction for serious crimes or other serious offences, including offences against drugs of dependence laws or involving fraud against Medicare Australia.

This last category should make it clear that doctors may have both criminal and professional penalties imposed for certain conduct and that being not of 'good character' remains a factor that may lead to deregistration or refusal to register.

Removal of a doctor's name from a medical register is not necessarily permanent. It is open to the doctor to later apply for re-registration; in some states the doctor is advised as to the earliest date an application for restoration will be considered.

8.17 TRUST AND THE MEDICAL PRACTITIONER

All of the examples of unprofessional conduct listed above represent, in one form or another, a breach of the trust that the community and individual patients place in doctors. The importance of trustworthiness was highlighted in Chapter 1 where it was emphasised that trust underpins the entire practice of medicine and is one of the essential qualities of medical professionalism. Without trust, patients will be hesitant to reveal intimate matters, to be examined and to undergo treatment. Trust is also assumed by employers who receive medical certificates of unfitness for work, by insurers and Medicare Australia who reimburse doctors for their fees, and by the state parliaments, which entrust the regulation of the medical profession predominantly to the profession.

8.18 SEXUAL MISCONDUCT

The most serious breach of trust by a doctor is to use the doctor–patient relationship for the doctor's sexual gratification or to establish a sexual or improper relationship. Where this occurs, typically the patient is vulnerable, by virtue of the illness for which they are seeking help or through a sense of powerlessness, making the breach of trust more egregious and creating long-term and ongoing harm to the patient. Medical boards in Australia and abroad have issued clear policy statements on this matter. All doctors should be very aware of the standards of the medical profession in this regard and the community can be reassured that medical boards will continue to regard complaints of this type very seriously. Sexual misconduct is discussed in detail in Chapter 10.

8.19 THE IMPAIRED PRACTITIONER

Protecting the public from doctors whose impairment through illness or drug dependence renders their practice a danger to patients is the third major function

of medical boards. The processes involved have changed in two ways in recent years: the impaired doctor is commonly dealt with by negotiation (with mandated suspension powers kept in reserve) and a greater emphasis is placed on assisting the doctor to recover and return to active practice.

The impairments of practitioners who may be putting the public at risk usually fall into one of three categories: psychiatric illness, drug or alcohol addiction, or illness leading to intellectual or physical impairment. Impairment usually involves loss of insight. Medical boards may be informed of potential impairment of doctors by one of the following routes:

- notification by concerned treating practitioners (mandatory in several states if the public is believed to be at risk)
- mandatory notification by medical directors of scheduled psychiatric hospitals
- notification of suspected or admitted drug dependence by officers responsible for policing regulations relating to handling drugs of dependence
- referral from medical administrators in hospitals
- self-notification
- uncommonly by patients who have observed odd behaviour by their doctors.

Confronting an ill and possibly impaired colleague or notifying a medical board of such concern is a serious and difficult responsibility for doctors. Perhaps for these reasons, such situations are often ignored or deferred, to the detriment of both the sick doctor and the community. The independent Doctors' Health Advisory Services in most states, and the opportunity for doctors with concerns to seek advice from this service or from the medical board, helps reduce delays and denial in this area. In Victoria, the Medical Practitioners Board and the Australian Medical Association have established an agency independent of the medical board known as the Victorian Doctors Health Program, modelled on North American 'diversion programs', designed to encourage ill doctors to obtain help before they become impaired. More details about this program as well as contact details for the Doctors' Health Advisory Services are provided in Chapter 11.

8.20 ILLNESSES LEADING TO IMPAIRMENT

The health of doctors, including ill health leading to impairment, is discussed in depth in Chapter 11. In general, the physical health of doctors is comparable with that of the general community. In addition, psychiatric disorders such as schizophrenia and manic depression are not more common in doctors. However, studies from several countries demonstrate that doctors have three to four times the rate of admission for alcohol-related disorders and several times the rate of admission for depression and attempted suicide as compared with the general population and matched for social class. The rates for narcotic dependency are even higher (see Chapter 11).

The regulations regarding the use of drugs of dependence, designed to protect the community and doctors, are discussed fully in Chapter 18. Despite these regulations, a small proportion of doctors misuse narcotics or tranquillisers, especially the former, and put themselves and their patients at risk. The most frequently abused narcotic is pethidine, although multi-drug abuse or drug and alcohol abuse are also common. Factors contributing to the misuse of narcotics include readiness of access combined with depression or social, financial or marital difficulties. Dependence appears to develop rapidly followed by escalating doses and detection by colleagues or authorities sooner rather than later. While medical boards generally deal with drug dependence as a health issue (see below), with emphasis on treatment and rehabilitation, a period of suspension from the register has proven to be a key factor in initiating effective treatment. Return to full medical practice can now be expected in upwards of 90 per cent of instances.

Apart from drug dependence and impairment, the use of drugs such as alcohol and cannabis while at work or on call also may give rise to allegations of unprofessional conduct. Doctors have a personal and professional responsibility not to use illegal drugs and to ensure that the use of a legal drug such as alcohol does not affect one's ability to practise and thereby endanger the community.

8.21 NOTIFICATION AND HANDLING OF POSSIBLE IMPAIRMENT

Most medical Acts have statutory provisions to give medical boards the framework and the powers to handle notifications of possible impairment. Where a doctor is so impaired that the risk to the public is grave, most boards have the power to suspend the registration of the doctor forthwith, pending the outcome of assessment and/or inquiry.

More commonly, the doctor is not suspended, but is obliged to undergo medical assessment by one or more independent specialists. The assessment report is used by the board to determine whether suspension or imposition of limitations or conditions on practice is required. The process by which this is achieved varies. In some states, the board receives the report and takes action, in others, an impaired practitioners' panel or subcommittee deals with the matter, or a board member is delegated with the power to negotiate appropriate conditions on a voluntary basis, backed by the necessary powers if voluntary agreement is not reached.

Restoration to the register or the lifting of limitations or conditions is subject to the receipt of a satisfactory progress report from an independent specialist and, where agreed, from the treating doctor. If the impaired practitioner objects to suspension or conditions or the board's refusal to lift these, the practitioner may appeal to the medical tribunal in the relevant state.

8.22 THE POORLY PERFORMING DOCTOR

Most medical boards have established an additional statutory path for evaluating issues of alleged poor performance as, in many cases, performance can be seen to be separate from impairment or misconduct. The principle behind this development is to attempt to identify poorly performing doctors as early as possible and thereby assist those doctors through education and retraining before disciplinary action is needed or before harm occurs to patients. A doctor who is the subject of allegations of poor performance is provided with the details of the allegations and is invited to participate in a peer review process. The peer review is intended to be constructive and is conducted by peers who have been trained in the task. The focus is on performance overall rather than the initial specific allegations that triggered the referral.

8.23 ADVERTISING BY DOCTORS

Restrictions on advertising by doctors are in place in all jurisdictions under the relevant legislation or attached regulations. In New South Wales, advertising by doctors must not be false, misleading or deceptive, must not create unjustified expectations of beneficial treatment and must not promote unnecessary or inappropriate use of medical services. In other states more detailed directions are provided to doctors in terms of what is permissible and what is proscribed. In Victoria, the *Health Professions Registration Act 2005* provides a similar framework, but empowers the medical board to issue more detailed guidelines after a process of public consultation and approval of the guidelines by the Minister of Health. In most states advertising of medical services by bodies corporate is also brought under medical board control. In addition, the federal *Therapeutic Goods Advertising Code 2007* sets standards for advertising that are relevant to doctors who might be invited to endorse or support particular products in advertisements.

8.24 DOCTORS WHO PRACTISE ALTERNATIVE MEDICINE

Alternative medicine, also known as unorthodox medicine and complementary medicine, is a loosely defined collection of approaches to providing health care, some of which are unproven or unconventional. Alternative medicine creates educational, philosophical and ethical dilemmas for the medical profession and these have led to inconsistent responses. These issues are addressed more fully in Chapter 15. Here it is simply noted that some Australian medical boards have issued advice to doctors [7]. The advice focuses on the ethical obligations of doctors who espouse alternative medicine methods, noting the duty to fully inform and not mislead patients about the lack of a scientific evidence base for most of

these methods. To conceal such information and to use medical qualifications to promote such methods is unethical. Such conduct may place doctors at risk of disciplinary action by medical boards.

References

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2. *Allinson v General Medical Council of Medical Education and Registration* (1894) 1QB750 at 763 per Lopes LJ.
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9 HEALTH-CARE COMPLAINTS SYSTEMS

Prior to the mid-1980s, the only agencies with statutory powers to handle complaints against doctors were the state and territory medical boards. Medical boards were obliged under the relevant medical Acts to investigate the complaints and determine whether a complaint constituted unprofessional conduct under the Act. Complaints were sometimes also made to state branches of the Australian Medical Association (AMA), to medical colleges and to the state health departments, but these organisations did not have disciplinary powers.

During the 1980s there was dissatisfaction with the health complaints processes in several states, especially in regard to their fragmented nature, difficulties in access, difficulties in knowing where to complain and the recognition that complainants' needs were not always met when the complaints were determined by the medical board according to the terms of the legislation. In New South Wales, the response to this dissatisfaction was the establishment in 1984 of a Health Complaints Unit within the Health Department, and in Victoria by the passing in 1987 of the *Health Services (Conciliation and Review) Act*. This Act established the office of the Health Services Commissioner, who was charged with receiving complaints from users of health services about providers and given the power to conciliate them confidentially.

In 1991 in Queensland the *Health Rights Commission Act 1991* established the Office of the Health Rights Commissioner. In 1993 in the Australian Capital Territory the *Health Complaints Act 1993* established the Office of the Commissioner for Health Complaints, since replaced by the Health Services Commissioner under the Australian Capital Territory *Human Rights Commission Act 2005*. In 1993 the *Health Care Complaints Act* of New South Wales established the Health Care Complaints Commission, which subsumed the role of the previous Health Complaints Unit and took on additional power to conciliate complaints. Since then (catalysed by the 1993 Medicare agreements between the Commonwealth and state governments), all states and territories have health complaints systems (see Table 9.1). The systems in each state have very similar powers, although in New South Wales the Health

Table 9.1 Health complaints commissioners (or equivalent)

State	Title	Address	Telephone and website
New South Wales	Health Care Complaints Commissioner	Level 13 323 Castlereagh Street Sydney NSW 2000	(02) 9219 7444 Toll free: 1 800 043 159 http://www.hccc.nsw.gov.au
Victoria	Health Services Commissioner	30th Floor 570 Bourke Street Melbourne Vic 3000	(03) 8601 5200 Toll free: 1 800 136 066 http://www.health.vic.gov.au/hsc/
Queensland	Health Quality and Complaints Commissioner	Level 18 288 Edward Street Brisbane Qld 4000	(07) 3120 5999 Toll free: 1 800 077 308 http://www.hqcc.qld.gov.au
Australian Capital Territory	Health Services Commissioner	Level 4 12 Moore Street Canberra City ACT 2601	(02) 6205 2222 http://www.hrc.act.gov.au/
Tasmania	Health Complaints Commissioner	99 Bathurst Street Hobart Tas 7001	Toll free 1300 766 725 http://www.healthcomplaints.tas.gov.au/
South Australia	Health and Community Services Complaints Commissioner	PO Box 199 Rundle Mall Adelaide SA 5000	(08) 8226 8666 http://www.hcscc.sa.gov.au/
Western Australia	Office of Health Review	GPO Box B61 Perth WA 6838	(08) 9323 0600 Toll free: 1800 813 583 http://www.healthreview.wa.gov.au
Northern Territory	Health and Community Services Complaints Commissioner	12/22 Mitchell Street Darwin NT 0800	(08) 8999 1969 http://www.nt.gov.au/omb_hcscc/hcscc/index.htm

Care Complaints Commission is also responsible for investigating allegations of unprofessional conduct of doctors, with subsequent referral if necessary to a New South Wales Medical Board Professional Standards Committee or the New South Wales Medical Tribunal for adjudication.

The right of patients to complain about their medical care is now included in the *Australian Charter of Healthcare Rights* issued in 2008 by the Australian Commission on Safety and Quality in Healthcare [1]. These rights cover access, safety, respect, communication, participation, privacy and the right to complain or comment on care received.

This chapter focuses only on the complaints-handling processes in regard to complaints made about doctors. It should be noted that health complaints commissions also handle complaints about other health-care professionals and health-care institutions and have a role in promoting improvements in health-care delivery. The chapter does not consider complaints relating to possible offences under the federal Medicare legislation; this is discussed in Chapter 14.

9.1 HEALTH COMPLAINTS COMMISSIONS

The purposes of the health complaints legislation in the states and territories are virtually identical and include:

- provision of an accessible and independent mechanism for resolving health-care complaints
- promotion of the rights of patients and the dissemination of information about such rights
- provision of the capacity to review and improve the quality of health services
- establishment of a committee to advise the minister on health services generally (in New South Wales this committee is a parliamentary joint committee).

In addition, in Queensland and the Australian Capital Territory, the Commissioner is charged with developing a code of health rights. More recently, the commissions in Victoria and Australian Capital Territory have assumed a statutory role in relation to health records (privacy) legislation in those jurisdictions. The health complaints commissions are funded from general revenue.

9.2 HEALTH-CARE PROFESSIONALS COVERED BY LEGISLATION

Each Act stipulates the range of health-service providers and institutions covered by the legislation, what constitutes a complaint, who may complain and about whom, and what power the Commissioner has to deal with complaints. Although the present chapter concentrates on complaints about doctors, the legislation generally covers anyone who holds him- or herself out as being able to provide

or as providing a health service, including the employers of such people. As an example, the Act in Victoria covers medical practitioners, dentists, pharmacists, nurses, ambulance services, chiropodists, osteopaths, chiropractors, dietitians, optometrists, audiologists, audiometrists, prosthetists, physiotherapists, psychologists, optical dispensers, masseurs, occupational therapists, speech therapists, naturopaths, acupuncturists and other alternative health providers. In other states, dental prosthetists and radiographers are added to this list.

Not only are individual health practitioners subject to these Acts, but institutions and organisations, public and private, that provide health services are also covered. Complaints that arise in public hospitals are expected to be responded to by an internal complaints officer, who in some states also has an obligation to regularly report activity levels and patterns to the health complaints commissioner. The annual reports of the commissioners indicate that most complaints lodged are about doctors, as may be expected, given the difference in the level of responsibility between doctors and other health-service providers.

9.3 WHO MAY LODGE A COMPLAINT?

The emphasis in the complaints system is on the 'users' of health-care services; that is, patients (or their nominated representatives) are able to lodge complaints. Complaints from medical colleagues, insurance companies, employers and drugs of dependence inspectors are usually referred to the medical board rather than to the health complaints office. In New South Wales, the Act also gives organisations the right to complain and complaints are received from employers, solicitors, the police, drugs of dependence authorities, the coroner, the health department and other health-care providers.

9.4 'SHARING' OF COMPLAINTS

In all states, the legislation makes it quite clear that the responsibility for adjudicating whether a doctor's conduct has been unprofessional rests with the disciplinary bodies stipulated under the relevant medical practice acts. While there are subtle differences between the complaints pathway in the various states, in general, complainants may lodge complaints either to the health complaints commission or to the medical board. Both bodies upon receipt of complaints are obliged under the legislation to share the complaints. In practice, this means an exchange of the text of any complaint, followed by negotiation over whether prima facie the complaint raises issues of unprofessional conduct and protection of the public or whether the complaint is suitable for conciliation and/or the complainant may possibly be entitled to compensation. In the event of disagreement between the commission and the medical board, the legislation broadly indicates that the complaint is to remain with the health complaints commission, though in practice, if one body

takes a more serious view of the complaint than the other, the more serious view prevails. There are also statutory provisions for subsequent reporting back by, and to, each body about the final disposition of a complaint.

9.5 WHAT CONSTITUTES A COMPLAINT?

In New South Wales the legislation does not prescribe what matters may be complained about, but in most states detailed descriptions are given in the Acts as to what may constitute a complaint. These include if:

- a provider has acted unreasonably by not providing a health service for the user
- a provider has acted unreasonably in the manner of providing a health service for the user
- a provider has acted unreasonably in providing a health service for the user
- a provider has acted unreasonably by denying or restricting the user's access to records kept by the provider and relating to the user
- a provider has acted unreasonably in disclosing the user's health records
- a public or private health-care institution has acted unreasonably by not properly investigating, or not taking proper action upon, a complaint made to the institution by a user about a provider's action of the kinds mentioned above.

The foregoing terminology with repetition of the word 'unreasonable' has been interpreted pragmatically and, as a result, the range of complaints accepted by the health complaints commissions bear great similarity to those traditionally examined by medical boards.

Complaints may be made orally, and subsequently put in writing, with assistance if needed. Complaints considered 'frivolous, vexatious or trivial' must be rejected, as must complaints that have already been determined by a medical board, tribunal or court. Time limits apply in regard to lodgement of complaints (for example, the periods are 12 months in Victoria and Queensland, 2 years in the Australian Capital Territory and 5 years in New South Wales). In all states, the commissioner has the discretion to accept a complaint beyond the stated time limit if the complainant was unaware of the matter before the time limit or if the complainant has sufficient reason for the delay in making the complaint. Should 'out of time' complaints raise issues of a doctor's professional conduct, it is still open to the complainant to address the complaint to the relevant medical board, where time limits do not apply.

9.6 HOW COMPLAINTS ARE HANDLED AND RESOLVED

Provided a complaint does not raise issues of possible unprofessional conduct and hence require referral to the medical board, the processes followed by the health complaints commissions are broadly as outlined below.

9.6.1 Resolution at the initial contact

Many inquiries and complaints received by commission staff are capable of resolution simply by clarification and provision of information.

9.6.2 Resolution at 'point of service'

If there is a reasonable possibility that complainants can resolve their complaints directly with their doctor, either they are invited to make a direct approach to the doctor or the complaint is forwarded by the commission to the doctor, with a request that the doctor respond directly to the patient. The New South Wales legislation differs as complaints must be notified promptly to the doctor, and 'point of service' and informal resolution of complaint is not covered by the legislation.

9.6.3 Informal resolution: assessment

Should the doctor reject the invitation to respond directly to the complainant or should the patient not be satisfied with the doctor's response, the commission may then become directly involved in assessment and/or investigation. During this phase, complaints may still be resolved, through such methods as explanation of established medical facts, agreement to provide a service, apology, refund or other means. Commissioners frequently use independent expert medical opinions at this stage and later in conciliation.

9.6.4 Conciliation

Complaints deemed suitable for conciliation are referred to people employed exclusively for this task. Between 5 and 20 per cent of complaints are processed via conciliation. The conciliation process is voluntary for both the complainant and the doctor and has statutory privilege – that is, anything said or disclosed by the patient or the doctor may not be used in evidence in a court or tribunal, accessed under Freedom of Information legislation, discovered by subpoena, used for any other investigation or reported to any person other than the health complaints commissioner.

Depending upon the nature of the complaint, the conciliation process may involve patient and doctor meeting face to face in the presence of the conciliator. The conciliation process is intended to be informal and legal representation is not usually involved. However, doctors are advised and encouraged by their medical indemnity organisation to seek advice throughout the process. The conciliation process thus provides a simple and reasonably efficient means of resolving

potential claims of negligence or personal injury and has been so accepted by the medical indemnity organisations. Conciliators are not medically trained and rely upon independent expert medical opinion in guiding patient and doctor towards a just settlement. In Queensland, the Act allows conciliators to be supported by professional mentors (people expert in dispute resolution), who are bound by the same rules of confidentiality.

During conciliation, if the conciliator becomes aware of issues that raise questions that would be more properly dealt with by a medical board or other authority or raise questions regarding the protection of the public interest, these issues must be referred to the commissioner and a decision taken as to whether conciliation should continue or whether part or all of the matters should be referred to the medical board or other authority. If conciliation is not achieved, it is also open to the commissioner to refer the complaint to the medical board.

Although the conciliation process is protected by statutory privilege, anything doctors may say, or information they may release, could still be used informally by a so motivated complainant to assist in preparation of a civil claim for negligence, as he or she is free to withdraw from conciliation at any time. It would remain open for a doctor to object to the use of such material, on the basis of the privilege established in the complaints legislation. The need for ongoing advice from the doctor's medical indemnifier is thus further stressed.

In all states, the commissioner has the power to directly and formally investigate complaints, with the associated power to subpoena witnesses, to hear evidence on oath, to compel the producing of documents and, via the court, request the issue of search warrants.

9.7 THE NATURE AND SOURCE OF COMPLAINTS AGAINST DOCTORS

Doctors should be aware of the range of complaints made against doctors and should be cognisant that most complaints are preventable. In Chapter 8, the nature of serious complaints leading to formal disciplinary hearings has been outlined. These include sexual misconduct, gross negligence or gross incompetence, issue of fraudulent certificates and conviction for serious crimes or for offences against drugs of dependence laws or for fraud involving Medicare Australia. While most complaints are lodged by patients, the families of patients or people representing patients, medical boards also receive information about alleged unprofessional conduct from a range of other sources including government agencies (such as Medicare Australia and state drugs and poisons inspectors), insurance companies, compensation bodies, health professionals and the police.

The less serious, but nevertheless important, complaints made against doctors and received by health complaints commissions and by medical boards are

discussed below. The use of an arbitrary single category is at times misleading, as many complaints contain more than one significant element. Failure in communication heads the list and underpins many other categories of complaint. The ethical imperative of adequate communication has been emphasised in this book by devoting Chapter 3 in its entirety to the issue. Complaints received fall into the categories discussed below.

9.7.1 Failure of communication

The effect of failure to communicate is seen in complaints including:

- failure to gain consent
- failure to warn about adverse effects or costs of treatment
- conflicting information provided by health-care team members
- failure by hospitals and specialists to forward information to the family doctor
- avoiding patients when things have gone wrong
- failure to explain procedures or physical examinations
- breaching confidentiality when talking to relatives and friends of the patient without permission
- failure to recognise and provide appropriate counselling for grief reactions in spouses and relatives
- appearing abrupt, rude or disinterested
- allowing staff, including receptionists to be discourteous, rude or unhelpful
- discouraging patients (overtly or covertly) from raising concerns or complaints
- creating over-inflated expectations of benefits of treatment.

This list is not exhaustive. Increased emphasis on training in communication skills should prevent many such complaints. Unfortunately, the doctors who are most deficient in this crucial skill often lack insight into their deficiencies, are unwilling to allow colleagues to constructively criticise them and are overconfident as to their own abilities.

9.7.2 Quality of treatment issues

This broad heading refers to such matters as failure to diagnose, unsatisfactory outcome of treatment (untoward complications or poor results), inadequate, incompetent or unskilful treatment, roughness or causing of pain through a physical examination and complications arising from medications (allergies, side effects). As much of medical practice remains an art and as the course of diseases, the outcomes of interventions and the occurrence of side effects are not totally within the control of the doctor, it cannot be expected that this category of complaint can be eliminated. However, attention paid to communication, consideration and care will be likely to reduce the incidence of such complaints and will improve the patient–doctor relationship.

9.7.3 Medico-legal examinations

Complaints arising in this field of medical practice have special features and their occurrence and means of prevention are discussed in Chapter 25.

9.7.4 Respect and trust

Behaviour by doctors designed to provide sexual gratification is unethical, is likely to lead to deregistration, and is discussed more fully in Chapter 10. It is not unusual for patients to misapprehend professionally appropriate examinations. To minimise the potential for such misunderstanding, doctors should:

- fully explain the reasons for and the nature of any intimate physical examination, and, during history taking, for probing into sexual behaviour, performance or dysfunction
- provide privacy while the patient undresses and dresses
- provide an appropriate combination of gown and cover sheet, while still conducting a thorough examination
- consider the use of a chaperone for the examination of particular patients, including those who are young or inexperienced, or from a different cultural background, or otherwise vulnerable.

Direct observation of a patient while the patient is disrobing is likely to be misinterpreted, may increase a patient's anxiety and may lead to complaint. While a previous generation of doctors may have been taught to use such powers of observation, especially in medico-legal examinations, an alternative means of making similar observations regarding physical abilities must be sought.

9.7.5 Medical reports and certificates

The responsibilities of doctors in relation to this aspect of medical practice are covered in Chapter 6. The two common themes of complaints are inordinate delays in responding to requests for medical reports and allegations that medical certificates have been issued when the circumstances suggest to the employer that the certificates may not have been justified.

9.7.6 Access to records

Patients frequently complain that when moving to a new area, or changing doctors, they have great difficulty in having their records forwarded to the new doctor. Some patients wrongly believe that the entire record is theirs and should be sent in its original form. Sensible doctors will respond professionally (and avoid complaints) by promptly providing relevant photocopied extracts or a summary, by explaining to the patient that the record is owned by the doctor and needs to

be retained (for future possible inquiries and for medico-legal purposes) and by offering to respond to any additional inquiries made by their new doctor. While some doctors charge for this service, the vast majority do not as they recognise that they also are the beneficiaries of patients transferring to their practice (see Chapter 6).

9.7.7 Fees and related matters

Patients are entitled to a frank disclosure of anticipated fees, especially for major interventions, admissions to hospital or extensive investigations, and particularly when doctors know that their charges and the charges of the hospital and other professional services will not be adequately covered by the patient's level of health insurance.

9.7.8 Practice environment; hygiene and accidents

Patients are aware of the risks of infection, especially by blood-borne pathogens associated with sharps injuries, so that complaints about inadequate standards of infection control in doctors' surgeries are quite common. The standards required are discussed in Chapter 16. Doctors need also to be very careful in regard to maintaining a hazard-free environment, as complaints do arise involving children accidentally being exposed to needle-stick injury or to the ingestion of chemicals.

9.8 PREVENTING COMPLAINTS AND RESPONDING TO THEM

Busy medical practice is emotionally, intellectually and physically demanding and no doctor can be expected to perform perfectly at all times. A small proportion of patients may create difficulties, sometimes by virtue of personality disorder or aggressive temperament, and thus most doctors should expect a complaint at some time in their careers. It is well established that the risk is less if the doctor has good communication skills, employs competent staff and demonstrates a patient, courteous and empathic manner. Should a complaint or the hint of a complaint arise, the doctor should be willing to make time available to listen to the complainant in a non-defensive manner. Many times, simply acknowledging the complaint, acknowledging the patient's right to complaint and (if appropriate) accepting the legitimacy of the complaint and undertaking to prevent recurrences will resolve the matter there and then and enhance the doctor–patient relationship.

Should the complaint come to the doctor via a medical board or a health complaints office, the complaint should be responded to promptly, fully, accurately and thoughtfully. Depending upon the potential seriousness of the complaint, advice should be sought from the doctor's medical defence organisation. Angry

responses, delayed responses or responses that do not address the complainant's concerns are of little help to the complainant or the responsible agency and put the doctor in an unfavourable light.

Reference

1. Australian Commission on Safety and Quality in Health Care. *Australian Charter of Healthcare Rights*, 2008. http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-01

10 THE DOCTOR AND SEXUAL BOUNDARIES

From the time of Hippocrates, the medical profession has acknowledged that the special relationship of trust between patient and doctor must not be abused by the doctor establishing any type of improper or sexual relationship. As stated in the Hippocratic Oath:

> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations, with both female and male persons, be they free or slaves. [1]

This prohibition has been widely restated in recent times and is enforced by the threat of suspension or removal of the name of the doctor from the medical register if found guilty of such unprofessional conduct [2–6]. For example, the Medical Practitioners Board of Victoria states: 'It is always wrong for a doctor and a patient to enter into a sexual or an improper emotional relationship. It is also wrong for a doctor to enter into a relationship with a former patient or a close relative of a patient, if this breaches the trust the patient placed in the doctor' [5]. Despite this clear prohibition, there is considerable evidence from North America, Europe and Australia that sexual boundary violations remain a problem [7–11].

This chapter defines sexual misconduct and summarises what is known of the incidence of sexual misconduct. It discusses the apparent causes of boundary violations, emphasising the psychological dynamics for the patient/complainant, who is usually female, and the doctor, who is usually male. An understanding of the psychodynamics of the patient–doctor relationship where these breaches of trust have occurred leads to an appreciation of the frequently harmful outcome for patients. This potential for harm, and other ethical arguments, explains the need for continuation of the strict prohibition of such relationships. The chapter describes a manner of response to allegations of sexual misconduct that is designed to meet the best interests of the complainant, the community and the medical profession. It also briefly touches on the use of chaperones for intimate examinations, and the making of false allegations.

10.1 WHAT CONSTITUTES SEXUAL MISCONDUCT

Sexual misconduct exists on a continuum from inappropriate or suggestive remarks about a person's appearance or attractiveness through inappropriate touching, improper emotional relationships and sexual liaisons to sexual assault and rape. The Queensland Medical Board has provided the following definitions [4]:

1. Sexual behaviour is defined as any words or actions that might reasonably be interpreted as being designed or intended to arouse or gratify sexual desires.
2. Sexual exploitation or abuse may be considered under two categories: sexual harassment or sexual relationship.
3. Sexual harassment is unwelcome behaviour of a sexual nature including, but not limited to, gestures and expressions. The intention of the person performing the behaviour is immaterial, but if that person intended to offend, humiliate or intimidate the patient, then the behaviour of the practitioner would be considered more serious. The conduct of the person performing the behaviour will be judged according to the standards of members of the same profession who are of good repute and competence. Sexual harassment incorporates (but is not limited to): a) making an unsolicited demand or request, whether directly or by implication, for sexual favours; b) inappropriate disrobing or inadequate draping; c) intimate examinations without informed consent (can also be defined as sexual assault and may be referred to the police); d) irrelevant mention of a patient's or practitioner's sexual practices, problems or orientation; e) ridicule of a patient's sexual preferences or orientation; f) comments about sexual performance that are not pertinent to the professional interaction; g) requesting details of sexual history or sexual preferences not relevant to the professional interaction; h) conversations regarding the sexual problems or fantasies of the health practitioner; i) making suggestive comments about a patient's appearance or body.
4. A sexual relationship describes the totality of the relationship between two people, where the relationship has some sexual aspect, including any sexual activity between a health practitioner and a patient. This holds whether the relationship is initiated by the patient or not and whether consented to or not. It includes, but is not limited to, physical stimulation, kissing, penetration, masturbation, or genital activity.
5. Sexual assault is also known as criminal assault which is defined in the Queensland *Criminal Code* s 245 as: 'A person who strikes, touches, or moves, or otherwise applies force of any kind to the person of another, either directly or indirectly, without his [sic] consent, or with his consent

> if the consent is obtained by fraud . . . is said to assault that other person, and the act is called an assault.'

Consent on behalf of the patient is not an acceptable defence against allegations of sexual misconduct, although it may diminish the seriousness of the offence, if it can be demonstrated that the patient was not vulnerable and that there was no power imbalance in the patient–doctor relationship. Termination of the doctor–patient relationship in anticipation of an improper or sexual relationship is sometimes used to attempt to justify or make the relationship acceptable. The success of this defence will depend on the relevant circumstances, especially the apparent vulnerability of the patient, the nature and duration of the therapeutic relationship, and the time elapsed since that relationship ended [12]. It must be emphasised that this defence is not accepted in the practice of psychiatry where it is generally agreed that, by virtue of the intensity of the therapeutic relationship as well as the possibility of needing to return for further therapy, past patients are held to be vulnerable [13]. It may also be unethical for a doctor to enter into a sexual relationship with a close relative of a patient (for example, with a patient's spouse or with the parent of a child where the child is the patient [14]). In situations where the clinical contact between doctor and patient, or doctor and parent, has been brief and free of any suggestion of patient vulnerability, and where there is social contact for other reasons as may happen in small communities, a subsequent sexual relationship will not automatically be deemed to be unprofessional [15].

10.2 THE INCIDENCE OF SEXUAL MISCONDUCT

Studies on the incidence of sexual misconduct are based mostly upon anonymous self-reporting by questionnaire and are directed primarily at sexual relationships arising from the doctor–patient relationship. Responses to such questionnaire studies are always incomplete and it is not possible to determine the true incidence of sexual misconduct among doctors. Thirteen per cent of physicians responding to a US questionnaire admitted to sexual contact with patients [7]. Of those admitting to such conduct, 80 per cent had been involved with an average of six patients. In a separate US study of 1057 male psychiatrists, 7 per cent of those responding to a questionnaire admitted to sexual relationships with patients [8]. In a study in the Netherlands, 4 per cent of respondent doctors had had sexual contact with patients [9]. A survey of Australian psychiatrists in 1994, to which over 300 responded, found that 18 psychiatrists (7.6 per cent) reported sexual intercourse with patients or former patients [11]. Medical board experience indicates that sexual misconduct is a frequent cause for complaint. In 2007, 35 instances were reported to the Queensland Medical Board and 25 to the Victorian Medical Practitioners Board, the latter figure representing 4 per cent of all complaints received [16–17].

It seems probable that the high incidence now reported in many countries represents a long-standing pattern of behaviour and that the medical profession has previously concealed the problem or denied its existence, with patients contributing by their understandable reluctance to complain. Medical board experience in Australia is consistent with under-reporting of such complaints, as additional complainants frequently come forward when a doctor is publicly identified after being found guilty of sexual misconduct. The increase in the number of complaints in Australia may be related to increased community awareness of sexual abuse generally and/or increased confidence of complainants that they will receive appropriate support if they do lodge complaints.

Up to 98 per cent of instances of sexual misconduct involve male doctors and female patients [7]. The problem is not confined to doctors, as inappropriate conduct or misuse of positions of power, influence or trust is also being reported increasingly in regard to psychologists, ministers of religion, counsellors and teachers in tertiary institutions. Studies from the USA have reported that 20 to 30 per cent of female tertiary students have been the subject of sexual approaches by their teachers and that 17 per cent of female psychology students reported sexual intimacies with their teachers [7].

10.3 REASONS FOR UNDER-REPORTING OR FAILURE TO COMPLAIN

Identification of incidents of sexual misconduct is dependent almost entirely upon complaints from those patients who have been the subject of such misconduct. There appear to be psychological, social and system-related reasons for victims being reluctant to complain. Studies have shown that female patients, particularly of psychiatrists and other counsellors, frequently are uncertain of the professional standards expected of doctors and counsellors and in addition, for the same reasons that have made them emotionally vulnerable to sexual exploitation, may blame themselves for allowing the sexual relationship to develop [7]. They experience shame, self-doubt and fear of being blamed. Patients are also very aware, when contemplating making a complaint, of the power imbalance between patient and doctor, recognising that in a court disciplinary hearing the onus is on the complainant to prove the allegations. They are also fearful of the stress involved in lodging a complaint and being subject to cross-examination by a barrister before a disciplinary hearing. Some complainants have described being discouraged by other doctors with whom they raised their concerns.

10.4 THE PSYCHODYNAMICS OF THE BREACH OF PROFESSIONAL SEXUAL BOUNDARIES

A number of North American systematic studies of the psychological profiles of victims and perpetrators have provided considerable insight into why such

serious ethical breaches occur and why they cause such harm. This brief summary of this literature focuses solely on the overwhelmingly most frequent occurrence, violation of trust and abuse of power between a male doctor and a female patient and draws heavily on the excellent book of Dr Peter Rutter [7].

These studies have noted several frequently recurring features of the female patients involved in sexual contact with doctors. Many have had disturbed childhoods that involved sexual abuse or in some cases incest. Most have poorly developed concepts of sexual boundaries, making them uncertain how to interpret the inappropriate conduct of the health professional. Up to a half of the women reported being unaware that sexual contact between patient and doctor was regarded by the medical profession as a very serious breach of ethical principles. Interviews of these patients also revealed that, in developing a professional therapeutic relationship with their doctor, the patients gained enormous support from the doctor, support they valued very highly in a non-sexual manner. This sense of support and trust in a male counsellor was seen to be of particular value because of the patients' past unhappy experiences with sexual abuse by other males. The therapeutic relationship had often become so important that the patients' overwhelming instinct was to do anything they could to hold on to the relationship. This inner psychological pressure, combined with the failure to realise ahead of time that entering a sexual relationship with their therapist would destroy the therapeutic relationship, made them extremely vulnerable to sexual advances.

An additional psychological theory has been invoked in the role of the female patient when a doctor crosses the sexual boundary, namely the concept of the female instinct to protect and heal the male. Some patients have described feelings towards their doctor consistent with this notion in situations wherein the doctor has (inappropriately) disclosed distressing events occurring in his private life [7].

The studies referred to have also included detailed analyses of the doctor–perpetrator of sexual misconduct and have used psychological theory that helps explain why some doctors are at greater risk of breaching sexual boundaries than are others. These theories depend upon acceptance of the extensive sexual fantasy-life that many males lead and link this to the existence in most doctor–perpetrators of psychological wounds from childhood that have not been admitted and dealt with. Upon such a background, the doctor may become so intensely involved emotionally with the patient in the therapeutic relationship that the doctor moves from reality to living out his sexual fantasies. The seeking of support and consolation in this way from patients is unethical and destructive to the patient. It is also harmful to the doctor in that his own problems are perpetuated, increased and unresolved by such behaviour. Consistent with this theory of the doctor using his relationship with his patient to solve his own psychological difficulties is the observation that doctors involved in this form of misconduct are frequently experiencing a breakdown of a marriage or relationship

or are experiencing other major life crises associated with depression and substance abuse.

In a detailed study of over 200 cases involving boundary violations by analysts or therapists, Celenza and Gabbard emphasised that for the majority of one-time offenders (but not for serial or predatory offenders) 'the typical characteristics of the analyst or therapist who engages in sexual misconduct . . . are qualities that are to some extent present in analysts generally' [18] and that it is often an additional life crisis that precipitates the transgression.

This framework helps to explain much of the professional misconduct of a sexual nature which occurs, especially where the complaint is not of a serial or predatory nature. However, it must be noted that there is also a proportion of doctors involved in serial exploitative sexual behaviour with patients where the doctors are amoral or psychopathic, or suffer from a personality disorder [19].

10.5 WHY SEXUAL MISCONDUCT BY DOCTORS IS ETHICALLY UNACCEPTABLE

The use of the doctor–patient relationship for the purpose of any type of sexual gratification or for the establishment of an ongoing sexual relationship is unacceptable because it breaches the trust that individual patients place in doctors and breaches the trust that the community places in doctors when they grant them the privilege and powers to have access to the most confidential and private information about patients. However, as some doctors deny the importance of this principle and have even claimed that the establishment of a sexual relationship with a patient can be of therapeutic benefit to the patient, it is important to look more deeply as to why such conduct is unacceptable.

The reasons have been touched on above and include first and foremost the frequently harmful effect such relationships have, especially on vulnerable patients. The harm includes aggravation of the original psychological problems that have led the patient to seek professional help, and can lead to suicide and other self-destructive behaviour, depression and family breakdown. The patient may develop deep mistrust and apprehension at ever attending a doctor of the same sex as the perpetrator again. Furthermore, the original problem for which the patient sought help is often not addressed and, worse, if the problem is primarily psychological, it may never be satisfactorily addressed. Leaving aside the amoral or psychopathic doctors who may engage in this behaviour, for most other doctor–perpetrators, involvement in such liaisons is also usually harmful to themselves in the longer term. This harm relates to the failure of the doctor to seek professional help for the underlying personal distress, as well as causing confusion and distress to family members and harm to the doctor's professional status if disciplinary action ensues [20].

10.6 REPORTING COMPLAINTS – THE DOCTOR'S ETHICAL DUTIES

The Australian Medical Association code of ethics [2] advises doctors to (1) 'report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body', and (2) 'where a patient alleges unethical or unprofessional conduct by another doctor, respect the patient's right to complain and assist them in resolving the issue'. Medical boards also remind doctors of this duty. There have been requests made by medical boards to governments for mandatory reporting by doctors of allegations of sexual misconduct but to date no state legislation incorporates this requirement. Such a requirement was introduced in the Canadian province of Ontario in 1994. Subsequently, there was initially a fifteenfold increase in reports (from 40 per year to 600) to the registration body. Under proposals for national medical registration (see Chapter 8), it is likely that mandatory reporting of allegations of sexual misconduct will be introduced in Australia.

10.7 HANDLING COMPLAINTS OF SEXUAL MISCONDUCT

Medical boards are obliged to follow due process in handling allegations of sexual misconduct made against doctors. These processes have been criticised by complainants, and by support groups and counselling centres established to assist complainants. These criticisms have included the lack of sensitivity and empathy of investigative personnel, the apparently unnecessary repetition of interviews to assess the complainant's evidence, the lack of support for complainants before, during and after the necessary formal hearing (see Chapter 8) to test the allegations, and failure to provide less stressful ways for boards and tribunals to conduct such formal hearings, for example permitting the complainant to give evidence by video link rather than having to face the doctor about whom they have complained. These factors are regarded as additional disincentives for patients who have been sexually exploited to lodge complaints. Medical boards in Australia and overseas have extensively revised their methods of dealing with these complaints and have adopted strategies including:

- policies to reduce the number of pre-hearing interviews
- employing appropriately trained and carefully selected staff to conduct the investigation of these complaints
- ensuring that complainants are directed to the relevant sources of ongoing support and counselling
- providing support to the complainant in relation to the formal hearing of any charges
- publicising the board's policies to the medical profession and the community
- being prepared to use video technology at disciplinary hearings
- using victim impact statements in determining penalties.

The investigation and prosecution of allegations of sexual misconduct require that the doctor who is the subject of the allegations is afforded fairness and natural justice. The requirement to treat the doctor fairly is not readily appreciated by distressed and angry complainants, emphasising again the need for appropriate and trained independent support for both the doctor facing the allegations and for the complainants.

Where sexual touching or intercourse is non-consensual, or there are other circumstances raising the possibility that the allegations represent a criminal offence (indecent assault or rape), the board is obliged to advise the complainant of the option of contacting the police and the board also has to consider whether it should refer the matter to the police [21]. If the police decide to investigate, their investigative processes will normally precede actions by medical boards, unless there are grounds for immediate suspension of the doctor's registration pending legal action and any formal disciplinary inquiry.

As patients are invariably harmed by the sexual relationship, some patients may seek compensation for this harm and are entitled to pursue this by conciliation or civil action (see Chapters 7 and 9). However, it is in the interests of both the community and the medical profession that patients are encouraged to participate in disciplinary proceedings first, rather than to solely seek compensation, as it is only via disciplinary proceedings that other patients can be protected from future harm.

10.8 DISCIPLINARY OUTCOMES

Where sexual misconduct is established via a disciplinary hearing, the penalties applied by medical boards and tribunals and by appeals courts vary widely. Some of this variation is explained by the evidence heard by the tribunal, the circumstances surrounding the offences, the apparent vulnerability of the complainant, the demeanour of the doctor and any expressions of remorse by the doctor. Nevertheless, most instances of proven sexual misconduct lead to periods of suspension from the medical register or deregistration. In addition, medical boards are increasingly placing orders to ensure that the doctor seeks counselling or psychotherapy and, if appropriate, placing conditions on the doctor's practice to prevent future recurrences.

10.9 FALSE ACCUSATIONS

Most authorities agree that false accusations by patients against doctors are rare [22–23]. Medical board experience, reinforced by the self-reporting of doctors via anonymous questionnaire, suggests that doctors who engage in sexual misconduct frequently offend more than once. Where more than one complainant comes forward, the task of proving allegations of sexual misconduct is made easier. The laying of a complaint takes considerable courage, as patients are usually aware of

the difficulties to be confronted at a disciplinary hearing, and as such misconduct has previously been under-reported. Thus doctors who are informed by patients of such possible misconduct by other doctors or professionals would be wise to assume the allegations are true, or at the very least require investigation, and thus adopt a supportive, proactive approach, leaving the evaluation of the accusations to the appropriate authorities. It should also be noted that experienced doctors of high standing in the profession are among the offenders [24].

10.10 BENZODIAZEPINES AND SEXUAL FANTASY

A number of studies and case reports have reported that a small proportion of female patients experience very realistic sexual fantasies including sexual assault when sedated with intravenous benzodiazepines [25–27]. Allegations of sexual assault against doctors and dentists have been defended on this basis and it may be that wrongful convictions have been recorded in the past [28–29]. Doctors who use intravenous benzodiazepines for sedation will appreciate the value of having a third person present throughout the procedure, including during recovery. Fortunately, this is usually required for medical reasons to observe the patient's vital functions.

10.11 PREVENTION OF SEXUAL MISCONDUCT BY DOCTORS

Medical educators in some countries have begun to systematically address prevention of sexual misconduct [30–31]. Such preventive programs should include the following elements:

- education of medical students and doctors regarding the psychodynamics and psychopathology that appear to explain many instances of sexual misconduct. Such education will include acknowledging one's own sexuality and training doctors how to appropriately manage sexual emotions in the doctor–patient relationship.
- more widespread acceptance and acknowledgment by the profession and the community that the problem exists and must be addressed
- dissemination of information to patients so that patients are aware of the ethical principle to which doctors must conform (for example, when a patient is to enter a period of counselling or intensive psychiatric support)
- reinforcement of the ethical principle that such abuse of trust is never acceptable.

Doctors and patients should also be aware of 'danger signs' in the professional relationship that sexual boundaries are at risk of being broken. These warning signs include patients requesting or receiving non-urgent appointments at odd hours, especially when other staff are not present, inviting each other out socially,

and the doctor revealing intimate life details to a patient, especially regarding personal crises or sexual desires or practices.

10.12 INTIMATE EXAMINATIONS AND THE USE OF CHAPERONES

Complaints about possibly inappropriate conduct during intimate physical examinations (such as breast, vaginal and rectal examinations) are a source of great distress to patients, and to innocent doctors [32]. As was emphasised in Chapter 3, good communication can usually prevent any difficulties, even in this sometimes fraught area. When a patient is required to undress, the need for this should be explained and the doctor should leave the room or direct the patient to an adequately screened area. A gown and/or a cover sheet should be provided, depending upon the examination to be undertaken. Care must be taken to explain the need for and nature of the examination, obtain consent and provide for privacy.

One means of reducing the risk of complaint is to use a chaperone, but this can bring its own difficulties, in terms of practicality and cost, as well as distress if the patient would prefer not to have one and has not been asked. When a chaperone is used, it is important to provide a time before or after the examination for confidential matters to be discussed in the absence of the chaperone. Doctors also need to be aware that allegations of inappropriate touching can arise from examinations not usually defined as intimate, such as examination of the ear with an auriscope [33].

10.13 SEXUAL ABUSE AND SEXUAL HARASSMENT OUTSIDE THE DOCTOR–PATIENT RELATIONSHIP

Doctors, like other members of the community, may be accused of criminal sexual activity including rape, incest and paedophilia. These are matters initially for the police and the criminal courts but, as they are serious crimes, medical boards are also asked to review the fitness to practice of doctors convicted of such crimes. This will normally be via a formal disciplinary hearing, which will examine not only the circumstances of the crime but also the doctor's mental health and the relevance of the crime to the nature of the doctor's clinical practice. These are difficult issues for boards to deal with, but if it is deemed that the doctor is fit to practise it may be possible to place conditions upon a doctor's practice such that vulnerable patients are not put at the slightest risk, for example by placing a condition that a doctor not consult with or examine children other than in the presence of a parent or guardian.

Sexual harassment or sexual exploitation of colleagues, students or staff by doctors may also be reported to medical boards. In their working relationships

with such people, doctors are engaged in professional rather than private conduct and a sexual relationship perceived to be exploitative or coercive could lead to charges of unprofessional conduct.

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11 PERSONAL HEALTH OF THE DOCTOR: ILLNESS AND IMPAIRMENT

Doctors are ethically responsible for ensuring that their own health problems do not interfere with the welfare of their patients. Although doctors generally enjoy good physical health as measured by standardised mortality rates, studies concerning the 'impaired practitioner' indicate that up to 10 per cent may become impaired during their professional lives [1–3]. Such impairment may lead to harm to patients. While doctors may appear well placed to attend to their own health, in practice the reverse often applies as doctors tend to deny the presence of psychological or physical health problems, putting off getting help until too late. Professional colleagues often contribute to this denial [4–5]. This chapter explores some reasons for this, examines the extent of the problems, describes the most frequently recognised health problems and outlines ways of identifying and assisting colleagues with them. Advice that may help prevent such personal health problems for doctors is also provided.

11.1 ETHICAL AND LEGAL RESPONSIBILITIES

The ethical principle of 'non-maleficence' underpins the professional codes, which state that doctors must not permit their own ill health to put their patients at risk. In this regard the *AMA Code of Ethics* states: 'Accept responsibility for your psychological and physical well-being as it may affect your professional ability' [6]. This ethical duty extends also to medical colleagues and treating doctors who have a responsibility to ensure that an impaired colleague or doctor–patient, who may be putting patients at risk by continuing to practise, is guided towards treatment and, if necessary, notified to the medical board. In most states, for doctors in a treating relationship with a doctor who is ill and impaired, and potentially placing other patients at risk, such notification is a statutory responsibility under the relevant legislation. These responsibilities and the manner in which medical boards handle these matters are described in Chapter 8.

11.2 THE EXTENT OF HEALTH PROBLEMS FOR DOCTORS

The full scope of psychological and physical health problems of doctors may not be known because of the tendency to denial, but available evidence, in particular those studies that have used appropriate control groups, discloses a sombre picture. The problems found include stress and 'burnout', drug and alcohol dependence, depression and suicide, delayed diagnosis of physical illness and marital, social and family difficulties. Schizophrenia and bipolar disorder, however, occurred no more commonly than in the general community.

11.2.1 Drug dependence

Studies indicate that 1 per cent of doctors become dependent upon legal narcotics and that up to 10 per cent misuse mood-altering prescription drugs [2, 7]. The most frequently abused narcotic in Australia is pethidine, although multi-drug abuse or drug and alcohol abuse are also common. Factors contributing to the misuse of narcotics include readiness of access combined with depression or social, financial or marital difficulties. Dependence appears to develop rapidly followed by escalating doses and detection by colleagues or authorities sooner rather than later. While medical boards generally deal with drug dependence as a health issue (see Chapter 8), with emphasis on treatment and rehabilitation, a period of suspension from the register has proven to be a key factor in initiating effective treatment. Return to full medical practice can now be expected in upwards of 90 per cent of instances.

11.2.2 Alcohol abuse

The reported incidence of alcohol abuse ranges from 10 to 17 per cent of doctors [2, 7–8]. These figures are likely to be understated because of problems of definition, detection and denial. More objective data derived from statistics concerning deaths from cirrhosis show that there is a threefold over-representation of doctors from such deaths in the United Kingdom [2]. The experience of state medical boards is that dependence upon narcotics is frequently combined with alcohol abuse and that both problems are linked to psychological, personal and sexual difficulties [7].

11.2.3 Depression and suicide

Studies show that male doctors are twice as likely as other male professionals to die by suicide while female doctors may be 4–6 times more likely to commit suicide than other female professionals [9–11]. These figures imply that a very significant incidence of major depression in doctors is going unnoticed or is denied, a matter

of serious concern given the positive outcome of successfully treated depression. Doctors are also more likely to die in motor vehicle accidents, where lack of sleep, alcohol abuse or suicide may be implicated [12].

11.2.4 Marital, social and family problems

The nature of the professional commitments of medical practice, and in particular clinical practice, have been repeatedly described as leading to marital disharmony, psychopathology in spouse and children, and other social difficulties [2, 12–14]. Such problems are frequently enmeshed with stress, depression or substance abuse.

11.2.5 Stress and 'burnout'

It is fashionable to perceive stress in almost every aspect of modern life. Nevertheless it is generally accepted that medical practice is stressful and probably becoming more so [15–22]. Strains imposed by the responsibilities of clinical practice are self-evident. Even medical students report that their experiences are stressful and studies have shown that inappropriate coping mechanisms commence in the undergraduate years [23–24]. In recent years, stress in clinical practice has been added to by increased or altered expectations of the community in regard to involvement in decision making, provision of information, a medico-legal and regulatory environment perceived as more threatening, changes to the organisation and funding of health care, and increased accountability of doctors for health outcomes. When such pressures are added to a professional life that is already emotionally intense through almost daily exposure to suffering, death, fear, sexuality and feelings of inadequacy, it is not surprising that diminished morale has been observed in the medical profession. Women doctors who combine work and family responsibilities and whose style of practice allows more expression of the emotional concerns of patients with attendant longer consultations may be more at risk of burnout and other consequences [25].

There is evidence also that the personality of some individuals who choose a career as a doctor makes them vulnerable to the adverse effects of stress. Such personality traits may also make them more empathetic doctors. In the absence of insight, support or professional help, doctors under stress may choose maladaptive responses, leading to emotional withdrawal, denial and social isolation [13].

The term 'burnout' has been applied to energetic and dedicated people, usually professionals, who after years of striving and achievement find themselves becoming cynical, inefficient, dissatisfied, bored or feeling trapped in work they no longer enjoy. As most doctors are ill equipped for a change in career direction, or are emotionally or financially committed to medical practice, maladaptive coping mechanisms are frequently resorted to. These may include narcotic and alcohol abuse, extramarital affairs or sexual misconduct with patients.

11.2.6 Physical disease

The only optimistic data about the health of doctors indicate that the incidence of serious physical disease as judged by standardised mortality rates is lower for doctors than for the population generally [1]. It is probable that this is related to social class, rather than any special benefit of medical insight, although doctors have led the way in reducing tobacco use. These data are sadly counterbalanced by the tendency to deny possible illness, delay in diagnosis, and under-treatment by colleagues [26]. Many doctors do not regularly use the services of a general or family practitioner and do not encourage their spouses and children to attend an independent general practitioner [5, 27–28]. Such problems in the medical profession in the United Kingdom have led to calls for mandatory use of a general practitioner by doctors. In Australia, general practitioners are readily bypassed, as self-referral by doctors to specialists is permitted under Medicare Australia guidelines. Equally doctors are free to refer themselves for investigations. Self-prescribing (illegal in some jurisdictions – see Chapter 18), using drug samples provided by pharmaceutical representatives, or asking colleagues to write prescriptions is also common [29].

Many of the above-mentioned health problems in doctors are either preventable or treatable, if detected in time [30–31].

11.3 WHY DOCTORS BECOME UNWELL

As described above, it is generally agreed that most areas of medical practice are stressful and that these stresses contribute in a major way to many of the identified health problems. The following factors have also been described.

11.3.1 A predisposing personality

Over 30 years ago, Vaillant identified a subgroup of doctors who appeared to be especially vulnerable to health problems and related this to unresolved emotional troubles commencing in childhood and adolescence [13].

Entry criteria to medical school are demanding, resulting in selection of high achievers, often with obsessive/compulsive traits. Such traits may be reinforced in training through the fostering of omnipotent aims, without sufficiently emphasising the need to accept errors and treatment failures not involving errors. There is also evidence that people who pursue a ‘caring’ profession may have unresolved psychological difficulties that are comforted, but never resolved, by assisting others [13]. Medical students and young doctors with these traits find the demands of medical practice more stressful than others, but are also described as being warmer and more empathic as doctors [32]. However, their unresolved difficulties may create ‘blind spots’ in their care of others.

11.3.2 Access to drugs

Ready access to and familiarity with drugs of dependence is a possible factor contributing to misuse of such agents. Ready access cannot be the sole factor, as other professionals with similar access such as dentists, pharmacists and veterinary surgeons have not been reported to misuse these drugs as frequently as doctors. Access needs to be combined with other factors such as stress, depression, financial worries and marital disharmony. Legal prescription or administration of narcotics by treating practitioners precedes self-administration in only 40 per cent of instances [33].

11.3.3 The doctor's role and current role models

Patients and medical students may subconsciously wish their doctor or teacher to be omniscient and omnipotent. The prime satisfaction of medical practice comes from helping patients and 'curing' disease. Good outcomes reinforce the doctor's omniscience; bad outcomes are often ignored, not discussed or attributed to the natural history of the disease. Failures of treatment may engender guilt with anxiety. Thus if a doctor has difficulty in acknowledging or accepting unsatisfactory outcomes for patients, it is not surprising that possible personal ill health is denied. Denial also occurs in medical colleagues alerted to the possible ill health and impairment of doctors with whom they work. This denial also extends to the contradictory behaviour of doctors referring non-medical staff to staff counselling services while denying the value of such a service to medical staff.

The apprenticeship nature of undergraduate and postgraduate medical training means that, whatever attempts the medical profession makes to instruct medical students and young doctors in regard to caring for their own health and the health of their families, the beneficial effects will be diminished by the existence of role models whose approach to their professional life depicts something quite to the contrary.

11.4 EARLY WARNING SIGNS

Despite the concerning statistics provided above, most doctors have satisfying careers and personal lives and do not develop health problems that lead to impairment. Little research has been done to distinguish how or why these people are successful while some of their colleagues are not. In the absence of any established preventive techniques or programs, the next best option is to be alert to early warning signs that all is not well with a colleague. These warning signs include:

- undue sensitivity to criticism
- sudden and unreasoning hostility to staff or colleagues
- irritability and argumentativeness

- odd behaviour or mood changes
- disruption of family or private life
- flight into work
- increased complaints by patients to staff
- increased alcohol use or evidence of drug use
- increased leave due to sickness or accidents
- frequent job changes
- decreased efficiency or failure to deal with essential work or to keep essential appointments.

From the doctor's personal perspective, there may also have been difficulty sleeping, feelings of being overworked or overtired, the use of alcohol or drugs to relieve unpleasant feelings and tension, or thoughts of suicide.

11.5 ASSISTING COLLEAGUES

If warning signs are to be of any use and, if stressed or impaired practitioners are to be directed to seek assistance, treatment or rehabilitation, medical colleagues must be aware of how and where help can be gained. A range of sources of self-help have been described [5, 34]. There are informal as well as structured and statutory sources of help, but all depend upon self-reporting, or engagement by colleagues and/or spouses, with recognition of the need for assistance. Informal help should be available from close medical friends and work colleagues. However, this is the least reliable means of gaining help, as colleagues are reluctant to become engaged in the issues, and denial of a problem may be accompanied by ready acceptance of the denial by the confronting colleague. This is especially difficult in smaller communities, but even doctors in large institutions do not handle these situations well.

Structured help is available in all states, usually from a doctors' health advisory service (DHAS). These are predominantly voluntary organisations that provide immediate access to medical assistance for sick doctors, whether the reporting is by self, spouse, family or colleagues. Advice can be sought anonymously and any subsequent action is totally confidential. The service is not linked to the medical board, although in some states the board contributes financially to the infrastructure costs. In Victoria, the Medical Practitioners Board, in partnership with the Victorian Branch of the Australian Medical Association, has established the Victorian Doctors Health Program, funded fully from annual medical registration renewal fees but managed at arm's length from the Medical Practitioners Board by an independent board. It is partly based on the North American 'diversion' model (see 11.6 'Treatment and rehabilitation') where doctors who may be ill and at risk of medical board intervention can be assisted to seek treatment and avoid the invocation of impairment processes [35]. The addresses and contact numbers of the various doctors' health advisory services are provided in Table 11.1 (below). In most states there are additional voluntary support groups for doctors, some based on Narcotics Anonymous or Alcoholics Anonymous.

Table 11.1 Names, addresses and telephone numbers of doctors' health advisory services

State	Address	Telephone
New South Wales Doctors' Health Advisory Service	PO Box 422 St Leonards 1590	(02) 94376552 (helpline) (02) 9902 8135
Victoria Doctors' Health Program	27 Victoria Parade Fitzroy 3065	(03) 9495 6011 (helpline)
Queensland Doctors Health Advisory Service	PO Box 123 Red Hill 4059	(07) 3833 4352 (helpline) (07) 3872 2222
South Australia Doctors' Health Advisory Service	Parkland Medical Practice Hughes Plaza University of Adelaide 5005	(08) 8273 4111 (helpline) (08) 8303 5050
Western Australia Doctors' Health Advisory Service	PO Box 604 Leederville 6007	(09) 321 3098 (helpline)
Tasmania Doctors' Health Advisory Service		(03) 6223 2047 (helpline)
Northern Territory Doctors' Health Advisory Service	PO Box 41046 Casuarina 0811	(08) 8927 7004
Australian Capital Territory Doctors' Health Advisory Service	PO Box 560 Curtin 2605	0407 265 414 (helpline) (08) 6270 5410

Problems arise where an impaired doctor who is known to the DHAS is not accepting advice and is putting the public at risk, and the ethical dilemma of breaking confidentiality has to be faced. This decision should be taken wherever possible by the treating doctor or by the spouse or colleagues who contacted the DHAS initially, in order that the reputation of the service itself for total confidentiality is retained. Statutory assistance is available via the state medical boards as described in Chapter 8. The process involved varies, but is generally directed at providing negotiated conditions that guide the doctor back to good health in a non-threatening manner while still protecting the community. As much of the ill health is associated with denial or loss of insight, all medical boards have reserve powers to suspend impaired practitioners. The rights of the doctors are preserved via the availability of legal representation and a capacity to appeal to a higher authority. In health-related matters, such appeals are rare.

11.6 TREATMENT AND REHABILITATION

Most health problems leading to impairment are treatable, provided intervention is prompt and compliance is adequately monitored. Very encouraging treatment

and rehabilitation outcomes have been reported from several states in the USA and from Canada for doctors who are dependent upon narcotics or alcohol [30–31, 36]. Common to these treatment programs are the following features:

- confidentiality
- statutory protection and independence from the medical board
- treatment programs negotiated by agreement
- the option of voluntary entry to the program
- where treatment programs cannot be negotiated or are not complied with, notification to the medical board if the public is at risk
- links with hospital 'sick doctor' committees
- funding via a surcharge on annual registration fees.

The negotiated treatment programs are intensive and monitoring of compliance is strict. The only program in Australia based on the above principles is the Victorian Doctors Health Program [35]. Treatment programs in Australia are generally less structured, or are based on medical board processes, as with the New South Wales Medical Board's Impaired Registrants Program [37] and the Queensland Medical Board's Health Assessment and Monitoring Program.

11.7 CARING FOR YOURSELF AND YOUR FAMILY

Most doctors, especially males, have difficulty in seeing themselves as patients and as a result commonly do not have their own general practitioner, delay seeking medical help, self-prescribe, and tend to refer themselves for specialist assistance [38–39]. Many doctors also appear reluctant to have an independent general practitioner attend to the needs of their immediate family, and inappropriately treat family members for serious illnesses. This is deemed inappropriate because of risks, which include a lack of objectivity in assessing the family member, failing to explore important aspects of many illnesses, especially the psychosocial domain, failing to examine the patient thoroughly, failing to respect the patient's autonomy, failing to keep proper records and failing to obtain proper consent [40]. In the light of a higher than average suicide rate in the spouses of doctors, this inappropriate conduct takes on greater significance [5]. Medical boards in Australia, NZ, Canada, the USA and the UK advise against treating family members other than for minor acute conditions or in an emergency when no other doctor is immediately available [41]. The Australian Medical Association's 2006 position statement on the health and wellbeing of medical students and practitioners emphasises that doctors and their families should have their own general practitioner and that care should be provided in the context of a formal doctor–patient relationship [42]. Wise doctors will assist their families to choose a truly independent general practitioner, although there are circumstances, for example in rural and remote areas, which make it necessary for the general practitioner to be a member of the doctor's practice. As any person is free to approach their

pharmacist for advice or obtain certain drugs over the counter, it is not realistic to place a total prohibition on doctors treating themselves or their family members for minor conditions.

There is a statutory prohibition on prescribing or administering to oneself drugs of dependence (narcotics and benzodiazepines). Note that in Victoria the legislation forbids all prescribing to oneself of Schedule 4, 8 and 11 medications (see Chapter 18). In addition doctors should not self-prescribe mood-altering drugs, including sedatives, tranquillisers, stimulants and antidepressants.

11.8 TREATING OTHER DOCTORS

As well as being reluctant patients, many doctors feel uncomfortable acting as the treating doctor for another doctor. This is not a subject for which any training is readily available, although more attention is now being given to it [12, 43]. Dr Narelle Shadbolt has researched the health issues of doctors in Australia and has provided the following practice points when seeing a doctor as a patient:

- Reassure the doctor–patient about confidentiality.
- Acknowledge the patient as a doctor, but explain that the consultation will be managed as for all other patients.
- Conduct a structured consultation so difficult areas (such as alcohol and drug use) are seen as routine.
- Normalise behaviour to make disclosure easier (for example, 'There are a lot of stressed doctors out there – how are you coping with juggling work and family?').
- Conduct a proper physical examination.
- While the doctor–patient will generally be aware of complications of procedures, check to see if there are particular fears to be addressed.
- Doctor–patients may need permission to return for review and to ask questions.
- The doctor–patient should not be required to arrange his or her own tests or prescriptions.
- Billing is a matter that should be addressed – be aware that reduced fees or no fees can devalue the service and may be a barrier to return visits as the doctor–patient may feel he or she is imposing on goodwill [43].

11.9 DOCTORS WHO CARRY A TRANSMISSIBLE DISEASE

Accidental blood-borne transmission by doctors to patients of serious viral illness (human immunodeficiency virus [HIV], hepatitis B and hepatitis C) has brought a new dimension to the principle of non-maleficence. The risk to doctors of accidental transmission of such infections from patients, as well as the emergence of other viral illnesses, has also revived debate on the ethical issue of the entitlement

of doctors, on the grounds of risk to their own health, to refuse treatment to a patient who carries an infectious disease. The key principles for doctors who carry a transmissible disease have been the subject of extensive debate and advice [44 – 47]. The statutory and ethical principles encompass the aspects in the following sections.

11.9.1 Responsibilities of individual doctors

Doctors must take every precaution to avoid transmitting infection to patients by seeking immunisation against hepatitis B (and other infections if immunisation becomes available), adhering to infection control guidelines and, if the doctor is accidentally exposed to infection, by following post-exposure protocols. Doctors who undertake invasive or exposure-prone procedures,* and who carry or may carry an infection, have an ethical duty to review their practice, lifestyle and health status, including their HIV, hepatitis B and hepatitis C antibody status. Doctors who have been exposed to an infectious agent and are possibly infected, or know that they are infected, must seek advice from a doctor qualified to manage the disease and must follow proper advice, such as ceasing to perform exposure-prone procedures. This should be done promptly not only to protect others but also to ensure early treatment [48].

11.9.2 Responsibilities of treating doctors

Any doctor who is treating another doctor for a transmissible disease has a responsibility to ensure that the public is not put at risk by the clinical activities of the doctor, to provide the doctor with appropriate care and to afford the doctor the same rights of confidentiality and counselling as any other patient. The treating doctor must be sufficiently skilled to assess the infectiousness of the doctor and the risk to the public and must reassess these issues regularly. State health department regulations regarding notification of an infectious disease must be complied with.

11.9.3 Other issues

Patients who carry infectious diseases such as HIV should not be denied access to necessary medical or surgical treatment on the grounds that such treatment could expose the doctor to personal risk. It is also unethical to withhold treatment from

* Exposure-prone procedures are a subset of invasive procedures and involve potential direct contact between the skin of the doctor (most often the thumb or a finger) and sharp instruments or tissues (bone or teeth spicules), usually during a procedure undertaken in a confined or poorly visualised anatomic site (including the oral cavity). By contrast, the following are also invasive procedures but have not posed any significant risk of infection transmission and are not classified as exposure-prone: venesection, intravenous cannulation, suturing simple lacerations, intramuscular or subcutaneous injections, and removal of simple skin lesions. [44]

any patient because of a moral judgment that the patient's lifestyle may have contributed to the patient's illness.

Mandatory testing of doctors for HIV, hepatitis B and hepatitis C has been considered but rejected in the USA, United Kingdom, Canada and Australia. However, the Royal Australasian College of Surgeons recommends to its fellows that 'surgeons who perform invasive procedures should be aware of their HIV/hepatitis B/hepatitis C status by routine and regular [annual] serological testing and if susceptible to hepatitis B, it is strongly recommended they undergo a course of hepatitis B immunisation' [46].

11.10 SEXUAL MISCONDUCT AND IMPAIRMENT

It is clearly stated in Chapters 8 and 10 that the abuse of trust involved in the establishment of a sexual relationship with a patient, or any other action designed to gratify the doctor's sexual desire, is regarded as serious unprofessional conduct. In some instances, such unprofessional conduct may be linked to, or partially explained by, ill health and impairment. Quadrio suggests that sexual offenders fall into two broad categories [49]. She describes the smaller proportion as amoral, exploitative and sexually predatory and the larger group as predisposed to this serious ethical misjudgment by factors in common with those that produce drug dependence, alcohol abuse or psychological illness in doctors. In the latter group, these factors are sufficiently strong for some American authorities to regard sexual misconduct as a form of impairment. Doctors found guilty of sexual misconduct frequently demonstrate one or most of the following features:

- recent stressful events, such as major marital difficulties
- serious psychological problems, including depression
- an unbalanced approach to professional and personal life (they are 'workaholics'), such that all or most of their identity and life satisfaction is linked to their work
- unresolved difficulties in childhood or adolescence
- a naive and misguided belief that the relationship was intended to help their patient.

Impairment leading to such misconduct does not lessen the significance of this unprofessional behaviour, as studies show that the individual patients are invariably harmed by the relationships (see Chapter 10) and in addition the community's trust in the medical profession generally is diminished.

11.11 THE ELDERLY DOCTOR

The structure of medical practice in Australia (see Chapter 14) does not encourage most doctors to plan financially for their retirement, and the time commitment of conscientious doctors prevents many from planning their leisure time for when

they do retire. As a result, some doctors remain in practice to the point where biological ageing, or illnesses of old age, lead to impairment of intellectual or technical capacity. Preservation of verbal and social skills in elderly doctors may lead to underestimation of impairment, and formal neuropsychological assessment is advised [50]. Occasionally, such doctors are resistant to advice from friends and family, and the reserve powers of the medical board to formally evaluate possible impairment are required [51].

Discussing and confronting an elderly colleague is difficult where that person has had an outstanding and unblemished career and especially so if that person has also been a teacher or mentor. However, just as for any other doctor who is impaired and putting patients at risk, this is a duty that must be faced.

In several Canadian provinces, registration authorities have established peer assessment or review processes for doctors over the age of 70 years. These consist of practice audits and site visits for discussions. Many older doctors choose to retire during these assessment processes. No Australian medical board has a policy in regard to age and boards are dependent primarily on complaints from patients to identify age-related impairment.

Some doctors seek partial retirement, often expressed as a wish to remain on the medical register, at a reduced fee, to enable them to write prescriptions and referrals for family, friends or 'old' patients. Medical board policies generally do not allow for or encourage such partial retirement, as the protection of the community demands that doctors on the register in any area of clinical practice be capable of functioning fully [52].

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12 MAINTENANCE OF PROFESSIONAL COMPETENCE

No doctor will deny an ethical obligation to provide competent clinical care to patients, but many have been reluctant to embrace compulsory continuing medical education (CME) or compulsory recertification of their professional competence. Such reluctance in regard to making this obligation compulsory relates to factors including scepticism that recertification will necessarily improve standards of patient care or prevent the problems created by incompetent members of the profession; awareness that the medical profession is generally very committed to CME, and to evaluation of care through clinical research and its dissemination and publication; and, lastly, sensitivity by many doctors to the accountability already required of them by the courts, health complaints mechanisms and medical boards. There has, however, emerged a more positive approach to the need to document maintenance of professional competence in the profession with formal initiatives taken by all the medical colleges. These initiatives, while eschewing examinations, are designed to reflect the realities of everyday professional life and are consistent with education and learning theory, itself still evolving. A small proportion of doctors still resent this perceived bureaucratic intrusion, but the benefits for the medical profession and the community outweigh any additional effort involved in documenting what most doctors already do.

Apart from the ethical dimension there are other influences at work in the move to document the maintenance of professional learning and competence of doctors. At the institutional level, voluntary accreditation of hospitals via a process attesting to the meeting of predetermined standards began when the Australian Council on Healthcare (initially 'Hospital') Standards (ACHS) was established in 1974. The first medical college to introduce mandatory recertification of competence was the Royal Australian College of Obstetrics and Gynaecology when it was established in 1978. The federal government has also been interested in this subject, dating back to an ultimatum, given to the medical profession in 1976 by the federal Minister of Health, that unless the profession established a system of peer review and audit within 3 years, the government would institute such a system.

In addition, state governments, via medical practice or health registration Acts, have edged slowly towards mandating participation in CME. For example in Victoria, the *Health Professions Registration Act 2005* (which came into force in 2007) gives registration boards the power under section 18(3)(b)(ii) to ask at renewal of registration for evidence of 'any continuing professional development undertaken during the existing registration period'. The New South Wales Medical Board requires doctors, when applying for renewal of registration, to advise of details of participation in continuing professional development. Similar provisions exist in South Australia.

This chapter outlines what the terminology means, describes examples of current maintenance of professional standards (MOPS) programs, now more commonly known as continuing professional development (CPD) programs, and gives examples of a range of other processes in place for accreditation and outcome evaluation or audit in health care. The chapter focuses primarily on the responsibilities of individual doctors and not on the responsibilities of those who manage hospitals and health-care institutions. Increasingly such institutions are expected to have in place a system of clinical governance (incorporating safety and quality of care, risk management and performance reporting); effective clinical governance involves significant input from clinicians [1].

12.1 THE TERMINOLOGY OF MAINTAINING PROFESSIONAL COMPETENCE

The language of this field includes reference to maintenance of professional standards, continuing professional development, continuing medical education, audit, quality assurance, peer review, accreditation, credentialling and granting of clinical privileges, vocational registration, clinical indicators, clinical practice guidelines and recertification. The following is a brief explanation of these terms.

12.1.1 Maintenance of professional standards and continuing professional development

This is a process directed at the individual doctor. It presumes that, upon entry into independent clinical practice, the doctor's competence was attested to by the satisfactory completion of an appropriate theoretical and practical training program and the award of the fellowship of the relevant medical college. Maintenance of competence is subsequently documented by recorded participation in all or some of the following activities: ongoing education and training, including continuing medical education (CME), quality assurance, audit, teaching, research, self-directed learning, self-assessment and peer review. With this documentation, which is subject to random audit, the relevant college will either issue a certificate of participation or 'recertify' the competence of the doctor.

12.1.2 Continuing medical education

While self-explanatory, the term now requires definition since participation in identified CME activities is one of the key elements of the 'recertification' of specialists and the maintenance of vocational registration for general practitioners. In most medical college programs, CME includes educational meetings with colleagues arranged by hospitals, colleges, specialty societies, group practices and the like, as well as attendance at state, national and international conferences. Active involvement is preferred to and is rewarded more than passive involvement. Furthermore, educational meetings earn more credits for participants when they are planned to meet participants' needs, are patient-care focused, encourage discussion and interaction, and are to be evaluated upon completion. Self-directed learning and completion of self-assessment programs also form part of CME.

12.1.3 Audit

Audit of treatment outcomes has been practised by surgeons for several decades and data are routinely published in surgical journals. In the initial Royal Australasian College of Surgeons recertification process, audit was defined as 'a regular critical review and evaluation of the quality of surgical care, documentation and response to these results' [2]. Surgical audit constitutes a large component of quality assurance in surgical practice.

12.1.4 Quality assurance

This term is borrowed from the manufacturing industry. For health care, 'quality of care' has been defined by the US Institute of Medicine as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' [3]. Quality assurance (QA) programs are mandatory for hospitals seeking accreditation with the ACHS. In their simplest form, they are represented by such activities as measuring morbidity and mortality and demonstrating efforts to improve outcomes. As QA programs themselves require resources, they should be targeted at problem areas, common conditions, or conditions that are resource intensive, and where improved results are likely to be achievable. An effective QA program is data-based, focuses on processes and systems (rather than the performance of individuals), records the QA activities and provides feedback leading to corrective action. As QA programs require unfettered discussion of identified problems, state and federal governments have legislated to provide exemption from Freedom of Information laws and protection from disclosure for civil litigation purposes, provided that the terms of the legislation are met.

12.1.5 Peer review

In almost every area of assessment of medical professional performance, whether by medical boards, civil courts or under Medicare Australia regulations, it is accepted that assessment should be made by professional peers. The term 'peer review' has been narrowed in its meaning to refer to the process of auditing the methods and results of clinical interventions by a group of medical peers. Peer review has been employed extensively in the USA in relation to the granting and reviewing of hospital privileges and to participation in the US Medicare and Medicaid programs. Peer review is implicit in Australia in many QA programs and in components of medical college recertification programs.

12.1.6 Accreditation, credentialling and granting of clinical privileges

Accreditation of public and private hospitals by the ACHS is used to document to the community and to government that explicit criteria have been met as measured by independent external review. Within accredited hospitals, medical practitioners are not free to undertake any procedure they choose. This restriction depends mainly on the nature of a doctor's hospital appointment (for example, as neurosurgeon, general surgeon or psychiatrist). However, with the rapid development of new technology, including new invasive procedures and surgical techniques, hospitals are becoming more precise in their appointment processes by requiring that doctors are limited to fields and procedures for which they have documented competence. This process, known as credentialling or the granting of clinical privileges, also forms a part of the RACS recertification requirements.

12.1.7 Vocational registration

This is the term used by Medicare Australia to identify general practitioners who have met certain criteria (relating to training, qualifications, experience and services offered) and are therefore eligible for higher Medicare rebates. To remain vocationally registered with Medicare Australia, general practitioners are required to document participation in CME.

12.1.8 Recertification and maintenance of professional standards programs in Australia

Commencing from 1978, the major medical colleges in Australia have progressively committed their fellowship to mandatory or voluntary programs of recertification and MOPS. The Royal Australian College of Obstetricians and

Gynaecologists insisted from its establishment in 1978 that fellows were to participate in CME programs and that fellowship was time limited. The initial program involved the award of 'points' for documented participation over a 5-year period in CME, quality assurance activities, self-assessment, planned learning projects and publications, presentations and teaching. The Royal Australian College of General Practitioners introduced a QA program for its members in 1987, but since 1989 the Medicare Australia process of vocational registration (see Chapter 14) has formalised the requirement for participation in this program. To remain on the vocational register, the doctor must continue to be predominantly in general practice and meet the College's requirements for quality assurance and continuing medical education.

The Royal Australasian College of Surgeons (RACS) introduced a recertification process for its fellows commencing from 1 January 1994, describing it as 'a process conducted by the College which requires Fellows to demonstrate their maintenance of proper professional standards of knowledge and performance'. The Royal Australasian College of Physicians (RACP) commenced a program of MOPS in 1994, with a plan that this be phased in over 5 years and then run on a 5-year cycle.

The Royal College of Pathologists of Australia Fellowship has a history of four decades of participation in quality assurance, especially via the accreditation process for pathology laboratories (see below). It added another dimension to these activities via a continuous professional development program that commenced in 1996.

Medical college programs for supporting and documenting participation continue to evolve in keeping with education research that shows how doctors may best learn in alignment with what most doctors already do. This is reflected in the recently revised programs of the RACP and RACS. For example, the RACP 2008 program, called 'Continuing Professional Development', places great emphasis on each fellow preparing an annual plan based on perceived needs and how they might be met, as well as promoting the concept of 'reflection', which research suggests is central to learning in practice-based settings [4–6]. Despite this apparent change in philosophical emphasis, the RACP program participants will continue to accrue credits for six categories of activities as in the original program, covering teaching, supervision and research, group learning activities, self-assessment programs, structured learning projects, practice appraisal and 'other' activities. The program is not mandatory for continued fellowship, but the RACP has expressed a 'strong expectation' of participation.

The 2007 edition of the RACS program, also known as 'Continuing Professional Development', takes a different approach, in that it is mandatory for surgeons to participate and has a very strong emphasis on personal record keeping and audit of surgical outcomes [7]. Both the RACP and RACS expect participants

to keep adequate records as a proportion of fellows will be subject to random audit each year.

As there are a proportion of doctors registered as general practitioners or specialists in Australia who are not fellows of Australian colleges, most colleges accept these doctors as fee-paying participants in their CME or CPD programs.

12.1.9 Clinical indicators

The term 'clinical indicator', developed by the ACHS, is defined as 'a measure of the clinical management and outcome of care' [8]. The development and use of clinical indicators is the logical extension of ACHS accreditation beyond the survey of hospital structures and processes to provide objective measures of the outcome of care provided. The development of clinical indicators is supported by all the colleges, whose members have been involved in their design and trial. Clinical indicators may be both hospital-wide (for example, rates of acquired infection, pulmonary embolus or unplanned readmission) and specialty specific (for example, outcome in myocardial infarction or upper gastrointestinal haemorrhage). Hospitals should endeavour to meet predetermined thresholds for performance based on these indicators. For objective comparisons, such indicators will need to allow for variations in case mix, disease severity and other factors affecting outcome.

12.1.10 Clinical practice guidelines

These have been defined as 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances' [9]. Their development was stimulated by studies showing unexplained variations between the practices of clinicians. They have developed in parallel with and are linked to several other health-care movements, including 'best practice', 'evidence-based medicine', 'consensus statements' and 'care paths'. Conceptually, clinical practice guidelines presume that a group of informed professionals are able to establish criteria for the management of specific conditions, based on published evidence in the form of controlled clinical trials or, if such evidence is not available, by consensus. The problems associated with clinical practice guidelines are numerous and include the cost of their development, their inflexibility, their alleged elimination of clinical judgment, their need for regular updating and the possible stifling of innovation [10]. There are often difficulties applying clinical practice guidelines to patients with co-morbidities. Not infrequently, guidelines issued by different authorities differ in their recommendations [11]. In addition, it is common that guidelines are not regularly updated [12]. The National Health and Medical Research Council (NHMRC) has issued guidelines

for the development and implementation of clinical practice guidelines and regularly publishes and revises guidelines relating to the management of common diseases [13].

12.2 EXISTING OUTCOME EVALUATION/AUDIT PROGRAMS

Recent interest in the adverse outcomes of clinical interventions has created an impression that there has previously been no systematic study of adverse outcomes by the medical profession. This is clearly incorrect as the published literature abounds in careful studies of treatments, their complications and outcomes. In addition, Australia has been a leader in systematic large-scale quality assurance programs and in the creation of national databases. The former include the work of the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity since 1961 and the Victorian Consultative Council on Anaesthetic Mortality and Morbidity since 1976. More recently Victoria has established a parallel Surgical Consultative Council. These councils have fostered the reporting of adverse events, their critical analysis and corrective responses. The latter include national databases in relation to organ transplantation, dialysis programs, cardiac surgery and incident monitoring in anaesthesia.

Upon this background, it was not surprising that the premature release in 1995 of a federal government-funded retrospective study of adverse events occurring in hospitals (the Quality in Australian Health Care Study) was angrily received by many in the medical profession. This study concluded that preventable adverse events occur in relation to 13 per cent of hospital admissions [4]. The authors contrasted this unfavourably with the results of a supposedly similar study from the USA [15]. The difference in mortality rates between the two studies suggests major differences in methodology or criteria for identifying adverse events [16]. Clinicians remain sceptical that, in the population of predominantly elderly and seriously ill people admitted to hospital in Australia, adverse events can be reduced by the proportion claimed. Nevertheless, the study provided an additional impetus to the processes of risk management, audit and quality assurance in hospitals [17]. One government response to the study was the establishment of what is now the Australian Commission on Safety and Quality in Health Care, as described in Chapter 14.

12.3 OTHER ACCREDITATION OR CERTIFICATION PROGRAMS

The preceding information has focused on the recertification of the competence of individual doctors engaged in direct patient care. There are also accreditation processes for hospitals, pathology laboratories and for facilities other than hospitals in which doctors provide patient care.

12.3.1 Pathology laboratory accreditation

The establishment of standards for pathology laboratories is undertaken by the National Pathology Accreditation Advisory Council based in Canberra. Its main functions are to consider and make recommendations to the Commonwealth, states and territories on matters relating to the accreditation of pathology laboratories and the introduction and maintenance of uniform standards of practice in pathology laboratories throughout Australia. The Council includes representatives of government and professional bodies involved in all aspects of pathology. The National Association of Testing Authorities (NATA) independently conducts accreditation assessments in accordance with these standards.

12.3.2 Day surgery and day procedure facilities

The Australian Council on Health Care Standards has published the standards required of autonomous day procedure facilities, and surveys and accredits such facilities. In addition, in New South Wales and Victoria day procedure centres are required to meet predetermined standards via a licensing or registration system under the *Private Hospitals and Day Procedures Centres Act 1988* of New South Wales and the *Health Services Act 1988* of Victoria respectively.

12.3.3 Accreditation of general practice

An independent body known as Australian General Practices Accreditation Limited offers accreditation of general practices and a separate program for accrediting optometry, physiotherapy and medical imaging practices.

12.4 QUALITY ASSURANCE IN PRIVATE MEDICAL PRACTICE

Some doctors in independent practice are not involved in peer review, audit or QA, despite the existence of the College recertification requirements. At present, there is no statutory obligation to undertake QA in private medical practice. While QA activities are often an element of MOPS, QA is not mandatory. However, the ethical obligation to provide competent patient care and the desire to provide better care in a competitive environment may motivate doctors to undertake QA in private practice. If so, consideration might be given to the range of relatively simple measurements proposed by Duggan [3], including studies of:

- patient satisfaction
- effectiveness of appointment systems
- efficiency of written communications

- efficiency of office systems
- adequacy of patient records
- the quality of the equipment and environment of the practice.

12.5 FUTURE DIRECTIONS AND CONTENTIOUS AREAS

Those who have not practised medicine and thus not experienced the inherent uncertainties often involved in the diagnosis and treatment of many conditions are inclined to seek simple solutions to the assessment of doctors' performance and to the prevention of adverse events. Even members of the medical profession at times fall into this simplistic approach, best exemplified by those who compare safety in hospitals with the safety of mechanical equipment such as aeroplanes [18]. Politicians and others have thus promoted the notion of publicising the actual results of treatment, especially surgical treatments of hospital departments and individual surgeons, as a means of improving performance. This notion, referred to as 'league tables', has gathered momentum despite the inherent problems involved, including statistical significance [19–21], reliability [22–23], effectiveness [24–25] and the potential for hospitals to avoid treating high-risk patients, to improve apparent outcomes.

In the theory and application of research into MOPS, Canadian medical regulators and educators have led the way. Noting that knowledge, skills and attitude are the precursors to competence, they have sought effective means of assessing actual doctor performance. This program is known as MEPP, for 'monitoring and enhancement of physician performance'. In the province of Quebec, work has been undertaken to find indicators of possible poor performance. Using those indicators, where a doctor is felt to be performing below standard, there will be a practice inspection followed by individualised 'practice enhancement' recommendations, such as participation in CME or a more structured remedial program. Inspection visits are conducted by peers and may also be made at random or targeted at solo practitioners or those in practice for over 35 years [26]. In the neighbouring province of Ontario, the registration body (the College of Physicians and Surgeons of Ontario) has consulted the profession on a plan of introducing a 'revalidation program' in 2010, working in collaboration with the national specialty colleges [27].

An international group has critically analysed what will be needed to create a fair and defensible practice performance assessment [28–29]. Given the size and cost of such a program if applied to a large proportion of the profession, it is difficult to imagine that this model will ever be used generally. It seems more likely that the current Australian medical boards' model of a performance assessment pathway, used when concerns about performance have surfaced, will prevail (see Chapter 8).

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13 ETHICS AND THE ALLOCATION OF HEALTH-CARE RESOURCES

Autonomy, beneficence, non-maleficence and justice are four of the basic principles upon which ethical medical practice is founded (see Chapter 1). In the allocation of health-care resources, be it at government, institutional or medical practitioner level, the principle of justice, particularly 'distributive justice', is central. In 1990, the National Health and Medical Research Council (NRMRC) in the *Discussion Paper on Ethics and Resource Allocation* said:

> In the allocation of any public resources our concern should be primarily with justice. This involves giving to each person his or her due. In allocating health care resources our concern is largely with distributive justice – to distribute amongst members of the community those benefits and burdens due to them. The basis of distributive justice is the notion of fairness. The most appropriate criterion for a fair distribution of resources would appear to be those of equity and need. More specifically, a just allocation should offer equal treatment for those whose needs are similar. In other words, each person is entitled to enjoy an appropriate share of the sum total of the resources available according to their need. However, the need which justifies one person's entitlement must be a need which can be fulfilled in a way compatible with fulfilling the similar needs of others. [1]

Modern society stresses that arbitrary discrimination between people with the same needs cannot be morally justifiable. Questions about the ethical justification of priorities in the provision of medical care are pressing relentlessly on the medical profession, the government and society as a whole [2–3]. Most developed countries have introduced changes to health-care funding and delivery in attempts to make health care more efficient, most noticeably and controversially the introduction of managed care in the USA. In many countries these changes have been resisted by the medical profession. One result has been that the medical profession has excluded itself from the debates and decision making. More recently the profession has sought to put itself 'back onto the political map of health' [4] under the guise of claiming renewed 'medical professionalism' [5–6].

Although Australia has not experienced dramatic changes in health-care funding nor overt rationing, like other countries we have seen rising health-care costs, changing community expectations, commercialisation of medical practice and the effects of globalisation of medicine and health care [7]. A strong health consumer movement in Australia may have pushed the medical profession into more effective community dialogue and thus helped to prevent some of the demoralisation that has accompanied changes in the funding of health care of other developed nations.

While some doctors might prefer not to see any relevance for them, ethics of the allocation of health-care resources have implications for the entire community and for doctors as stewards of the community's health-care resources. As especially informed members of the community, doctors need to understand the issues and participate appropriately in the required decision-making processes. The issues involved have now been introduced to medical students in some courses [8].

This chapter does not address in any depth the issues of resource allocation as experienced by politicians, health economists, health administrators and others, but focuses on the ethical principles involved such that practising doctors might more usefully engage in debate and decision making and more fully understand that there are links between resources used in treating individual patients and the resources available to the entire community.

13.1 LEVELS OF DECISION MAKING IN THE ALLOCATION OF RESOURCES

There are broadly three levels of decision making about the allocation of resources: the macro-, meso- and micro-levels.

13.1.1 Macro-level

Macro-allocation of resources is outside the experience of most doctors. The federal government is first involved in deciding what proportion of gross domestic product will be spent on health, education, welfare, defence and so on. After this allocation, the health departments, however named, at both the federal and state levels receive their allocations. Government has traditionally directed how the health budget will be divided as, for example, between hospital and community care or between treatment and prevention. More recently, governments have tended to shift this authority to regional areas, on the basis that the local community is better placed to identify its own health-care needs, although another effect is to distance governments from unpopular decisions.

13.1.2 Meso-level

The allocation of medical resources at a regional level moves into the intermediate level of decision making, or meso-allocation as described by Gillon [9]. At this level, decisions may be influenced by politicians, administrators and committees interacting with institutions and hospitals. Meso-allocation also includes the role of hospital managers who are responsible for allocating resources to competing services and specialties.

13.1.3 Micro-level

Doctors in their daily clinical work participate at this level, namely the micro-allocation of resources, for example when they allocate the use of their own time and of other resources to patients, via the use of appointments, waiting lists, triage and decisions re diagnosis and treatment. The impact that such micro-allocation decisions have cumulatively on expenditure on health care is now widely recognised and, together with cost pressures and relative efficacy, is a key factor behind such innovations as the introduction of clinician managers, clinical practice guidelines and managed care.

13.2 NEW APPROACHES TO RESOURCE ALLOCATION

Nearly all of the changes taking place in the organisation and delivery of health care in the developed world involve issues of resource allocation. At the level of macro-allocation of resources, the most striking innovation has been the development in the USA of the Oregon plan. Oregon, like all other US states, provides medical care to the uninsured population with funds derived predominantly from the federal government Medicaid program and to a lesser extent from the state itself. The Oregon legislature developed a system for consulting with the community in order that medical interventions could be prioritised and agreement thus reached as to which interventions the state could afford to fund. Initially, some 709 medical interventions, including preventive health programs, were ranked according to social values and then costed, with the outcome that only the first 587 services were able to be afforded. Interventions excluded from funding included cancer where treatment would not provide a 10 per cent 5-year survival rate, stripping of varicose veins, liver transplantation for alcoholic liver disease and ventilatory support for extremely low birth weight babies. The latter two exclusions were held by the federal government to be in breach of federal laws and a revised ranking system of 696 items was produced of which the first 565 were funded. This revised plan was approved by the US federal government and commenced operation in 1994 [10–12]. It has remained in place and a 2002 assessment

of access and satisfaction based on a survey of eligible citizens gave positive findings [13]. While of great interest in its development and progress, the importance and relevance of the Oregon plan to other health-care systems should not be overstated, as the plan relates to rationing of care only to the non-insured and does not impinge on the health care available to those citizens who have health insurance or who subscribe to a health maintenance organisation.

Other changes in health-care delivery driven primarily by issues of resource allocation include:

- the development of clinical practice guidelines, at a local or national level, by groups of doctors and others who attempt to combine objective evidence about effectiveness of treatment with the most efficient use of available resources
- the development, usually within hospitals, of care paths or care maps, to guide multidisciplinary patient care teams in the most effective and efficient use of resources to achieve desired patient outcomes
- the introduction in the USA of managed care where the health-care budget holder (the insurer) determines to a preset formula what resources will be made available to the doctor for the treatment of a particular medical condition
- the introduction in the UK of general practitioner fund holding.

Some of these changes have the potential to interfere in what doctors have traditionally regarded as the key ethical determinant for offering treatment, namely their judgment of the optimal way to meet patient need. Managed care in particular has been criticised as carrying this potential and, in addition, raises concerns if patients are unaware that they may be denied access to treatment.

13.3 COMPETING CONCEPTIONS OF JUSTICE IN ALLOCATING HEALTH-CARE RESOURCES

One conception of justice (sometimes called 'commutative justice') is a fair adjudication of competing claims. Another, commonly called distributive justice, is the fair allocation of limited resources among those with a legitimate claim to a share. There are competing views as to how justice in the allocation of health-care resources might be achieved. Libertarians argue that an allocation of health care is just if it represents what individuals actually choose to spend their own resources on and what health professionals actually choose to devote their resources to. Utilitarians argue that an allocation is just if it represents the greatest good for the greatest number. Egalitarians argue an allocation is just if it ensures that each person, irrespective of wealth or position, has equal access to an adequate, though not maximal, level of health care contingent on social resources and sufficient to ensure 'equality of opportunity'. Lastly, 'common good' or 'natural law' philosophers of the Aristotelian tradition argue that an allocation of health care is just if it is based on health-care need, where the satisfaction of that need is compatible

with the fulfilment of similar and more important needs of other members of that community [14].

Traditionally, the apportionment of health-care resources has been based on medical need. This raises the question of how and by whom such needs are identified, compared and ranked. As consistently translating any theory of justice into practice is not easy, most doctors are inclined to focus on meeting the immediate needs of individual patients in front of them and to ignore the fact that, in their decision to access available and affordable treatment options, they are tacitly accepting broader allocation decisions taken by others [9].

The application of any single philosophical theory to justice in health-care allocation may produce outcomes not acceptable to all parts of society. For example, libertarians would be likely to seek self-sufficiency and may be reluctant to support a taxation system that gave equal health care to the poor and the rich, unless they added an additional moral value to influence their thinking. A strict utilitarian approach, pursuing a taxation system intended to maximise the health care of all, might unacceptably restrict freedom of choice or more importantly might give the highest priority to therapies aimed at improving the length and quality of life in those likely to make the greatest future social contributions and the lowest priority to basic care for the terminally ill, the elderly and the handicapped. Whatever theoretical framework is applied to distributive justice in practice, two key elements must be addressed. First, on any plausible conception of justice in the allocation of health-care resources, some categories of patients are going to be unwitting rivals with other categories of patients for scarce health-care resources. Thus a moral determination of the priority of competing claims to health care must be made using a rationally defensible process that applies a measure of the importance of a person's need and excludes irrelevant factors such as chance, social worth or race. Secondly, that measure will need to be sensitive to the different criteria by which people can claim to 'need' health care – for instance, urgency, likelihood of greater or longer benefit, likelihood to suffer lesser burdens of treatment, likelihood to suffer greater harms without treatment, less at risk of various ill effects of treatment, or likelihood to need treatment for a shorter time or less frequently [9, 15–16].

13.4 OTHER ETHICAL VALUES IN THE ALLOCATION OF HEALTH-CARE RESOURCES

The application of justice in the distribution of health-care resources is complicated by the finite nature of the resources; increasingly, implicit or explicit rationing of health care is necessary, bringing with it a need to identify aspects of justice additional to fairness. Weale has identified three such values: effectiveness, efficiency and democratic responsiveness [17].

13.4.1 Effectiveness

Effectiveness means the use of health-care methods that are medically effective. This is unarguable in principle and its usefulness is supported by the widespread embrace of evidence-based medicine. The latter in turn raises ethical issues around the application of evidence to resource allocation, as discussed further below.

13.4.2 Efficiency

Efficiency brings with it notions of cost–benefit analysis and avoiding wasteful practices. However, cost–benefit analysis may involve the placing of a value on the quantity and quality of human life, bringing additional social and ethical considerations.

13.4.3 Democratic responsiveness

Democratic responsiveness means a process whereby society, via democratic government, is able to express a collective opinion regarding the type of health-care system the society will have.

To these values could be added considerations of compassion for those who are suffering. However, the above values generally have not been applied systematically in the varying responses of nations as to how to best allocate health-care resources.

Critics have suggested that too often rationing is hidden by implicit decisions [18]. The approach taken appears to be influenced by the existing health-care funding system. In the UK, where health care is nationalised, governments have used a variety of instruments including a purchaser–provider split, general practitioner fund-holding and national expert committees to advise on clinical practice guidelines [19] to seek to make health care more efficient. In the USA, where only the elderly and the indigent are covered by a national health-care funding framework, government has mostly left 'rationing' to the marketplace, such that managed care has become the dominant model. There are exceptions to this model, including the longstanding health maintenance organisations exemplified by Kaiser Permanente, and the Oregon plan as described above [10–12].

In Australia, some state public health-care systems have applied 'case mix' funding tools to push clinicians and hospitals towards greater efficiency and have combined this with annual efficiency targets. Other 'rationing' tools in use in Australia include measures such as limiting drugs that are subsidised under the Pharmaceutical Benefits Scheme by reference to efficacy and value for money, limiting subsidies for a range of investigations and keeping patient reimbursements for doctors' fees generally below the annual rise in the consumer price index. Outside the public hospital system, Australian medicine is based predominantly

on 'fee for service' and doctors have generally been able to adapt to changes in reimbursements, and thus maintain income, by changing their practices rather than reducing services, as have their US counterparts [20].

13.5 ETHICAL ISSUES IN APPLYING EVIDENCE TO HEALTH-CARE RESOURCE ALLOCATION

The rising cost of health care has also contributed to the evidence-based medicine (EBM) movement. Most doctors probably feel that they have long based their practice on available evidence, but EBM strives to formalise this approach. Health administrators have sought to bring EBM into their methods of allocating resources [21]. Such an approach brings its own set of ethical difficulties as pointed out by Kerridge and colleagues [22], who argued that many important outcomes of treatment cannot be measured, that EBM is unable to resolve competing claims of different interest groups and that the crude application of the results of clinical trials may disadvantage some patients. They accused those charged with making decisions (about resource allocation) as 'seeking simplistic solutions to inherently complex problems'. Other critics have observed that EBM provides less than desirable guidance for general practice, where the ambiguity of early presenting symptoms favours reliance on experience rather than evidence. Similarly in the management of chronic disease, these critics noted that a 'complex calculus' is needed to incorporate a number of factors not readily dealt with from the evidence base [21]. They also pointed out that, in specialist practice, applying the evidence base requires first having the correct diagnosis. We agree with the views that the promises of EBM are 'seductive to those faced with management decisions' and 'EBM must never take precedence over sound ethical decision making by the physician' [21].

13.6 THE DOCTOR AND RESOURCE ALLOCATION

Doctors have traditionally seen themselves as assisting individual patients to access appropriate health care and have resisted suggestions that any factors, other than their perception of a patient's needs, should influence the availability and allocation of resources. This narrow view was understandable in an earlier era when the major resource to be allocated was the doctor's time and expertise. Its persistence may reflect denial of the difficult issues involved in making priority judgments involving patients with similar needs if resources are limited. The fact that neither the latest version of the World Medical Association *Declaration of Geneva* [23] nor the Australian Medical Association current code of ethics [24] makes direct reference to this ethical issue suggests that this denial is insufficiently recognised.

In the present day, the narrow view of the doctor simply being concerned that his or her patients access good health care is no longer realistic. Commencing with the General Medical Council of the United Kingdom, which advised that doctors 'must pay due regard to efficacy and the use of resources' [25], many Australian medical boards have since issued similar advice [26–27]. In Canada, the 2005 edition of CanMEDS Physician Competency Framework identifies a key competency to be to 'allocate finite healthcare resources appropriately' [28]. Similarly, the UK Royal College of Physicians' 2005 report *Doctors in Society: Medical Professionalism in a Changing World* states 'doctors must be conscious of the need for prudent management of limited resources across an entire health service' [4].

This theme is covered in more depth by the authors of a 2002 charter on medical professionalism [5]. This document, emanating from a group based in North America and Europe, may be seen as one response by the medical profession to the enormous changes that have taken place in countries in those regions in response to the desire of governments, and the communities they represent, to more rationally use finite health-care resources. As one of three fundamental principles, the charter identifies the principle of social justice, stating that 'the medical profession must promote justice in the health-care system, including the fair distribution of health-care resources' and, as one of ten professional responsibilities, the seventh is stated to be a 'commitment to a just distribution of finite resources' [5].

In a publicly funded, fee-for-service health-care system as represented by Medicare Australia (see Chapter 14), resources are wasted by doctors who provide unnecessary services to patients, although penalties for such over-servicing are directed more at the pecuniary motives and character of the doctor than to the harm done to the community when resources are ill used. Doctors also waste resources when they fail to use their professional knowledge to evaluate claims about new treatments and allow themselves to be swayed by marketing [29] or when they wittingly or unwittingly participate in 'disease mongering' [30].

In public hospitals, resources can also be wasted by doctors in numerous ways: by ordering unnecessary tests; by delaying or cancelling procedures through lack of punctuality; by failing to notify planned leave; by failing to arrange pre-admission assessment; and by failing to communicate previous investigative results. The source of such inefficiencies can now be measured and their effects costed in ways that can create an effective motivational tool when used appropriately. Hospital managers have appreciated, in the last three decades of budget restriction and the searching for efficiency, that it is invaluable to include those responsible for clinical decisions that influence the use of resources in the decisions regarding the allocation of resources in the hospital; hence the advent of clinician managers [31]. In this way, doctors are also involved in the meso-allocation of resources, a role that may produce conflict with doctor colleagues, as the clinician manager

strives to meet the hospital's financial targets and still provide sufficient resources for fellow clinicians to meet their patients' needs.

Some have argued that it is nigh on impossible for the individual doctor to be both the champion for the individual patient and keeper of the community health-care budget, because of the conflict of the two roles [32], while others have excused the doctor the latter responsibility on the basis that, in a fee-for-service model of health funding, doctors cannot affect where saved resources are to be directed [33]. This lack of influence is likely to be more marked in a managed care system, where doctors might sceptically see savings going to corporate profit and not to other needy patients [20]. These arguments should not be used to diminish the professional responsibility of doctors to make justifiable clinical decisions.

Doctors in European countries that have universal health-care coverage appear to be more ready to accept the need for cost containment [34] and already participate in bedside rationing [35], despite the difficult moral dilemmas so posed. Doctors everywhere will be required increasingly to consider carefully whether any treatment offered to a patient is appropriate. Such decisions are likely at times to produce ethical conflict, and even family and patient dissatisfaction, especially when the doctor is basing a decision on an assessment of (or lack of) patient need for a treatment to which the patient feels he or she has an entitlement or 'right'. The latter may be a product of community misunderstanding of the professional responsibility of a doctor to treat a patient's needs and not desires or expectations. Jennett has suggested the following criteria for deeming a specific treatment as inappropriate [36]:

- unnecessary – because the patient is not seriously enough affected to need it or the desired objective can be achieved by simpler means
- unsuccessful – because the patient has a condition too advanced to respond to or benefit from treatment
- unsafe – because the risks outweigh the probable benefits
- unkind – because the quality of life following the treatment is not likely to be good enough or long enough to justify such treatment
- unwise – because it diverts resources from activities that would benefit others to a greater extent.

The first four of these criteria explore the various senses in which a patient can be said to 'need' or 'not to need' a treatment. The fifth relies on the idea that, though a patient may be said to need a treatment, someone else has a competing and more important need to be met. To these criteria may be added terms such as 'not clinically indicated' and 'futility'. Doctors who advise against treatment, particularly in the elderly, on the grounds that treatment is not clinically indicated, may be confusing two ethical questions: whether the treatment will be of benefit to the patient and whether resources should be allocated to this patient ahead of others [37]. With regard to futility, a treatment is futile if, relative to some

agreed goal such as improvement in the patient's prognosis, comfort, wellbeing or general state of health, it will not work. Decisions by doctors regarding futile or unnecessary treatments, without adequate consultation with the patient and family, or without reference to criteria laid down by the community, are rightly open to the criticism of being paternalistic, even if the decision made is the correct one.

Hurst and Danis have proposed six minimal requisites for rationing by clinical judgment: a closed system that offers reciprocity; attention to general concerns of justice; respect for individual variations; application of a consistent process; explicitness; and review of decisions [38].

13.7 THE LAW AND RESOURCE ALLOCATION

In some countries, it is theoretically possible for patients to sue hospitals and doctors for not providing care to which they believe they are entitled, or to seek a court order that a treatment be provided. To the authors' knowledge, this pathway has not been pursued in Australia, but precedent exists in other countries. In the UK in 1995, the father of a 10-year-old child with cancer, who had been refused chemotherapy and a second bone-marrow transplant under the NHS, petitioned the High Court. The health authority argued that the treatment would not be in the child's best interests nor an effective use of resources, in view of the present and future needs of other patients. The judge required the health authority to reconsider its decision to refuse treatment. The health authority appealed to the Court of Appeal, which rejected all of the High Court's criticisms and ruled that the authority had 'acted rationally and fairly' and treatment via the NHS was thus denied [39].

Such cases present courts, as the judicial arm of government, with difficult issues about the principle that the powers of government (judicial, legislative and administrative) should be given to separate organs of government: the principle of separation of powers. Courts faced with such claims are likely to conclude that there is an issue they can resolve (a 'justiciable' issue) only where the allegation is that an established policy has been mis-administered. Where the allegation is that the policy itself is unsound, courts have traditionally declined to decide questions that are essentially political and not judicial [40].

In the USA, legislation has been developed in many states, setting out minimum lengths of stay for confinements which managed care programs are obliged to fund [41].

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14 THE AUSTRALIAN HEALTH-CARE SYSTEM

While doctors who obtained their undergraduate and postgraduate training in Australia are likely to have a reasonable understanding of the Australian health-care system, overseas-trained doctors may have more difficulty negotiating the Australian system to adequately meet the needs of their patients and to avoid legal problems for themselves. This chapter outlines the Australian health-care system in simple terms and describes in more detail the two main elements relevant to doctors: Medicare and the Pharmaceutical Benefits Scheme (PBS).

Medicare and the PBS are managed by Medicare Australia, formerly known as the Health Insurance Commission [1]. These two elements are central to the clinical practice of medicine outside the public hospital system, as they provide government payments for medical services and pharmaceuticals and include centralised monitoring, enforcement and disciplinary procedures related to payments to doctors for medical services [2]. Doctors who deliberately or through ignorance breach the regulations of these systems may face heavy fines and/or disqualification from participation. They are also likely to be subject to disciplinary action by medical boards. This chapter focuses on health services provided by doctors and does not canvas regulations relating to dentists, pharmacists or other health-care providers.

14.1 AN OVERVIEW OF THE HEALTH-CARE SYSTEM

People seeking medical attention in Australia are free to attend any general practitioner of their choice or to attend a public hospital to see a doctor employed by the hospital. General practitioners are part of what is called the 'private' component of the Australian health-care system. A person who receives care from a private general practitioner is responsible for the account rendered by the doctor, although in practice approximately 70 per cent of general practitioners' attendances are 'bulk billed'; that is, the doctor waives the right to charge a fee determined by the doctor and instead accepts direct

reimbursement for those services from Medicare Australia. Medicare provides health insurance for all Australian residents for general practitioner attendances, non-inpatient specialist services, pathology and radiology; and for the medical component (including pathology and radiology) of private admissions to hospital. Medicare does not cover visitors or tourists, who are responsible for their own health costs, assisted either by the purchase of travel insurance or via reciprocal health-care agreements between the Australian Government and the governments of the UK, New Zealand, Malta, Ireland, Italy, the Netherlands, Finland and Sweden.

Specialist medical services from physicians, surgeons, obstetricians, paediatricians, psychiatrists and others are also provided predominantly in the private health-care system, in which most doctors are independent and self-employed. Specialists generally do not see patients who refer themselves, as this is prohibited by the ethical rules of their colleges and discouraged by Medicare regulations under which the higher rebate for specialist fees will be paid only if the patient has been referred to the specialist by another doctor, usually a general practitioner. To foster the central role of the general practitioner, Medicare Australia rules deem that specialist-to-specialist referrals are valid only for 3 months. In addition, the *AMA Code of Ethics – 2004* (revised 2006) states that 'should a consultant or specialist find a condition which requires referral of the patient to a consultant in another field, only make the referral following discussion with the patient's general practitioner – except in an emergency situation' [3].

The public component of the health-care system is predominantly hospital-based, consisting of public hospitals of varying sizes located in cities, suburbs and country towns. The public hospital system is the responsibility of the health departments of the states and territories, who are in part funded for this purpose by the federal government. General practitioner and other health-care services are also provided by community health services in some states, funded partly by the state government and partly by Medicare.

Mental or psychiatric health care is also provided in both the private and public system, with most inpatient care and involuntary care being undertaken in public psychiatric wards, increasingly incorporated within general public hospitals. There are numerous other health-care programs, funded by state or federal governments, which form part of the public health-care system, including district nursing services, ambulance services, immunisation programs, family planning services and so on.

The level of funding from taxes collected by the Commonwealth and returned to the states for health is negotiated periodically in a complex agreement (the 'Medicare agreement'), which considers several factors including hospital efficiency, outpatient attendance levels and the billing experience of public hospitals. Public hospitals are able to admit 'private' patients and thereby earn income from private insurance funds as well as provide access for their medical staff to

Medicare rebates for medical services and investigations. Public hospitals are generally owned by the state health departments and run by boards of management appointed by the state government. A small number of public hospitals are owned by religious organisations and are run by boards appointed by those organisations. However, these hospitals, such as St Vincent's Public Hospital in Melbourne and in Sydney, are funded by the state government and in a funding sense are almost identical with the other public hospitals.

Large public hospitals generally have emergency departments and public hospitals usually offer outpatient care in specialist services, the extent of the latter varying between the states. There are extensive informal linkages between the private and public health-care systems through the medium of public hospitals. These linkages include:

- referral of patients by general practitioners to public hospitals for consultations, investigation and inpatient care
- sessional or part-time appointment to the staff of public hospitals of specialists who are otherwise in private practice
- ready movement of patients between public and private hospitals, according to severity of illness, the need for access to technology or particular levels of care, and the adequacy of health insurance
- admitting rights for general practitioners in country and some urban public hospitals
- rights of private practice for full-time specialists employed in public hospitals.

14.2 GOVERNMENT HEALTH DEPARTMENTS

Health-care responsibility is divided between the Commonwealth and the state and territory governments; their health departments carry names that are changed from time to time. For example, at the time of writing the Commonwealth department is entitled the Department of Health and Ageing. For simplicity, the generic title 'health department' is used throughout this chapter. Through this divided responsibility, some sixty different programs have been developed to resource and deliver health care. The main Commonwealth Department of Health programs are those relating to Medicare and the PBS [1]. These two programs are described in some detail later in this chapter.

In addition, the Commonwealth health department is responsible for several other important programs, including those of its Therapeutic Goods Administration (TGA), which derives its powers from the *Therapeutic Goods Act 1989* and the *Customs (Prohibited Imports) Regulations*. The department services several important committees established to advise government in this area, including the:

- Australian Drug Evaluation Committee, established to advise government on the safety and efficacy of therapeutic substances

- Pharmaceutical Benefits Advisory Committee, established to advise upon the addition to and deletion of therapeutic substances on the PBS
- Adverse Drug Reactions Advisory Committee, established to monitor and report suspected and proven adverse reactions to drugs dispensed in Australia
- National Drugs and Poisons Schedule Advisory Committee (see Chapter 18).

The TGA is responsible for assessing the safety, quality and efficacy of new drugs and medical devices in order that they be registered or listed on the Australian Register of Therapeutic Goods, which covers both orthodox and complementary medications. With some exceptions, for example in approved research, only registered or listed drugs can be legally prescribed and dispensed, or used, in Australia (see also Chapter 18). The TGA also maintains another database to cover problems, hazard alerts and recalls of therapeutic devices both in Australia and overseas [4].

The Commonwealth Government is responsible for providing health care for veterans of the armed forces via the Commonwealth Department of Veterans' Affairs. Medical services and pharmaceuticals for veterans are provided predominantly by the private health sector, funded via the Department of Veterans' Affairs.

State health departments are responsible for running the public hospital system. Other state responsibilities include mental health, child and maternal health, public health, infectious diseases, regulation of private hospitals and community health.

14.3 MEDICARE AUSTRALIA (FORMERLY THE HEALTH INSURANCE COMMISSION)

Medicare Australia (MA) is a Commonwealth Government body established under the *Health Insurance Act 1973* (Cth). A large part of the work of MA is the universal health insurance cover provided by Medicare. Medicare is funded partly by a levy on income tax and partly from general revenue. All eligible participants (that is, Australian residents) are issued with a personal or family Medicare number and Medicare card, which are used for all transactions.

The level of cover provided for medical, pathology and radiology services is based on the published Medical Benefits Schedule [5]. Historically this Schedule was determined from a study of the most common fee charged for medical consultations and procedures several decades ago. It has not kept pace with inflation and the Schedule now falls well below the list of fees recommended by the Australian Medical Association (AMA) for its members. Patients who claim a rebate from Medicare for their doctors' charges are entitled to a rebate of 85 per cent of the scheduled fee (reduced to 75 per cent for services to patients admitted to hospital). Doctors who seek the rebate directly from Medicare Australia with the signed authority of their patients ('direct-billing' or 'bulk-billing') are accepting

85 per cent of the schedule fee as full payment for their services and are committing an offence should they seek any further contribution from the patient. Doctors who do not direct-bill are free to set their own fees, follow the Commonwealth Schedule or follow AMA recommended fees. In these latter instances, the patient is personally responsible for the fee, but is able to claim the Medicare rebate. Patients may also purchase private health insurance to help meet the costs of hospital-based medical care and some other health care, as discussed below.

Participating doctors are issued with one or more Medicare provider numbers (each number being specific for a geographic site of practice). Primarily designed to make health care accessible to all Australians, Medicare provider numbers also provide an efficient means of tracking the provision and utilisation of medical services.

In built to the Medicare arrangements is protection for individual patients via the Medicare Safety Net for the cost incurred by the gap between the Medicare rebate and the scheduled fees for medical services received out of hospital. In addition, people who are unemployed or receiving a pension are entitled to a Medicare concession card. This concession card extends also to the PBS (see below).

Medicare also entitles patients to free treatment in public hospitals. For any inpatient or day patient admission, the private health funds are able to pay the 'gap' of doctors' accounts, between the Medicare rebate (75 per cent for admitted patients) and the Schedule fee.

14.4 MEDICARE REGULATIONS RELATING TO DOCTORS

Doctors in clinical or investigative medical practice must be aware of the key regulations governing the Medicare system and must take responsibility for their own actions and those of their staff. The oversight of doctors' conduct in relation to Medicare and the PBS is carried out by an independent agency, Professional Services Review (http://www.psr.gov.au).

The key Medicare regulations cover:

- the need for accuracy when determining whether the appropriate category of consultation has been identified and whether it has taken place in hours or after hours
- the requirement that doctors maintain adequate and contemporaneous records
- the availability of higher fees to vocationally registered general practitioners. Such practitioners must participate in RACGP quality assurance and continuing education programs
- the requirements that a referral notice or letter must be received by specialists prior to seeing a patient for whom they intend to claim at the specialist or consultant rate and that the referral notice or letter must be retained for a minimum of 18 months. Exceptions to this requirement include emergency referral and 'in-hospital' referral (where an appropriate entry in the patient record will suffice).

- the requirement that accounts given to patients to be used to make a claim on Medicare must include the name of the referring doctor, the date of referral, the referring doctor's provider number (or alternatively the referring doctor's full practice addresss) and the duration of the period of referral
- the requirement that requests for pathology tests must be signed by the requesting doctor. Pathologists must retain these requests for 18 months.
- the requirement that requests for radiology or diagnostic imaging must be both in the doctor's handwriting and signed by the doctor. Amendments to the *Health Insurance Act 1973* in 1992 introduced a 'show cause' provision, which can be used to seek explanations from doctors who appear to be requesting diagnostic imaging services excessively.
- a number of excluded services, being provisions designed to prevent 'double dipping'. Thus medical services that are to be paid for by accident insurance or worker's compensation or other schemes are excluded from Medicare benefits. So too are screening examinations, other than certain designated procedures such as Pap smears. Patients who attend for medical examination for life assurance purposes, or for fitness for driving or flying, and other assessments not related to the appropriate treatment of a patient must not be billed to Medicare. Cosmetic surgery and unproven therapies such as chelation therapy are also excluded from Medicare benefits.
- the requirement for documentation of need and acute care certificates. Thus for procedures usually undertaken as day cases, a doctor who admits a patient overnight will need to sign a certificate stating that the admission was justified because of the patient's medical condition. Should a patient require hospitalisation longer than 28 days, the doctor will be required to sign a certificate attesting to the continuing need for hospital, as distinct from nursing home, care.

In addition, the Medicare legislation provides a penalty of a fine up to $10 000 or up to 5 years' imprisonment may be imposed upon doctors who make statements or issue documents that are false or misleading in relation to claiming Medicare benefits. In addition, a penalty of up to $1000 fine or imprisonment of up to 3 months may be imposed if a direct-billing form is signed by a patient without the form having the details of the medical service entered or if a copy of the completed form is not given to the patient.

The above details are a summary only and medical practitioners should not rely on this chapter to fully inform themselves of their professional and legal obligations under the *Health Insurance Act 1973*. Medicare Australia conducts information sessions on these matters on a regular basis.

14.4.1 Inappropriate provision of medical services

As the patient's direct financial contribution to the cost of medical services is nil or limited under Medicare, there is potential for unscrupulous doctors to provide

excessive and unnecessary services. There is also potential for patients to attend doctors unnecessarily and for anxious or otherwise incapacitated patients to be manipulated into accepting unnecessary services. Inappropriate practice is defined under section 82 of the *Health Insurance Act 1973* as 'conduct that is such that a Professional Services Review Committee [see below] could reasonably conclude would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services'. The review process is initiated by the Director of Professional Service Review upon referral from Medicare Australia.

The Director must then conduct an investigation and decide whether the matters need to be referred to a Professional Services Review Committee (PSRC) consisting of three medical practitioners, two of whom must belong to the same specialty, general practice being regarded as a specialty for this purpose. The PSRC has the power to apply a range of penalties, including reprimand, counselling and fine or disqualification from participation in Medicare or ordering the Medicare benefits be repaid to the government.

14.4.2 Fraud

Making false or misleading statements (for example, by signing false Medicare claims) is fraudulent behaviour and is a criminal offence under the Medicare legislation. This will be prosecuted by the federal police and penalties of up to $10 000 or up to 5 years' imprisonment apply. The court can also order recovery of monies by the Commonwealth. Following such a conviction, the doctor will be subject to examination by the Medicare Participation Review Committee and may be disqualified from participation for up to 5 years. The doctor is also likely to be the subject of a formal hearing to examine professional conduct by the state medical board or tribunal and may be deregistered. Doctors who are deregistered are automatically disqualified from participation in the Medicare system.

Additional committees established under Commonwealth legislation include:

- the Medicare Benefits Advisory Committee. This Committee has eight members, five of whom are medical practitioners. Its prime task is to assess claims for higher fees for more complex or lengthier medical services covered by the Schedule.
- the Medicare Benefits Consultative Committee. This is an informal advisory committee comprising representatives of the Commonwealth Department of Health, Medicare Australia, the AMA and relevant craft groups. It provides advice on the appropriate level of fees in the Schedule.
- the Pathology Services Tables Committee. This is established under the Medicare Australia *National Health Act 1953* and its main role is to advise on the level of pathology fees.

14.5 SPECIALIST RECOGNITION FOR MEDICARE PURPOSES

Although the medical boards of Queensland, South Australia and the Australian Capital Territory maintain specialist registers, it is necessary for all specialist doctors to be so recognised for their patients to received higher benefits for their services under the National Health Scheme. This process is conducted according to the Commonwealth *Health Insurance Act 1973*. Until 1997, the recognition of new medical specialties was based on the advice of the National Specialist Qualification Advisory Committee, but this function has been transferred to the Australian Medical Council (AMC) as described in Chapter 8.

Application for specialist recognition under the *Health Insurance Act 1973* by individual doctors should be made to the CEO of Medicare Australia, PO Box 9822, in any state or territory capital city. *Guidelines for the Recognition of Medical Practitioners as Specialists or Consultant Physicians for Medicare Purposes* under the *Health Insurance Act 1973*, and the application form, are available at http://www.medicareaustralia.gov.au.

14.6 THE PHARMACEUTICAL BENEFITS SCHEME

The Pharmaceutical Benefits Scheme (PBS) is an important Commonwealth Government program that provides equitable access to medications for the entire resident population. In essence, it is a scheme that makes available essential medications at a price subsidised by the Commonwealth Government. A working knowledge of the PBS is essential for doctors and pharmacists. Not all drugs are listed in the Schedule of Pharmaceutical Benefits [6]. Those listed have been assessed by the Pharmaceutical Benefits Advisory Committee as being of proven efficacy, cost-effective in their application and reasonably necessary for the treatment of disease. New drugs are not listed automatically, but will usually be placed on the list if doctors generally regard them as very useful in clinical practice. For drugs on the PBS list, patients pay no more than a set amount per dispensed item, no matter what the real cost of the drug. Medicare concession card holders pay a greatly reduced contribution per dispensed item. In addition, a safety net applies, in that when a patient has reached a set total expenditure in one calendar year for PBS items, a lower rate applies to subsequent prescriptions for the remainder of that calendar year. The calendar year safety net for concession card holders is set much lower and beyond this level pharmaceutical items are supplied at no charge. The amounts are indexed to inflation rates and revised regularly. Doctors should also be aware of several restrictions on the availability of drugs via the PBS scheme. These restrictions include:

- limits on the strength, quantity and number of repeat prescriptions for drugs

- the disease specific listing of many medications; prescriptions for these drugs must be annotated 'S.P.' for 'specific purpose' as compliance with this restriction may be subject to scrutiny and examination of the doctor's records for that patient
- the availability of some drugs only 'on authority' for certain specified diseases; a formal process must be followed for obtaining such authority and special prescription pads must be used for these drugs.

The PBS system is paralleled by an additional list of medications available to Veterans' Affairs patients. This list is known as the RPBS, the 'R' standing for the former name of Veterans' Affairs, the Repatriation Department. To aid doctors to comply with PBS/RPBS requirements, Medicare Australia, which administers the system, makes available at no cost a range of prescription pads. These may be ordered from the Medicare Australia in each state and are personalised with the doctor's name and practice address and identified with the doctor's allocated prescriber number. (*Note*: the prescriber number is different from the Medicare provider number). Similar personalised prescription pads are supplied for PBS authority-only drugs. Medicare Australia also provides non-personalised prescription pads, pads for use by locum medical practitioners and forms for computer-generated prescriptions. Prescriptions for PBS/RPBS pharmaceuticals must fulfil criteria laid down by the government [6]. These include the following:

- The prescription may be written for the medical treatment of only the person named on the prescription.
- The prescription must be in ink and, if not written on a pad or computer format provided by Medicare Australia, must include all the stipulated information, including provision of a duplicate.
- Up to three separate items may be listed on a PBS/RPBS prescription, whereas only one item may be listed on an authority prescription.
- Non-PBS items must not be prescribed on a prescription for PBS/RPBS items.
- If non-PBS items are prescribed on a pad provided for PBS/RPBS purposes, the notation PBS/RPBS must be clearly crossed out.
- PBS/RPBS prescriptions must be presented to a pharmacist and dispensed within 12 months of the date on which the prescription was written.

In addition to these provisions, state regulations in regard to drugs of dependence (see Chapter 18) must be adhered to.

As indicated in Chapter 18, doctors have a responsibility to adequately inform patients of possible side effects and adverse effects of drugs. To assist doctors and pharmacists in this regard, the *Therapeutic Goods Act 1989* was amended in 1992 to make it mandatory that pharmaceutical companies provide consumer product information in simple language to accompany all new drugs and to cover all existing drugs by January 2002. This information is made available as package inserts, tear-off leaflets and electronically, for distribution primarily via pharmacists.

14.7 PRIVATE HEALTH INSURANCE

It is possible to purchase private health insurance to cover the cost of admission and treatment as a day patient or inpatient in a private hospital. The proportion of the population purchasing private health insurance has fluctuated over time. Such private health cover may be purchased from a number of not-for-profit organisations, which are regulated under the *National Health Act 1953*. According to the premium paid, it is possible to insure for all expenses associated with admission to hospital and for other expenses such as ambulance transport, optometry, physiotherapy and dental services. Health insurance funds are prohibited by law from providing cover for private medical charges, other than those incurred during admission to hospital.

Privately insured patients, if admitted to a public hospital, may opt to use their private insurance. This provides them with their choice of doctor and is encouraged by the public hospitals as it provides additional income to the hospital. Patients, providers or hospitals aggrieved by the actions of private health funds may complain to the Private Health Insurance Complaints Commissioner.

The billing and insurance arrangements in private hospitals can be complex and difficult for patients to understand and to work with. Most funds have negotiated with private hospitals and with medical specialists a system of 'no gap' agreements, which enable the funds to pay the hospital and the doctors directly, thereby reducing the complex paperwork for patients.

14.8 THE ROLE OF UNIVERSITIES AND COLLEGES

The medical courses conducted by Australia's eighteen medical schools leading to the MB BS (Bachelor of Medicine and Bachelor of Surgery) or like qualification are designed to produce a broadly trained undifferentiated doctor who must then complete an internship before being granted unrestricted registration (see also Chapter 8). The MB BS course has generally been of 6 years' duration throughout Australia, but several medical schools, including Flinders in South Australia, the University of Sydney, the University of Queensland and most recently the University of Melbourne, have changed to a 4-year graduate-entry course, while Monash University offers both undergraduate and graduate entry. A full listing of medical schools accredited by the Australian Medical Council (AMC) is to be found at http://www.amc.org.au/index.php/ar/bme/schools.

After completing internship, virtually all doctors undertake further training. This postgraduate training takes place predominantly in public hospitals (with the exception of training for general practice) and is under the control and direction of the medical colleges. The largest college in terms of its membership is the Royal Australian College of General Practitioners. The other colleges cover internal medicine (physicians), surgery, obstetrics and gynaecology, anaesthetics,

pathology, radiology, psychiatry, dermatology, emergency medicine, ophthalmology and medical administration. Many of these colleges serve both Australia and New Zealand and may carry the title 'Australasian'. Existing medical colleges must be accredited by the AMC while proposed new colleges must go through an AMC assessment process leading to recommendation to the Commonwealth health minister (see Chapter 8).

The pathway to fellowship in any of the established colleges is demanding of time and study, as several years of full-time professional experience under decreasing levels of supervision are combined with rigorous theoretical and clinical examinations conducted by the colleges. One study showed that the average time from graduation as MB BS to completion of postgraduate training and taking up a teaching hospital specialist appointment was 9 years. Most of these specialists arranged funding for themselves for 2 years of training abroad [7].

In addition to providing training programs and conducting fellowship examinations, the specialist colleges are responsible for the continuing education of their fellows (see Chapter 12), for setting ethical standards and for providing the community with information on health matters. The charters of the colleges prevent their involvement in industrial issues and negotiations over fees. This role is left to the Australian Medical Association (AMA) and smaller craft-based associations.

The existence of so many colleges is indicative of the specialisation that has steadily developed in medical practice. For lawyers, insurance companies and other groups seeking advice from an appropriate specialist, access to the system may be confusing. For example, the Royal Australasian College of Physicians has adult medicine and paediatric medicine divisions as well as additional 'faculties' and 'chapters' including Public Health Medicine, Rehabilitation Medicine, Occupational Medicine and Addiction Medicine. Furthermore, fellows of the college (FRACP) as physicians may choose to specialise in any of the following fields: allergy, cardiology, endocrinology, gastroenterology, geriatrics, haematology, hepatology, hypertension, immunology, infectious diseases, intensive care, oncology, nephrology, neurology, pharmacology, rheumatology or respiratory medicine. General physician fellows (consultants in internal medicine) cover all these areas, but not in the same depth as a person concentrating on one special field. Similar sub-specialisation occurs in surgery and to a lesser degree in other walks of medical practice. To confuse matters further, many doctors, especially general practitioners, develop 'special interests' such as acupuncture, hypnotherapy and the like, which they announce to their colleagues and their patients.

14.9 TEACHING HOSPITALS

The major public hospitals in Australia also function as 'teaching' hospitals. The university medical school is usually grafted on to an existing teaching hospital

or in a few instances fully integrated into its management. As well as providing for the undergraduate and postgraduate training for doctors, teaching hospitals, in conjunction with universities and colleges, are involved in training nurses, allied health professionals, medical scientists and most other disciplines and trades required by hospitals. Teaching hospitals are also the sites at which most clinical research is conducted. While there has been some involvement of large private hospitals in undergraduate and postgraduate training and in research, this is not highly developed in Australia.

14.10 THE AUSTRALIAN MEDICAL ASSOCIATION AND OTHER ASSOCIATIONS

Most of the medical colleges are not able to represent their members in political and industrial matters and as a result their members usually also seek membership of parallel professional associations. The largest and most broadly representative of these is the Australian Medical Association (AMA). Membership is voluntary and approximately 60 per cent of practising doctors are members. As well as being the point of contact with government for advice and for negotiation over a wide range of matters impinging on medical practice, the AMA, via branches in each state, provides a wide range of services to its members, provides a democratic system of representation of craft groups and the broader membership, and directly and indirectly is involved in continuing education, quality assurance and the maintenance of standards of medical practice. In addition to the AMA, most doctors belong to craft or specialist associations and societies, which engage in continuing education and representation to government and other bodies over industrial and professional issues. Such associations cover virtually every area of specialisation in medical practice. Other associations, such as the Rural Doctors Association, the Doctors Reform Society and the Overseas Trained Doctors Association, have been established for broader purposes.

14.11 AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS

The Australian Council on Healthcare Standards (ACHS) is a voluntary organisation, formed in 1974 on behalf of the Australian Hospitals Association, the AMA, health departments, major colleges and other organisations, and is funded via the fees it charges for its primary function, which is to accredit Australian public and private hospitals that meet required standards. Accreditation may be granted by the Council for periods of 1, 3 or 5 years after receipt of recommendations from an external review team that spends up to a week examining a hospital. Most state governments encourage public hospitals to seek accreditation with the ACHS, often through funding incentives. The Council publishes detailed criteria

for accreditation [8]. The Council has also been actively involved in promoting quality assurance programs within Australian hospitals. This is discussed more fully in Chapter 12.

14.12 THE AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

This organisation was established as a joint Commonwealth and state health ministers' initiative in response to the highly publicised concern that patients in hospitals were being harmed by preventable adverse events [9]. It began life as the Australian Council on Safety and Quality, but in 2006 its structure was changed to that of a commission with a brief to develop a national strategic framework and associated work program to guide its efforts in improving safety and quality across the health-care system in Australia [10]. Its activities have included the production of guidelines on diverse topics including fall prevention and clinical handover, a national patient charter of rights and a national inpatient medication chart. It is mirrored by similar state-based initiatives (see also Chapter 7).

14.13 REGISTRATION OF OTHER HEALTH-CARE PROVIDERS

Just as medical practitioners must be registered with the state or territory medical board and may be subject to disciplinary proceedings, or to restrictions if their health is impaired, most other health-care professions are also required to be registered at the state or territory level. Registration boards exist in most states and territories for pharmacists, nurses, dentists, psychologists, physiotherapists, dietitians, chiropractors and osteopaths, optometrists, podiatrists (formerly known as chiropodists), dental technicians and radiographers. As for medicine, the Council of Australian Governments has announced a national registration scheme for most of the health professions to commence in 2010 (see Chapters 8 and 15). Medicare does not cover the fees of these professions (with the exception of optometrists and recently clinical psychologists and dentists in certain situations), but rebates are available through the 'extras tables' of most private health insurance funds for some of their services.

14.14 ALTERNATIVE HEALTH-CARE PROVIDERS

Many Australians report attending alternative health practitioners, such as naturopaths, acupuncturists, iridologists and the like. With the exception of traditional Chinese medicine practitioners in Victoria, these practitioners are not registered by the state and their services are not recognised by Medicare Australia as attracting Medicare rebates for fees charged. In the absence of a registration authority, people who wish to lodge a complaint against an alternative provider can do so

via the health complaints commissioner established in each state (see Chapter 9). Some registered medical practitioners are attracted to the practice of alternative or complementary medicine methods. This is not prohibited by medical boards, but doctors who use unproven methods and remedies should be aware of an even greater than usual ethical responsibility to inform their patients that the methods are unproven and are not part of accepted medical practice (see Chapter 8). Complementary and alternative medicine is discussed more fully in Chapter 15.

14.15 THE NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

The National Health and Medical Research Council (NHMRC) was first established by the federal government in 1936 and became a statutory body under the *National Health and Medical Research Council Act 1992*. Its charter includes:

- raising the level of individual and public health in Australia
- fostering consistent health standards throughout Australia
- fostering medical research and training, and public health research and training
- fostering the consideration of ethical issues in health.

In pursuing this charter, its main functions have evolved to include:

- disbursement of government-funded medical research grants by a strictly controlled peer review system, overseen by the Research Committee, one of five 'principal committees' of the Council
- developing and promoting guidelines for the ethical conduct of medical research, through another principal committee, the Australian Health Ethics Committee (AHEC). The NHMRC, with the advice of the AHEC, also oversights the human research ethics committees that are required to be established under the guidelines in hospitals and other institutions that conduct medical research in humans (see Chapter 17)
- issuing guidelines on ways of improving health and preventing, diagnosing and treating disease through its National Health Committee (formerly known as the Health Advisory Committee)
- overseeing and licensing research involving human embryos via the Licensing Committee, and
- advising the NHMRC and the community on issues in human genetics via the Human Genetics Advisory Committee, a new principal committee established in response to a recommendation from an enquiry conducted in 2003 by the Australian Law Reform Commission and the NHMRC [11].

Examples of the output of the NHMRC can be found in this book, for example the publication, *Communicating with Patients: Advice for Medical Practitioners* (see Chapter 3), and guidelines on ethical conduct of human research (see Chapter 17).

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Additional reading

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15 THE DOCTOR AND INTERPROFESSIONAL RELATIONSHIPS

Doctors work closely with nurses, pharmacists, social workers, physiotherapists and many other professionals in delivering health care. The quality of this care is enhanced in these working relationships if there is good communication, mutual respect and a proper understanding of the roles, responsibilities, capabilities, constraints and ethical codes of these various professions. Until the last 10 years, little formal attention was paid to the importance of such interprofessional relationships in the undergraduate medical curriculum or in postgraduate medical training, but this is now changing in Australia and elsewhere [1–5]. Prior to this change, the good working relationships that usually exist between health professionals appeared to owe more to human nature and shared goals than to formal training about each other's place in the health team. There are good reasons for promoting better understanding of each other's roles and approaches. A recent Swedish study demonstrated that an interprofessional learning segment in the undergraduate curriculum enhanced the confidence of young medical graduates [6]. On the other hand, there is evidence that poor interprofessional relationships diminish the quality of patient care and add to the stress of working in the health team [7–8]. Through ignorance or a negative attitude some doctors may deny patients access to the specialist skills available from other health professionals. The importance of good communication between doctors and other health-care professionals is also addressed in Chapter 3.

In hospitals the key interprofessional relationship for doctors is with nurses. Changes to nursing education, the scope and organisation of nursing practice and nursing philosophy have led to gradual change in the balance of this relationship during the past 30 years [9–13]. This chapter summarises the professional roles of nurses and other health care providers in patient care and discusses ways to enhance interprofessional relationships. It provides guidance on the relationships that are expected between doctors and lawyers acting on behalf of patients, attends to the importance of the spiritual dimension in the care of many patients and discusses some of the ethical and professional issues around the use of complementary and

alternative medicine. Nursing and pharmacy are discussed first as these are the two professions with which doctors most frequently interact. Other clinical professions are then considered alphabetically, with the exception of chiropractic and osteopathy, which are described under the heading of complementary and alternative medicine.

15.1 THE LEGAL AND ETHICAL CONTEXT

All health-care professionals, including doctors, share similar ideals, being concerned with helping people to prevent or overcome illness, relieving suffering and maintaining life of good quality. These professionals share similar ethical codes, being bound to respect patients, maintain their confidentiality, be honest and behave with integrity. Most are subject to legal regulation through a registration process, with disciplinary mechanisms for professional misconduct, and mechanisms to deal with practitioners whose health is impaired to the extent that the public is at risk. Some of the legislation also places limits on the scope of practice of the health-care professional [14].

15.2 NURSES

In their undergraduate and postgraduate training, doctors work alongside nurses and thus doctors may well feel they are familiar with the training of nurses and the scope of their responsibilities. However, data from the USA indicates that doctors are not well informed [15–16]. In addition most doctors are unlikely to be fully aware of the philosophy of nursing practice, the regulations governing it, the development of specialisation in nursing, including the role of the nurse practitioner, and the changes that have occurred in nursing education. Doctors are probably unaware of how the medical profession and the nursing profession view each other's roles. In a survey in the USA, two-thirds of each profession indicated general satisfaction with working relationships, but observed that when problems arose the professions sought to solve them competitively rather than collaboratively [17]. Doctors valued nurses for their capacity to communicate with doctors, their willingness to help and their competence, whereas nurses valued doctors who demonstrated trust and respect for nurses [17]. Other surveys have found considerable discordance between nurses' and doctors' views as to the health of their interprofessional relationship, with doctors being more positive than nurses [15–16]. Doctors may also be unaware that among the stated reasons for nurses leaving the profession are inadequate respect from doctors and having to deal with aggressive or disruptive doctors [18].

In the nurse–doctor working relationship of caring for patients, there are responsibilities which are clearly those of nurses, clearly those of doctors, and responsibilities which may be shared. Even when it is clear where a particular

responsibility lies, there are overriding responsibilities for both professions to act always in the best interests of the patient. Nurses who recognise a situation of potential or actual harm to a patient must take steps to prevent it. This may lead to a nurse intervening as a patient advocate to argue for a different course of action, or even refusing to follow a treatment order; failure to take such action could represent to the nurse an abrogation of responsibility to the patient and a breach of her or his ethical code. Nurses are accountable in law primarily to patients and to their employer, and nurses have to take personal responsibility for their own professional actions. Misunderstandings in regard to responsibilities will be prevented if there is a collaborative partnership role of mutual respect and appreciation of the training, philosophies, skills and expertise each profession brings to patient care. Where differences arise, as they always will in the complexity of hospital practice and health care, open respectful discussion achieves the best for the patient, while allowing each profession to support the other and providing checks and balances when needed.

15.2.1 Philosophy of nursing

The nursing undergraduate course contains significant components of science and clinical practice and has elements in common with medicine. Although nurses generally share the care of patients with doctors, they are encouraged to be accountable for their own actions, to act as the patient's advocate or friend and to consider the social and psychological dimensions of being ill. Through longer time spent with patients in hospital, nurses may have greater insight into the real concerns of patients and their families. Nursing philosophy has turned away from paternalism, looking to a partnership with patients and sharing their goals. Consistent with this philosophy, nurses seek a collaborative working relationship with doctors. They do not seek to take over the role of the doctor in hospital care, but they do wish to be seen, heard, respected and involved in a genuine team approach. While some commentators have viewed this altered philosophy and role as reflecting the influence of the women's movement in society, it can also be seen as the nursing profession's response to changes in community expectations, education for health-care delivery, technology and cost of health care [19–20].

15.2.2 Nursing education and training

Nursing is now a 3-year degree course, conducted in over thirty universities throughout Australia, combined with supervised clinical placement in hospitals and other health-care settings. At the completion of the degree, new graduates must undertake a year of closely supervised practical experience termed the 'graduate' year, analogous to the intern year for doctors.

15.2.3 Registration

All nurses must be registered with a state-based nurses' board, although this will change in 2010 with the introduction of national registration for all health professionals (see Chapter 8). These boards accredit or approve the courses undertaken by student nurses in their jurisdictions. Other requirements for registration include competence in English, documented nursing competence and absence of a criminal record. Nursing competence is tested by examinations, which are conducted either by the state nurses' board or by a tertiary institution the examinations of which are approved by the board. In several states, restoration to the register requires submission of evidence of recent practice or recent refresher training.

15.2.4 Postgraduate training; career paths

In most states, registration is granted in general, midwifery and psychiatric nursing. Most nursing faculties offer postgraduate masters and doctoral courses. Nurses also may specialise, via diploma or certificate courses, in such fields as coronary care and intensive care nursing. In addition, nurses are increasingly specialising in fields such as diabetes education, oncology and stomal therapy and may function as consultant nurses. Outside the hospital, nurses specialise in other fields, such as public health, community health, child and maternal health and mothercraft nursing. Following development of the role of nurse practitioner in comparable developed countries, Australian nurses may also choose this professional path, for which the Australian Nursing and Midwifery Council has set down national competency standards [21] (see below).

Within the hospital system, nurses usually accept increasing responsibility during their careers, with some adding ward management to normal nursing duties. Some move into nursing administration or more general hospital administration and, to prepare for this, pursue postgraduate degrees in nursing or general management. Others pursue careers in nursing education and research.

15.2.5 Nurse practitioners

Nurse practitioners are registered nurses with advanced education and experience who are authorised by a state nursing board to practise in an expanded nursing role. They can work in a diverse range of clinical settings – from acute hospitals to aged care and community settings. Their role can include aspects of care that have traditionally been provided by doctors, such as diagnosis of some medical conditions, referring patients, prescribing medicines and requesting and interpreting investigations [14]. Different restrictions on the scope of practice of nurse practitioners apply in different states and territories. In New South Wales authorisation

by the Nurses Board allows nurse practitioners to initiate diagnostic investigations, to prescribe medications and to make limited referrals, provided they are working under approved clinical guidelines. The scope of practice is defined separately from the authorisation by the Nurses Board, and documentation of the scope must be developed in consultation with a health-care team and agreed to by the area health authority [22].

15.2.6 Ethical and medico-legal constraints

In law, nurses are now regarded as members of the health-care team, taking professional responsibility for their role. Nurses have been sued personally for negligence, have been apportioned responsibility for the deaths of patients by coroners and are subject to disciplinary action by nurses' boards for unprofessional conduct [23]. Weighing heavily on the minds of nurses are situations where their duty of care will not be fulfilled if they follow a doctor's treatment decision, for example where a nurse genuinely believes a treatment plan proposed for a patient is not in the patient's best interests. In the ideal world, good communication between doctor and nurse should prevent such situations arising. Where such situations do arise, nurses hold strongly to the view that their ultimate responsibility is to the patient, an ethical imperative to be understood and respected by doctors.

15.2.7 Ethical codes

The nursing profession, like the medical profession, has developed codes of ethics at international and national levels. First issued in 1953, the International Council of Nurses *Code of Ethics for Nurses* states in the preamble to the 2006 edition that:

> Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal. Inherent in nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, or sexual orientation, nationality, politics, race or social status. Nurses render health services to the individual, the family and the community and co-ordinate their services with those of related groups. [24]

At the national level, the Australian Nursing and Midwifery Council (ANMC), in conjunction with the Royal College of Nursing Australia and the Australian Nursing Federation, has published a *Code of Ethics for Nurses in Australia*, which is complementary to the *International Council of Nurses Code* [25]. The Australian

code lists the six value statements, to which are added explanatory notes. The code is accessible on the ANMC website. The ethical code is supplemented by a *Code of Professional Conduct for Nurses in Australia*. Additionally, the Royal College of Nursing Australia develops position statements and discussion papers on nursing issues.

15.2.8 Shared and delegated responsibilities and skills

A number of medical responsibilities cannot be delegated to nurses, other than to nurse practitioners as outlined above. These include the making of a medical diagnosis by history and physical examination, the prescribing of drugs (other than in limited or special circumstances), the requesting of tests, the giving of anaesthetics and the performance of surgery. In specialised areas such as coronary care and intensive care, nurses are trained and expected to be skilled in resuscitation, including defibrillation. Although there are differences between the states, nurses share with doctors responsibilities such as giving intramuscular or intravenous injections and storage of and recording the use of drugs of dependence. Nurses are also expected to make nursing diagnoses and such conclusions are frequently the basis for medical intervention. In addition to the nurse practitioner role described above, the performance of a number of other procedural tasks by nurses (and other health professionals), including flexible sigmoidoscopy, is being trialled [26]. In Australia, the AMA, the RACP and the RACS have issued policy statements supporting these developments, provided certain criteria are met [27–29].

In all Australian states, qualified midwives are legally able to conduct antenatal care and deliver babies without the supervision of doctors. This model of practice is described as collaborative and will work only where there is goodwill and mutual respect between those expected to collaborate (the midwife and the doctor). The Australian Nursing and Midwifery Council publishes national competency standards for midwives.

As health care is increasingly delivered outside hospitals, general practitioners will need to be better informed of the range of nursing skills and services available, and ensure via good communication, mutual respect and collaboration that patients receive the best available care. Bennett has written with insight on the challenges and benefits of such collaboration [30].

15.3 PHARMACISTS

The role of pharmacists does not overlap to any significant degree with that of doctors and in general there exists mutual respect and little sense of competition. However, doctors and pharmacists have individual and joint responsibilities to ensure that patients use medications safely and effectively. The commonest

problem that arises between doctors and pharmacists relates to communication, usually due to a failure on the part of the doctor. Much less frequently, interprofessional tensions arise when doctors seek to dispense and sell medications or when doctors misunderstand the role pharmacists legitimately play in giving advice and recommending medicines. Pharmacists through their training and experience recognise common ailments by their symptoms and, if necessary and appropriate, recommend treatment with medicines that may be legally sold without prescription. Where this is not appropriate, the pharmacist will advise that medical attention be sought. In 2006, following amendment to the *Workplace Relations Act 1996*, pharmacists were provided with the authority to certify illness causing unfitness for work. The Pharmaceutical Society of Australia and the Pharmacy Guild of Australia have jointly issued guidelines for this new task, but these guidelines are not available to the public [31].

While medical students have little contact with pharmacists, new graduates usually develop some concepts of the role and expertise of pharmacists while working in hospitals; most doctors thus appreciate the central role of pharmacists in the health-care team in dispensing drugs and contributing to their the safe and effective use.

The basic means of communication between doctor and pharmacist is the prescription, the enhanced use of which has been the subject of a joint statement by the Royal Australian College of General Practitioners and the Pharmaceutical Society of Australia entitled *General Practitioners' and Pharmacists' Interprofessional Communications*, issued in 1996. This statement clarified the conventions of prescription writing and encouraged a more formal process for pharmacists to refer patients to doctors.

The education and training of pharmacists covers the following responsibilities:

- dispensing prescriptions
- providing general information and drug administration instructions to patients
- counselling patients with regard to minor ailments, the use of over-the-counter drugs and the need to see a doctor
- keeping up to date with the laws and regulations about drugs
- keeping up to date with knowledge about drugs
- recognising the possibility of common drug side effects
- recognising and resolving, usually in consultation with the prescriber, any problems that may be related to a patient's drug therapy.

Pharmacists seek to work collaboratively with doctors. They wish to be respected for their particular skills and knowledge and wish, by collaboration with doctors, to ensure that patients benefit maximally from the skills of both professions [32]. In providing advice, pharmacists direct many people to their family doctor and are sensitive to the judgment required to avoid unnecessary or late referrals.

15.3.1 Education and training

Pharmacy students undertake a 3-year degree course (or equivalent), which is based on science, pharmacology and pharmacy. Since 1998, these courses have been accredited by a national process. During the course, students undertake practical training supervised by pharmacists in various settings. On completion of the degree, they are required to do 1 year of practical training prior to registration.

15.3.2 Registration

To practise as pharmacists, all graduates must be registered with their respective state pharmacy boards. The requirements for registration, composition of the boards and disciplinary processes are very similar to those of medical registration. The practice of pharmacy itself is, however, much more tightly regulated than the practice of medicine. Pharmacists are bound by state laws relating to drugs of dependence (see Chapter 18) and Commonwealth laws relating to the Pharmaceutical Benefits Scheme (PBS) (see Chapter 14). Pharmacists must be approved by Medicare Australia before they can participate in the PBS and dispense PBS prescriptions. In addition, pharmacy board regulations cover such matters as the requirement for a registered pharmacist to be on the premises at all times a pharmacy is open, the number of pharmacies one pharmacist may own and the keeping of records, which may be inspected at any time. The legal and ethical implications of these strict regulations are detailed below.

15.3.3 Postgraduate training and continuing education

Postgraduate training leading to higher degrees, including graduate diploma, Master of Pharmacy and PhD, is available. The Pharmaceutical Society of Australia conducts a national and state-based continuing pharmaceutical education program very similar to CME programs, in that it is a points-based system with points awarded for a range of activities, including attendance at conferences and workshops, participation in computer-assisted learning and correspondence courses, preparation for and participation in teaching, and self-directed learning.

15.3.4 Career paths

Like doctors, most pharmacists are self-employed in private practice, managing private pharmacies. Other career opportunities exist in hospital pharmacies, regulatory authorities, the pharmaceutical industry, research and teaching. The pharmacy profession underwent a great restructuring in the first half of the 1990s, overseen by a Commonwealth Pharmacy Restructuring Authority. This process provided financial incentives for pharmacists to close businesses in

areas which were over-supplied, to make the remaining businesses more viable in the longer term.

15.3.5 Ethical and legal constraints

The regulation of pharmacists in both private and hospital practice has been mentioned above. Pharmacists must abide by these regulations or risk prosecution by Medicare Australia, the state authority regulating the handling of drugs and poisons or the pharmacy board. To prevent harm to patients, a pharmacist has a duty to dispense a prescription only if it is consistent with patient safety. Thus pharmacists must not dispense prescriptions if the prescription is not clearly legible or if the dose is thought to be dangerously incorrect. This ethical and legal duty must be understood and respected by doctors. Pharmacists have at times been joined with doctors in actions for damages where both parties should and could have collaborated to resolve a medication safety issue. Pharmacists also have an obligation to ensure patients are instructed in the use of medications and their side effects. This includes an obligation to provide and explain consumer product information leaflets relevant to prescribed drugs. Doctors need to appreciate this obligation and to inform the pharmacist when a prescription has been written with unusual directions or for non-approved purposes, as the consumer product information leaflet may not be fully relevant in such situations. If satisfied of the therapeutic need, pharmacists may supply certain drugs, including Schedule 3 drugs, directly to patients, keeping records as required under the legislation, but may dispense Schedule 4 and 8 drugs only on receipt of a written prescription from a doctor (see Chapter 18 for more information on drug schedules). Pharmacists are open to disciplinary action including substantial fines if they are found guilty of misconduct by the pharmacy board. They may be sued for negligent actions and have been subject to adverse findings of the coroner through dispensing errors.

15.3.6 Ethical codes

The Pharmaceutical Society of Australia has issued its *Code of Professional Conduct* [33], which includes the following principles:

- The primary concern of the pharmacist must be the health and wellbeing of clients and the community.
- A pharmacist must at all times uphold the reputation of the profession and adhere to the legislation applicable to the practice of pharmacy.
- A pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to clients and their families. Such information shall not be disclosed to anyone without the consent of the client. Exceptions may arise where the health of the client or others is at risk, where information is sought by an officer of a statutory authority empowered under

legislation, where a court order requires the release of confidential information, or the information is released to those assuming responsibility for the patient (such as next of kin, parent, relative, guardian or anyone with powers of attorney).

- A pharmacist must maintain a contemporary knowledge of pharmacy practice and professional issues in order to ensure a high standard of professional competence.
- A pharmacist must neither agree to practise under conditions that compromise their professional independence, judgment or integrity, nor impose such conditions on other pharmacists.
- A pharmacist must respect the skills and expertise of other health professionals and work cooperatively with them to optimise the health outcomes of their mutual clients.

15.3.7 Mutual expectations and responsibilities

Pharmacists expect and rely upon doctors to write legible prescriptions with clear instructions as to how the medication is to be taken. By law, pharmacists cannot fill a prescription unless the pharmacist is certain of which drug is being prescribed and what directions have been given for its administration. Doctors expect pharmacists to accurately dispense the medication prescribed and to attend to labelling and record-keeping requirements. Doctors can create problems for pharmacists when they:

- write illegible prescriptions or prescriptions with unhelpful or unclear instructions about dispensing requirements, strength, quantity and so on
- fail to provide on the prescription a telephone number for contact and the address of the doctor, information which is legally required
- refuse to accept a telephone call or behave discourteously when asked by a pharmacist to clarify details of a prescription
- are generally ignorant of the requirement that pharmacists are obliged to be concerned for patient safety and to ensure that patients understand what a medication is for and how it is to be used
- make careless comments that can be interpreted as denigrating pharmacists or undermining their legitimate professional role.

Doctors who fail to meet their professional responsibilities in their dealings with pharmacists are open to disciplinary action by state medical boards. Complaints in this area often relate to rudeness and abruptness and are important because of their potential effect on patient care and because they reflect poorly on the doctor's attitude to communication.

The medical profession in Australia has not traditionally involved itself in stocking, dispensing and selling medications for profit. This approach of differentiating between the professional roles of pharmacists and doctors exists because it is believed to be in the best interests of patients. At least one state medical board

has stated that to routinely dispense medication for profit represents unprofessional conduct [34]. Such differentiation of roles will:

- provide a system of checks and balances, whereby pharmacists contribute to patient safety by monitoring their use of medications and by drawing the attention of doctors to possible prescribing errors
- avoid the profit motive in doctors' prescribing, and distance doctors from direct incentives to prescribe a sponsor's products
- ensure that medications are dispensed in a regulated framework, where pharmacists are subjected to regulations covering record keeping, labelling and dispensing – adherence to these regulations is reinforced by an inspection system that does not apply to doctors
- for PBS prescriptions, ensure that patients have full access to the benefits of this system, including its safety-net provisions.

There are, however, exceptions to this role differentiation, including the use of drugs from the doctor's emergency bag, the provision of drugs in remote areas or where a pharmacy is not immediately available, and the supply of 'starter' packs. Doctors who dispense drugs in these situations are obliged to meet all the regulatory requirements facing pharmacists, including labelling and adequately instructing patients about the purpose and side effects of the drugs.

Apart from their professional responsibilities to patients and their collaborative responsibility to medical practitioners, pharmacists have additional responsibilities to others. For example, pharmacists are expected to play a key role in ensuring that residents in such places as nursing homes, hostels and special accommodation have appropriately supervised and supported pharmacy services, in keeping with the level of service available in hospitals.

15.4 AMBULANCE OFFICERS/PARAMEDICS

The education, training and skills of ambulance officers have progressively increased. In urban areas particularly, ambulance officers are now the main source of immediate medical care at accident and trauma sites, and they are increasingly replacing family medical practitioners as the first source of emergency care for patients who have collapsed, are unconscious or have had a cardiac arrest. This has resulted in the development of a form of specialisation for ambulance officers as 'paramedics' (see below). The primary role of ambulance officers is to provide emergency and non-emergency care to patients before and during transportation to hospital or other health-care facilities.

15.4.1 Education and training

Student ambulance officers are required to undertake a 3-year tertiary course involving theoretical and practical teaching in the classroom and experience

working alongside qualified ambulance officers. An alternative pathway to this career is via the paramedic training programs of the armed forces.

15.4.2 Mutual expectations

Ambulance officers have a very important contribution to make in providing crucial information to doctors working in emergency departments, as they have often witnessed the earliest phases of rapidly evolving illnesses. Information gleaned from direct conversation or from the report that accompanies the patient can be very valuable in establishing a diagnosis and in guiding early management. Ambulance officers are trained to observe and record vital signs and other observations. This information is handed over verbally and in writing to emergency department nurses and doctors and is highly valued by them [35].

The profession of being a 'paramedic' had its origins in the provision of emergency care on the battlefield and in the space of only 10 or so years has become an element of emergency services which the Australian community takes for granted. Paramedics are recruited from ambulance staff whose training is provided by several Australian universities [36]. The role of paramedics includes the assessment of seriously ill people, administration of pain-relieving drugs, and administration of life support at emergencies using airway access and intravenous support. Although the title is protected in law in some countries, this does not yet apply in Australia [37].

15.5 ADVICE TO DOCTORS ABOUT REQUESTING AN AMBULANCE

The ambulance service is a valuable resource that must be used with due consideration. Apart from patient- or doctor-initiated services in a genuine emergency, all other requests for ambulance transport should involve the doctor giving consideration to whether cheaper transport alternatives are available, within reasonable bounds of patient safety. In some cities, alternate and less expensive transport for elective procedures and ambulatory consultations is available and should be used where appropriate.

With the introduction of computer-aided dispatch technology to ambulance communications in Australia, the detail of information doctors provide to the call takers is vital in determining the level of response, namely whether that be a general-purpose ambulance or a mobile intensive-care ambulance and whether that resource is sent 'lights and sirens' or under normal driving conditions.

In emergency situations the person who is with the patient is in the best position to call for an ambulance because that person can answer the call taker's questions accurately with up-to-date details of the patient's condition.

As ambulance communications systems vary within and between states, doctors should familiarise themselves with their local service protocols to elicit the appropriate ambulance response for their patients.

15.6 CLINICAL PSYCHOLOGISTS

Clinical psychologists undertake a 4-year university degree course followed by either 2 years of supervised practice in clinical psychology or completion of a course for a masters or doctoral degree, which includes practical experience. The initial university degree course covers the theory and practice of psychological assessment, the main psychological approaches and interventions and the ethics of psychological practice.

Clinical psychologists may specialise in such fields as neuropsychology, counselling, educational and developmental psychology, forensic psychology and sports psychology. Practising psychologists must be registered with the state registration board and must conform with codes of ethics and standards of professional conduct in relation to their clients, which are similar to those applying to doctors and nurses. Clinical psychologists are equipped to treat social, emotional and behavioural problems in children, adults and families and are thus an important component of the healthcare system. Clinical psychologists in their training use the diagnostic categorisation systems common to psychiatry (DSM IV or ICD systems) and thus share a common language with doctors. They are able to accept referrals from doctors or clients may refer themselves. Access to their services has been enhanced by recent changes to the Medicare system. To receive psychological services under Medicare, a person must be referred by his or her GP or in some instances by a psychiatrist or a paediatrician.

15.7 DENTISTS

15.7.1 Education and training

Dentists generally undertake a full-time university course of 5 years' duration offered by seven Australian universities, although Sydney University offers a 4-year graduate entry program. Entry requirements and competition for entry are very similar to those for medicine. Dental students in their clinical placements also share with medical students the ethical responsibility to be immune to or immunised against contagious diseases such as hepatitis B.

15.7.2 Career paths

While most dental graduates work in general private dental practice, some pursue specialist areas like orthodontics, periodontics, paediatric dentistry,

prosthodontics, endodontics, and oral and maxillofacial surgery, all of which require additional training. Other career opportunities include teaching and research and service in the military forces.

15.7.3 Registration

Dentists are required to be registered by state dental boards. The provisions of registration are closely aligned with those of doctors and in several states are included in 'health profession' registration acts covering medicine, dentistry, nursing and the other health-care professions. Overseas-trained dentists can qualify for registration by undertaking an Australian dental degree or by sitting examinations conducted by the Australian Dental Council [38]. Like its medical counterpart, the Australian Dental Council is responsible for accrediting the undergraduate dental education courses conducted in the universities. Dentists will be incorporated into the new national registration scheme for all health professionals.

15.7.4 Ethical code

The Australian Dental Association (ADA) issues a code of ethics under the title *Principles of Ethical Dental Practice* [39]. This is supported by codes of ethics issued by state branches of the ADA. Approximately 90% of dentists are members of the ADA.

15.7.5 Mutual expectations and responsibilities

Interactions between dentists and doctors are relatively infrequent. However, when required, the interactions are usually about serious issues, including the precautions to be taken with dental patients who are on anticoagulants or who might require prophylactic antibiotics to reduce the risk of bacterial endocarditis. Thus it is important that doctors make themselves accessible to dentists who are seeking information or advice about shared patients.

15.8 DIETITIANS

Dietitians are trained to provide nutritional advice and care for individuals and groups, both for patients and for healthy individuals. As the knowledge of dietary factors in health and disease has grown, doctors have increasingly come to rely on dietitians for detailed dietary histories, to make nutritional assessments and to provide specific counselling about dietary modifications. For diseases where dietary therapy is the primary or main mode of therapy, doctors who do not possess adequate knowledge and skills to undertake these tasks have an ethical obligation to refer patients to dietitians.

15.8.1 Education and training

Dietitians undertake a 3-year Bachelor of Science degree or its equivalent, followed by a postgraduate qualification in dietetics and nutrition usually of 2 years' duration. Their education covers biochemical, physiological and psychological factors relating to human nutrition as well as the principles of communication, education and health promotion.

15.8.2 Career paths

Dietitians work predominantly in hospitals, community health-care centres and private practice, but may also work in food-service management in hospitals, in government, industry, education or research.

15.8.3 Registration

Dietitians are not required to be registered but, through the Dietitians Association of Australia, have developed a system equivalent to registration whereby dietitians can apply to be accredited practising dietitians. To be accredited, a dietitian must be appropriately qualified and must undertake to participate in continuing professional development, to practise only in their area of expertise and to adhere to the code of practice of the Association.

15.8.4 Mutual expectations

Dietitians value but do not insist upon receiving letters of referral from doctors. However, doctors should consider providing a letter in every instance, to improve communication and to enhance the value of the dietitian's contribution to the care of the patient. In return, dietitians undertake to provide written communication back to the referring doctor to outline assessment and treatment plans.

15.9 OCCUPATIONAL THERAPISTS

Occupational therapists are trained to assess, treat and retrain persons with physical, cognitive and psychosocial problems. The goal is to maximise their patients' functional abilities, including personal care, domestic tasks and community living skills, so that they can return to independent daily living. Therapy programs are individually designed and may include retraining of skills, provision of adaptive equipment, home assessment and worksite visit. A more extended definition has been provided by the World Federation of Occupational Therapists [40].

15.9.1 Education and training

Occupational therapy is a 4-year university degree course involving theoretical and practical work. Studies are undertaken in anatomy, physiology, neurosciences, clinical psychiatry, human development, ergonomics, medical sciences, psychosocial assessment and intervention, design and development, experiential studies and research. Practical training takes place in teaching hospitals, rehabilitation centres and community-based organisations.

15.9.2 Career paths

Occupational therapists most frequently work with patients in hospitals, rehabilitation centres, community health centres and geriatric centres. Specialised fields include workplace safety and ergonomics, hand therapy and motor vehicle driving assessment and assistance.

15.9.3 Registration

Registration of occupational therapists is currently required in South Australia, Queensland, Western Australia and the Northern Territory.

15.9.4 Ethical codes

Occupational therapists' ethical codes cover such matters as patient confidentiality, professional relationships and responsibilities, and clinical competence.

15.9.5 Mutual expectations and shared responsibilities

Occupational therapists work very closely with doctors and accept patients only upon referral from a doctor. Occupational therapists expect the referring doctor to provide sufficient information regarding diagnosis and prognosis to enable the development of an individually designed treatment program. Occupational therapists reserve the right, and have a professional responsibility, to make their own assessment of the problem and its appropriate treatment. Some occupational therapist services are now covered by Medicare.

15.10 OPTOMETRISTS

Optometrists are trained in the diagnosis and correction of refractive errors. Their training is a 3-year tertiary degree course and entails some instruction in the pathology and clinical features of diseases of the eye. Optometrists are trained to examine the retina and upon recognition of disease will refer patients

to their doctor. Optometrists either dispense lenses based on prescriptions written by doctors (ophthalmologists) or diagnose the refractive errors themselves. In addition, in most states, optometrists who undertake additional training and satisfy the registration board of their competence are authorised to prescribe a limited range of topical treatments. Competency standards have been developed by the Optometrists Association of Australia. The optometrist must provide evidence of successful completion of an educational course or program that has been accredited by the Optometry Council of Australia and New Zealand. There is considerable variation, state by state, as to the range of conditions for which an optometrist is permitted to use, supply or prescribe topical preparations. For example in New South Wales, this is restricted to the following circumstances:

- for dry eye and related conditions
- as an anti-infective prophylaxis after foreign body removal
- as an adjunct to co-management of surgical cases with an attending ophthalmic surgeon
- for non-vision-threatening inflammatory diseases of the anterior segment
- for infectious and inflammatory disease of the anterior eye, with the exception of uveitis and herpetic conditions [41].

15.11 PHYSIOTHERAPISTS

Physiotherapists contribute to the health-care team through their knowledge and skills in the area of analysis and treatment of movement problems. Through the use of physical modalities of treatment, physiotherapists aim to facilitate recovery or to retrain function that has been lost through disorders of the musculoskeletal, neurological and other systems. Physiotherapists are also skilled in the area of manual handling, especially in patient handling, and they have the knowledge and skills to assist in creating a safe working environment for all staff [42].

15.11.1 Education and training

Physiotherapy is generally a 4-year university degree course involving theoretical and practical work, much of it hospital-based. Studies are undertaken in anatomy, medical biology, physics, physiology, applied anatomy and kinesiology, psychology, research methods, pathology and physiotherapy.

15.11.2 Registration

Physiotherapists must obtain registration with the state registration board and are then subject to disciplinary and impairment provisions similar to those applying to doctors. Physiotherapists are strongly advised to have professional indemnity insurance.

15.11.3 Career paths and postgraduate training

Physiotherapists work predominantly in hospital or independent private practice, but also may be employed in rehabilitation centres, sports medicine centres, community health centres, schools, industry, research and education. Most physiotherapy schools offer a range of postgraduate masters and doctoral courses in advanced physiotherapy practice. The College of Physiotherapy also provides formal specialisation leading to fellowship. Physiotherapists may practise as generalists or concentrate on specialist areas. These specialised domains are usually closely aligned to medical practice, covering such areas as orthopaedic and reconstructive surgery, neurology, cardiothoracic medicine and surgery, and others.

15.11.4 Ethical codes, ethical and legal restraints

Physiotherapists' ethical codes cover such matters as patient confidentiality, sexual misconduct, practising only in areas in which they are trained and competent, and advertising.

15.11.5 Mutual expectations and shared responsibilities

Physiotherapists have traditionally worked very closely with doctors and until the late 1970s had a policy of accepting patients only upon referral from a doctor. Physiotherapists expect doctors who refer patients for treatment to provide sufficient information regarding the patient's history and diagnosis to enable relevant therapy to be applied. However, physiotherapists reserve the right to, and have a professional responsibility to, make their own assessment of the problem and its appropriate management. Only a small proportion of doctors claim expertise in and provide treatment by manipulation or by such methods as diathermy or ultrasound. The vast majority will refer patients who may benefit from such methods to physiotherapists. Some physiotherapy services are now supported by Medicare.

15.12 PODIATRISTS

The range of treatments provided by podiatrists, previously called chiropodists, is not commonly known by doctors. Podiatrists are primary contact practitioners who deal with the prevention, diagnosis, treatment and rehabilitation of medical and surgical conditions of the feet and lower limbs.

They are able to administer local anaesthesia and perform surgical procedures of the foot such as ingrown toe nail removal. They may also refer patients for X-rays of the foot, which attract a Medicare rebate.

Over 80 per cent of podiatrists are in private practice, while others work in community health centres and hospitals. Training involves a 3-year (South

Australia, Western Australia and Victoria) or 4-year (Queensland and New South Wales) tertiary degree, and podiatrists are required to be registered in all jurisdictions other than the Northern Territory.

15.13 PROSTHETISTS AND ORTHOTISTS

Prosthetists and orthotists provide treatment to people with neuromuscular and musculoskeletal disorders through the provision of prostheses (artificial limbs) or orthoses (orthopaedic appliances and braces). Prosthetists and orthotists draw on knowledge of biomechanics and materials to design devices intended to promote mobility and independent function. Prosthetic management is provided to upper- and lower-limb amputees from immediate and early postoperative care through rehabilitation to long-term care. Orthotic management is provided to people with a wide variety of pathology, including paediatric disorders such as congenital hip dislocation, post-trauma care such as fracture management or devices for those with spinal cord injuries and degenerative disorders such as arthritis.

15.13.1 Education and training

Prosthetists and orthotists are trained in patient assessment, prescription and manufacture related to the provision of prostheses and orthoses. Training involves theoretical and practical work and clinical placement within prosthetic and orthotic facilities. Studies are taken in anatomy, physiology, biomechanics, materials technology, pathology, neurology, prosthetics and orthotics. An honours year and higher degrees are also available.

15.13.2 Registration

Prosthetists and orthotists are not required to be registered. The Australian Orthotic and Prosthetic Association (AOPA) awards certification to appropriately trained and experienced prosthetists and orthotists; certified members of AOPA are required to adhere to the code of practice of the Association.

15.13.3 Career paths

Prosthetists and orthotists work within the public hospital system, in private practice and to a more limited extent in research and education.

15.13.4 Ethical codes, ethical and legal restraints

The prosthetic and orthotic code of ethics covers matters such as patient confidentiality.

15.13.5 Mutual expectations and shared responsibilities

Prosthetists and orthotists are a relatively new addition to the multidisciplinary team, yet prostheses and orthoses have been integral to the management of certain conditions, particularly amputation, for many years. Prosthetists and orthotists expect health professionals who refer patients for treatment to provide sufficient information regarding diagnosis and suggested functional outcome to enable relevant prostheses and orthoses to be provided. Prosthetists and orthotists have a professional responsibility to make their own assessment, ensure the prosthetic or orthotic design is appropriate for the individual patient, provide prostheses and orthoses that are structurally sound and educate the patient about the appropriate use of the device.

15.14 RADIOGRAPHERS

Radiographers are involved in the technical side of radiology and are trained to safely operate radiographic equipment to produce high-quality images. They work under the direction of medically qualified radiologists. Their training is a 3-year degree course followed by a year of internship in a large radiology service, usually in a public hospital. Training is also available for therapeutic radiographers, who are involved in the application of X-rays to treatment, usually of cancer.

15.15 SOCIAL WORKERS

Social workers are concerned primarily with the welfare of people, helping individuals and families to cope with personal or social problems, and in health-care settings to cope with the impact of illness. As much distress that presents to doctors is triggered by personal or social problems and as serious illness or hospitalisation can lead to social and financial difficulties, close cooperation between doctors and social workers deserves to be fostered. Social workers have a broad knowledge of the service system, enabling them to access resources on behalf of patients and families. Social workers are trained to work as members of multidisciplinary teams.

15.15.1 Education and training

There are a variety of tertiary pathways to a social work qualification, but all involve three or four years of study embracing subjects including sociology and psychology.

15.15.2 Career paths

Social workers are extensively employed in public hospitals, voluntary organisations and government departments.

15.15.3 Registration

There is no requirement for social workers to be registered. However, they usually belong to the Australian Association of Social Workers.

15.15.4 Ethical codes

The social workers' code of ethics covers personal and professional standards and obligations, and responsibilities to clients, to colleagues and to the employing organisation.

15.15.5 Mutual expectations

Social workers in hospital settings appreciate early identification where possible of social problems by doctors and others in the health-care team, as assessment and more particularly the harnessing of resources prior to the patient's discharge can take considerable time. Timely intervention can mitigate the effects of crisis situations. The assistance of social workers to patients will be enhanced by doctors providing a clear outline of the patient's condition, including diagnosis, prognosis, psychological state and medical plan of management.

15.16 SPEECH PATHOLOGISTS

Speech pathologists are trained to diagnose and treat patients with communication disorders. The work includes teaching compensatory strategies to assist communication. Speech pathologists also assess and manage patients with pharyngeal swallowing disorders and, with the health-care team, assist patients to return to oral intake, as safely and quickly as possible [43].

15.16.1 Education and training

Speech pathologists undertake a 4-year university course, which covers a wide range of theoretical and practical subjects including linguistics, speech and language development and disorders, psychology, anatomy and physiology and audiology. The course also includes clinical training, which is carried out in a variety of settings including hospitals, schools and community health centres.

15.16.2 Registration

Queensland is currently the only state where speech pathologists need to obtain registration. Speech pathologists are strongly advised to have professional indemnity insurance.

15.16.3 Career paths

Speech pathologists work in a variety of settings from within the school system, community health centres, hospitals, special institutions, rehabilitation centres and education and research centres. Speech pathologists also work in independent private practice throughout Australia.

15.16.4 Ethical codes

The Speech Pathology Association of Australia has a code of ethics to which speech pathologists are expected to conform. The code covers such areas as patient confidentiality, standards of professional competence, and provision of information to patients and others.

15.16.5 Mutual expectations and shared responsibilities

Speech pathologists have different referral expectations depending on the work setting. Speech pathologists working in hospitals accept patients upon referral from a doctor. The speech pathologist expects the doctor who referred the patient to provide sufficient information about the patient's medical history to assist diagnosis and assessment. The speech pathologist liaises closely with the doctor in regard to results of assessment and patient management.

15.17 CHAPLAINS AND PASTORAL-CARE WORKERS

Patients who are seriously ill, who are in hospital or facing major surgery frequently avail themselves of support offered by pastoral-care workers. This may include patients who have not claimed adherence to a religion or have declared themselves to be agnostic. This is consistent with the common experience, even in a secular society, that there is a spiritual component or deeper meaning to life, or an awareness of an inner being or soul, especially when reminded of one's mortality. These feelings are not always shared or even recognised by younger people, especially young doctors who have not themselves faced serious illness. Doctors should note the important role played by pastoral-care workers and hospital chaplains in the overall care of many patients and regard them as members of the care team committed to a holistic approach to healing. Pastoral-care departments have long existed in hospitals founded by religious orders and now have been established in secular hospitals. These departments are multidenominational and ecumenical in their approach and strive to achieve:

- access by all patients to pastoral care, where possible via a person of the same religious affiliation

- provision of pastoral care by people appropriately trained in this discipline
- support for and liaison with external religious visitors who wish to visit patients in hospital.

The day of the amateur do-gooder in pastoral care has long gone. Hospitals recognise their duty of care to patients by ensuring that pastoral-care workers and chaplains appointed to hospitals are trained in pastoral counselling, psychology and interpersonal relationships, and are knowledgeable about religious beliefs and practices other than their own. In their training, it is emphasised that pastoral-care workers take care not to step into the professional domains of doctors, nurses and social workers. The latter groups equally need to respect the training and skills of pastoral-care workers and welcome the contributions they can make to the care of many patients.

On admission to hospital, patients frequently experience a sense of depersonalisation or a sense of being lost. They may struggle to cope with the threat of illness and its physical and emotional effects, as well as the confusion created by separation from family and friends and by receiving care from a complex team. To have access to a pastoral-care worker who is an independent advocate yet part of the health-care team and who can respond to the non-medical, non-physical needs of a patient is of great value to many patients. This support and the deeper spiritual needs of many patients should be recognised and respected by clinicians. The pastoral-care worker's role is to address the spiritual and other affective needs of patients, often, but not always, involving religious issues. This is achieved by visiting patients, listening to their stories, accompanying them in their journey through their illness and offering support and counselling to them and to their families.

In many areas, pastoral care workers can play important additional roles. They can be critically valuable in anticipating grief and in grief counselling, especially in such fields as organ donation and transplantation. They can also assist hospital staff by facilitating debriefing sessions when patients have died in distressing situations. They can help staff recognise distress, 'burnout' and associated depersonalisation. In addition, they can assist staff by sharing the emotional burden of caring for seriously ill and dying patients and their families, both while the patient is in hospital and in the weeks and months that follow deaths in hospital.

15.18 INTERPRETERS

Interpreting is now a profession requiring training and accreditation by the National Accreditation Authority for Interpreters and Translators (NAAIT). The role of the interpreter is to facilitate communication between people who do not speak the same language. The importance of interpreters in health care was

underscored by the publication of a notice to medical practitioners in 1993 by the Federation of Ethnic Communities' Councils of Australia, stating in part:

> Take notice that for many non English speaking background persons information can only be provided and 'informed' consent to health care and medical treatment can only be obtained through the use of properly trained and qualified health interpreters and that failure to provide this service may entitle a patient to institute civil proceedings. [44]

Doctors should also be aware that bilingual staff, unless appropriately accredited, should not be presumed to have the necessary skills to act as interpreters. Where a qualified interpreter is not available in person, the Telephone Interpreting Service should be used. This service has a dedicated telephone number for doctors in private practice and the service is free when doctors are providing care claimable under Medicare to Australian citizens or permanent residents. Doctors must register to use the service and this can be done by phoning 1300 655 820 or via the website http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/free-services.htm. If an unqualified interpreter has been used, for example in an emergency, a qualified interpreter should be obtained as soon as possible to ensure that the patient has understood what has taken place.

15.18.1 Education and training

Accreditation with NAAIT may be achieved by passing the examinations of that body or by graduating from approved tertiary courses conducted for interpreters. These courses cover subjects including interpreting skills, linguistics, communication skills, sociology, ethics and the terminology of major fields such as law and medicine. A prerequisite of such courses is documented proficiency in English and at least one other language. Health interpreters must add to this training detailed knowledge of medical terminology and understanding of the health-care system.

15.18.2 Mutual expectations

Interpreters expect to be treated as any other health professional and to work as part of a team. Their ethical code demands that they interpret accurately and honestly, maintain confidentiality and are impartial and objective. Doctors must respect this and not expect the interpreter to be an ally for the doctor or the patient. More detailed guidance to the appropriate use of interpreters is available and is commended to doctors and other health professionals [45–48] (see also Chapter 3).

15.19 LAWYERS

The role of the law in medical practice is noted in several chapters of this book. In Chapter 25, the expectations upon doctors when providing medico-legal reports, responding to subpoenas and appearing in court are detailed. Doctors may come into contact with lawyers in other ways, however, and it is important that in such contact both parties adopt a respectful and cooperative professional stance. Where each party understands the professional role of the other, difficulties should not arise. Where they do arise, this can often be traced to an uncooperative, defensive or ill-informed attitude of the doctor or an aggressive, confrontational and equally ill-informed attitude of the lawyer. In most states, there are formal mechanisms for regular discussions between representatives of the two professions to develop better understanding and to prepare protocols to guide the professions [49]. These are clearly helpful but are unlikely to be at hand to guide a doctor responding to a telephone call from a lawyer. As it is rare in the extreme that an instantaneous response is required of the doctor, the doctor who is uncertain of the approach to be taken should seek advice, usually from his or her medical indemnity organisation, before responding. Contact by lawyers with doctors usually occurs by way of referral for medico-legal assessment, request for access to records or a report on care previously given to a patient, request for an independent opinion on medico-legal reports prepared by other doctors or a subpoena to produce records or to appear in court to give evidence. The appropriate responses to these contacts are described in Chapters 6 and 25. In responding, doctors must keep in mind the need to act professionally at all times, to respect patient confidentiality unless the patient has given express permission to waive this right or unless directed by a court, and to respect the powers that the community has granted to the courts and their officers.

15.20 MEDICAL LIBRARIANS

As the information explosion continues, and as the means of accessing that information expands, librarians are becoming an even greater resource than ever before for medical students and doctors. Their training and experience provide the skills to identify and retrieve relevant material for doctors and other health professionals quickly and efficiently.

15.20.1 Education and training

To qualify as a librarian involves either a 4-year tertiary degree in librarianship or a 3-year general university degree to which is added a 1-year graduate course leading to a diploma in librarianship or a 2-year graduate course leading to a postgraduate degree. There is no specialised training in medical librarianship

other than via experience in a medical library, although a role for 'clinical librarians' is evolving.

15.20.2 Professional development

Members of the Australian Library and Information Association are expected to undertake ongoing professional development activities.

15.20.3 Ethics

The Australian Library and Information Association issues a code of professional conduct for librarians [50].

15.20.4 Mutual expectations

Medical librarians expect doctors to be aware of the complexity and diversity of information resources and desire doctors to recognise and use the expertise of librarians in managing and retrieving information. This includes learning information management skills from librarians. Librarians are assisted when doctors communicate their requirements clearly, working directly with the librarian and not through an intermediary. Doctors need to appreciate that high-quality information retrieval is labour intensive and that, for other than genuinely urgent needs, sufficient time should be allowed for processing requests. Library regulations must be observed. Librarians appreciate feedback from users on the library's resources and services.

15.21 POLICE

As the police play a key role in the protection of the community, it is highly desirable that doctors work cooperatively with them. Conflicts occasionally arise, for example in the following situations:

- Doctors believe that the illness or injury is such that its treatment needs to take precedence over the duties of the police to investigate a crime, take statements or obtain blood and tissue samples.
- Police misunderstand the ethical responsibilities of doctors, especially in regard to patient confidentiality.
- Doctors misunderstand the responsibilities of police under the law.

Interacting with patients in circumstances where police have an interest (for example in cases of physical or sexual assault or where the wellbeing of a person held in custody or where the fitness of a person to be interviewed is in question) requires knowledge and experience. If there is any uncertainty on the part of the

doctor about how to proceed, advice should be sought. Difficulties and conflict can be avoided by approaching these situations with courtesy and consideration and spending time making sure that the views of both sides are understood. Should an impasse remain, higher authority should be consulted both by the doctors and the police.

Doctors have a responsibility, as does any citizen, to assist the police in the investigation of serious crime. Release of confidential information regarding a patient in this situation may be justified in the public interest but should be done with forethought and appropriate advice (see also Chapter 5).

15.22 COMPLEMENTARY AND ALTERNATIVE MEDICINE PRACTITIONERS

As mentioned in Chapter 8, alternative or complementary medicine creates educational, philosophical and ethical issues for the medical profession, leading at times to ambivalent or contradictory stances taken by segments of the profession. The term 'complementary and alternative medicine' (CAM) has entered the medical lexicon but is rarely defined. The Australian Medical Association restricted its 2002 policy statement to 'complementary medicine', a term embracing both complementary medicines and complementary therapies. Thus complementary medicines refer 'to a wide range of non-prescription products with health claims such as herbal medicines, homeopathic medicines, nutritional and other supplements' while complementary therapies 'include acupuncture, chiropractic, osteopathy, naturopathy and meditation' [51]. Additional types of practices that are sometimes encompassed under the complementary and alternative medicine banner include hypnotherapy, aromatherapy, music therapy, iridology, megavitamin therapy, traditional Chinese medicine, reflexology, spiritual healing, colonic irrigation and orthomolecular medicine. Alternate names for CAM include 'natural medicine', 'holistic medicine' and 'integrative medicine'. More recently CAM has been subcategorised into five groups of modalities 'belonging to (or emanating from) (i) indigenous medical systems, (ii) recently developed (non indigenous) medical systems, (iii) spiritual or energetic healing techniques, (iv) methods of relaxation, and (v) extensions of conventional scientific findings' [52].

The 1998 report of the independent Millbank Memorial Fund of the USA concluded that very few of these fields of practice use methods of treatment that have been evaluated positively by accepted scientific methods of assessing evidence [53]. Those fields for which there was claimed to be some published evidence of effectiveness were chiropractic, acupuncture, hypnotherapy, massage, herbal medicine and traditional Chinese medicine. The report noted that 'many CAM

practitioners are sceptical about demands for evaluation', that measurable clinical endpoints for assessing efficacy were little used, and that consensus statements or guidelines for CAM were noticeably lacking when contrasted with orthodox medicine [53].

Since that report, there has been an exponential increase in research publications about CAM, stimulated particularly by the US federal government decision to establish an Office of Alternative Medicine within the prestigious National Institutes of Health (NIH) [52]. Barker Bausell, a biostatistician who has worked in the field of evaluation of CAM, has recently published a detailed analysis of the currently available research. He observed that in 2002, one register of CAM research findings contained over 350 000 published articles. Using the Cochrane Collaboration database [52], he identified ninety-eight systematic reviews that covered a minimum of two clinical trials in the use of acupuncture, aromatherapy, art therapy, biofeedback, chelation therapy, echinacea, herbal therapy, homoeopathy, prayer, massage and several other CAM modalities. He made several conclusions, including (1) 'there is no compelling, credible scientific evidence to suggest that any CAM therapy benefits any medical condition or reduces any medical symptoms (pain or otherwise) better than placebo' and (2) 'no CAM therapy has a scientifically plausible biochemical mechanism of action over and above those proposed for the placebo effect' [52]. His report also contains a valuable history and analysis of the mechanism of the placebo effect.

While the title of Barker Bausell's book might suggest a dismissive attitude to CAM practitioners and to those who use CAM therapies, the author emphasises that in his view most CAM practitioners 'believed fervently in the value of what they are doing' and have their 'patients' best interests at heart'. He also acknowledges that some CAM therapies involving lifestyle and dietary changes are likely to have health benefits and that many conventional doctors also believe that some CAM therapies have effects over and beyond the placebo effect. He is critical of CAM therapists, stating that 'most CAM therapists are probably oblivious to the possibility that their elaborate machinations may in effect be engendering a placebo effect and nothing else' [52]. This blind spot means that CAM therapists work in a mode or philosophy that is quite different to the conventional scientific mode used by doctors and thus attempts at dialogue or mutual understanding will be difficult.

As in the USA, complementary medicine is also widely used by Australians. In its 2002 report, the AMA quoted figures of approximately 50 per cent of Australians using at least one complementary medicine per year and 20 per cent consulting at least one CAM practitioner per year [51]. Most people do not spontaneously report such use when attending medical practitioners. With the rise in use of CAM, the medical profession has responded in different ways. Many general practitioners have incorporated CAM, particularly acupuncture,

hypnosis and meditation, into their practice, and refer patients to chiropractors. A small number of doctors have participated in controlled clinical trials of CAM, while others caution doctors about the ethical and professional issues involved in embracing CAM [54]. In recognition that doctors need to learn about CAM, at least to the extent that they can communicate with their patients, many of whom will be using CAM methods in parallel with orthodox treatment, medical schools now incorporate some exposure to CAM in the medical curriculum [55–56]. This educationally desirable step, along with the recognition given to CAM by the NIH in the USA, may serve to confuse the community about the evidence base for the scientific basis and effectiveness of CAM.

It is probably fair to comment that CAM practitioners tend to be ambivalent about their professional place in the health-care system: some would like to be recognised via registration processes and thus sit alongside mainstream medicine while others fear that such recognition might reduce the 'mystique' of CAM and affect its popularity with the general public. Concern over the quality of the products of one CAM manufacturer in 2003 drew the attention of government to the regulation of alternative medicine and the federal government set up an expert committee to advise on this [57]. However, the 'level of evidence' required for CAM products to be marketed in Australia remains significantly below that required for pharmaceutical products [58].

The medical profession has been reluctant to totally oppose alternative medicine. Not all approaches used by doctors are evidence-based. From time to time remedies arising from alternative approaches do find their way into mainstream medical practice, the risk of harm is usually low and doctors recognise that some elements of orthodox medical practice represent 'art' rather than 'science'. Many doctors are highly critical of both the quantity and the quality of empirical scientific evidence concerning the efficacy and at times the safety and cost of CAM interventions, in comparison to mainstream medical practice. Additional concerns relate to the real, but at times unknown, potential for adverse events as a consequence of interactions between orthodox and less orthodox therapies, and the problems of sharing patient care with providers whose ethical principles are not always explicit.

It is important that opinions and attitudes concerning CAM are conveyed to patients in a responsible manner. Doctors have a professional responsibility to advise patients about the benefits and risks of conventional and less conventional therapeutic and investigational interventions, and about what is known and not known about them. The reality is that some patients seek access to CAM out of frustration that orthodox medicine is not helping them, out of distress [59] and in some instances out of the desire to have more sense of control over their own health care. Wise doctors will be alert to these possibilities and seek to work uncritically and positively with such patients.

15.23 CHIROPRACTORS

Chiropractic is defined as the treatment of disease by manipulation of the spinal column. Chiropractors are taught that alterations to the spinal column may interfere with nervous pathways that control tissues and organs throughout the body and if the nervous system is impaired, malfunction in other areas may follow. The Chiropractors Association of Australia states that 'chiropractic is the science of locating offending spinal structures, the art of reducing their impact to the nervous system, and a philosophy of natural health care based on your inborn potential to be healthy' [60]. Training is based on a tertiary course involving theory and practice and available in several Australian states. To become a chiropractor in Australia requires completion of a 5-year university course in Australia or completion of a similar course overseas that is recognised by Australian chiropractor registration boards. Chiropractors are required by law in each state and territory to be registered. Previous constraints upon doctors referring patients to chiropractors no longer apply; nevertheless, there is generally little sharing of patients or clinical information between doctors and chiropractors. Chiropractors may refer patients for simple X-rays of the spine or pelvis and such patients are entitled to Medicare benefits for such radiological services.

15.24 OSTEOPATHS

As stated by the Australian Osteopathy Association, the underlying basis of osteopathy is founded on a theory that the human body operates in much the same way as a machine, with all parts interrelated, and with structure being closely related to function. Extending the machine analogy further, damage to one part can have adverse effects on other systems or organs. Osteopathy originated in the USA in the 1870s. Osteopaths believe that the human body has all of the necessary elements to attain, and maintain, optimal health, and an in-built repair system that enables people to recover from injury and disease. Osteopaths claim to maintain, via techniques believed to promote blood flow, optimal function of the internal organs, in turn promoting and maintaining the body's balanced production of natural chemicals. The principal technique employed is osteopathic manipulative therapy, which includes soft tissue massage, muscle stretching, a passive range of motion and gentle joint manipulation. Osteopaths also consider the roles of appropriate exercise programs, a healthy diet and nutrition, and emotional well-being (through techniques such as stress reduction exercises and strategies) as important factors in treatment. The Australian Osteopathy Association describes osteopathy as a form of complementary medicine [61]. Training in Australia involves a full-time 5-year university-based course. In most states osteopaths have to be registered, and in some states this is via a joint chiropractors and osteopaths board [62].

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16 ENTERING AND LEAVING PRACTICE AND PRACTICE MANAGEMENT

Most Australian doctors undertake full-time or part-time private clinical practice as general or specialist practitioners and are thus effectively running a small business. To successfully manage such an enterprise requires knowledge, some skill, and investment of time and energy. For larger medical groups, a practice manager may be employed to undertake some of this work or the task may be allocated to a medical member of the group who has the necessary skills and interest. This chapter is intended to give a broad overview of the tasks involved in establishing and managing a practice and to direct the reader to more detailed sources of information and professional help. It does not attempt to address the management issues specific to the investigative branches of clinical medicine such as radiology, pathology, day procedure centres and the like.

16.1 IMPORTANCE OF GOOD PRACTICE MANAGEMENT

Good practice management may appear superficially to be based on self-interest, aimed to maximise income and improve quality of life. While this is of some relevance, good practice management is a prerequisite to good patient care and is in the best interests of patients, as in such a practice appointment systems work, patient records are not misplaced, investigation results are not overlooked, direct-billing errors to Medicare do not occur and patients are guided efficiently to the help and resources they need. As mentioned in Chapter 3, better patient outcomes are achieved where there is good communication and a good patient–doctor relationship is established. This relationship begins from the moment a patient first telephones the practice for an appointment or first enters the waiting room. Patients may not be able to assess a doctor's medical knowledge or clinical acumen, but they are able to assess waiting times, the friendliness and competence of staff, the appearance of the waiting room and consultation room and the general ambience of the practice [1]. Effort spent initially in planning, furnishing, equipping, organising and staffing a practice and then in maintaining good management of it will

be rewarded. Extensive detailed and helpful guidance is available, especially for general practitioners, through a series of excellent publications of the Royal Australian College of General Practitioners (RACGP) available on the College website [2]. The RACGP also offers a practice advisory service and regular educational activities in practice management. The Royal Australasian College of Surgeons produces a guide for younger fellows of the College entitled *Preparation for Practice Guide*, which covers practice establishment and practice management issues in considerable depth and can be found at http://www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/default.htm.

In addition, each state branch of the AMA provides professional advice and services in aspects of practice management, the Commonwealth Department of Health and Ageing provides material relevant to a range of Commonwealth services (Medicare, the Pharmaceutical Benefits Scheme, Veterans Affairs, Aged Care, Social Security, and so on) and the medical newspapers carry regular columns devoted to aspects of practice management. This chapter draws heavily on the RACGP publications and on an excellent summary for consultant physicians issued by the Royal Australasian College of Physicians [3].

16.2 CHOOSING YOUR CAREER

Some medical students are able to determine their career direction at an early stage, but many wait at least until they have experienced their first postgraduate ('intern') year before seriously considering this. The intern year has assumed increased importance as a time for decision making because the second year after graduation is when doctors are 'streamed' into general practice, medicine, surgery or other fields, in preparation for joining formal training programs the following year. Despite such streaming, second-year positions providing further broad experience are available. More importantly, many successful careers have followed even when doctors in training have changed direction part way through or upon completion of a training program in general practice or a speciality. In choosing a career in medicine, at the least a young doctor should:

- gain some experience in the field being considered and, while doing so, look as objectively as possible at what work in that field of practice will entail
- talk to many people, informally and formally, about career choices, opportunities and the work each person does; attend 'career expos' where available; and make use of the experience of senior medical staff available to counsel young doctors on career choices that teaching hospitals have usually identified
- observe that most patient care takes place outside the major public hospitals and that hospital training will have given most young doctors a narrow view of health care; apart from clinical practice and medical research, medical

graduates' skills are also used in non-clinical settings including administration, basic research, industry and even the media
- note that many doctors are now more flexible in their approach to their careers and that some fields of practice provide greater flexibility than others.

Women doctors constitute 50 per cent or more of new graduates and are gradually increasing their presence in all fields of medical practice, despite issues around part-time training, job-sharing and on-site child care. No career path should be regarded as impossible for women graduates and their best source of career advice and encouragement is likely to be from other women already established in their chosen career paths.

All young doctors, men and women, in contemplating career choices, should examine their strengths and weaknesses as part of the process of making major decisions. Self-knowledge thus gained can also assist in personal and professional development (see also Chapters 2 and 11).

16.3 ENTERING PRIVATE PRACTICE

It is important for doctors who have decided to enter independent private practice to seek knowledge of the essentials of good practice management. Such knowledge is also relevant when undertaking locum work or entering a group practice on a trial basis, as this will assist in evaluating the management of the practice that the doctor may intend to join.

For general practitioners, whose postgraduate training is now predominantly based in general practice, taking notice of how each practice is managed is one starting point for acquiring such knowledge. Following completion of training, working as an employee in one or more general practices will also provide insights. For specialists entering private practice, finding opportunities to experience a well-run practice is usually a very informal process, but the simple approach of young doctors informing mentors and other specialists with whom they have worked that they wish to commence in private practice or are available to provide holiday cover may bring surprising and beneficial results.

16.4 SETTING UP A MEDICAL PRACTICE

For both general practitioners and specialists, establishing a medical practice requires considerable preparation and planning. Ideally this should involve setting of professional, personal and financial priorities, seeking information on practice management and obtaining knowledge about contracts and obligations for locum and assistant work. As much of the planning will involve financial decisions, professional advice should be sought. Other key decisions to be faced include the following points.

16.4.1 Location

General practitioners will need to consider such factors as population trends, the number and location of competing practices, visibility or exposure of potential sites, personal and family choice, their own medical interests and capabilities, and local medical resources. Specialists will need to be aware of such matters as public and private hospital appointments, transport access or parking, and the perceived medical needs of the area being considered. Local planning and zoning regulations must also be considered by both groups. Advice and information may be available from other doctors in the area but, as they might not welcome your arrival, this cannot be totally relied upon. For general practitioners, a more detailed discussion of this critical decision is provided by the RACGP [2].

16.4.2 Solo or group practice

A partnership of doctors implies a contract (preferably written) whereby all expenses and income are shared between the partners according to an agreed formula. It also involves a formal structure, which should involve a regular meeting to discuss and deal with the business and practice issues that arise continuously. An associateship of doctors implies an agreement (also preferably written) to share the costs of providing the practice infrastructure but without sharing the practice income. Associates bill in their own names and retain the income, apart from that required to pay the agreed share of overheads.

16.4.3 Premises

Whether to purchase, lease or rent, or newly build, is primarily a financial decision, but even when purchasing an existing practice or building a new practice, careful consideration should be given to the design of the building. This will require examining it from the patient's viewpoint (access, comfort, privacy and quietness); the staff's viewpoint (space, lighting, comfort, toilets, staff room, parking, security and storage); and the doctor's own viewpoint (consultation and procedure rooms, access to staff and colleagues, security, and capacity to deal with urgent cases). A well-designed practice assists in marketing the practice and adds greatly to staff efficiency and morale. Consideration must also be given to safety, especially for children, as well as issues of heating and cooling.

16.4.4 Equipping a practice

Considerable capital is required to equip a new practice or to purchase a practice that is already equipped. There are also additional costs for a doctor who proposes to provide new services that may have sophisticated technological requirements.

The list of probable requirements includes furnishings, furniture, computer systems, a medical records and storage system, basic medical and office equipment, and communication equipment (telephone, facsimile and photocopier). In preparation for formal accreditation of general practice, the document *Standards for General Practice* should also be consulted [4]. While some essential stationery such as Medicare stationery, Pharmaceutical Benefits Scheme prescription pads and Veterans' Affairs stationery is provided freely by the Commonwealth Department of Health and Ageing, this and other practice stationery should be ordered several months before going into independent practice.

16.5 RECOGNITION BY MEDICARE AUSTRALIA

The principles of Medicare and the PBS are described in Chapter 14. So that patients may claim rebates from Medicare and doctors may direct-bill Medicare, each doctor must be a registered medical practitioner and be granted a provider number by Medicare Australia. A separate provider number is required for each practice location. General practitioners who are appropriately qualified may also apply for vocational registration with Medicare Australia. Vocational registration entitles the patients of that doctor to a higher rebate from Medicare, but this carries with it continuing medical education obligations. Consultant physicians, psychiatrists and specialists also need to apply for recognition of their status and, should this not be granted, Medicare rebates will be paid at the general practitioners' rates. Doctors must also apply to Medicare Australia for a PBS prescriber number when they may also receive interim PBS prescription pads. Doctors may also order personalised PBS and NHS authority prescription pads from Medicare Australia. Medicare Australia staff will also issue a copy of the Schedule of Pharmaceutical Benefits, the *Doctor's Bag Order Form* booklet and the *Medicare Benefits Schedule Book*, and supplies of all the relevant Medicare stationery and direct-billing manual imprinter. A separate approach is necessary to the Department of Veterans Affairs to be appointed as a local medical officer and to receive their stationery and guidelines.

Doctors should also contact the relevant state health departments in order to ensure that they are on mailing lists and receive copies of publications relevant to their fields of practice.

16.6 MEDICAL INDEMNITY

Medical indemnity cover is essential for doctors in independent practice. Existing levels of cover will need to be reviewed, especially when entering private practice directly from a training program or when deciding to undertake procedural work. The guidance and services provided by medical indemnity organisations are addressed in other chapters.

16.7 SELECTING, EMPLOYING AND TRAINING STAFF

Selection of staff requires careful attention as they represent the practice's greatest asset and the greatest expense. Most young doctors have had little involvement in writing job descriptions, interviewing and selecting staff, evaluating references or speaking with former employers, so advice should be sought and professional assistance considered. Prior to interviewing potential staff, a job description should be written and information obtained on current award conditions and market rates. Some doctors employ family members in their practice as receptionists/secretaries. While this may have economic advantages, it does not necessarily provide all the skills required.

New staff need to be adequately informed of their role and responsibilities, which should be documented, at least in simple outline. They also need to be informed of the terms and conditions of employment. Their remuneration must cover the required superannuation, workers compensation and taxation provisions as penalties for not meeting these provisions are severe. The advice of an experienced accountant (see below) should be sought on these matters. It is especially important to ensure that new staff members are aware of the requirement of confidentiality in all matters, of the manner in which complaints are handled in the practice and of the fact that the doctor is ultimately responsible for the actions of staff.

As employers, doctors should become aware of the range of training courses available for medical practice staff and of the associations they may wish to join. Staff also need support and supervision and even the smallest practice should develop a practice manual, which in the first instance can be developed to cover all the information a temporary replacement person would need to know about the practice. This manual may then be further developed to include details of available community resources, local hospitals, specialist services and businesses that are commonly approached.

Just as good communication with patients is vital, so it is with staff. Regular meetings should be held to maintain morale and discuss problems. When a staff member is performing poorly, care must be taken to adhere to relevant industrial legislation regarding disciplinary procedures and dismissal.

16.8 CARING FOR STAFF AND STAFF SAFETY

There are legal requirements to provide workers compensation insurance and to meet occupational health and safety regulations. This extends to assessing the risks posed by aggressive or violent patients and taking sensible precautions to reduce those risks, as well as training staff how to handle such situations [5–6]. An infection-control strategy should be in place. Depending upon the staff member's duties, hepatitis B vaccination may be sensible. In general it is preferable that staff

do not become patients of the practice. As caring managers, doctors should make time for staff feedback, where they and their staff can discuss how the practice is performing, what difficulties staff may be experiencing and how improvements may be made.

16.9 INFECTION CONTROL AND PATIENT SAFETY

As the hazards of cross-infection and of transmission of viral infection (hepatitis B, hepatitis C and HIV) are increasingly recognised and as more 'office procedures' are undertaken, doctors need to be aware of and take steps to prevent risks to patients. This requires compliance with infection-control guidelines [4, 7] and ensuring that sharps, disposal containers and hazardous chemicals are not within reach of children.

16.10 AFTER-HOURS ARRANGEMENTS

Options to be considered include providing your own cover, purchasing cover from an after-hours deputising service or making cooperative arrangements with other practices. Staff and patients need to be made aware of the after-hours cover arrangements. General practitioners need to meet the requirements of vocational registration in regard to after-hours cover.

16.11 FINANCIAL, BUSINESS AND LEGAL ADVICE

As the owner–manager of a small business the doctor will require initial and ongoing professional assistance from an accountant, a solicitor and a bank manager. Such people should be chosen carefully, preferably upon the recommendation of other doctors who can vouch for their ability and knowledge of the issues surrounding medical practice. A solicitor will be needed to advise on purchasing or leasing premises, staff contracts, partnership agreements and arranging incorporation or trust funds, while an accountant will advise on matters including taxation, superannuation, workers compensation, practice insurance and the accounting and the billing system to use to run the practice.

16.12 MARKETING THE PRACTICE

There are acceptable means of informing prospective patients and professional colleagues of the establishment of the practice. For general practitioners this will usefully include an information sheet or brochure about the services offered. General practitioners new to a community should visit local pharmacists, hospitals, hostels, nursing homes, domiciliary nursing services, hospice services and other doctors, thereby learning about the community while making the practice known.

16.13 PLANNING FOR A HEALTHY APPROACH TO WORK

It is important when starting in independent practice to plan for a healthy lifestyle. This will include providing time to be spent in social and family activities, leisure or sporting activities, and for continuing medical education. Doctors who do this are less likely to suffer the stress-related problems discussed in Chapter 11. In the development and running of a medical practice, doctors should take positive steps to integrate into the local community where appropriate.

16.14 CLOSING A MEDICAL PRACTICE

There are a large number of matters to be attended to when a medical practice is to be closed or the doctor is retiring from practice. These include meeting legislative requirements (in Victoria, the Australian Capital Territory and New South Wales), good medical practice requirements in regard to notifying patients regarding future access to medical records (see also Chapter 6), notifying the medical indemnity organisation of planned retirement, and informing a range of other bodies including the tax office, Medicare Australia, the workers compensation agency, the public liability insurer and the medical board. Advice may also be needed in regard to staff entitlements. Drugs and prescription pads must be disposed of in a manner consistent with state legislation. The Australian Medical Association state branches or medical indemnifiers can provide more detailed advice in these matters.

16.15 PLANNING FOR RETIREMENT

As this chapter is directed primarily to doctors starting off in medical practice, it may come as a surprise to find a section devoted to retirement. For a range of reasons, perhaps related to the tendency of doctors to deny illness (see Chapter 11), doctors tend not to plan ahead for retirement, either financially or in terms of what they will do after retirement. As a result, many retire to an unhappy or unsatisfying life. Harvard-based psychiatrist George Vaillant, who initially studied the causes of distress in younger doctors (see Chapter 11), has turned his attention to ageing and retirement [8]. He believes that retirement is only stressful in four situations: if involuntary and unplanned, if finances are limited, if work has been an escape from an unhappy home, or if retirement has been precipitated by ill health.

Doctors should find the time well before retirement to begin planning for it. This can involve reading, attending seminars such as those conducted by superannuation funds, and talking to older colleagues about their experiences.

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17 CLINICAL RESEARCH

Research aimed at understanding and preventing disease or at improving the diagnosis or treatment of disease is generally welcomed by society, especially where it is conducted primarily with altruistic motives. Such research may carry risks for the human subjects involved. Experience has shown that even well-motivated researchers may pursue their research inappropriately, to the detriment of the research subjects. To protect research participants, international and national codes of research ethics have been in place for nearly 50 years. In Australia, health and medical research is now overseen by nationally regulated research governance systems in place in hospitals and medical research institutes [1–2], a key element of which is prospective ethical review of research proposals by human research ethics committees (HRECs). This chapter summarises the ethical principles of human research, the governance of research, the expected standards of good research practice, the responsibilities of clinical researchers and the topic of research misconduct by doctors. Overlapping with research are clinical audit and quality assurance studies in which doctors are increasingly expected to participate and which can raise similar ethical issues.

17.1 CODES OF ETHICS IN CLINICAL RESEARCH

The stimulus for the development of an international code of medical ethics, specifically in regard to research, was the gross abrogation of accepted ethical standards involved in so-called medical research by some doctors in Nazi Germany before and during the Second World War. The *Declaration of Geneva*, about clinical practice, is the modern version of the Hippocratic Oath (see Chapter 1) and was adopted by the World Medical Association (WMA) at its First Assembly in Geneva in 1948. The first international code of research ethics, entitled *Recommendations Guiding Medical Doctors in Biomedical Research Involving Human Subjects*, was adopted by the WMA in 1964 at its eighteenth Assembly in Helsinki and is now better known as the *Declaration of Helsinki*. The document has been revised on five occasions. The most

recent revision was completed in 2008 (http://www.wma.net/e/policy/t3.htm). While still relevant to Australian health and medical research, it is no longer the key guiding ethical code, having been supplanted by the *National Statement on Ethical Conduct in Human Research* (the 'National Statement') [3] and the *Australian Code for the Responsible Conduct of Research* ('the Code') [4], which are issued jointly by the National Health and Medical Research Council (NHMRC), the Australian Research Council and Universities Australia.

Compliance with the National Statement requires institutions and researchers to have any proposed human research reviewed and approved by an HREC. This review and approval is designed to ensure that all such research meets the key ethical requirements of research merit and integrity, justice, beneficence and respect for humans, so as to provide adequate protection for the participants. Compliance with the Code requires institutions and researchers to address issues including researcher training, data storage, intellectual property, authorship, copyright and publication of research findings. The Code also contains definitions of research misconduct and specifies procedures to address allegations of such conduct.

Like the *Declaration of Helsinki*, the National Statement and the Code are revised periodically, in a process which includes broad public consultation. The National Statement is supported by codes for research in specific contexts such as assisted reproductive technology and gene therapy, and codes for research involving specific populations such as Aboriginal and Torres Strait Islander people [5]. These documents are available on the NHMRC website (http://www.nhmrc.gov.au). These specific guidelines are consistent with the key ethical principles for medical research as described below drawn from the National Statement and the Code. These form an important element of research governance.

17.2 RESEARCH GOVERNANCE

Research governance describes the policies and procedures by which institutions (hospitals, universities, research institutes, and so on) are accountable for the quality, safety and ethical propriety of the research they sponsor or conduct [1–2]. Research governance in Australia is now guided by two key documents: the *National Statement on Ethical Conduct in Human Research* [3] and the *Australian Code for the Responsible Conduct of Research* [4]. For clinical research, these documents derive their authority from the *National Health and Medical Research Council Act 1992*. NHMRC funding of research is dependent upon institutions and their staff complying with the guidelines in these two documents. When an institution accepts a research grant on behalf of a researcher, a deed of agreement is signed with the NHMRC binding the institution to follow the guidelines. The *Therapeutic Goods Act 1989* makes it illegal for a clinical trial of an unregistered therapeutic agent to begin before the protocol has been approved by an HREC registered with the NHMRC. The Australian Council on Health

Care Standards now includes research governance as a standard to be met when hospitals are accredited.

Aspects of clinical research may also be governed by laws, codes of conduct or other guidelines covering such aspects as privacy, consent, biosafety and radiation safety. Institutions and researchers also have to take due care to attend to such matters as data storage, intellectual property and copyright, indemnity insurance and the publication of research findings. This chapter does not attempt to fully address all these matters.

As provided in the National Statement:

> Responsibility for the ethical design, review and conduct of human research is in fact exercised at many levels, by: researchers (and where relevant their supervisors); HRECs and others conducting ethical review of research; institutions that set up the processes of ethical review, and whose employees, resources and facilities are involved in research; funding organizations; agencies that set standards; and governments. While the processes of ethical review are important in this field, individual researchers and the institutions within which they work hold primary responsibility for seeing that their research is ethically acceptable. [3]

17.3 WHAT CONSTITUTES CLINICAL RESEARCH

In the setting of medical practice and the delivery of health care, the term 'research' includes any systematic study or experiment designed to generate new knowledge. Research may involve an individual or groups of patients, and may include the evaluation of new or unproven medicines, diagnostic tests, therapies and procedures, or studies not necessarily directed primarily towards management or treatment of the patient's condition. Where a doctor is unsure whether what is proposed represents research, the doctor should seek independent advice, preferably from an HREC. Some types of audit and quality assurance studies may be difficult to distinguish from clinical research. Doctors should read the advice issued by the NHMRC on this topic, *When Does Quality Assurance in Health Care Require Independent Ethical Review?* [6] and/or consult an HREC. Ethics approval is likely to be required if quality assurance studies involve activities outside routine health care, or pose burdens or risks beyond those of routine care, or involve data collection that does not fulfil the privacy definitions of acceptable secondary purposes.

17.4 REQUIREMENTS FOR ETHICALLY ACCEPTABLE RESEARCH

The ethical principles or values that guide clinical research have much in common with the ethical principles for medical practice (see Chapter 1). The values include

respect for human beings, research merit and integrity, justice and beneficence; these values underpin a relationship of trust and mutual responsibility between the research participant and researcher [3]. Other values include altruism, contributing to societal or community goals, respect for cultural diversity, and the values identified by Aboriginal and Torres Strait Islander peoples: reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity [5].

The value of respect is central to all research involving humans. Respect acknowledges that every human being has value in himself or herself and includes the principle of respect for autonomy – for the capacity to determine one's own life and make one's own decisions. It also involves providing for the protection of those with diminished or no autonomy. Unless proposed research has merit and the researchers who are to carry out the research have integrity, the involvement of human participants cannot be ethically justifiable. In research, justice includes distributive justice and procedural justice. Distributive justice refers to the fair distribution of the benefits and burdens of research participation, and of the outcomes of research, while procedural justice refers to fair treatment in the recruitment of participants and the review of research. Beneficence is demonstrated via establishing that risks of harm are justified by the potential benefits of the research to participants and to others, being alert to the wellbeing of research participants and reflecting on the social and cultural implications of the research [3].

The requirements for ethically acceptable research involving humans are spelled out in considerable but not exhaustive detail in the National Statement [3]. The following principles must be considered and adhered to when planning and conducting any type of medical research, including laboratory research using human tissue samples, clinical research into aetiology, prevention, diagnosis, therapy, or screening for disease, and epidemiological research:

- Research should be justified by its potential benefits, including its contribution to knowledge and understanding, to improved social welfare or to the skill and expertise of researchers. Not only must the researcher have this view but also he or she must satisfy an HREC that this is the case. Such an HREC must be established and function in accordance with the National Statement and be registered with the NHMRC, and must have been provided with all the relevant scientific background material and the detailed research protocol.
- All prospective participants must be provided with factual information about proposed treatments or procedures, their risks, costs, inconvenience and discomforts, and the existence of alternative measures, in order that they can give properly informed consent.
- The ethical obligations that doctors owe their patients differ from those that researchers owe to participants. While doctors are required to act in their patients' best interests, researchers are required to act with respect for and to protect participants. In order to avoid any suggestion of coercion, consent

should preferably not be obtained by a doctor in a treating relationship with the patient. In any case, the patient must understand that participation is voluntary, that refusal to participate will not affect the doctor–patient relationship or access to care and that, should the patient agree to participate, the patient is equally free to withdraw at any time in the future.

- The privacy of the patient must be respected at all times and the confidentiality of information collected in the research that relates to the patient must be protected. There exists a complex arrangement of Commonwealth and state legislation and guidelines covering privacy in health research, which is overseen by HRECs [7–9].
- In randomised clinical trials, control-group participants must be assured of receiving the best currently proven available means of prevention, diagnosis or treatment.
- The progress of a research study must be regularly reviewed and progress reports made to and considered by an independent committee. This is usually the HREC that approved the protocol, but in large-scale therapeutic trials where side effects and end points may be difficult for one of many involved researchers to evaluate objectively, a separate oversighting or data and safety monitoring committee may be required.
- Volunteers may be recruited for non-clinical, non-therapeutic biomedical research, but care must be taken that participation is free of pressure, coercion or inducement. Staff or students of the researcher's institution should not be directly approached or actively recruited to participate, although as individuals such people are free to respond to advertisements. The greater the risks of the research, the greater is the need to avoid any suggestion of coercion or inducement of staff or students to participate. Volunteers may be reimbursed for reasonable expenses, including loss of wages, but the level of remuneration should not be disproportionate to the contribution, such as to induce participants to expose themselves to risks.
- For research that involves Aboriginal and/or Torres Strait Islander peoples, the dedicated guidelines [5] must be consulted and followed.
- For particular fields of research (for example, clinical trials, use of data or tissue banks, and genetic research) and for particular subsets of participants (such as children, pregnant women, people of diminished competence or people in other countries), the relevant chapters of the National Statement must be consulted and followed.

17.5 SPECIAL AREAS IN MEDICAL RESEARCH

There are a number of problematic areas in the conduct of medical research deserving specific attention. These are included in the following sections.

17.5.1 Research where capacity to give fully informed consent is questionable

There are many clinical situations where the purpose or aims of a research project appear to be extremely valuable but where the potential subjects may not be able to provide fully informed consent. This is most obvious where a patient is mentally ill, intellectually disabled or critically ill. Specific chapters in the National Statement identify the ethical matters that need to be addressed so that HRECs can approve appropriate research protocols.

Less obvious impediments to obtaining proper consent are also the subject of specific chapters in the National Statement, such as where the person being considered for participation in clinical research is in a dependent relationship with the doctor or is in another comparable situation. These can include elderly people whose independence is reduced, and hospital and laboratory staff.

17.5.2 Research involving children and young people

Research involving children and young people raises issues about their capacity to understand what the research entails and whether their consent to participate is sufficient for their participation. Because the consent of parents is usually required, issues of possible coercion and of conflicting values and interests of parents versus the child may arise. Researchers must respect the developing capacity of children and young people to be involved in decisions about participation in research. The child or young person's particular level of maturity has implications for whether his or her consent is necessary and/or sufficient to authorise participation. Different levels of maturity and of the corresponding capacity to be involved exist and will vary from child to child. Even young children with very limited cognitive capacity should be engaged at their level in discussion about the research and its likely outcomes. The National Statement sets out minimum procedures for consent to participation by children.

The central ethical dilemma in research involving children is the tension between the need for knowledge about the effects of treatments or medication with children, rather than extrapolating from the research with adults, and the need to minimise the risks to children. In most cases, risks to children need to be kept to low levels of not more than discomfort. However, in some projects, researchers may need to justify higher levels of risk by the necessity of seeking results that relate to children. In recognition of this dilemma, the National Statement declares that:

> when children and young people are not of sufficient maturity to consent to participation in research, it is justifiable to involve them only when (a) it is likely to advance knowledge about the health or welfare of, or other matters

relevant to, children and young people; or (b) children's or young people's participation is indispensable to the conduct of the research. [3]

17.5.3 Research using human embryos

Research using stored human embryos that have been declared excess to the needs of the parents, and certain other types of embryos, may be undertaken in Australia under licence and under the strictly regulated conditions provided for in the *Research Involving Human Embryos Act 2002*. The Act established the Embryo Research Licensing Committee as a new principal committee of the NHMRC. The Licensing Committee may not issue a licence for any proposed research unless it is satisfied that the research proposal has been considered and approved by an HREC in accordance with the *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research, 2007* developed by the Australian Health Ethics Committee and issued by the NHMRC (for more detail, see Chapter 20).

17.5.4 Medical records and research

Medical records held by doctors and health-care institutions, as well as other records about health held by government agencies and the like, are an important resource for clinical, public health and epidemiological research. The basic ethical and legal principle is that such records may not be used for other purposes, such as research, without the consent of the person to whom the record applies. However, public interest in protecting the privacy of the individual can compete with the public interest in seeing important research conducted. To resolve this tension, Commonwealth and state legislation and associated guidelines give to HRECs the task of weighing these competing interests.

In planning research involving access to medical records, the feasibility of seeking the consent of each patient should first be assessed. Another possibility for some types of research is to use information from the records that is fully de-identified. As neither approach may be satisfactory or feasible, sections 95 and 95A of the Commonwealth *Privacy Act 1988* provide another approach. Under these sections of the Act, the NHMRC is charged with issuing guidelines that, when approved by the federal Privacy Commissioner, permit some medical and health research to proceed in ways that would otherwise infringe the National Privacy Principles and the Information Privacy Principles. The current guidelines [7–8] demand that such research may only be conducted after an HREC has examined the proposal and, following the NHMRC guidelines, carefully weighed the competing interests involved. Any doctor considering research involving access to medical records or other stored information, including tissue and genetic samples, will need to be familiar with this legislation and seek appropriate advice.

17.6 STANDARDS FOR RESPONSIBLE RESEARCH CONDUCT

As noted above, the standards of professional conduct for researchers, research supervisors and trainee researchers are laid down in the *Australian Code for the Responsible Conduct of Research* [4], issued jointly by the NHMRC, the Australian Research Council and Universities Australia. The Code sets out the broad principles of responsible and accountable research practice, and identifies the responsibilities of institutions and researchers in areas such as data and record management, publication and dissemination of findings, authorship, conflict of interest, supervision of students and research trainees, and the handling of allegations of research misconduct. The document also describes the institutional responsibilities in each of these domains.

The Code defines the principles underpinning good research practice as follows:

> Responsible research is encouraged and guided by the research culture of the organisation. A strong research culture will demonstrate: honesty and integrity, respect for human research participants, animals and the environment, good stewardship of public resources used to conduct research, appropriate acknowledgment of the role of others in research, and responsible communication of research results. [4]

The Code places an onus on institutions to ensure that researchers are trained in research ethics and research practices according to the Code, the *National Statement on Ethical Conduct in Human Research* and related documents, and places an onus on researchers to make themselves familiar with these documents. One study of the staff of a large research institute suggested that clinician researchers were the group least informed about these documents [10]. A medical student or doctor planning to become involved in research should not rely on this chapter but should study the Code and the National Statement and any other guidelines specific to the proposed field of research.

Chapters of the Code of particular note for doctors include those on publication of results, authorship and conflicts of interest, as summarised below.

17.6.1 Publication and dissemination of research findings

The process of publishing clinical research serves several purposes, including the opportunity for peer review and independent evaluation by the medical profession and other readers, the dissemination of advances in scientific and medical knowledge and the advancement of the careers of the authors. The Code emphasises that researchers have a responsibility to the research and wider community to disseminate an accurate and complete account of their research as broadly as possible. Researchers also have an obligation to provide research participants with an appropriate summary of the research results [11].

Researchers must ensure that they cite the relevant work of others accurately. Use of the work of other authors without acknowledgement is plagiarism and constitutes research misconduct.

17.6.2 Authorship

The Code states that, to be named as an author, a researcher must have made a substantial scholarly contribution to the work and be able to take responsibility for at least that part of the work they contributed. Furthermore, authorship must be based on substantial contributions in a combination of the conception and design of the project, analysis and interpretation of research data, drafting significant parts of the work, or critically revising it so as to contribute to the interpretation. The Code notes that the 'right to authorship is not tied to position or profession and does not depend on whether the contribution was paid for or voluntary. It is not enough to have provided materials or routine technical support, or to have made the measurements on which the publication is based. Substantial intellectual involvement is required.' Where a work has several authors, one should be appointed executive author to take overall responsibility and to manage communication about the work with the publisher. Editors of medical journals normally require that manuscripts be accompanied by a statement that the research that involves human participants has been the subject of independent ethical review and a statement that all authors accept responsibility for the contents of the manuscript [12]. Institutions usually issue guidelines to their employees setting down their policies in regard to publications. Any publication wherein an individual patient may be identified, such as a case report or a study containing a clinical photograph, requires the written consent of that patient.

17.6.3 Conflicts of interest

Conflicts of interest in research, most often related to the sources of research funding, occur quite frequently. They are more likely to occur where the researcher stands to gain financially from the success or continuation of a research project and where the funding of the research is provided by an organisation such as a pharmaceutical company that is not disinterested in the outcome. As defined in the Code, 'a conflict of interest exists where there is a divergence between the individual interests of a person and their professional responsibilities such that an independent observer might reasonably conclude that the professional actions of that person are unduly influenced by their own interests'. The Code also emphasises that 'the perception that a conflict of interest exists is also a serious matter and raises concerns about the integrity of individuals or the management practices of the institution'. The Code explains that researchers should manage

conflicts of interest by being fully informed of the conflict of interest policy of their institution, maintaining good records of activities that may lead to conflicts (such as consultancies, membership of committees, boards of directors, advisory groups, and receipt of payments, services or equipment from outside bodies), reviewing current activities for actual or apparent conflicts, and bringing possible conflicts of interest to the attention of the research management office.

17.7 PATENTING OF MEDICAL PROCEDURES

Society accepts that pharmaceuticals and technological equipment may be subject to patent protection. Until recently, doctors had tacitly agreed that clinical procedures (such as new operations, new physical treatments and new ways of performing clinical procedures) would not be subject to such protection. Indeed under the Hippocratic Oath and subsequent codes of ethics, there is a clear ethical imperative to pass on such advances freely to other doctors. While the medical profession at large does not wish to disturb this desirable situation, individual doctors have applied for patents for new treatments and it appears that courts will deal with such applications on legal grounds and not be influenced by medical ethics [13].

17.8 RESEARCH UNDERTAKEN IN PRIVATE MEDICAL PRACTICE

The concept that independent medical practitioners should maintain an intellectual curiosity in their daily clinical practice is worthy of support. Research in private practice is legitimate and ethical provided the doctor follows NHMRC guidelines, including the requirement that the research be approved by an HREC. Occasionally, research is undertaken independently of an institution because the ideas of the researcher are unacceptable to mainstream medical thinking or because the personality of the doctor is such that the doctor is unable to work cooperatively within an institutional framework. If such research is done without HREC approval, the doctor is at risk of being disciplined by the medical board for unprofessional conduct.

17.9 MISCONDUCT IN MEDICAL RESEARCH

Almost all clinical research involving human subjects or human tissue is conducted in hospitals, research institutions and universities and is subject to scrutiny by HRECs, internal and external funding bodies, peer review and medical journal editors and their reviewers. While this extensive system of oversight offers considerable reassurance that clinical research is conducted ethically, instances of misrepresentation, fraud and the abuse of the rights of research subjects continue

to occur, albeit infrequently. This sometimes results in the serious injury or death of research participants [14]. Just as trust of the community in the medical profession can be undermined by the unethical behaviour of one doctor in clinical practice, so too can trust in medical research be undermined by a single instance of research misconduct. There is therefore an ethical obligation for doctors who suspect or believe that a colleague is engaged in unethical research practices to notify their suspicions to an appropriate authority.

The investigation and adjudication of allegations of research misconduct have been problematic in many countries [15] and in Australia there have been instances where the outcome has been unsatisfactory for the researcher and the institution [16]. *The Australian Code for the Responsible Conduct of Research* [4] provides a definition of research misconduct and clear guidance on how allegations of misconduct are to be handled by institutions. The Code also flags the possibility of a centralised system of handling allegations of misconduct in the future. It should also be noted that any doctor who is alleged to have been involved in research misconduct is at risk of having his or her conduct examined by a medical board [14].

The rewards of scientific publication are sufficient to tempt some researchers to exaggerate, falsify or invent research data, which may be published and the fraud not detected for lengthy periods of time. When a doctor suspects that research data may be false or fraudulent, the doctor clearly has a duty to raise those suspicions with the appropriate authority as described in the Code [4]. Alternatively, the matter may be referred to the relevant medical board as a possible instance of 'unprofessional conduct'. Any doctor who does report suspicions in good faith deserves adequate support from peers and employers, as such 'whistleblowers' may encounter intimidation and coordinated campaigns of vilification [17].

17.10 BIOMEDICAL RESEARCH USING ANIMALS

As many doctors undertake research involving experiments with animals, prospective researchers should familiarise themselves with the guidance issued on the use and care of animals used in biomedical research. This comprises the *Australian Code of Practice for the Care and Use of Animals for Scientific Purposes* [18] and the state and territory legislative regimes that license institutions to conduct such research, establish periodic inspections to ensure compliance and require prior ethical review of research by animal ethics committees, in conformity with the Australian code of practice.

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18 PRESCRIBING AND ADMINISTERING DRUGS

This chapter focuses on the regulatory framework for prescription drugs in so far as that framework guides doctors in their daily practice. The chapter does not attempt to provide details in regard to the manufacture, approval and distribution processes for drugs or how the regulatory framework affects pharmacists, dentists, nurses and others. The Commonwealth Government is responsible, through the *Therapeutic Goods Act 1989*, administered by the Therapeutic Goods Administration of the federal Department of Health and Ageing, for the oversight of the national system that controls the safety, quality, efficacy and availability of therapeutic goods, whether produced here or abroad. It is also responsible for the Pharmaceutical Benefits Scheme (PBS), which is designed to ensure community access to prescription drugs at affordable prices (see also Chapter 14). Those aspects of the PBS which regulate or control the prescribing by doctors of those drugs included in the PBS are covered in this chapter. The Therapeutic Goods Administration website provides a useful overview of this regulatory system [1].

While the registration of drugs (therapeutic goods) is a federal responsibility, the regulation processes controlling who has access to registered drugs are constitutionally the responsibility of the states and territories. Each jurisdiction has legislation that controls the availability and use of drugs as well as poisons. The controls exist primarily to protect the public, and to a lesser extent to protect doctors from the dangers of self-administration and dependency. The legislation provides for criminal penalties, and convictions are usually examined by a medical board to determine whether unprofessional conduct has been involved and whether restrictions should be placed on the practice or prescribing rights of the doctor. The relevant state and territory Acts are listed in Table 18.1 and contact details for the drugs and poisons agency in each jurisdiction are available at http://www.tga.gov.au/ndpsc/stdpu.htm.

The chapter also examines the subject of the relationships between the medical profession and pharmaceutical and medical device companies. The ethical and professional issues around the important relationship that should exist between doctors and pharmacists are also covered here; more

Table 18.1 Legislation controlling prescribing and using drugs

State	Name of legislation
New South Wales	*Poisons and Therapeutic Goods Act 1966* (as amended 1996) *Poisons and Therapeutic Goods Regulations 2002*
Victoria	*Drugs, Poisons and Controlled Substances Act 1981* *Drugs, Poisons and Controlled Substances (Commonwealth Standards) Regulations 2006* *Therapeutic Goods (Vic) Act 1994*
Queensland	*Health Act 1937* *Health Regulation 1996* *Health (Drugs and Poisons) Regulations 1996*
South Australia	*Controlled Substances Act 1984* *Controlled Substances (Poisons) Regulations 1996* *Drugs Act 1908* *Controlled Substances (Prohibited Substances) Regulations 2000*
Western Australia	*Poisons Act 1964* *Poisons Regulations 1975*
Tasmania	*Poisons Act 1971* *Poisons Regulations 2001*
Northern Territory	*Poisons and Dangerous Drugs Act 1983* *Poisons and Dangerous Drugs Regulations 2004*
Australian Capital Territory	*Poisons Act 1933* *Poisons and Drugs Act 1978* *Drugs of Dependence Act 1989* *Drugs of Dependence Regulations 2005* *Poisons and Drug Regulation 1993*

information about the pharmacy profession can be found in Chapter 15. However, the clinical knowledge, skills and judgement required to prescribe drugs effectively and efficiently are not addressed in this book.

18.1 STANDARD SCHEDULE OF DRUGS AND POISONS

To ensure substantial uniformity of the approach taken by the states and territories to the regulation of drugs and poisons, the Commonwealth *Therapeutic Goods Act 1989* provided for the establishment of the National Drugs and Poisons Schedule Committee of the Australian Health Ministers' Advisory Council. This committee brings together the relevant state and territory representatives. A key task of the committee is to maintain the Standard for the Uniform Scheduling of Drugs and Poisons. The Schedules, with some examples of the drugs included in

each, are given below. The Schedules of most relevance to medical practice are four (prescription only medicines) and eight (controlled drugs including drugs of dependence):

- Schedule 1 – 'poisons of plant origin of such danger to health as to warrant their being available only from doctors, pharmacists or veterinary surgeons'. This schedule is intentionally empty.
- Schedule 2 – 'poisons for therapeutic use that should be available to the public only from pharmacies; or where there is no pharmacy service available, from people licensed to sell or supply Schedule 2 poisons'. No prescription is required and these drugs may be advertised direct to the public. Examples are aspirin and paracetamol in larger pack sizes; codeine when compounded with aspirin or paracetamol in tablets or capsules containing 10 mg or less of codeine in packs of 25 or less; diphenhydramine and promethazine in primary packs of 10 or less for travel sickness; pseudoephedrine, other than in preparations for stimulant or weight-control purposes; benzocaine and lignocaine lozenges and suppositories; some non-steroidal anti-inflammatory drugs.
- Schedule 3 – 'poisons for therapeutic use that are dangerous or are so liable to abuse as to warrant their availability to the public being restricted to supply by pharmacists or doctors, dentists or veterinary surgeons'. No prescription is required for the public to obtain Schedule 3 poisons from a pharmacist. Examples include up to 14 days' supply of some histamine H_2 receptor antagonists for relief of symptoms of gastro-oesophageal reflux; solid dose antihistamines; salbutamol-metered aerosol inhalers.
- Schedule 4 – 'poisons that should, in the public interest, be restricted to medical, dental or veterinary prescription or supply, together with substances or preparations intended for therapeutic use, the safety or efficacy of which requires further evaluation'. This schedule includes most of the common drugs prescribed by doctors but also includes anabolic steroidal agents; local anaesthetics; analeptic substances; antibiotics; some antihistamines; benzodiazepines; antimalarials; chemotherapeutic agents; vaccines for human use; sex hormones; monoamine oxidase inhibitors, alpha- and beta-adrenoreceptor blocking agents and the like.
- Schedule 5 – 'poisons of a hazardous nature that must be readily available to the public but require caution in handling, storage and use'. Includes many of the domestic poisons such as acetic acid; acetone; copper sulfate; formic acid; kerosene; methylated spirits; mineral turpentine and dilute acid and alkalis.
- Schedule 6 – 'poisons that must be available to the public but are of a more hazardous or poisonous nature than those classified in Schedule 5'. Includes the industrial and agricultural poisons as well as some antibiotics in preparations for intramammary infusion in animals; aldrin; dieldrin; eucalyptus oil; formaldehyde; lead compounds except for human therapeutic use (Schedule 4) or in preparations for use as hair cosmetics (Schedule 5).

- Schedule 7 – 'poisons which require special precautions in manufacture, handling, storage or use, or special individual regulations regarding labelling or availability'. Included are arsenic; ethylene dibromide (EDB); strychnine; cyanides; and agricultural poisons such as paraquat.
- Schedule 8 – 'poisons to which the restrictions recommended for drugs of dependence by the 1980 Australian Royal Commission of Inquiry into Drugs should apply'. Common drugs in this schedule are barbiturates; cocaine; codeine except when included in Schedules 2, 3 or 4; dexamphetamine; dextromoramide; fentanyl; flunitrazepam; hydrocodone; hydromorphone; methadone; methylphenidate; morphine; opium; oxycodone; pentazocine and pethidine.
- Schedule 9 – 'poisons which are drugs of abuse, the manufacture, possession, sale or use of which should be prohibited by law except for amounts which may be necessary for medical or scientific research conducted with the approval of the Commonwealth or State health authorities'.

Despite attempts at uniformity between the jurisdictions, there remain some differences between some states' and territories' legislation as to the classification and controls on some drugs. For example, in New South Wales the use of the benzodiazepines is controlled via additional restrictions under Schedule 4, while in Victoria these drugs are listed under a separate category of Schedule 11 along with chloral hydrate, certain stimulants, dextropropoxyphene and ephedrine.

18.2 SOME RELEVANT TERMINOLOGY

The legislation controlling prescribing by doctors refers to a number of terms including drugs, therapeutic goods, poisons and drug dependence. The terminology is explained as follows:

- A drug is any chemical substance, synthetic or extracted from plant or animal tissue, and of known or unknown composition, that is used as a medicament to prevent, alleviate or cure disease.
- Therapeutic goods are defined as goods that are represented to be, or are likely to be, taken or used for therapeutic purposes. They include medical drugs and under the *Therapeutic Goods Act 1989*, they also include therapeutic devices and materials used in pregnancy testing and testing for susceptibility to diseases.
- A poison is any substance that when absorbed into the blood adversely affects health or destroys life. The resulting effect from the ingestion, absorption or inhalation of a poison is called poisoning.
- Drug dependence is defined by the World Health Organization (WHO) as a syndrome consisting of 'a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting

in its use despite harmful consequences, a higher priority given to drug use than other activities and obligations, increased tolerance, and sometimes a physical withdrawal state' [2]. The WHO has discarded the terms 'addiction' and 'habituation' in favour of the single term 'dependence'.

As some state and territory legislation in Australia still refers to, and differentiates between, drugs of addiction and drugs of dependence, some additional relevant terms are defined below:

- A drug addict is a person who has acquired an overpowering desire for the continued administration of any drug of dependence and in whom the cessation of the administration of such drug leads to definite symptoms of mental or physical distress or disorder.
- Drug abuse [3] or harmful use [2] have specific definitions and are used to describe behaviour that occurs in individuals who are taking drugs of dependence with resultant problems, but who do not meet the criteria for drug dependence. These descriptions may be relevant to the problems that occur in some individuals who use prescribed drugs for non-medical purposes or use prescription drugs obtained illegally.
- Drug tolerance involves the adaptation of body tissues, predominantly the cerebral cortex, to steadily increased dosages of a drug to achieve a constant physical or psychological effect. When the drug being used is withdrawn, an illness of variable intensity usually follows. Both tolerance and withdrawal symptoms are physical phenomena that respond to physical treatment.

18.3 PRESCRIBING DRUGS – GENERAL ADVICE

Doctors can prescribe drugs in Schedules 2, 3, 4 and 8 for the medical treatment of their patients, although a pharmacist may supply Schedule 2 and 3 drugs without a doctor's prescription. In certain circumstances a pharmacist may supply a limited quantity of Schedule 4 drugs to ensure continuity of treatment while a further prescription is obtained. Doctors need to always take care in writing prescriptions as errors and/or illegibility may cause deaths. Doctors should not prescribe for themselves (see Chapter 11); self-prescribing is illegal in Victoria and the Northern Territory.

The following advice in regard to prescribing is a combination of the statutory requirements and sensible precautions to protect the interests of the community, pharmacist colleagues and the doctor:

- Prescription pads should be stored securely and should be accessible only to authorised people. If stolen, the police and the Department of Health must be notified.
- The prescription must clearly show the doctor's name, address and telephone number, the last item being particularly important to enable prompt contact from the dispensing pharmacist.

- The date the prescription is written must be shown.
- The prescription must be legible.
- It is illegal for a pharmacist to dispense a prescription if the pharmacist is uncertain of the name of the drug or the directions written on the prescription.
- A precise dose should be specified and in general the frequency of administration specified. A doctor who uses the term 'as directed' needs to be especially careful that the patient is fully informed as to those directions, preferably in writing.
- The quantity of medication and number or repeat authorisations must be shown.
- Where an unusually large dose is prescribed, the drug and the dose should be underlined and initialled or signed in ink.
- The patient's name and address must be shown. (In the instance of children, the age or body weight of the child should also be indicated.)
- The full details on the prescription must be in the doctor's own handwriting (unless computer-generated – see below).
- The prescription may be written for the medical treatment of only the person named on the prescription.
- No space should be left between the last item on the prescription and the doctor's signature, to reduce the risk of forged additions.
- For drugs that are prescribed and funded under the Commonwealth Pharmaceutical Benefits Scheme (PBS), the requirements outlined in the *Schedule of Pharmaceutical Benefits* must be followed. This book, which is regularly revised, is available from the Pharmaceutical Branch, Medicare Australia, GPO Box 9826 in each capital city. It is also available online to doctors at http://www.medicareaustralia.gov.au/provider/pbs/pharmacists/schedule.jsp
- For PBS prescriptions, only three items may be prescribed on one prescription page. Only one prescription per item per day may be written for a patient and back dating and forward dating of prescriptions are not permitted. Under regulation 24 of the *Schedule of Pharmaceutical Benefits*, where patients may experience hardship (for example, if they have to travel long distances or are going overseas), pharmacists are permitted to fill repeat prescriptions ahead of the due date, provided the doctor has initialled the prescription with the symbol 'R24'.

18.4 COMPUTER-GENERATED PRESCRIPTIONS

There are additional legal requirements placed on doctors who generate prescriptions by computer, primarily because of the risk of fraud. Only doctors may have access to the prescription-writing computer program. All the information described above for handwritten prescriptions must be included on the

prescription. The name of the prescribing doctor must appear immediately beneath the last item on the prescription, followed by the handwritten signature of the doctor. Any space below the signature must either be electronically blocked out or the prescription must specify the number of items prescribed on that prescription. The computer program must ensure that the details of each prescription are kept with the records of the patient and preserved for at least 1 year. No handwritten amendments may be made to a computer-generated prescription and, if a change or amendment is needed, a new prescription must be generated. For drugs of dependence, only one item per prescription is permitted and the doctor must confirm in hand writing all the particulars, including the name of the drug, the strength, quantity and repeats.

18.5 AUTHORITY PRESCRIPTIONS

These are prescriptions which require the authority of Medicare Australia under the Pharmaceutical Benefits Scheme (PBS) in order to prescribe the drugs concerned. Such prescriptions include:

- restricted drugs
- increased maximum quantities
- increased numbers of repeats.

Application is made on a combined application/authority prescription form (Form PB86) available as personalised pre-printed prescription pads from the PBS. With the exception of drugs of dependence, applications may be made by telephone or via the internet (http://www.medicareaustralia.gov.au/providers). The triplicate copy of the prescription must be retained in the patient record for a minimum of 12 months. Only one item can be prescribed on each authority prescription form. The maximum quantity of a drug of addiction or drug of dependence authorised at any one time will generally not exceed 1 month's therapy. Where supply for a longer period is warranted, authorised quantities will normally not exceed 3 months' supply.

Similar arrangements pertain to authority prescriptions for veterans but the authority has to be sought from the Department of Veterans' Affairs.

18.6 PRESCRIBING DRUGS OF DEPENDENCE

A doctor prescribing drugs of dependence, including narcotics, benzodiazepines and certain stimulants, needs to be aware of the regulations, sensitive to the possibility of inducing dependence in any patient and alert to the manipulative behaviour of some drug-dependent patients. The vast majority of patients who visit their doctor to seek assistance are cooperative and want to be truthful. It takes an altered mind-set on the part of the doctor to be suspicious of

drug-seeking behaviour and not take every patient at face value. The following may help identify a drug-dependent person:

- Be wary of a patient who is new to your practice and seeks a drug of dependence at the first visit.
- Be wary of a patient who claims to be travelling interstate and has run out of supplies or has lost a prescription.
- Be wary of a patient who produces a letter from another doctor purporting to authorise the administration of a narcotic. It may be appropriate for a doctor to provide such a letter to a patient in genuine need, but the onus to confirm the provenance of the letter is on the new doctor, who if in doubt should contact the apparent author of the letter.
- Avoid rushed consultations where a proper history and examination are not completed. The examination should include looking for tell-tale signs of drug use, such as pupillary constriction or injection marks.
- If the patient is unknown to you and you believe a narcotic is justified on clinical grounds, strictly limit the amounts prescribed and direct the patient back to their own doctor.

Doctors also need to be aware that dependence is a characteristic of the drug and not necessarily the patient, so that the possibility of dependence should be kept in mind in all patients to whom such drugs are prescribed. Experts working in the field of pain management observe that physical dependence (physical symptoms on sudden withdrawal) will develop in most patients following prolonged use of drugs of dependence, such as the opioid medications. They differentiate this from addiction (see above), which includes compulsive drug taking as well as physical dependence. The motive for using a drug may become linked with avoidance of the distress of withdrawal and thereby adds to the psychological component that always precedes and interacts with the physical dependence.

Doctors should not hesitate to use the services of the relevant drugs of dependence sections of state health departments for general advice and for specific advice as to whether any patient of concern is already known to the section. An up-to-date centralised listing of the state and territory drugs of dependence offices and contact details is maintained by the Commonwealth Department of Health and Ageing and is accessible at http://www.tga.gov.au/ndpsc/stdpu.htm. In addition, Medicare Australia runs a 'Prescription Shopping Information Service' (telephone 1800 631 181) designed to allow doctors to ask if a particular patient is already of concern to Medicare staff who audit prescribing information. Doctors have at times been severely criticised by coroners for failing to heed the following principles and thereby contributing to the death of drug-dependent people. The regulations vary from state to state but share the following underlying principles:

- The doctor shall not prescribe, supply or administer a drug of dependence unless, after adequate assessment, the drug is necessary for the treatment of a medical condition.

- The doctor must make a genuine attempt to check the patient's identity and the details of treatment provided recently by other doctors or hospitals.
- The doctor must attempt to ascertain if the patient is drug dependent. If so it is an offence to prescribe further drugs of dependence (although in Victoria and Queensland this may be done after the relevant permits are obtained).
- The doctor must comply with the regulations regarding the details to be written on a prescription; these provisions exist to reduce the opportunity for addicted patients to alter the prescription.
- The doctor must also comply with the state regulations regarding the need for a permit if a drug of dependence is required to be prescribed for prolonged periods.
- If a doctor has reason to believe that a person has obtained drugs under false pretences, the doctor must notify the state drugs and poisons office (see below) or the police.
- There is a total prohibition on self-prescribing or self-administering drugs of dependence.
- Where narcotic drugs are stored in a clinic, surgery or hospital, security must be attended to and records maintained (see below).
- The requirements of the PBS must also be met. A permit from state health department drugs of dependence sections does not absolve the doctor from separately obtaining PBS authority for increased quantities if these are needed.

18.7 STORAGE AND RECORD KEEPING OF DRUGS OF DEPENDENCE

Under the legislation, doctors are obliged to store drugs of dependence in a locked steel cabinet and to transport them securely in a locked car or a locked doctor's bag. In addition a written record must be kept for a minimum of 3 years, showing to whom any such drug has been administered or supplied. The unaltered record must also show for each such drug an accurate balance of the stock at hand. Any supplies given to patients must be labelled with the drug details, the name of the patient, the date of supply, the directions for use and the doctor's name and address. These labelling regulations also apply to supplying Schedule 4 drugs, including pharmaceutical 'starter packs', an obligation often overlooked.

Each year, doctors are prosecuted in courts and/or disciplined by medical boards for offences in regard to drugs of dependence. Ignorance of the regulations is not accepted as a defence before the courts or medical boards. Common offences include prescribing for a drug-dependent person without a permit, prescribing for a continuous period other than that specified in the permit, prescribing in excess of the quantity specified in the permit, failing to notify the health department of a patient he or she has reason to believe is drug dependent, and prescribing

methadone without a permit. These offences appear to be based upon several failings, including:

- ignorance of the regulations
- ignorance of the dangers of prolonged prescribing of Schedule 8 drugs
- naivety in dealing with obviously drug-dependent people
- ignorance of the generic and trade names of some Schedule 8 drugs (that is, not recognising a drug to be a narcotic).

18.8 RELATIONSHIPS OF DOCTORS WITH PHARMACISTS

Professional relationships between doctors and pharmacists deserve special attention. As both professions are regulated to protect the public, the mutual cooperation of the two professions will only enhance the level of that protection and the quality of medical care. In these relationships, prompt and courteous receipt of, or return of, a telephone call from any pharmacist is good medical practice and is a sign of a competent professional. Ensuring the prescription and the doctor's signature are legible and providing a telephone number for contact by the pharmacist is also good medical practice. The professional training and the responsibilities of pharmacists are discussed more fully in Chapter 15. In the context of prescribing drugs of dependence, doctors must be aware that:

- pharmacists are also subject to strict regulations concerning their handling of these drugs
- regular inspection of prescriptions held by pharmacists are undertaken and this aids the identification of:
  - doctors who self-prescribe
  - patients who 'doctor shop' to gain additional supplies of drugs.

18.9 PRESCRIBING IN AN EMERGENCY

Verbal prescriptions, in person or per telephone, or prescriptions by facsimile are acceptable in an emergency and may be made to a pharmacist, or in a hospital or nursing home, to a nurse. (In the Northern Territory, Schedule 8 drugs are excluded from these provisions.) In all instances, the verbal instructions must be confirmed in writing within 24 hours or as soon as is practicable. Telephoned prescriptions to pharmacists should also be put in writing and mailed that day.

18.10 PRESCRIBING FOR PATIENTS TRAVELLING ABROAD

Detailed advice for both doctors [4] and patients [5] in regard to travelling with medications is available. From a regulatory perspective, doctors need to be aware that drugs subsidised by the PBS can be taken or sent out of Australia only for the personal use of the traveller or someone they are accompanying, such as a

child, and that there are legal restrictions on the quantity of PBS medications that a traveller can take or send overseas [6].

18.11 PRESCRIBING IN HOSPITALS AND NURSING HOMES

Patient medication charts must be written and signed by a doctor in order that administration of most drugs may be permitted. A brief list of nurse-initiated medications (for example, mild analgesics or laxatives) is usually available in such institutions. In practice, a letter from the doctor referring the patient to hospital and including instructions regarding drugs, or a telephone call from the doctor, will be accepted, provided the medication chart is subsequently completed within 24 hours.

18.12 PRESCRIBING OR DISPENSING UNREGISTERED DRUGS

The *Therapeutic Goods Act 1989*, which establishes the Australian Register of Therapeutic Goods (ARTG), makes it unlawful to supply therapeutic goods that are not registered or listed on the ARTG.* It is unusual for a doctor to have access to an unregistered drug, other than in the context of clinical trials that are regulated through the combination of the *Therapeutic Goods Act 1989* and associated guidelines issued by the National Health and Medical Research Council (see Chapter 17), but this could occur if a patient attends with a medication that has been personally imported without authorisation.

18.13 PRESCRIBING DRUGS OUTSIDE THEIR SPECIFIC INDICATIONS

Another aspect of the ARTG at times overlooked by doctors is that drugs are registered for specific indications. These indications are documented in the prescribing information issued by the manufacturer after approval by the TGA. Use of any registered drug for conditions not covered by the indication is permitted in the context of a clinical trial or on compassionate grounds. Use for other conditions not listed in the prescribing information is known as 'off label' prescribing in the USA. In Australia, such use is apparently not in breach of the *Therapeutic Goods Act 1989* [7]. Depending upon the clinical situation and the availability of any safety and efficacy data, doctors who choose to use drugs in this manner need to pay particular attention to gaining patient consent.

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* The distinction between 'registered' and 'listed' refers to the different levels of evidence in regard to safety and efficacy required for a drug to be so entered; most complementary medicines are 'listed' on the ARTG. See also Chapter 15.

18.14 PRESCRIBING BENZODIAZEPINES

During the past two decades, there has been considerable publicity and increased awareness of most doctors concerning the dangers of prescribing benzodiazepines and in particular their long-term use. An Australian study in 1988 showed that more than a third of general practice patients over 70 years of age and more than 10 per cent of the entire population were users of benzodiazepines [8]. Also, 80 per cent of general practice patients of all ages using such drugs had been prescribed them for more than 6 months. All people are at risk of becoming dependent and withdrawal symptoms have been reported after only 1 week's use of a normal dose of a benzodiazepine. It is probable that 45 per cent of long-term users in Australia are physiologically dependent and most of these people gained little from their treatment [8–9]. The long-term use of benzodiazepines, the absence of clear indications for such use and their association with falls and cognitive impairment in the elderly remain a problem here and around the world [10–11].

In addition to the above risks, inappropriate prescribing of benzodiazepines (and other drugs of addiction) has led to deaths of patients, contributed to diversion and illegal sale of the drugs and resulted in doctors being investigated by both the drugs and poisons branch of the state health department and by the medical board. This problem has recently been examined in depth by the Victorian Parliament's Drugs and Crime Prevention Committee. Its report, entitled *Inquiry into Misuse/abuse of Benzodiazepines and Other Pharmaceutical Drugs*, was published in late 2007. It takes a national and international approach and is an invaluable source of educational material for medical students and doctors (http://www.parliament.vic.gov.au/dcpd/Reports%20in%20PDF/Benzo_Final_web_web_res.pdf).

18.15 GENERIC VERSUS TRADE NAMES

The PBS authorises pharmacists to dispense a cheaper generic alternative for some drugs prescribed by their trade name unless the doctor indicates on the prescription that generic substitution is not permitted.

18.16 RESPONSIBILITIES OF PATIENTS

Patients commit criminal offences by forging or altering prescriptions or by attending several practitioners to obtain drugs for themselves or to sell to others. In Victoria, patients are obliged to inform doctors if they have received drugs of dependence from other doctors in the previous 8 weeks.

18.17 RELATIONSHIPS WITH PHARMACEUTICAL AND MEDICAL DEVICE COMPANIES

The relationship between the pharmaceutical industry and the medical profession has been the subject of considerable controversy in recent years [12–14]. The pharmaceutical industry has contributed enormously to the research and development of new drugs for the treatment of disease in partnership with the medical profession, research institutions and hospitals. However, the success and size of the industry, its competitive nature, and the necessary close working relationship with doctors in research and in the promotion of drugs provide opportunities for questionable practices and even flagrant abuses of the ethical principles of biomedical research [15]. In addition, the medical profession appears to have a 'blind spot' in relation to the marketing practices of the industry [16]. Similar issues surround the emerging medical devices industry.

The pharmaceutical industry in Australia has a voluntary association, now known as Medicines Australia, which has developed codes of conduct for its member companies [17]. The medical profession has also developed codes of conduct regarding the relationship between doctors and the pharmaceutical industry [18–19]. These have been prepared by medical colleges and professional associations and are directed at guiding individual doctors in their relationship with pharmaceutical companies and at establishing ethical frameworks for the manner in which pharmaceutical companies may provide financial support for such things as medical conferences and continuing medical education activities.

These codes to date have not reassured the community as to the propriety of the relationship between the pharmaceutical industry and the medical profession. While it may seem to some that the pharmaceutical industry should take responsibility for this state of affairs, we believe that the ethical onus is squarely on the medical profession. The issues have been spelled out repeatedly [12–16] and are only summarised here. There is overwhelming scientific evidence that drug company techniques do influence the prescribing patterns of doctors [14]. Surveys indicate that most doctors, including some leaders of the medical profession, choose to deny this influence, somehow believing that the scientific evidence applies to all other doctors but not to themselves. The techniques used by industry include the engagement of 'key opinion leaders', direct marketing by company representatives, and standard advertising approaches. 'Key opinion leaders' are usually specialist physicians and psychiatrists who are engaged in clinical trials of new drugs and who then are invited to join speakers' panels and international advisory boards. Many appear to be 'captured' by the industry and can no longer be seen to be neutral expert advisers to other doctors, nor neutral when advising governments about the funding of new drugs. Doctors need to be alert to the

repeated evidence of the industry publishing incomplete, and hence misleading, accounts of clinical trials. They should also note the recent trend towards the creation of 'new' diseases and hence new markets for the industry.

There has also been concern expressed in many quarters at the degree of dependence on the pharmaceutical industry for the funding of accredited continuing medical education [20–21]. A major conference of medical educators funded by the Macy Foundation in the USA in 2008 recommended that accredited organisations providing continuing medical education should not accept commercial support, directly or indirectly, from drug or medical device companies [22]. Medical associations in the USA have also been urged to reduce their financial dependence on the pharmaceutical industry and find ways of better managing the conflicts of interest that are necessarily involved in most current funding mechanisms [23]. In the UK, the Royal College of Physicians of London issued a report in 2009 that, among other matters, recommends 'decoupling' the pharmaceutical industry from continuing professional development for doctors [24].

From an ethical viewpoint, the key issue in clinical practice is information asymmetry between patients and doctors and the need that patients have for their doctors to be unbiased in the advice given to, and prescribing undertaken for, patients. A small number of initiatives to counterbalance the effect of marketing and sponsorship have begun to emerge, including websites that monitor unethical practices, and actions by a few US medical associations to reduce their reliance on sponsorship from industry [16]. In addition, relationships with the pharmaceutical industry frequently create conflicts of interest, to which doctors should be alert and take steps to mitigate [25–26].

In 2002, the Medical Technology Association of Australia published a code of practice for its members. Members primarily are companies that develop and market medical and surgical devices and companies providing in-vitro diagnostics. The code covers, in relation to interaction with the medical profession, issues around gifts and possible inducements, as well as guidelines for support given for conferences, education and training [27]. In the USA, some teaching hospitals have developed stricter conflict of interest policies that ban all gifts to staff from device and drug companies. In 2007, five orthopaedic device companies paid government a total of US$311 million to settle claims of alleged 'kickbacks' [28]. In Australia in 2008, the media covered the local implications of this news [29].

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19 DIAGNOSING AND CERTIFYING DEATH AND THE ROLE OF THE CORONER

Doctors have significant responsibilities in regard to certifying the death of a person and in regard to reporting particular types of death to the coroner. In the field of organ transplantation, specialist doctors have the responsibility for accurately diagnosing brain death. This chapter covers these responsibilities and provides advice about such matters, including the additional requirements to be met where a deceased person is to be cremated and the ethical use of tissues removed at autopsy.

19.1 RECENT DEVELOPMENTS IN THE DIAGNOSIS OF DEATH

Before the modern advances of intensive care and life-support systems, there was little conflict between the law and medicine on the issue of the diagnosis of death. At common law, a breathing person with a circulation was alive; conversely, a person with irreversible cessation of cardiac and respiratory function was dead [1]. In the USA in 1968, an ad hoc committee at Harvard Medical School developed guidelines for the withdrawal of circulatory and respiratory support in patients diagnosed with 'irreversible coma' or 'brain death'. The authors emphasised that the primary purpose of the guidelines was to assist decision making in regard to withdrawal of futile treatment; organ donation was seen as a secondary aspect [2]. As part of the response to developments in organ transplantation, by the mid-1970s there was widespread acceptance by doctors, lawyers and theologians, if not by the public, that the death of the brain was equivalent to the death of a person. In 1977 the Australian Law Reform Commission advised that government had a responsibility to legislate, however generally, on the definition of death. It recommended that the law should state that death occurred when either there was:

- irreversible cessation of all function of the brain; or
- irreversible cessation of all circulation of blood in the body of the person [3].

Table 19.1 Legislation providing for the definition of death

State or territory	Relevant legislation
New South Wales	*Human Tissue Act 1983* s 33
Victoria	*Human Tissue Act 1982* s 41
Queensland	*Transplantation and Anatomy Act 1979* s 45
South Australia	*Death (Definition) Act 1983* s 2
Western Australia	*Human Tissue and Transplant Act* 1982 s 24
Tasmania	*Human Tissue Act 1985* s 27A
Northern Territory	*Human Tissue Transplant Act* 1979 s 23
Australian Capital Territory	*Transplantation and Anatomy Act* 1978 s 45

s = section

This definition was subsequently incorporated in the relevant state and territory legislation (see Table 19.1), although in South Australia and Western Australia, the legislation achieved the same end via slightly different terminology [4]. In South Australia the definition of death is to be found in the *Death (Definition) Act 1983*. In Western Australia the *Human Tissue and Transplant Act 1982* does not define death, but 'irreversible cessation of all function of the brain of the person' is needed before organs can be removed for transplantation. More recently, the states and territories have made legislative changes that seek to make more uniform the legal requirements concerning the certification of death by doctors and to align the law with the altered nature of the way in which doctors provide care in and out of hours. These changes are discussed below.

19.2 RESPONSIBILITIES OF DOCTORS ATTENDING A PERSON THOUGHT TO BE DEAD

In the discussion that follows, certifying death refers to the matters concerning the completion of the death certificate – formally known as the 'Medical Certificate concerning the Cause of Death' – and is distinguished from diagnosing, or confirming the fact of, death. A doctor when called to a person thought to be dead has the following responsibilities:

- to confirm that death has taken place
- to exclude where possible, on medical grounds, any suspicions of foul play in relation to the death
- to issue a death certificate when in a position to do so
- if unable to issue a death certificate, to refer the death to a coroner.

A doctor who is fully registered (that is, has general, full or unrestricted registration) may certify a death anywhere in the state or territory of registration. Doctors with provisional (conditional in Western Australia) registration may sign death certificates only within the context of that registration. Thus interns may sign death certificates only in the hospital in which their provisional registration applies.

Table 19.2 Legislation providing for the certification of death

State or territory	Relevant legislation
New South Wales	*Births Deaths and Marriages Registration Act 1995*, s 39(1) and (2)
Victoria	*Births Deaths and Marriages Registration Act 1996*, s 37 (1), (3) and (4)
Queensland	*Births Deaths and Marriages Registration Act 2003*, s 30
South Australia	*Births Deaths and Marriages Registration Act 1996*, s 36(1) and (2)
Western Australia	*Births Deaths and Marriages Registration Act 1998*, s 44(1) and (4)
Tasmania	*Births Deaths and Marriages Registration Act 1999*, s 35(1) and (2)
Northern Territory	*Births Deaths and Marriages Registration Act 1997*, s 34(1) and (2)
Australian Capital Territory	*Births Deaths and Marriages Registration Act 1997*, s 35(1) and (2)

s = section

19.3 RESPONSIBILITY FOR COMPLETING THE DEATH CERTIFICATE

In general, the person responsible for completing the death certificate is the doctor responsible for the person's medical care immediately before death or the doctor who examines the body of the deceased person after death. Uniform legislation in each of the states and territories requires that deaths be registered with the Registrar of Births Deaths and Marriages (see Table 19.2). Sections 39(1) (a) and (2) of the *Births Deaths and Marriages Registration Act 1995* of New South Wales was the first enactment of these uniform provisions and reads in part as follows:

> 39(1) A doctor who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death must, within 48 hours after death (a) give the Registrar notice of the death and of the cause of death in a form and manner required by the Registrar, or (b) . . .
>
> (2) however a doctor need not give a notice under this section if (a) another doctor has given the required notice or (b) the death has been reported to a coroner under the *Coroners Act 1980*.

The Queensland *Births Deaths and Marriages Registration Act 2003* achieves a similar outcome using the following words in section 30:

> (a) a doctor—
> (i) . . .
> (ii) for any other deceased person—
> (A) attended the deceased person when the person was alive; or
> (B) examined the deceased person's body; or
> (C) has considered information about the deceased person's medical history and the circumstances of the deceased person's death; and
> (b) the doctor is able to form an opinion as to the probable cause of death.

Almost exactly the same wording is found in the births, deaths and marriages registration Acts of the other states and territories. Prior to the introduction of these model provisions, the obligation to complete a death certificate was owed by the doctor 'in attendance during the last illness'. In all jurisdictions other than Queensland this obligation is now owed by a doctor 'responsible for [the] person's care immediately before death'. This widens the field of doctors who may now complete the death certificate. 'In attendance during the last illness' was construed as meaning that the doctor was required to have been treating the patient for the condition that caused the death. While such a doctor is still entitled to complete the certificate, any doctor who was responsible for the patient's care immediately before death can also so certify, provided that the doctor is satisfied he or she has sufficient information to attest to the cause of death. If the doctor is not so satisfied, the death must be reported to the coroner. Where there is doubt in the doctor's mind, it is always possible to obtain telephone advice from the coroner's office. This change in the legislation addresses the common situation experienced in hospital and group practices where the 'treating' doctor may be absent when the patient dies. So long as the covering doctor has sufficient information, that doctor is now authorised to provide a death certificate.

There is no requirement to have actually seen the patient or to have seen the patient within a specified period before death (other than in New South Wales and the Australian Capital Territory as described below). However, if the deceased is not personally known to the doctor or has not been seen for a long time, the doctor will probably be more cautious in certifying the cause of death. In New South Wales and the Australian Capital Territory, the coroners Acts require that if there has been no attendance by a medical practitioner in the 3 months before death, the death must be reported to the coroner.

The other major change in the state and territory legislation is that a doctor (any doctor) 'who examines the body of a deceased person after death' can also complete a death certificate, provided the death is not one reportable to the coroner. There are currently no guidelines dealing with this situation but it is reasonable to advise that an 'examination of the body' will be of little value unless:

- sufficient reliable information about the patient's medical history is available and considered
- sufficient reliable information about the circumstances of the patient's death is available and considered
- the actual examination of the body is such that potentially reportable deaths are excluded; as a minimum this should include a visual inspection of the entire body surface, front and back.

19.4 THE CAUSE OF DEATH

A death certificate is an important legal and social document. If incorrectly completed, it could have legal implications in matters such as life insurance payments

and compensation schemes. Errors may have implications when family members are striving to construct accurate genetic histories. Apart from its importance in this way, the death certificate is the source of information used in Australia, as in most other countries, for the preparation of statistics concerning the causes of death. These statistics are widely used in assessing public health problems and for medical research. Officers of the Australian Bureau of Statistics (ABS) select the underlying cause of death from the statement of the cause of death on death certificates and classify this according to the WHO International Classification of Causes of Death. The quality of these statistics depends largely on doctors presenting the sequence of events leading directly to death clearly and coherently to the officers of the ABS. To assist with this, the WHO has defined the underlying cause of death as the:

- disease or injury that initiated the train of morbid events leading directly to death, or
- circumstances of the accident or violence that produced the fatal injury.

To enhance the quality and accuracy of statistics derived from death certificates, the ABS has issued an information paper for the guidance of medical practitioners in completing medical certificates of the cause of death. The guide emphasises the need for legibility, completeness, avoiding abbreviations and basing the information on the doctor's 'best medical opinion'. The guide is available on the ABS website or may be obtained at no cost from the ABS state and territory offices [5].

19.5 THE DIFFERENT TYPES OF DEATH CERTIFICATES

19.5.1 Standard death certificates

These certificates concern the death of a person aged 28 days and over and consist of three parts:

1. the counterfoil, which is retained by the attending doctor
2. the Medical Certificate concerning Death (destined for the registrar)
3. the Notice of Signing (usually provided to the funeral director).

19.5.2 Perinatal death certificates

These are similar in structure to those of the standard death certificates, but include an additional section to identify the maternal or other causes giving rise to the underlying cause of death in the child or fetus. These certificates vary slightly between jurisdictions. The perinatal death certificate has two applications: to a stillborn child of at least 20 weeks gestation (or at least 400 grams weight if gestation cannot be determined); and to a live born child (regardless of gestation) who dies within 28 days of birth. In some states, attending doctors are asked to

complete a further form – a Confidential Medical Report on Perinatal Death – and to forward this with the perinatal death certificate to the Registrar of Births, Deaths and Marriages.

In 1980, the ABS adopted the following World Health Organization (WHO) definitions:

- neonatal death – a death occurring in an infant whose birth weight was at least 500 grams or, if the weight is not known, an infant born after at least 22 weeks' gestation, and who dies within 28 days of birth
- stillbirth – any stillborn infant weighing at least 500 grams or, if the weight is not known, born after at least 22 weeks' gestation.

The above WHO definitions are used in some states for their statistical surveys but do not conform to the legal definitions contained in their various births, deaths and marriages registration Acts (see also Chapter 19). The legal definition of 'stillbirth' in all these Acts is as occurs in section 4 of the *Births, Deaths and Marriages Registration Act 1995* of New South Wales, namely:

> "Stillborn child" means a child that exhibits no sign of respiration or heartbeat, or other sign of life, after birth and that:
> (a) is of at least 20 weeks' gestation, or
> (b) if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, has a body mass of at least 400 grams at birth.

Section 4 of the New South Wales Act prescribes, as do all other state and the territory Acts, that 'death does not include a stillbirth'. The latter must be registered as a birth but not as a death, despite the fact that doctors complete a perinatal death certificate. Attempts by consultative councils on maternal and perinatal mortality to have the weight of 400 grams occurring in these Acts changed to 500 grams so as to conform with the WHO definition have to date been unsuccessful.

19.6 PROVIDING THE DEATH CERTIFICATE

This section deals with the question of what the doctor must do with the completed certificate. In New South Wales, Queensland, the Northern Territory and the Australian Capital Territory, the legislation (see Table 19.2) provides that the doctor must, within 48 hours after the death, forward the certificate to the Registrar of Births, Deaths and Marriages. In Tasmania, Victoria and South Australia the legislation states that the doctor, as well as forwarding the certificate to the Registrar, must also provide the certificate to the funeral director or person disposing of the remains. Under the legislation in Western Australia, responsibility for notifying the Registrar of a death falls to the funeral director or other person who arranges for the disposal of the remains. That person must give notice within

14 days of the death, including a certificate of cause of death which the doctor is required to pass on to them.

19.7 DEATHS REPORTABLE TO CORONERS

As the births, deaths and marriages registration Acts (Table 19.2) and coroners Acts (Table 19.3) of the states and territories are interrelated, doctors need to understand not only their obligations in relation to the certification of deaths but also their obligations in relation to deaths reportable to coroners. Approximately 16 000 of the 130 000 or so deaths that occur each year in Australia are reported to and investigated by coroners. These investigations are designed to find out, if possible:

- the identity of the deceased
- the cause of death
- how death occurred (the circumstances in which the death occurred)
- the particulars needed to register the death under the relevant state and territory legislation
- to identify and report on factors that should be avoided to prevent further deaths.

There are eight different coroners Acts operating in Australia (Table 19.3). The relevant legislation has been summarised by Stewart and colleagues [4]. The Victorian Coroner's Office website provides links to all other offices with the exception of Northern Territory [6]. In half of the coroners Acts there is a definition of a 'reportable death' (Victoria, Tasmania, Western Australia and the Northern Territory). In the other half, the Acts create an obligation on certain categories of people to report deaths where they have reasonable grounds to believe that the coroner has jurisdiction to hold an inquest into the death (New South Wales, Queensland, South Australia and the Australian Capital Territory). The effect of these provisions is similar, but terminology is not consistent and often lacking in detail, allowing for different interpretations between jurisdictions or even within jurisdictions. Tables 19.3 and 19.4 (pp. 302 and 303) set out in summary form the various deaths that should be reported to coroners in Australia.

One example of inconsistency of the legislation is seen in relation to deaths that have resulted from accident or injury. These terms are not included in the Queensland Act, but are probably encapsulated in the phrase 'a violent or unnatural' death. In New South Wales it is specified that the death must have occurred within a year and a day of the accident, which contrasts with deaths resulting directly or indirectly from accident (or injury in Victoria). So, while there is general consistency of coronial caseloads around the country, there will be some deaths reportable in one state that are not reportable in another. Within jurisdictions, also, it may be that a death considered by one doctor to be unexpected (and therefore reportable to the coroner in Victoria, Tasmania, Western

Table 19.3 Comparison of states' coroners Acts: reportable deaths generally

State	Definition	Anaesthetic and surgical deaths	No medical attendance or death certificate
New South Wales *Coroners Act 1980*	A violent or unnatural death or a sudden death the cause of which is unknown; died within a year and a day after the date of any accident to which the cause of his or her death is or may be attributable	While under, as a result of or within 24 hours of an anaesthetic administered in the course of a medical surgical or dental operation or procedure or operation or procedure of a like nature	Not attended by a doctor in the 3 months prior to death
Victoria *Coroners Act 1985* (see table note)	Unexpected, unnatural or violent or resulting directly or indirectly from accident or injury	During an anaesthetic or as a result of an anaesthetic and not due to natural causes (see table note)	No death certificate available
Queensland *Coroners Act 2003*	Death where the person is unknown, or the death was violent or unnatural, or happened in suspicious circumstances, or occurred while in care or in custody	Death was not reasonably expected to be the outcome of a health procedure	Not attended by doctor in the 3 months prior to death; no death certificate available
Southern Australia *Coroners Act 2003*	Death by violent, unknown or unusual causes		
Western Australia *Coroners Act 1996*	Unexpected, unnatural or violent or resulting directly or indirectly from accident or injury	As for Victoria	No death certificate available
Tasmania *Coroners Act 1995*	Unexpected, unnatural or violent or resulting directly or indirectly from accident or injury	During an anaesthetic or sedation or as a result of an anaesthetic or sedation and not due to natural causes	Cause of death unknown
Northern Territory *Coroners Act 1993*	Unexpected, unnatural or violent or resulting directly or indirectly from accident or injury	As for Victoria	
Australian Capital Territory *Coroners Act 1997*	Is killed, found drowned or died a sudden death the cause of which is unknown; cause of death directly attributable to an accident	During or within 72 hours after or as a result of (1) an operation of a medical, surgical or dental or like nature; or (2) an invasive medical or dental procedure (except as specified in regulations)	Not attended by doctor in the 3 months prior to death; no death certificate available

Note: A new *Coroners Act 2008* has been passed in Victoria and is due to come into force in November 2009. It will define reportable deaths to include deaths during or following medical procedures where the death is or may be causally related to the procedure and where the medical practitioner would not have reasonably expected the death.

Table 19.4 Comparison of states' coroners Acts: deaths in custody and other specific circumstances

State	Custody provisions	Other circumstances
New South Wales	Resident for the purpose of receiving care or assistance in a hospital within the meaning of the *Mental Health Act*; facility under the *Community Welfare Act*; residential centre for a handicapped person under the *Youth and Community Services Act*; residential child care centre under the *Children (Care and Protection) Act*; and deaths in custody	Suspicious or unusual circumstances; excludes deaths of over the age of 65 years where the person died after injury from an accident attributed to the age of the person and not caused by an act or omission of another person (not applicable to a hospital or nursing home)
Victoria	Person held in care, including people under the control of the Justice Department or police, and people who were patients under the *Mental Health Act*	Identity unknown; Attorney-General directs
Queensland	While detained in care or in custody	In the coroner's opinion the person has died within the state in such a place as to require inquiry; minister directs; drowning
South Australia	Death occurred or cause of death arose in custody pursuant to an act or law of the state; accommodation or institution for mentally ill or intellectually retarded	Dependent on non-therapeutic use of drugs; death in an aircraft or on a vessel during a voyage to a place of disembarkation to South Australia
Western Australia	Person who immediately before death was held in care; or whose death was caused or contributed to while held in care or by any action of police force	Identity unknown
Tasmania	Held in care or held in custody; escaping or attempting to escape or in the process of police or a prison officer attempting to detain that person	Death of a child less than 1 year which was sudden and unexpected; identity unknown
Northern Territory	Person held in care or custody	Identity unknown
Australian Capital Territory	In custody	Dies under suspicious circumstances; Attorney-General believes circumstances should be better ascertained

Australia and the Northern Territory) or sudden and the cause of death unknown (and therefore reportable to the coroner in Queensland, New South Wales and the Australian Capital Territory) may be viewed differently by another doctor in the same state.

19.8 SURGICAL, ANAESTHETIC AND ADVERSE EVENT-RELATED DEATHS

All coroners Acts except the one in South Australia include reference to deaths occurring while under an anaesthetic or in the course of an operation. There are subtle distinctions between the states about exactly which anaesthetic deaths should be reported. These are difficult to summarise. Some general comments can be made about such deaths for Victoria, Tasmania, Western Australia and the Northern Territory where the wording is almost identical, being derived from that first enacted in Victoria in 1985:

- Any death occurring while the patient is under the effects of anaesthesia (for example, general anaesthesia or regional anaesthesia) must be reported to the coroner.
- Where deaths occur as a result of anaesthesia and are not due to natural causes, they must be reported to the coroner.

The latter is intended to capture those deaths where there is an anaesthetic error (such as an overdose of medication, wrong gases administered or unrecognised oesophageal intubation) but where the patient 'survives' the event and dies some time later. These are deaths due directly or indirectly to accident or injury but have been regarded by the lawmakers as sufficiently important to specify separately. Where a patient during anaesthesia has a myocardial infarction that is a complication of the patient's underlying coronary atherosclerosis and the patient dies sometime later, this death is not reportable. It is a natural death and a certificate may be completed. However, if the death from myocardial infarction occurs during anaesthesia, it must be reported. This different handling by the law of a death from the same cause and in the same setting, simply because one was delayed, is an inconsistency.

It is important to understand that reporting such a death to the coroner will not necessarily lead to an autopsy. For example, the death of a patient on the operating table during urgent surgery for a ruptured atherosclerotic abdominal aortic aneurysm is a death during an anaesthetic and must be reported in every jurisdiction except South Australia. The body and the medical record will be conveyed to the forensic pathology facility. Practice varies between jurisdictions, but commonly a pathologist will read the medical record and examine the surgeon's operation notes and, provided the clinical situation is clear and the family has not

expressed concern to the coroner, the coroner will usually accept the pathologist's advice that there is nothing to be gained by requiring an autopsy.

Beyond the matter of deaths under anaesthesia, deaths in hospital possibly related to other adverse events may also raise questions for doctors completing a death certificate or considering referral to the coroner. In this situation, the following issues should be considered:

- whether the death may be 'directly or indirectly due to accident or injury' (Victoria, Tasmania, Western Australia, Northern Territory), 'unnatural' (Queensland, New South Wales), 'accidental' (Australian Capital Territory) or 'due to violent or unusual causes' (South Australia)
- whether there are circumstances from which later allegations of a 'cover- up' may arise. Understanding the family's preferences can be helpful here. If the family voices concern about the adequacy of the patient's management while in hospital, a safe course would be to refer the death to the coroner. Pursuing this course does not necessarily mean that the coroner will accept the referral or, if it is accepted, that there will be an autopsy.
- whether an autopsy at the hospital should be sought by the treating doctor, with the consent of relatives. The hospital, whose staff have knowledge of the patient and are usually in close communication with relatives, is the best place to evaluate the patient's pathologies and the medical management of these when there is no specific identifiable accident or injury directly or indirectly causing death. If during the course of the hospital autopsy, or later, it becomes evident that the death should be reported, then it is quite appropriate for the death to be referred to the coroner at that point. If the coroner accepts the referral, the hospital autopsy report will usually also be accepted.

19.9 DEATH RELATED TO FRACTURED NECK OF FEMUR IN THE ELDERLY

The question often arises as to whether deaths that may occur some weeks or months after a surgical repair of a fracture, and are usually precipitated by bronchopneumonia, are reportable. If the attending doctor believes that the fracture was pathological (for example from a malignancy or advanced osteoporosis) and spontaneous, such deaths may reasonably be regarded as 'natural deaths' and are not reportable. If the doctor believes the fracture was the consequence of a fall, then the death has resulted from an accident and is reportable to a coroner. As mentioned previously, the reporting of such deaths does not necessarily mean that an autopsy will be ordered by the coroner. In New South Wales and Queensland, statutory discretionary powers are given to doctors to issue death certificates in these circumstances without reporting the death to a coroner. For

example, the amended New South Wales *Coroners Act 1980* section 12B(2), (3) and (4) provides as follows:

> (2) . . . a medical practitioner may give a certificate as to the cause of death of a person if the medical practitioner is of the opinion that the person:
> (a) was 65 years of age or older, and . . .
> (b) died after sustaining an injury from an accident, being an accident that was attributed to the age of that person, contributed substantially to the death of the person and was not caused by an act or omission by any other person.
> (3) Subsection (2) does not apply if the accident concerned occurred in a hospital or nursing home.
> (4) If a medical practitioner certifies the cause of death of a person in pursuance of subsection (2), the certificate must state that it is given in pursuance of that subsection.

19.10 CREMATION

The requirements preceding cremation of human remains in Australia are designed to safeguard against improper destruction of evidence of foul play or negligence in relation to a death. The legislation is not uniform throughout the country, although all legislation contains provisions for a second doctor, independent of the doctor who provided the death certificate, to confirm that the requirements for cremation have been met. As detailed below, in some jurisdictions the second doctor is called a 'medical referee', appointed under the relevant legislation.

In New South Wales, an application for cremation is made to a medical referee or a coroner. An application to a medical referee must be accompanied by a 'cremation certificate' from a medical practitioner who attended the person immediately before, or during the illness terminating in, the death of the person, who can 'state definitely the cause of death'; or an expert in anatomical pathology who has performed a post-mortem and can state the cause of death (New South Wales *Public Health Act 1991* and *Public Health (Disposal of Bodies) Regulations 2002*).

In Victoria, a medical referee, other than the registered medical practitioner who signed the death certificate, is required to provide a certificate authorising the cremation. This doctor has to attest to having sighted the death certificate, to having made 'careful and independent inquiry into the circumstances surrounding death' and to having been satisfied that the death was not reportable to the coroner. Heavy penalties apply if a doctor provides a certificate where the doctor has a financial interest in the person's death under a life insurance policy or has a

right or expectation to property on the person's death (Victorian *Cemeteries and Crematoria Act 2003* and *Cemeteries and Crematoria Regulations 2005*).

In Queensland, an officer in charge of a crematorium must have received a permission and a certificate to cremate a body from a doctor, who may sign the certificate only after having seen the medical certificate of the cause of death completed by a different doctor for the purposes of the death registration process, or received a coroner's certificate for the cremation of a body. The officer in charge of a crematorium in Queensland is liable to significant penalty, or imprisonment, for cremating a body without all the required certificates (Queensland *Cremation Act 2003*).

In South Australia, an application for cremation is made to the Registrar of Births Deaths and Marriages and must be accompanied by certificates from two doctors (one of whom was responsible for care of the deceased immediately before death, or who examined the deceased after death), or a certificate from a doctor who has performed a post-mortem and concluded that the deceased died of natural causes, or authorisation for cremation from a coroner. Significant penalties or imprisonment may apply if a doctor gives a certificate where the death was reportable to the coroner. A maximum penalty of 4 years' imprisonment may be applied where a doctor gives a cremation certificate and stands to benefit financially from the death (South Australian *Cremation Act 2000*).

In Western Australia, application for cremation is made to a medical referee appointed by the governor. Before issuing a permit for cremation the medical referee must see the certificate of cause of death provided for the purpose of the death registration, or a certificate from the coroner authorising cremation (Western Australian *Cremation Act 1929*).

In Tasmania, an application for cremation is made to a medical referee and must be accompanied by a medical practitioner's certificate (from a doctor who attended the deceased in the course of their final illness and is able to certify as to the cause of death) and a confirmatory certificate (from a second medical practitioner who is not related to the first, or to the deceased) (Tasmanian *Burial and Cremation Act 2002*).

In the Northern Territory, an application for cremation must be accompanied by either certification by two doctors (one of who must have provided the death certificate), or by a certificate from a doctor who conducted a post-mortem examination and declares that the death was due to natural causes, or by a certificate from the coroner authorising cremation (Northern Territory *Cemeteries Act 1979*).

In the Australian Capital Territory, an application made to a cremation authority must be accompanied by a certificate from a 'medical referee' stating there is no medical reason why the remains should not be cremated, and by a death certificate from a medical practitioner or a certificate from the coroner

authorising cremation. To be appointed, medical referees must have been practising for at least 5 years (Australian Capital Territory *Cemeteries and Crematoria Act 2003*, *Cemeteries and Crematoria Regulations 2003*).

19.11 THE DIAGNOSIS OF BRAIN DEATH

The diagnosis of brain death is of critical importance in the field of organ donation and transplantation. Even where organ donation is not at issue, the diagnosis of brain death is important in clinical situations, usually in intensive care, where decisions need to be made about the continuation of futile life-support treatments. A full account of the procedures to be followed in diagnosing brain death can be found in the recommendations on brain death and organ transplantation produced by the Australian and New Zealand Intensive Care Society [7]. Some aspects of these procedures, in particular the experience and expertise required of the doctors involved (see 19.12 'Brain death and transplantation'), are laid down in legislation.

A correct diagnosis can be made by appropriately qualified and experienced doctors using relatively simple bedside tests with assistance from laboratory tests [2, 7–8]. The first step is to exclude any reversible condition depressing brain function. The apnoeic coma must not be due to:

- depressant drugs. Any sedative, hypnotic, tranquilliser or anaesthetic drug is capable of producing depression of the brain. If this effect cannot be completely excluded by history, then prolonged observation, or drug screening, is necessary.
- neuromuscular blocking (relaxant) drugs. These occasionally persist following an anaesthetic and their presence may be excluded by the use of a peripheral nerve stimulator.
- hypothermia. A combination of drugs and hypothermia is not uncommon.
- metabolic or endocrine disturbances as in, for example, renal failure or hypoglycaemia.

Once the possibility that the apnoeic coma is the consequence of any of the above has been excluded, and a diagnosis that accounts for the patient's state (such as massive intracerebral haemorrhage) is established, then relatively simple bedside tests may be used for diagnosing brain death. Some of these may require supportive laboratory tests. These tests establish the following:

- Both pupils are fixed to light. There must be no response when these are examined with bright light in a darkened room. The pupils will commonly be dilated, but their size is irrelevant.
- There is no response to corneal stimulation with cottonwool.
- There is no response to the presence of the endotracheal tube nor any evidence of cough when suction is applied to the trachea.

- There are no eye movements when 20 mL of ice-cold water is injected into each ear. Clear access to the eardrums must be established first.
- There are no cranial nerve motor responses to painful stimuli as, for example, by supraorbital pressure and firm pinching of the earlobes.
- Spontaneous breathing is absent during hypercapnia. There must be no respiratory movements on disconnection of the respirator for long enough to ensure that the Pa CO2 rises above the threshold for stimulation.

When all the above criteria are satisfied, and the patient is not an organ donor, the tests need not be repeated. If there are equivocal results with any one or more tests, treatment must be continued and the test repeated after an interval of not less than 4 hours. Purely spinal reflexes may persist and do not preclude the diagnosis. The time of death is the time death was established, not the time when the respiratory support was withdrawn.

19.12 BRAIN DEATH AND TRANSPLANTATION

The responsibilities surrounding the diagnosis of death are brought into even sharper relief when donor organs are offered for transplantation. Beating-heart donors are increasingly needed to enable the transplantation of kidneys, hearts, livers and other organs. It is essential, when diagnosing brain death in potential donors, that clear distinctions are made between brain death and a prolonged state of coma in patients who are vegetative but in whom there is some evidence of brain-related function. The terms 'brain death', 'irreversible coma' or 'post-coma unresponsiveness (vegetative state)' are not synonymous and do not overlap. Once a person is dead, he or she is no longer in a coma.

Generally, tests or treatment carried out on a patient before death must be for the benefit of the patient and not solely to preserve organs and tissues for transplantation. Circumstances in which such procedures are lawful and ethically justified are addressed in guidelines issued by the National Health and Medical Research Council [9]. Extra blood for tests, such as tissue typing, screening for infections or other procedures may be taken when blood is required for tests directly concerned with the care of the patient. Costs for these extra tests should not be charged to the patients or their families [9]. There must be complete segregation of the medical team caring for a patient in irreversible coma who is dying and the medical team caring for a patient who requires a transplant. It is important to ensure that the determination and certification of death are made without any interest in the use of organs from the deceased in a subsequent transplant procedure.

The states and the territories have all legislated to ensure that neither of the two appropriately qualified doctors separately declaring that irreversible cessation of all functions of the brain has occurred can be a member of the transplant team, or a doctor treating the proposed recipient of the organ or tissue. In addition,

such doctors may not be the designated officer who authorises the removal of the organ or tissue. As an example, section 26(7)(b) of the *Human Tissue Act 1982* of Victoria prescribes:

> (b) where the respiration or the circulation of the blood of the deceased person is being maintained by artificial means—two medical practitioners, neither of whom is a designated officer or the first-mentioned medical practitioner and each of whom has been for a period of not less than five years a medical practitioner, have each certified in writing—
>
> (i) that he has carried out a clinical examination of the person while the respiration or the circulation of the blood of that person was being maintained by artificial means; and
>
> (ii) that, in his opinion, at the time of examination, irreversible cessation of all function of the brain of the person had already occurred.

The 'designated officer' is the medical officer designated by the hospital (usually a medical administrator) to authorise the removal of tissue for transplantation. 'Five years a medical practitioner' includes the year when the doctor may be provisionally registered (for example, internship).

Some states specify particular qualifications for one of these two doctors. For example in Western Australia, one must have specialist qualifications in neurology or neurosurgery; in the Northern Territory, one must be a specialist (anaesthetist, general surgeon, neurologist, neurosurgeon or physician); in Queensland, one must be a neurologist, neurosurgeon or other specialist as prescribed; in New South Wales one must be 'a designated specialist'; and in the Australian Capital Territory one must have specialist qualifications in neurology, neurosurgery or other specialty as prescribed; Victoria, South Australia and Tasmania have no such specialty requirements over and above the requirement to be a medical practitioner of at least 5 years standing.

With renewed interest in procuring organs for transplantation from patients dying a circulatory death ('donation after cardiac death'), the 2008 edition of the ANZICS Statement now provides guidance as follows:

> ANZCIS recommends that death be determined to have occurred when all the following features are present:
>
> - immobility;
> - apnoea;
> - absent skin perfusion; and
> - absence of circulation as evidenced by absent arterial pulsation for a minimum of two minutes, as measured by feeling the pulse or, preferably, by monitoring the intra-arterial pressure [7].

19.13 THE USE OF TISSUES REMOVED AT AUTOPSY

In Australia the use of tissues removed at autopsy for diagnostic, teaching and research purposes came under scrutiny in the wake of the Bristol Royal Infirmary and Alder Hey Hospital scandals in the UK [10]. Until then the law and practice in this area in Australia were in keeping with the findings of the Australian Law Reform Commission (ALRC) Report No. 7 in 1977 on human tissue transplants. The ALRC recognised that, while autopsies were commonplace, there was no legislation regulating them and the relevant common law was poorly developed. The ALRC recommended as follows:

> The procedures and characteristics of normal autopsies, and the beneficial uses to which tissue routinely removed during autopsy may be put, are such that the [ALRC] unhesitatingly recommends some departure from the general principle of consensual giving upon which the rest of this report is based. [11]

This recommendation was incorporated into most state and territory human tissue Acts, so that consent for autopsy (or coronial authority for an autopsy) was also consent for the use for medical, scientific or therapeutic purposes of tissue removed for the purposes of the autopsy. Following the public interest in this issue, it rapidly became clear that while such retention and use of human organs tissues following autopsy was generally lawful in Australia, this practice (without family consent) was out of step with public expectations [12].

Subsequently, a number of inquiries were undertaken, and reports and guidelines formulated, at both state and federal levels [10, 13–14]. The *National Code of Ethical Autopsy Practice* [14] commits each state and territory to changing their human tissue Acts to require consent to use autopsy tissue. The relevant provisions have been changed in New South Wales, Queensland, South Australia and Tasmania. In 2002, the Royal College of Pathologists of Australasia revised and expanded its 1993 position statement on autopsies (a document which in 1993 had anticipated these problems) [15]. Pathologists are advised to follow these guidelines pending any new legislative responses.

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Additional reading

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20 BIRTHS, REPRODUCTIVE TECHNOLOGY, FAMILY LAW AND CHILD PROTECTION

Doctors need sufficient knowledge of the legislation concerning births notification, reproductive technology, child protection and family law to ensure they fulfil any statutory duties relating to their medical practice in these areas. In addition doctors may be the first to recognise the possibility of child abuse and thus should be aware of the relevant laws in this area. In regard to reproductive technology and the treatment of infertility, this chapter is restricted to the legal and regulatory aspects and does not attempt to address the ethical and social issues surrounding this specialised area.

20.1 NOTIFICATION OF BIRTHS (INCLUDING STILLBIRTHS)

It is a legal requirement of the births, deaths and marriages registration Acts of the states and territories that the name, sex, parentage and date and place of birth of all newborn children be provided to the respective registrars of birth. The Acts place the onus of notification primarily on the chief executive officer of a hospital where a child is born in a hospital and on the doctor or midwife if the child is born elsewhere. In addition, the parents are identified as having a responsibility to register a birth. The general principles in regard to notification of births are the same in each jurisdiction, but there are differences in the period of grace before notification. The relevant legislation and the time frames for notification of live and still births are summarised in Table 20.1.

The term 'stillborn child' under the various Acts means a child that exhibited no signs of respiration or heartbeat, or other signs of life after birth, was at least 20 weeks' gestation or, if the latter cannot be established, had a body mass of at least 400 grams at birth, with the exception of the Australian Capital Territory where the period of gestation is set at 22 weeks and the body mass at 500 grams in accordance with the World Health Organization's definition. Notification of a stillbirth must be accompanied by a certificate

Table 20.1 Births, deaths and marriages registration Acts – summary of notification obligations

State	Year of legislation	Notification of live birth	Notification of stillbirth
New South Wales	1995	7 days	48 hours
Victoria	1996	21 days	48 hours
Queensland	2003	2 working days	2 working days
South Australia	1996	7 days	48 hours
Western Australia	1998	1 month	1 month
Tasmania	1999	21 days	48 hours
Northern Territory	1995	10 days	10 days
Australian Capital Territory	1997	7 days	48 hours

completed by the doctor attesting to the apparent cause of the stillbirth or stating that such certification will be provided later. Any infant, regardless of maturity or birth weight, who breathes or shows any other signs of life after being born, must be registered as a live birth and, if death subsequently occurs within 28 days, as a neonatal death (see Chapter 19).

20.2 REPRODUCTIVE TECHNOLOGY

Reproductive technology (RT), best exemplified by in-vitro fertilisation (IVF) and embryo transfer, and gamete intrafallopian transfer, also includes the longer-standing technique of artificial insemination by donor (AID). The practice of reproductive technology is regulated by legislation in Victoria, South Australia and Western Australia and guided by a combination of self-regulation and NHMRC guidelines in the other states. These laws and guidelines cover the institutions that wish to undertake these procedures and the doctors who perform them. Legislation in all jurisdictions clarifies the status of children born as a result of RT practice.

The *Infertility (Medical Procedures) Act 1984* of Victoria was the first legislation introduced in Australia concerning reproductive technology. This Act regulated the doctors and hospitals that were approved to undertake these procedures and the records that were required to be kept, and restricted access to such treatment to married couples. This legislation was superseded by the *Infertility Treatment Act 1995* of Victoria. The guiding principle of that Act placed emphasis on the welfare of any person born following these procedures, and stated that human life must be preserved and protected, that the interests of the family should be considered and that infertile couples deserve assistance. The 1995 Act established the Infertility Treatment Authority (ITA), which was responsible for adequate record keeping, licensing of treatment centres, approving and

monitoring research and approving the import or export of embryos. The legislation covered the period of treatment for infertility that must elapse before a couple can have access to these procedures, the need for pre-treatment counselling by registered counsellors when donor gametes are used, the use of embryos when an intended recipient dies or is no longer able to use the embryos and the fees to be paid to donors. New legislation, the *Assisted Reproductive Treatment Act 2008*, has been passed in Victoria but at the time of writing has not been promulgated. The new Act will bring many changes including widened rights of access to IVF, the replacement of the ITA with the Victorian Reproductive Technology Authority, the establishment of a patient review panel and the regulation of surrogacy.

In South Australia, the *Reproductive Technology (Clinical Practices) Act 1988* places controls over doctors and hospitals via a licensing process and over the participants in IVF programs. The Act is administered via the South Australian Council on Reproductive Technology. Participants in the program need to be married or to have been in a de facto relationship for at least 5 of the preceding 6 years. The Act is supported by the *Reproductive Technology Code of Ethical Clinical Practice Regulations 1995*, which set out the conditions that must be met before infertility treatment may be given to a patient by a licensee. Consent to the infertility treatment must be given by both members of the couple. Such consent is valid for six cycles of treatment. Couples are to be enrolled only if they have been counselled and are fully advised about what is involved in the treatment program. The South Australia Act and regulations cover record keeping, the storage and use of gametes and embryos and their use and/or disposal if the participants revoke their consent, die or divorce. The maximum time a frozen embryo may be stored is 10 years. Participants are to be given access to their records if they make written application for such access.

In Western Australia, the *Human Reproductive Technology Act 1991* established the Western Australia Reproductive Technology Council, which published a code of practice. Through the Act and the code, provisions are made to advise the Minister of Health, approve research, license premises for storage and clinical practice, control record keeping, require consent and prohibit certain procedures.

In the states and the territories that do not have legislation specifically regulating reproductive technology, clinical IVF services are overseen via a self-regulatory system operated by the Fertility Society of Australia (http://www.fsa.au.com), which established the Reproductive Technology Accreditation Committee (RTAC) (http://www.fsa.au.com/rtac/). IVF services accredited by RTAC agree to be guided by the NHMRC 2004 guidelines (amended in 2007) titled *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research* [1]. RTAC expects accredited services to abide by its *Code of Practice for Units Using In Vitro Fertilisation and Related Reproductive Technologies* [2].

In 2006, the *Prohibition of Human Cloning for Reproduction and the Regulation of Human Embryo Research Amendment Act 2006* ('the Amendment Act') was enacted and came into force on 12 June 2007. These amendments extended the range of licensable activities. This Act is administered by the Embryo Research Licensing Committee of the NHMRC (see Chapter 17).

The Amendment Act changed the title of the *Prohibition on Human Cloning Act* to the *Prohibition of Human Cloning for Reproduction Act* 2002 ('the PHCR Act'). There are a large number of practices which are prohibited under the Commonwealth PHCR Act. These are listed in the 2004/2007 NHMRC guidelines as follows:

> Sections 9 to 21 of the PHCR Act prohibit certain practices under the following headings as used in the Act: placing a human embryo clone in the human body or the body of an animal (s 9); importing or exporting a human embryo clone (s 10); creating a human embryo for a purpose other than achieving pregnancy in a woman (s 12); creating or developing a human embryo by fertilisation that contains genetic material provided by more than 2 persons (s 13); developing a human embryo outside the body of a woman for more than14 days (s 14); heritable alterations to genome (s 15); collecting a viable human embryo from the body of a woman (s 16); creating a chimeric embryo (s 17); developing a hybrid embryo (s 18); placing of an embryo (s 19); importing, exporting or placing a prohibited embryo (s 20); and commercial trading in human eggs, human sperm or human embryo (s 21).
>
> Sections 22 to 23B of the PHCR Act prohibit certain practices unless authorised by a licence, under the following headings: creating a human embryo other than by fertilisation, or developing such an embryo (s 22); creating or developing a human embryo containing genetic material provided by more than 2 persons (s 23); using precursor cells from a human embryo or a human fetus to create a human embryo, or developing such an embryo (s 23A); creating a hybrid embryo (s 23B – note: a licence to create or develop a hybrid embryo can only be issued under the RIHE Act (s 21) and only for prescribed purposes) [1].

The guidelines also explain that the Commonwealth *Research Involving Human Embryos Act 2002* ('the RIHE Act') provide as follows:

> Sections 10 and 11 state that the following uses of excess ART embryos are exempt and therefore do not require a licence: storage; removal from storage; transport; observation; allowing the embryo to succumb; use by an accredited ART centre of an embryo that is not suitable to be placed in the body of the woman for whom it was created (where suitability is determined only on the basis of its biological fitness for implantation), and the use forms part of diagnostic investigations conducted in connection with the ART treatment of the woman for whom the embryo was created; or use carried out by an

accredited ART centre and for the purposes of achieving a pregnancy in a woman other than the woman for whom the excess ART embryo was created.

Sections 10A and 10B of the RIHE Act state that the following practices are prohibited unless authorised by a licence: using a human embryo: created by a process other than the fertilisation of a human egg by a human sperm; or created by a process other than fertilisation that contains genetic material of more than 2 persons; or created using precursor cells taken from a human embryo or human foetus, or using a hybrid embryo; and undertaking research or training involving the fertilisation of a human egg by a human sperm up to, but not including, the first mitotic division, outside the body of a woman for the purposes of research or training in ART. Section 11 of the RIHE Act prohibits the use, outside the body of a woman, of a human embryo created by fertilisation of a human egg by a human sperm that is not an excess ART embryo for a purpose unrelated to the ART treatment of a woman. [1]

20.3 PARENTAGE ISSUES IN AID AND IVF

In June 1981 the Standing Committee of Attorneys-General agreed to prepare legislation in their various states and the territories to clarify the legal status of children conceived by AID. They agreed also that the identity of sperm donors should never be revealed and that the donors should not have any legal relationship with children resulting from their donations. In October 1983 the Commonwealth amended the *Family Law Act 1975* (Cth) to achieve the latter recommendations with the limitations of its Commonwealth powers. Now that children born as a result of AID and other artificial conception procedures are attaining adulthood, many are showing interest in identifying their biological origins, interest which raises many ethical, social and legal issues. One response has been legislation in the Victoria *Infertility Treatment Act 1995* ss 62–82, which required certain details of donors to be recorded and granted limited rights of access to this information to children born as the result of RT procedures.

Section 60H of the Commonwealth *Family Law Act 1975* sets out the outcomes achieved by state legislation concerning the status of 'children born as a result of artificial conception procedures':

60H.

(1) If:

(a) a child is born to a woman as a result of the carrying out of an artificial conception procedure while the woman was married to a man; and

(b) either of the following paragraphs apply:

(i) The procedure was carried out with their consent;

(ii) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of the woman and of the man; then,

whether or not the child is biologically a child of the woman and of the man, the child is their child for the purposes of this Act.

(2) If:
  (a) a child is born to a woman as a result of the carrying out of an artificial conception procedure; and
  (b) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of the woman; then, whether or not the child is biologically a child of the woman, the child is her child for the purposes of this Act.

(3) If:
  (a) a child is born to a woman as a result of the carrying out of an artificial conception procedure; and
  (b) under a prescribed law of the Commonwealth or of a State or Territory, the child is a child of a man; then, whether or not the child is biologically a child of the man, the child is his child for the purposes of this Act.

(4) If a person lives with another person as the husband or wife of the first-mentioned person on a genuine domestic basis although not legally married to that person, subsection (1) applies in relation to them as if:
  (a) they were married to each other; and
  (b) neither person were married to any other person.

(5) For the purposes of subsection (1), a person is to be presumed to have consented to an artificial conception procedure being carried out unless it is proved, on the balance of probabilities, that the person did not consent.

20.4 SURROGATE MOTHERHOOD

Surrogate motherhood refers to the practice whereby a woman, often a relative, agrees to be inseminated naturally or artificially with the gamete of another woman's husband, bear the child and then give the child to the other woman for its upbringing. A variant of surrogacy includes the in-vitro fertilisation of a woman, using gametes from a husband and wife, on the understanding that the offspring will be given over to the husband and wife as their child.

One effect of the status of children legislation and the amendment to the *Family Law Act 1975*, as set out above, is that RT procedures lead to legal relationships contrary to the intentions of those undertaking surrogacy arrangements. This legislation establishes that the woman who gives birth to the child is, in law, the child's mother and, if she is married, her husband is the father.

Although surrogacy has been practised legally in some parts of the world, the Australian community has been reluctant to approve of it, to the extent that Victoria, Queensland, South Australia, Tasmania and the Australian Capital Territory have legislation that prohibits commercial surrogacy contracts. In Queensland and South Australia, voluntary surrogacy agreements are also illegal

while in Tasmania the same ends are met by declaring all surrogacy agreements void. In the Australian Capital Territory a sister/sister surrogacy occurred within the definition of its *Substitute Parent Agreements Act 1994*. This Act differentiated between 'substitute parent agreements' and 'commercial substitute parent agreements'. In 2000, as the result of a widely publicised case, amendments were made in related legislation that enabled commissioning parents who are genetically related to the child born through a surrogate motherhood arrangement to be registered as the child's legal parents. These amendments have been retained in the Australian Capital Territory *Parentage Act 2004*, which also banned commercial surrogacy and criminalised advertising surrogacy and third-party procurement of surrogacy. In Victoria, the *Assisted Reproductive Technology Act 2008* will regulate non-commercial surrogacy via the new Patient Review Panel.

In the NHMRC *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research*, the Australian Health Ethics Committee declined to issue ethical advice in regard to surrogacy, instead stating that this topic, together with the similarly controversial topics of sex selection of embryos and the possibility of genetic manipulation of embryos, deserved further community debate and consideration by elected governments. An appendix to the guidelines provided an outline of reasons both in favour of and against the use of surrogacy [1].

20.5 *FAMILY LAW ACT 1975* (Cth)

This Act is a Commonwealth Act that applies to all states and the territories of Australia. The Family Court is a federal court and was created to administer and to exercise the powers contained in the *Family Law Act 1975* (Cth). The Family Court has jurisdiction at first instance, exercised in all states other than Western Australia, and appellate jurisdiction, which is Australia-wide. It has at least one registry in each state. The Act is administered in Western Australia by the Family Court of Western Australia created by the *Family Court Act 1997* and funded by the federal government. Proceedings in all jurisdictions are heard in closed court and usually neither the judge nor counsel wears robes. The Act is primarily concerned with marriage breakdown and divorce and enables orders to be made in regard to maintenance of a spouse or child, custody or access to children, property settlement and financial agreements. It provides for the enforcing of court orders and for the parties to a marriage to have joint custody of each of the children of their marriage until the children attain 18 years of age. The latter may be very relevant to the issue of consent for procedures on minors. The paramount consideration of the Family Court is the welfare of the child.

Section 69W of the *Family Law Act 1995* (Cth) enables the Family Court to make orders for carrying out of parentage-testing procedures for the purpose of assisting in determining the parentage of a child. Such orders may be made in

relation to the child, the mother and any other person whom the court considers the test might assist in determining parentage. Persons 18 years and older who refuse to obey such an order are not liable to any penalty, but the court may draw such inferences as appear just in the circumstances. The Act also empowers the Family Court to authorise special medical procedures in children (see Chapter 4).

20.6 CHILD ABUSE AND CHILD PROTECTION

Child abuse can be physical, sexual or emotional, or involve neglect. Doctors are in a position where they can usefully contribute to the detection of such offences and to the protection of children at risk, but are more likely to do so if they are aware of their legal responsibility and maintain reasonable levels of clinical suspicion. Doctors who fail to consider the possibility of child abuse in children who present with repeated or unexplained injuries or illnesses, or with emotional disturbances, have been subjects of criticism by coroners and medical boards.

All states and territories have enacted laws to provide protection for children from abuse by placing a mandatory responsibility on doctors and others to report suspected child abuse and providing protection from civil litigation when such reports are made in good faith. This duty extends also to other health professionals and in Victoria to teachers and police. Under the relevant legislation, reporting must be done immediately in Queensland, as soon as practicable in Australian Capital Territory, New South Wales, the Northern Territory, South Australia and Victoria, and as soon as possible in Tasmania. In Western Australia, the legislation provides immunity from civil action to those who report alleged child abuse in good faith.

Section 162 of the Victorian *Children, Youth and Families Act 2005* lists the following as grounds for a child to require protection:

- the child has been abandoned and no other suitable person can be found to care for the child
- the child's parents are dead or incapacitated and no other suitable person can be found to care for the child
- the child has suffered or is likely to suffer significant harm from physical injury or sexual abuse
- the child has suffered or is likely to suffer emotional or psychological harm of such a kind that the child's emotional or intellectual development is likely to be significantly damaged
- the child's physical development or health has been or is likely to be significantly harmed and the parents have not provided or are unlikely to provide basic or effective medical, surgical or other care.

Any belief of sexual abuse or physical injury that results from abuse or neglect must be reported. Sexual abuse occurs when any person uses his or her power over the child to involve that child in sexual activity. Sexual abuse can involve a wide

Table 20.2 Notification of suspected child abuse

State	Authority to be notified	Relevant legislation
New South Wales	Chief Executive of Family Services or Police	*Children and Young Persons (Care and Protection) Act 1998*
Victoria	Secretary of the Department or Police	*Children, Youth and Families Act 2005*
Queensland	Department of Child Safety or Police	*Child Protection Act 1999*
South Australia	Department of Family and Community Services or Police	*Children's Protection Act 1993*
Western Australia	Department for Child Protection or Police	*Children and Community Services Act 2004*
Tasmania	Secretary, Department of Health and Human Services or Police	*Children, Young Persons and Their Families Act 1997*
Northern Territory	Minister for Community Welfare or Police	*Community Welfare Act 1983* *Care and Protection of Children Act 2007*
Australian Capital Territory	Chief Executive, Family Services or Police	*Children and Young People Act 1999*

range of sexual activity, including fondling, masturbation, voyeurism, exposure to pornography and sexual intercourse. Children are unable to give proper consent to sexual activity because of their dependence and developmental immaturity. Physical injury that results from abuse may be caused by striking, shaking, burning, squeezing or assault with a weapon. Neglect that results in physical injury may be caused by lack of supervision or lack of protection to the child.

In 2005, the Victorian Government amended the *Coroner's Act 1985* to introduce a new system for dealing with multiple child deaths. The legislation provides that, where there has been a second or subsequent death of a child to a parent, this death is 'reviewable' by the state coroner. The Act creates an obligation on medical practitioners (and others) to report such cases to the coroner.

Child protection agencies provide resources to assist health professionals in identifying and responding to possible child abuse. For example, a number of valuable publications are available from the Western Australia Department of Child Protection at http://www.community.wa.gov.au/DCP/Resources/Child± Protection/#neglect. In Victoria, the Victorian Forensic Paediatric Medical Service provides a range of resources and a 24-hour consultative service (http://www.vfpms.org.au). The Australian Institute for Health and Welfare (AIHW) supports a national child protection clearing house at http://www.aifs.gov.au/nch/

and AIHW published a detailed report entitled *Child Protection Australia 2006–07*, which provides comprehensive information on state and territory child protection and support services, available at http://www.aihw.gov.au/publications/index.cfm/title/1. Notification must also be made by the staff of the Family Court if they suspect abuse or believe a child is at risk of being abused. Notifications are to be made to the relevant state or territory authority. These authorities are listed in Table 20.2.

References

1. National Health and Medical Research Council. *Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research*. NHMRC, 2004 (amended in 2007). http://www.nhmrc.gov.au/health_ethics/health/art.htm
2. Reproductive Technology Accreditation Committee of the Fertility Society of Australia. *Code of Practice for Units using In Vitro Fertilisation and Related Reproductive Technologies*. http://www.fsa.au.com/rtac/

21 TERMINATION OF PREGNANCY AND RELATED ISSUES

This chapter focuses on the legal aspects of termination of pregnancy (abortion) in Australia and the issues of child destruction, concealment of birth and infanticide. Abortion may raise serious ethical questions for the doctor, consideration of which may be influenced by personal and religious beliefs. This chapter does not attempt to address the complex ethical, social and community considerations surrounding abortion but an extensive bibliography is provided.

21.1 ABORTION – HISTORICAL BACKGROUND

The criminal law relating to abortion in Australia varies from state to state. With the exception of the Australian Capital Territory, and more recently Victoria, procuring a miscarriage is a criminal offence to which there is a defence if certain criteria (see below) set by law are met. The law in the Australian states and the territories had its origin in British law where the *Miscarriage of Women Act 1803* made it a capital offence for any person 'unlawfully to administer any noxious and destructive substance or thing with intent to procure, the miscarriage of a woman "quick" with child'. Later the offence was extended to include the period prior to quickening.

The law of abortion protected the fetus *in utero* and the law of homicide protected the infant after birth, but during the process of birth itself, the fetus did not have the protection of the criminal law. To fill this gap the *Infant Life (Preservation) Act 1929* (UK) was passed to create the offence of 'child destruction'. The Act provided that a person is not guilty of 'causing a child to die before it has an existence independent of its mother' if it could be proved that 'the act which caused the death of the child was done in good faith for the purpose only of preserving the life of the mother'. In 1938 Mr Justice Macnaghten, in the UK case of *R v Bourne* [1], adopted this concept

of preservation of the life of the mother in determining the circumstances in which an abortion could be said to be lawful and said:

> if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances and in the honest belief, operates, is operating for the purpose of preserving the life of the woman. [1]

In 1967, the *Abortion Act* was passed in England. It laid down the grounds and conditions under which the termination of pregnancy would be lawful. In brief, the legality of abortion under the Act depends upon two doctors forming the opinion in good faith that either there is a risk to the life of the woman or a risk of injury to her physical and mental health or of any existing children of her family greater than if the pregnancy were terminated, or that there is substantial risk of serious abnormality in the child. The passage of this legislation may have influenced some key decisions made by Australian courts shortly thereafter.

21.2 ABORTION LAW IN AUSTRALIA

Abortion was decriminalised in the Australian Capital Territory in 2002 and in Victoria in 2008. In the remaining jurisdictions, the law and its current interpretation is based primarily on the case of *R v Davidson* [2]. Dr Davidson was prosecuted in 1969 in the Supreme Court of Victoria on five counts of abortion contrary to section 65 of the *Crimes Act 1958* of Victoria, which made it a felony to 'unlawfully' procure, or attempt to procure, an abortion. The trial judge, Mr Justice Menhennit, reviewed the then relevant legislation and decisions in Great Britain and Australia and gave the following ruling on the meaning of the term 'unlawfulness' as it then applied:

> On the basis of all the foregoing, I accordingly decide that the relevant law in relation to unlawfulness is as follows:
>
> For the use of an instrument with intent to procure a miscarriage to be lawful the accused must have honestly believed on reasonable grounds that the act done by him was
>
> (a) necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and
>
> (b) in the circumstances not out of proportion to the danger to be averted [2].

The jury acquitted Dr Davidson on all five counts of abortion.

In 1972, again in Victoria, Southwell J applied similar reasoning at the trial of a doctor on eight counts of abortion. Six of these women were teenagers and single, and the remaining two women were separated from their husbands. Expert medical witnesses for the defence all agreed that to refuse to terminate 'a single teenage girl's pregnancy of less than twelve weeks would expose her to serious risk of substantial injury to her physical and mental health'. They expressed the same view about the two separated married women. The doctor was acquitted on one charge and the jury could not agree on the others [3].

In 1972 Levine J in *R v Wald and Others* examined the meaning of 'unlawful' in the *Crimes Act 1900* of New South Wales and said:

> The accused must have had an honest belief on reasonable grounds that what they did was necessary to preserve the women involved from serious danger to their life, or physical or mental health, which the continuance of the pregnancy would entail, not merely the normal dangers of pregnancy and child birth, and that in the circumstances the danger of the operation was not out of proportion to the danger intended to be averted. The Crown of course bears the onus of establishing that the operations were unlawful. [4]

In addition to the preceding case law, which guides doctors in the 'common law state' of New South Wales, 'the criminal code states' of Western Australia, Tasmania, South Australia, Queensland and the Northern Territory have legislative provisions, closely aligned with the above common law decisions, to guide doctors concerning the lawfulness or otherwise of abortion. The Northern Territory has provisions under its *Criminal Code Act 1983* and the *Medical Services Act 1982*. Section 11 of the latter Act in the Northern Territory provides for different justifications according to the stage of the pregnancy. In Queensland, the *Criminal Code Act 1899* permits abortion where the doctor acts in good faith for the 'preservation of the mother's life'. In Tasmania, the *Criminal Code Act 1924* permits abortion where two doctors (one an obstetrician) certify in writing that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated.

In Western Australia, under the *Criminal Code* and the *Health Act 1911*, abortion is illegal other than where the woman would suffer serious personal, family or social consequences, or suffer serious danger to her physical or mental health, or where the pregnancy is already causing serious danger to her physical or mental health. As in other jurisdictions, informed consent is required, but in Western Australia this carries the legislative rider that counselling in regard to the risks of abortion and other options open to the mother must be provided by a doctor other than the treating doctor.

In 1969, South Australia amended section 82(a) of its *Criminal Law Consolidation Act 1935* to provide that two doctors must personally examine the woman and form the opinion either that the continuance of the pregnancy would involve

greater risk to her life or physical or mental health than would its termination, or that there is a substantial risk that the child, if born, would be seriously handicapped, either physically or mentally. If they form either of these opinions, the abortion may be carried out but only in a hospital. It is specifically declared that in forming their opinion the doctors may take into account the woman's present and foreseeable future environment.

It should be noted that only the South Australian legislation expressly permits abortion on the grounds of fetal abnormality. In other states, although in practice severe fetal abnormality is a common reason that abortion is considered, meeting the legislative requirements must focus on the risks to the mother [5]. In those jurisdictions in which abortion is still covered by the criminal code, an abortion will not be regarded as lawful solely because the:

- mother is in difficult economic circumstances
- conception was the result of a rape
- fetus has an abnormality
- mother is single or a teenager
- birth will cause the marriage or relationship to break up
- existence of the baby will have a deleterious effect on the existing children
- mother wishes it.

These factors, however, may well be relevant to a jury in assessing the necessity of the abortion in preserving the woman from a serious danger to her life or her present or future physical or mental health. While prosecutions against properly qualified practitioners are rare* [6] and unlikely to be successful, doctors must be aware that the law to be applied is general and the involvement of a jury means there can be no certainty of outcome in the trial should a doctor be charged.

21.3 THE LAW IN AUSTRALIAN CAPITAL TERRITORY AND VICTORIA

In the Australian Capital Territory, abortion was decriminalised in 2002 with the passage of the *Crimes (Abolition of Abortion) Act*, provided that the procedure is performed by a doctor in a licensed facility. In Victoria, abortion was decriminalised by the passing of the *Abortion Law Reform Act 2008*. The Act permits a registered medical practitioner to perform an abortion on a woman who is not more than 24 weeks pregnant. Beyond 24 weeks of pregnancy, abortion is permitted if the doctor 'reasonably believes that the abortion is appropriate in all the circumstances' and has consulted another doctor who forms the same

* In a New South Wales' case in 2006, a doctor was found guilty of using a drug to unlawfully procure a miscarriage [6]. The punishment was to enter into a good behaviour bond. The finding appears to have been based primarily on the failure of the doctor to make sufficient assessment so as to form a belief on reasonable grounds that the termination was medically necessary.

reasonable belief. Section 8 of the Act addresses the obligations of registered health practitioners who have conscientious objections (see below).

21.4 ABORTION AND CONSCIENTIOUS OBJECTION

While doctors who conscientiously object to abortion cannot be forced to undertake, or participate in the procuring of, an abortion, there is an ethical (and in Victoria a legal) obligation to inform patients of that conscientious objection and ensure that patients are not denied or delayed access to another doctor who does not have a conscientious objection to abortion. Section 8 of the *Abortion Law Reform Act 2008* in Victoria provides as follows:

> (1) If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must:
> (a) inform the woman that the practitioner has a conscientious objection to abortion; and
> (b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.
> (2) Subsection (1) does not apply to a practitioner who is under a duty set out in subsection (3) or (4).
> (3) Despite any conscientious objection to abortion, a registered medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.
> (4) Despite any conscientious objection to abortion, a registered nurse is under a duty to assist a registered medical practitioner in performing an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

In addition, there is a professional obligation on doctors who conscientiously object to abortion to not deny pregnant women access to screening tests (tests that could detect a fetal abnormality leading to consideration of termination of the pregnancy).

21.5 PROPORTIONALITY OF RISK

The issue of proportionality of risk to the mother must always be addressed by the doctor – are the dangers being averted by the abortion greater than the normal dangers of pregnancy? On this basis, a first trimester abortion cannot be justified simply by reference to the mortality of abortion and the mortality of pregnancy. There must be some other serious danger to the life or physical or mental health of the mother over and above the normal dangers of pregnancy. If such serious

danger exists in the first trimester, there will probably be no difficulty in meeting the proportionality criteria because of the relative risks to life of abortion and the continuance of pregnancy to term. In the second or third trimester, the risks of termination to the life of the woman and to her physical and mental health increase. The risks to life now probably exceed the risks of continuing a normal pregnancy and thus, to satisfy the proportionality criterion, the seriousness of the threat to the woman's physical or mental health of continuing the pregnancy would have to be more substantial than would be sufficient to justify an abortion in the first trimester. All of this assumes that when one talks about dangers to be averted, one is only talking about the mother. This assumption is probably correct since in criminal law the fetus has no standing. A jury may, however, take another view.

21.6 LATE TERM (THIRD TRIMESTER) ABORTION

Despite the existence of child destruction laws, third-trimester abortions are performed in some states without prosecution, presumably because they are considered to have met the foregoing conditions described for legal abortion, viz. of imminent danger to the wellbeing of the mother. In Victoria, in response to a request from the Health Minister, the Medical Practitioners Board in 1998 produced a detailed report on the ethical and clinical practice issues of late-term termination of pregnancy entitled *Report on Late Term Terminations of Pregnancy* [7] and in the same year issued guidelines for such procedures as follows:

1. All pregnant women should be informed of the availability of and be offered access to appropriate and timely foetal diagnostic services.
2. If late term terminations of pregnancy are to be performed, they should only be done in facilities able to provide immediate resuscitation and response to life threatening complications, including appropriate ongoing management.
3. If late term terminations of pregnancy are to be performed, they should only be done by clinical units which consist of appropriately trained medical practitioners in conjunction with other health professionals, including specialist nursing staff, ultrasonographers, clinical geneticists and counsellors. The clinical units should also have the ability to consult other specialists where necessary.

The Board would also commend all measures to minimise the risk of termination being delayed until late term. To this end, it is recommended that all women seeking advice about pregnancy should have access to appropriate pre-pregnancy counselling and timely specialist foetal diagnostic services. [8]

The report, which predates the recent changes to abortion law in Victoria, noted that terminations of pregnancy at or beyond 20 weeks gestation are performed in two of the three major obstetric hospitals in the state and are carried

out for serious fetal abnormality or life-threatening maternal illness, on the grounds of being necessary to preserve the mother from a serious danger to her physical or mental health [7]. The report emphasised the broad specialist services involved in the care of the mother and recommended that the standards of practice in place in those hospitals should be the minimum standards expected by an institution performing terminations of pregnancy at or beyond 20 weeks in Victoria. Both institutions provided comprehensive care of the mother, encompassing her physical and emotional needs and those of her family, with careful regard for the grieving process and the respectful handling of the delivered fetus. Under the provisions of the Victorian *Births, Deaths and Marriages Registration Act 1959*, if a fetus dies at or after the 20th week of pregnancy or weighs 400 grams or more, it must be registered as a stillborn child. At these two hospitals, late-term terminations of pregnancy are therefore registered as births and a perinatal death certificate is completed, in accordance with the requirements of the law. On the basis of its public consultation process, the Board observed that 'it is unlikely that the ethical and moral issues related to late term termination can be resolved in view of the strongly held and widely diverse views of individuals and organisations within the community' [7].

21.7 CHILD DESTRUCTION

The crime of child destruction is a felony and exists in all states and the territories. It relates to infants who are capable of being born alive or are in the process of being born. Such infants are not protected by the definition of murder, which requires that the child exists independently of the mother before being killed. The offence overlaps the law against abortion. Unlike the offence of infanticide, which applies only to the mother, the offence of child destruction may apply to any other person who 'with intent to destroy the life of a child capable of being born alive, by any wilful act unlawfully causes such child to die before it has an existence independent of its mother' [9]. It is prima facie proof in most state and territory Acts that the child was 'capable of being born alive' if its mother had 'been pregnant for a period of twenty-eight weeks or more'. The maximum penalties are those for murder.

21.8 CONCEALMENT OF BIRTH

This offence is contained in legislation in all the states and the territories. The maximum penalty varies from 2 to 3 years' imprisonment and the provisions in all Acts are very similar. As an example, section 83 of the *Criminal Law Consolidation Act 1935–1980* of South Australia prescribes:

> (1) Any person who by any secret disposition of the dead body of a child, whether such child died before, at, or after its birth, endeavours to conceal

the birth thereof, shall be guilty of a misdemeanour and liable to be imprisoned for any term not exceeding three years.

(2) If upon the trial of any person for the murder of a child recently born, the jury is not satisfied that the accused is guilty of murder or manslaughter, but is satisfied that such accused is guilty of an offence against subsection (1), it shall be lawful for the jury to return a verdict of 'guilty of concealment of birth' and thereupon the accused shall be liable to be punished in the same manner as if convicted on an information under subsection (1).

Unlike infanticide, it is not necessary to prove that the child was alive and capable of separate existence at its birth.

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5. Gleeson K. Bracket creep in Australian abortion indications: When did rubella arrive? *Journal of Law and Medicine* 2007; 15: 423–33.
6. *R v Sood* (2006) NSWSC 1141.
7. Medical Practitioners Board of Victoria. *Report on Late Term Terminations of Pregnancy*. http://www.dhs.vic.gov.au/ahs/archive/report/report.pdf
8. Medical Practitioners Board of Victoria, *Annual Report 1998*, p. 36. http://www.medicalboardvic.org.au/pdf/AR_1998.pdf
9. *Crimes Act 1958* (Vic), s 10.

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22 WITHHOLDING OR WITHDRAWING TREATMENT IN THE SERIOUSLY OR TERMINALLY ILL

The capacity to save lives through advances in treatments, especially the use of intensive care and life-support systems, is one of the 'miracles of modern medicine'. However, these advances have created ethical and legal questions for the medical profession, legislators, the courts and the community. Some of these questions have been resolved by new legislation, for example the redefining of death to include brain death and the separate laws that give force to advance care directives. Other questions have been addressed by new ethical guidelines, for example in regard to the care of patients in post-coma unresponsiveness (previously known as the 'vegetative state'). Further questions continue to confront the community, for example the ongoing debate about euthanasia. This chapter outlines the law and the professional and legal responsibilities of doctors in these areas, but does not enter into the wider social, ethical and philosophical debate surrounding euthanasia.

22.1 TREATMENT DECISIONS FOR NEWBORN INFANTS

Technological advances have created ethical dilemmas for parents and for doctors caring for extremely premature or severely malformed newborn infants [1–2]. In 1986 in *F v F* in the Supreme Court of Victoria, Mr Justice Vincent observed:

> No parent, no doctor, no court, has any power to determine that the life of any child, however disabled that child may be, will be deliberately taken from it. [3]

However, the law does recognise the responsibilities of parents, in conjunction with treating doctors, to decide whether medical intervention will commence or continue. The reserve power of the Supreme Courts of the states to overrule such decisions has rarely been used in Australia but may be requested when parents and doctors, or members of the health-care team, are in disagreement, or seek authorisation for a proposed course of action. Internationally

paediatricians have developed codes of practice that forbid hastening death but allow selective treatment or non-treatment, the guiding principle being the consideration of the best interests of the infant, having regard to the future quality of life of the infant, the benefits and burdens of treatment and whether the treatment is futile [4]. In Australia, Yu has described three principles of selective non-treatment relating to (1) when death is considered inevitable, (2) when severe physical or mental disability is likely if the child survives, and (3) when survival is likely to lead to a life of intolerably poor quality, particularly involving persistent pain [1–2].

In reaching agreed decisions regarding the treatment of extremely premature or severely malformed infants, informed parental involvement is essential. It is important that the following roles are clear: the doctor should act in the best interests of the infant patient and as medical adviser to the parents, while the parents have legal responsibilities to act on behalf of their child. If it is decided that treatment should be withheld or withdrawn, adequate palliative care must continue. Throughout the decision-making and palliative care processes, continuing support for the parents is required and members of the health-care team should be involved in all these stages [1–2, 4–5]. As discussed below, there are uncommon situations that demand additional efforts on the part of the doctor and the health-care team.

Where differences of view between family and treating doctors have led to common law decisions in the courts, the courts have considered the best interests of the child and aspects including present and future quality of life, the futility of current treatment and examination of the burdens and benefits of present and future treatment [4]. Consideration of such issues in discussion with parents may assist decision making in this ethically difficult area.

22.2 WITHHOLDING OR WITHDRAWING TREATMENT FROM CHILDREN

Similar approaches to those described above for the newborn apply also in decisions related to children. As discussed in detail in Chapter 4, the primary decision makers in the treatment of children are the parents although, as the child matures, the wishes of the child also need to be taken into consideration.

Uncommonly, situations arise where parents refuse to consent to the treatment that the doctor advises, or demand treatment that the doctor believes is not in the best interests of the child. In such situations, the doctor needs to do one or more of the following: spend more time discussing all the relevant issues with the parents and other members of the health-care team, offer the parents a second medical opinion, ensure that all possible sources of support for the parents are made available, discuss the matter with a clinical ethics committee and, as a last

resort, refer the matter to the guardianship authority or apply to the relevant court [6].

22.3 REFUSAL OF MEDICAL TREATMENT

Competent patients are entitled to refuse medical treatment or to have medical treatment withdrawn even though such refusal or withdrawal may lead to death. Generally speaking those who act on behalf of incompetent patients are able to make such decisions so long as they are acting in the best interests of the patient, although some doubt exists as to these powers in New South Wales (see also Chapter 4). The availability of technology to maintain or prolong life, and the ageing of the population, with a rising incidence of dementia and associated incompetence to make personal decisions about health care, have created ethical dilemmas that have been addressed in part by legislation. Concerns about the legal position of attending doctors caring for patients who have refused treatment, and a desire to support autonomous decisions of patients in refusing medical treatment, have led to the enactment of legislation or amendment of guardianship legislation in most Australian jurisdictions (see Tables 22.1 and 4.1). The need for legislation has also been driven by the community sense that some terminally ill patients have been treated too aggressively or that treatment has become burdensome for little or no gain, in addition to the perceived need to restore patient autonomy in the face of technological advances that may be unduly prolonging life, and to protect the interests of doctors who might be accused of either prematurely withdrawing treatment from, or of over-treatment of, the terminally ill.

The South Australian *Consent to Medical Treatment and Palliative Care Act 1995* allows adults of sound mind to give advance directives about accepting or refusing treatment in relation to a terminal illness or the persistent vegetative state. A certificate must be completed and witnessed by another person as designated under the Act. The *Natural Death Act 1988* of the Northern Territory provides for adults of sound mind who are terminally ill to refuse extraordinary treatment measures, while the *Medical Treatment (Health Directions) Act 2006* of the Australian Capital Territory enables adults to refuse or withdraw from medical treatment, preferably documented in writing, but other modes of communicating this decision are valid if witnessed.

The availability of technology to maintain or prolong life, and the ageing of the population, with a rising incidence of dementia and associated incompetence to make personal decisions about health care, have created ethical dilemmas that have been addressed in part by legislation. In developing this legislation, parliaments have heeded concern that the legislation might be used to promote euthanasia and thus the legislation typically does not cover refusal or withdrawal of palliative care. Palliative care is defined in the Victoria legislation as 'the provision of reasonable medical procedures for relief of pain, suffering and discomfort

or the reasonable provision of food and water'. In Victoria, the interpretation of palliative care has been examined in the courts [7] and the court determined that feeding provided by percutaneous gastric tube was medical treatment and not palliative care. The legislation also typically provides for the completion of 'advance care directives' or 'refusal of treatment certificates'.

22.4 ADVANCE CARE PLANS AND DIRECTIVES

Advance care planning provides for a comprehensive approach to what treatment and care a patient desires, or does not desire, in future situations in which the patient may become unable to express his or her wishes. Sometimes, advance care plans include advance care directives, commonly in the form of directives that specified treatment not be provided in designated clinical situations. The ethical and legal premise of such directives is that they give effect to the person's wishes at a time when those wishes cannot otherwise be established. In ethics, this allows for respect for autonomy and in law, the right of a competent person to refuse treatment.

Some advance care directives take the form of appointing a person to make the decision at the requisite time. Implementing such directives involves giving effect to the patient's wishes and is, in ethics, referred to as one of substituted judgment. The decision maker decides what the patient would have decided. By contrast, where the wishes of the patient are not known or are not applicable to the new clinical situation, the decision maker must apply a best interests standard; that is, the decision maker decides, in his or her opinion, what is in the patient's best interests. These two ethical bases for decisions – substituted judgment and best interests – are not always kept distinct but it is prudent to attend to them.

The common law has long recognised the right of a patient to make an advance care directive in regard to medical treatment should the person become incompetent. This is now reinforced in law in most states (Table 22.1). In New South Wales, the Department of Health has issued guidelines [8] for doctors (see below) which are linked to the New South Wales Guardianship legislative framework. Advance care directives have also been known as 'living wills'. Advance care plans are based on the ethical principles of respect for the dignity and autonomy of dying patients. In Victoria the *Medical Treatment Act 1988* also provides for a 'refusal of treatment' certificate, which must be signed by two witnesses, the doctor and another person. This Victoria certificate relates only to medical conditions current at the time of signing and thus may not be of use at a later date. The refusal can be withdrawn verbally by the patient at any time to anyone. A doctor acting in good faith in pursuance of a certificate is not guilty of any offence, acquires no civil liability and cannot be proceeded against by the Medical Practitioners Board of Victoria. A doctor who undertakes, or continues to undertake, any

Table 22.1 Legislation regarding advance care directives and refusal of treatment

State or territory	Relevant legislation
Victoria	*Medical Treatment Act 1988*
Queensland	*Powers of Attorney Act 1998*
South Australia	*Consent to Medical Treatment and Palliative Care Act 1995*
Western Australia	*Guardianship and Administration Act 1990* [as amended by *Acts Amendment (Consent to Medical Treatment) Act 2008,* but amendment not promulgated at time of writing]
Northern Territory	*Natural Death Act 1988*
Australian Capital Territory	*Medical Treatment (Health Directions) Act 2006*

medical treatment to which the certificate applies commits a new offence of medical trespass.

More information about advance health care directives and any relevant forms may be found on the guardianship website in each jurisdiction (see Table 4.1 in Chapter 4).

In New South Wales, the Health Department 2004 guidelines *Using Advance Care Directives* [8] confirm the common law position stated above. The guidelines provide advice to doctors on best practice in advance care planning and the use of advance care directives. Similar advice is available on some state guardianship websites. The key issues canvassed in the New South Wales guidelines include the importance of developing health-care plans as people approach the end of their lives, the aims of advance care planning, the purpose of advance care directives, recommendations about best practice and advice about documentation of advance care plans.

Surveys have shown that plans and directives are not consistently prepared in Australian hospitals, in contrast with the USA where it is a legal requirement that a patient being admitted to a hospital or nursing home must be asked if a plan or directive has been completed [9]. Doctors have a role to play in assisting patients (and, if the patient agrees, the family) to discuss and finalise advance care plans, but lack of time and discomfiture in discussing such matters militates against consistent good practice [9]. In assisting often elderly and ill patients to complete a directive, the doctor also must judge the competence of the patient. The test of competence is whether the patient understands the nature and purpose of any treatment that is to be refused [10–11].

Where a treating doctor is provided with an advance care directive that has been completed and witnessed as required by law, the treating doctor does not need to determine if the patient was competent and adequately informed at the

time of signing or if the directive was made voluntarily. However, the treating doctor must examine whether the directive covers the clinical situation now confronted. This may involve discussion with family members who may be able to clarify the patient's wishes about oral directives, and may even require legal or guardianship board advice. If doubt exists as to what the patient's wishes are in the current clinical situation, the patient's best interests must guide decision making [10].

As advance care directives become more commonly used, a number of practical issues for doctors will emerge. One such issue is the length of time for which an advance care directive is valid. The law appears to be silent on this issue. Provided with an advance care directive, doctors should assure themselves that the directive conforms with the legislation in their jurisdiction and examine whether the directive clearly applies to, or clearly anticipated, the clinical situation now faced (10). In Victoria, copies of 'refusal of treatment' certificates are required to be sent to the Victorian Civil and Administrative Tribunal, and in South Australia medical powers of attorney can be registered centrally. In the absence of a central register and where no advance directive is held by the hospital, doctors should inquire of immediate family and friends as to whether such a document exists.

Many terminal illnesses are steadily progressive and there is usually time for the patient (if competent) or the patient's representative to communicate fully with the treating doctor and other members of the health-care team and to come to terms with what is appropriate treatment. This may be more problematic where the course of the illness is less predictable, for example where people with severe brain damage are recovering from coma and decisions have to be made about continuing treatment to support life.

22.5 POST-COMA UNRESPONSIVENESS

The diagnosis and appropriate management of patients with what in the past has been known as a 'vegetative state' raise difficult clinical and ethical issues for health professionals and for the families concerned. In response to a request from the New South Wales Health Department, the National Health and Medical Research Council has issued two key documents to guide clinicians in the diagnosis and ongoing care of such people [12–13]. The request arose following a New South Wales Supreme Court decision in which the judge found deficiencies in a hospital's policies and procedures that were exacerbated by the lack of national guidelines [14]. In suggesting the new name of 'post-coma unresponsiveness', the NHMRC pointed out that it was desirable to move away from the pejorative term 'vegetative' and that it wished to separate post-coma states from the unresponsiveness seen in the terminal phase of some progressive illnesses.

The NHMRC defines post-coma unresponsiveness (PCU) as:

> generally applying to patients emerging from coma in an apparently wakeful unconscious state in which there is:
> 1. a complete lack of responses that suggest a cognitive component preservation of sleep–wake cycles and cardio-respiratory function
> 2. partial or complete preservation of hypothalamic and brain-stem autonomic functions [12].

In its diagnostic guidelines, the NHMRC recognised 'that, while PCU as a clinical entity is conceptually well defined, it may be difficult to differentiate from other conditions that follow severe brain damage, which form part of a spectrum of impaired responsiveness' [12].

While the law has been involved at times both in Australia and elsewhere to determine the issue of withdrawal of medical care, including withdrawal of nasogastric and percutaneous tube feeding [7, 14–15], these national guidelines, if followed, should greatly reduce the need of families or doctors to have recourse to the courts.

The NHMRC management guidelines issued in 2008 as *Ethical Guidelines for the Care of People in Post-Coma Unresponsiveness (Vegetative State) or a Minimally Responsive State* emphasise that the diagnosis must not be considered before a minimum of 4 weeks after the appearance of unresponsive wakefulness and that the diagnosis and any estimate of prognosis made after that should be regarded as provisional, to be reviewed at regular intervals [13]. The guidelines cover the responsibilities of the patient's representative (in particular to pay attention to the person's best interests) and the weight to attach to past expressions of the patient's wishes. Treating clinicians have the ethical responsibility to ensure that care and treatment are serving identified medical goals and that the treatment is neither futile nor unduly burdensome. In determining who is to act as the patient's representative, guardianship legislation, allied in some states with legislation allowing patients or their agents to refuse medical treatment, provides the appropriate mechanisms (see the discussion of refusal of treatment above and also Chapter 4).

22.6 'NOT FOR RESUSCITATION' ORDERS

The use of cardiopulmonary resuscitation (CPR), particularly when hospitalised patients with serious underlying conditions deteriorate suddenly, also raises ethical and legal issues. Concern has been expressed that CPR is at times used without clinical justification (that is, where the natural process of dying should have been allowed to proceed); that decisions not to resuscitate are made without input from the patient or the family and by a single member of the health-care team, and that

decisions about 'not for resuscitation' are not clearly documented. Failure of documentation frequently contributes to inappropriate CPR. Most, but still not all, hospitals have established guidelines for medical and nursing staff to assist them in this difficult area. Many use a standardised format, which has been shown to improve conformity with local NFR policies, while some have also prepared helpful patient information leaflets [16]. The 1994 published guidelines of the John Hunter Hospital in Newcastle, New South Wales, are [17]:

1. A no-CPR order should always involve appropriate members of the health care team (eg nurses, allied health professional, medical staff) in the decision making, although the final decision remains the responsibility of the senior attending medical officer.
2. A no-CPR order should be recorded as a formal order in the patient's progress notes in a clear and unambiguous manner.
3. A no-CPR order should incorporate a brief description of discussions with the patient and/or family members, and
   (a) a statement of the patient's wishes (when the patient is competent) or
   (b) the role of the family/surrogate (when the patient is incompetent).
4. Where a decision has been made not to involve a patient or surrogate in decisions regarding resuscitation status, an explanation should be provided in the progress notes as to the rationale underlying this decision.
5. Any no-CPR order should include a statement of the medical condition to justify a no-CPR order.
6. Any no-CPR order should include a statement about the scope of the order, specifying the management plan (curative and/or palliative) subsequent to the no-CPR order.
7. Any no-CPR order should be subject to review on a regular basis and can be rescinded at any time. Any review should be implemented and documented in the patient's progress notes in the manner specified above.

In 1994, Eburn summarised the circumstances in which CPR may be lawfully withheld as [18]:

1. Where there is a competent patient who has expressly refused consent to the treatment, and that refusal was informed, valid, continues and covers the situation which has in fact arisen.
2. Where there is an incompetent patient and a legally appointed agent or guardian has refused consent to treatment in accordance with the powers granted to them.
3. Where there is an incompetent patient and no person able to consent or refuse consent to the treatment and, in the reasonable opinion of the treating medical practitioners, the treatment would be futile or otherwise not in the best interest of the patient.
4. The patient is dead.

22.7 EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

The capacity for doctors to deliberately end the life of patients by medical means has long existed, but euthanasia has become a topic of great interest only in recent decades. Possible explanations proposed include the availability and use of modern technology to prolong life of poor quality and making death no longer a natural and uncontrolled event. Others have pointed to the increasing emphasis on patient autonomy, which, together with the advance of medicine, has made the timing of death much more a matter for decision. While community and professional attitudes to euthanasia may be gradually changing, and indeed the legal position was changed for a short period in one Australian jurisdiction, the ethical opposition of the medical profession has not altered and in all Australian jurisdictions the deliberate ending of another person's life remains murder.

22.7.1 The law on killing

A person who kills another person, either intending to kill or intending to cause serious bodily harm, is guilty of murder. There exist defences against a charge of murder, including self-defence, which defences if established may lead to acquittal. If provocation is established or if it is established that the accused did not intend to kill the victim or did not intend to cause serious bodily harm, the lesser charge of manslaughter applies.

22.7.2 The terminology of euthanasia

The word 'euthanasia' in its original use meant an easy and gentle death and did not imply that there was an active role for doctors in bringing about that death. In its modern or popular use, it has come to mean a positive act by a doctor to end the life of a patient who is terminally ill and in distress. Euthanasia is to be distinguished from suicide in that another person, other than the patient, is involved. Professional and public debate about euthanasia is frequently accompanied by misuse or misunderstanding of terminology on which there is little international agreement. For example, some speak of active voluntary euthanasia, which others refer to as physician-assisted suicide, while yet others speak of passive euthanasia or 'mercy killing' even where the intent of those prescribing medications is clearly to provide appropriate palliative care. In addition many participants in the debate appear to be ignorant of, or to wilfully ignore, the well-recognised pharmacological tolerance that can develop rapidly for narcotic drugs.

We use the following definitions:

- Voluntary euthanasia means that the patient has requested or consented to a medical intervention designed to cause or hasten death.
- Involuntary euthanasia means the positive act of killing a patient where the patient's wishes are ignored, unknown or unknowable.

- Assisted suicide refers to the provision by a doctor of the means by which patients can take their own lives and covers such things as providing a patient-controlled computer program for the intravenous infusion of a lethal dose of a drug.
- Passive euthanasia refers to withdrawing all care, including food and water, and allowing the patient to die.

22.8 THE STATED POSITION OF THE MEDICAL PROFESSION

The formal position adopted by both the World Medical Association (WMA) and the Australian Medical Association (AMA) clearly indicates opposition to the practice by doctors of voluntary or involuntary euthanasia and assisted suicide. In Madrid in 1987 the WMA adopted the following declaration on euthanasia [19]:

> Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.

In 1992 at its meeting in Marbella in Spain the WMA promulgated the following Statement on Physician-Assisted Suicide:

> Instances of physician-assisted suicide have recently become the focus of public attention. These instances involve the use of a machine, invented by the physician who instructs the individual in its use. The individual thereby is assisted in committing suicide. In other instances the physician has provided medication to the individual with information as to the amount of dosage that would be lethal. The individual is thereby provided with the means for committing suicide. To be sure, the individuals involved were seriously ill, perhaps even terminally ill, and were wracked with pain. Furthermore, the individuals were apparently competent and made their own decision to commit suicide. Patients contemplating suicide are frequently expressing the depression that accompanies terminal illness.
>
> Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient. [20]

In 2007, the Australian Medical Association (AMA) issued an updated statement of policy on euthanasia [21]. It is a detailed document designed to advise doctors very broadly about caring for patients who are dying. While recognising that some doctors support the concept of physician-assisted suicide, the AMA policy continues to reject such a role for doctors. In contrast, in 2005, in the context of a UK parliamentary debate on proposed legalisation of physician-assisted suicide, the British Medical Association, which had previously opposed euthanasia, declared a neutral stance [22]. Subsequently, a postal survey of 3733 doctors in the UK revealed that approximately two-thirds of doctors responding were opposed to the legalisation of euthanasia and physician-assisted suicide [23].

In addition, it must be stressed that it is unethical to fail to provide adequate terminal and palliative care to patients. A doctor who fails to identify and respond to the needs of a terminally ill patient, for example by denying the patient access to modern methods of pain control or access to available palliative care services, is open to disciplinary action. In providing appropriate treatment to relieve distressing symptoms, it is recognised that such treatment may hasten a patient's death (known as the principle of double effect). Provided the primary aim of treatment is symptom relief, a doctor is not at risk of ethical or legal sanction [24].

22.8.1 The present legal position in Australia

In all Australian states taking active steps to assist a patient to die, by for example giving a lethal infusion or providing patients with a lethal supply of drugs for ingestion, may constitute murder. While a person who commits suicide is not guilty of a crime in Australia, it is unlawful for a doctor, or anyone else, to assist a patient to commit suicide. In New South Wales, under the *Crimes Act 1900* it is an offence to aid or abet suicide. The Victorian *Crimes Act 1958* provides that a person who assists a party to commit suicide is guilty of a criminal offence. However, in 1995 seven Victoria doctors who publicised their involvement in voluntary euthanasia were not prosecuted or subjected to disciplinary action as evidence of their actions was not accessible.

22.8.2 The law in other countries

In the Netherlands, guidelines were approved by parliament in 1993 to regulate active voluntary euthanasia and assisted suicide and did so by stipulating conditions that need to be met for doctors to avoid prosecution. These guidelines were reviewed and revised twice but in 2002 were replaced by legislation. A survey of doctors in the Netherlands undertaken in 2005 reported that 1.7% of all deaths were the result of euthanasia and 0.1% the result of physician-assisted suicide [25]. In Belgium and in the US state of Oregon physician-assisted suicide is legal under guidelines similar to those in the Netherlands.

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23 THE LAW AND THE MENTALLY ILL

Legislation to guide the care of the mentally ill is society's means of resolving the conflict between an individual's right to liberty and the need to ensure care for those whose illness renders them incapable of making rational choices and places them at risk of causing harm to themselves or others [1]. The state also has a duty to provide care for people who have lost the capacity to recognise their need for treatment. Society continues to struggle with achieving the right balance in this conflict, and responses have swung from excessive use of powers of constraint and treatment on the one hand to an overzealous and insufficiently discriminating grant of individual freedom on the other. The former can result in denial of human rights to freedom while the latter can result in inadequate treatment and protection of severely mentally ill people.

In most states, the provision of resources and the organisation of services for the mentally ill have been progressively changed in response to the National Mental Health Strategy agreed by state and Commonwealth governments in 1992. This strategy emphasised minimisation of institutional care, the concept of the least restrictive modes of treatment and care, provision of multidisciplinary community-based care designed to assist people with a mental disorder to live, work and participate in the community, and the 'mainstreaming' of psychiatric care (placing psychiatric hospitals in general hospital environments). Although widely supported by the health professions and the community, the effectiveness of this new 'paradigm' depended on adequate funding, which has not been forthcoming.

Additionally, the rights of the mentally ill have been the subject of a national study, *Human Rights and Mental Illness*, issued by Human Rights Commissioner Brian Burdekin in 1993, known also as the Burdekin Report [2]. This report emphasised the need to deinstitutionalise mentally ill people where possible. It also highlighted discrimination against the mentally ill and made recommendations about admission processes, the use of drugs in treatment, the privacy rights of patients and the need for independent review procedures.

Table 23.1 Mental health legislation and mental health review tribunals

State	Legislation	Tribunal
New South Wales	*Mental Health Act 2007*	Mental Health Review Tribunal http://www.mhrt.nsw.gov.au/
Victoria	*Mental Health Act 1986*	Mental Health Review Board http://www.mhrb.vic.gov.au/
Queensland	*Mental Health Act 2000*	Mental Health Review Tribunal http://www.mhrt.qld.gov.au/
South Australia	*Mental Health Act 1993*	Guardianship Board http://www.agd.sa.gov.au/services/tribunals.php
Western Australia	*Mental Health Act 1996*	Mental Health Review Board http://www.mhrbwa.org.au/contact
Tasmania	*Mental Health Act 1996*	Mental Health Tribunal http://www.mentalhealthtribunal.tas.gov.au/
Northern Territory	*Mental Health and Related Services Act 1998*	Mental Health Review Tribunal http://www.nt.gov.au/justice/courtsupp/mentalhealth/
Australian Capital Territory	*Mental Health (Treatment and Care) Act 1994*	Mental Health Tribunal http://www.courts.act.gov.au/magistrates/tribunals/mht/mhthome.htm

Prior to the National Mental Health Strategy agreement in 1992 and the Burdekin Report most states had taken steps to clearly separate the care of the mentally ill from the care of the intellectually disabled. A brief summary of the legislation pertaining to aspects of the care of the intellectually disabled is given in Chapter 4 and the present chapter concerns only the mentally ill.

All Australian state and territory governments have enacted specific legislation governing the care of the mentally ill and the relevant Acts are listed in Table 23.1. The basic aims of the various Acts are similar but there are considerable differences of detail. This chapter should not be relied upon as an authoritative guide to the detail contained in these Acts.

Although psychiatrists and other mental health professionals have specialised knowledge and skill in the care of the mentally ill, all practising doctors should be capable of recognising serious mental disorder. Any doctor may be called upon to determine whether a person is so mentally ill that the person should be hospitalised against their wishes. It is important therefore that doctors be familiar with the

principles and concepts of the mental health legislation on which this judgment is to be made and with special aspects of the relevant legislation in the state or territory in which they practise.

23.1 DEFINITION OF MENTAL ILLNESS

The lack of uniformity between the states becomes immediately apparent when the definition of mental illness is sought. In New South Wales and the Australian Capital Territory legislation, mental illness is defined in detail while in Victoria the *Mental Health Act 1986* defines mental illness in one sentence: 'A person is mentally ill if he or she has a mental illness, being a mental condition that is characterised by a significant disturbance of thought, mood, perception or memory.' Similar brief definitions apply in Queensland and Western Australia, while in South Australia 'mental illness means any illness or disorder of the mind'.

The New South Wales *Mental Health Act 2007* defines mental illness as a condition:

> that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: (a) delusions, (b) hallucinations, (c) serious disorder of thought form, (d) a severe disturbance of mood, (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

Similar definitions apply in Tasmania, the Australian Capital Territory and the Northern Territory. In some legislation an additional state of 'mental disorder' (New South Wales), 'mental dysfunction' (the Australian Capital Territory) or 'mental disturbance' (the Northern Territory) is defined, so that the legislation can be used to temporarily detain people at risk where their dysfunction is due to an illness other than a mental illness. The Northern Territory Act puts this succinctly as follows: mentally disturbed means 'behaviour of a person that is so irrational as to justify the person being temporarily detained under this Act'. The New South Wales *Mental Health Act 2007* prescribes that:

> a person (whether or not the person is suffering from mental illness) is mentally disordered if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary: (a) for the person's own protection from serious harm; or (b) for the protection of others from serious harm.

With the exception of Western Australia, the mental health Acts also declare a large number of behaviours as not necessarily representing mental illness. These include expressions or refusals of expression of particular political opinion or belief, religious opinion or belief, philosophy, sexual preference or orientation;

and engagement or refusal to engage in particular political activity, religious activity, sexual promiscuity or illegal conduct; or if a person has a developmental disability of mind, has taken alcohol or any other drug or has engaged in antisocial behaviour.

The foregoing is a summary only and good professional practice in this area requires knowledge of the law in the jurisdiction or the seeking of informed advice.

23.2 ADMISSION PROCEDURES

A major focus of mental health legislation is on the processes to be followed to admit a mentally ill person to hospital and, once admitted, to retain such a person in hospital against their will. This is termed 'involuntary admission' or 'involuntary detention' and applies to patients admitted for their own protection or to prevent deterioration in their health or to protect others. These involuntary patients are distinguished from the larger proportion of patients who seek admission voluntarily and enjoy the same rights as a person admitted to a general hospital for a medical or surgical illness. The care and treatment of voluntarily admitted patients will not be discussed further in this chapter, except to note that if the mental health of a voluntarily admitted patient deteriorates and the patient becomes a risk to themselves or others, the admission may be converted to an involuntary one, provided the appropriate steps are followed.

23.3 INVOLUNTARY ADMISSION

The legislation in all states and territories provides a very similar framework for involuntary admission and detention of mentally ill patients. Most Acts provide for admission to public psychiatric facilities, not private psychiatric hospitals, although in Victoria the Act specifies 'approved mental health services' and in some other jurisdictions there are provisions for involuntary detention in private psychiatric facilities. There is also provision for involuntary detention orders to be extended to general hospital care, to allow for instances where an involuntary patient requires transfer to a general hospital for treatment, diagnostic tests or surgery that is not available in the psychiatric hospital. The following elements are common to statutory involuntary procedures:

- A relative, friend or authorised person must request that a person be involuntarily admitted.
- This request is to be supported by an assessment or recommendation made by an independent doctor.
- The independent recommending doctor must have personally and recently examined the patient and determined that the person is mentally ill and that the only appropriate care is via detention in a psychiatric hospital. The doctor is required to conduct a mental state examination and to record the evidence

confirming that the person has a mental illness within the meaning of the law of the jurisdiction.

- The doctor's assessment may include observations made by other people, but the assessment must clearly distinguish these observations from the doctor's own observations. The recommendation or certificate of the doctor remains in force for a limited period – days only – primarily to avoid wasteful repetition of assessment when patients abscond between assessment and admission.
- Reasonable force may be used by police, ambulance personnel and others to take recommended patients to psychiatric hospitals. The *Mental Health Act 1986* of Victoria identifies the type of doctor who may administer sedatives to assist in transporting patients; this includes general practitioners, medical officers in psychiatry, forensic physicians and directors of emergency departments.
- Upon admission, a patient must be further examined by a qualified psychiatrist in usually less than 24 hours for the purpose of verifying that the person is mentally ill and requires involuntary detention for treatment.
- The periods of involuntary detention have strict limits, at which time formal review of the need for continuing detention must occur.
- Appeal processes against involuntary detention exist (see below) and patients must be informed of these processes and the means of access to them.

The legal requirements that the assessing psychiatrist must meet to authorise continuing detention are similar in principle although worded differently in each state. For example in the Australian Capital Territory, the Act requires that the psychiatrist must believe that the person is unable through mental illness or mental dysfunction to make reasonable judgments or take necessary steps to look after his or her own health or safety and so is at substantial risk or likely to do serious harm to others.

23.4 USE OF SECLUSION AND RESTRAINT

Involuntary patients may be secluded or physically restrained under provisions legislated in Victoria, Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory when they are assessed as being a serious risk to themselves or staff. The legislation calls for strict continuous professional monitoring of such isolated patients.

23.5 PEOPLE INCAPABLE OF CARING FOR THEMSELVES

Concerned citizens may at times identify other members of the community who appear to be incapable of caring for themselves, by virtue of mental illness or other incapacity. In most states, mental health or guardianship legislation provides for a response to these concerns (see also Chapter 4). The citizen may appeal to

the police or to a magistrate and this will lead to a visit, usually by a police officer accompanied by a doctor, to assess the situation and, if necessary, make recommendation for involuntary detention or other arrangements for care. In most states, urgent assistance is also available from 'crisis assessment teams' provided on a regional basis by the state mental health authority.

23.6 COMMUNITY TREATMENT ORDERS

To meet the aims that as far as possible mentally ill people are treated in the least restrictive manner within their community and not in institutions, the legislation in all states provides for community treatment orders. The making of such orders implies these elements:

- a diagnosis of a mental illness requiring the need of compulsion to accept treatment
- an assessment that neither the patient nor the community is at serious physical risk if the patient is not detained in a psychiatric hospital
- a structure or organisation that permits monitoring of the treatment of the patient.

A person placed under a community treatment order is, from a legal view point, an 'involuntary' patient, but one who does not require detention in an institution. Should the person not comply with the order, the order may be revoked and the person admitted or readmitted to hospital.

23.7 SECURITY ADMISSIONS

One of the more serious dilemmas for the community is the management of a mentally ill person or a person of psychopathic disposition who has been charged or convicted of serious crime and who continues to pose a risk to the community. This dilemma led New South Wales and Victoria to pass specific legislation to detain individuals who were perceived to be a danger to the community but who could not be legally or safely detained under the provisions of the respective mental health Acts. In Victoria there are provisions for courts to make an order, based upon psychiatric reports and other evidence, that a person found guilty of a criminal offence may be detained as an involuntary patient. In addition, the Director-General of Corrections has the power to transfer prisoners to psychiatric inpatient services.

23.8 PATIENTS' RIGHTS

The continued improvement of the standard of care for mentally ill members of society has occurred in parallel to increased awareness of the rights of mentally ill

people, which are now incorporated in legislation in most states. This legislation covers such matters as:

- the provision of a printed statement of rights when a person is admitted to a psychiatric hospital. This statement will outline appeal provisions (see below) and include the names, addresses and telephone numbers of people and organisations that may be of assistance to the patient.
- access to legal advice and representation
- access to a friend and the right to be represented by a friend
- contact with people by telephone and letter
- the right to withdraw and spend money
- the right to complain
- the right to another psychiatric opinion.

23.9 COMMUNITY AND OFFICIAL VISITORS

To assist in protecting the rights of mentally ill people who may be socially isolated or unable to access assistance and advice, the legislation in most states provides for the appointment of 'official visitors' or 'community visitors' to psychiatric hospitals. In New South Wales and Victoria, these visitors are appointed to particular hospitals, while in Queensland each health region must have a minimum of two official visitors, one with legal knowledge and one with special knowledge of mental health. Visitors are to attend psychiatric hospitals regularly to assess facilities, services and patient wellbeing, and to be available to respond to complaints. Patients are able to access the official visitor without hindrance. Where possible, official visitors are expected to attempt to resolve a problem locally, but they do have the power to take problems to a higher authority and are expected to report regularly to that higher authority.

23.10 SPECIAL TREATMENT PROCEDURES

The mental health legislation in most states provides specific controls over the practice of psychosurgery, electroconvulsive therapy (ECT), insulin-induced coma and deep-sleep therapy. Psychosurgery is defined under the Victoria *Mental Health Act 1986* as follows:

> (a) any surgical technique or procedure by which one or more lesions are created in a person's brain on the same or on separate occasions primarily for the purpose of altering the thoughts, emotions or behaviour of that person; or
> (b) the use of intracerebral electrodes to create one or more lesions in a person's brain on the same or on separate occasions primarily for the purpose of altering the thoughts, emotions or behaviour of that person; or

(c) the use of intracerebral electrodes to cause stimulation through the electrodes on the same or on separate occasions without creating a lesion in the person's brain for the purpose of influencing or altering the thoughts, emotions or behaviour of that person.

In Victoria, Queensland, South Australia, Western Australia and the Australian Capital Territory, the relevant Act lays down the steps to be followed before psychosurgery may proceed. In New South Wales and the Northern Territory, psychosurgery is prohibited. In those states where it is permitted, the legislation demands the consent of the patient as well as approval by an additional authority. That authority in Victoria is the Psychosurgery Review Board, in Queensland and South Australia is the Mental Health Review Board and in the Australian Capital Territory is the approval of the Chief Psychiatrist after receiving advice from an expert committee.

The legislation in regard to ECT is less restrictive than for psychosurgery, and focuses particularly on the adequacy of the information provided to patients and their ability to consent. In New South Wales, for voluntarily patients, in addition to their consent, two doctors (one a psychiatrist) must agree that ECT is necessary. For incompetent patients unable to consent, ECT can be authorised by the Guardianship Board in South Australia, and the Mental Health Tribunal in New South Wales and the Australian Capital Territory. In Victoria, the authorised psychiatrist may order ECT if this is deemed urgent, the patient is involuntarily detained and the guardian or primary carer cannot be contacted. In South Australia emergency ECT may be given without waiting for the authority of the Guardianship Board.

Insulin-induced coma and deep-sleep therapy are prohibited by legislation in New South Wales, Queensland, Western Australia and the Northern Territory.

23.11 CONSENT TO NON-PSYCHIATRIC TREATMENT

Involuntarily admitted patients may experience other non-psychiatric illnesses that require treatment. In seeking consent for such treatment, the doctor is entitled to and should first seek consent directly from the patient, as mental illness will not necessarily invalidate such consent. Where valid consent cannot be obtained from the patient, the state guardianship provisions apply, other than where emergency life-saving measures are needed (see Chapter 4) or where the *Mental Health Act*, as in New South Wales, Victoria, Western Australia and Northern Territory, provides specific guidance to consent for non-psychiatric treatment.

23.12 REVIEW AND APPEAL PROCEDURES

An appeal or review procedure to protect patient's rights is legislated for in all state Acts and can be accessed by patients, their representatives or official

community visitors. There are also provisions for automatic review of detained patients at regular intervals by the review tribunal or board. Such mental health review tribunals have wide-ranging powers. For example in New South Wales, the tribunal has a wide jurisdiction, and conducts both civil and forensic hearings. In its civil hearings, the tribunal may:

1. make Involuntary Patient Orders authorising the continued involuntary detention of a person made an involuntary patient by a Magistrate's Order
2. review involuntary patients in mental health facilities, usually every three or six months, and in appropriate cases every 12 months
3. review voluntary patients in mental health facilities, usually every 12 months
4. hear appeals against an authorised medical officer's refusal to discharge an involuntary patient
5. make, vary and revoke Community Treatment Orders
6. hear appeals against a magistrate's decision to make a community treatment order
7. approve the use of ECT for involuntary patients
8. determine if voluntary patients have consented to ECT
9. approve surgery on a patient detained in a mental health facility
10. approve special medical treatment (sterilisation)
11. make and revoke orders under the Protected Estates Act for a person's financial affairs to be managed by the Protective Commissioner.

The tribunal also reviews the cases of all forensic patients:

- who have been found not guilty by reason of mental illness
- who have been found unfit to be tried
- who have been transferred from prison to hospital because of a mental illness.

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24 THE LAW AND COURTS OF LAW IN AUSTRALIA

This chapter summarises for doctors the sources and forms of the law and the structure and roles of courts and tribunals in Australia. The constitutions of the Australian states and the *Commonwealth of Australia Constitution Act 1900* derived their authority from legislation passed in the United Kingdom Parliament. That Parliament in theory was able to amend the Australian Constitution until 3 March 1986 when the *Australia Act 1986* came into operation by a proclamation signed by the Queen on that date. The *Australia Act 1986* terminated the power of the Parliament of the United Kingdom to legislate for the Commonwealth of Australia or its states and territories. It also ended the links that had existed between the Australian court system and the English court system by terminating the right of appeal to the Privy Council from either the High Court of Australia or the Supreme Courts of the states [1–2].

24.1 SOURCES AND FORMS OF LAW IN AUSTRALIA

The two main sources and forms of law in Australia are legislation and the common law. Legislation comprises laws made by parliament, or regulations or other types of delegated legislation made by some other person or body authorised by parliament to so do. Laws passed by parliament are embodied in printed documents called Acts of Parliament or statutes. Common law consists of the principles developed by judges in cases that come before them and includes the vast body of unenacted law developed by the English courts over many hundreds of years. In recent decades, superior courts in Australia (state Supreme Courts, the Federal Court and the High Court of Australia) have also referred to and relied on case law from other countries sharing the same English common law heritage, such as Canada, New Zealand and, to a lesser extent, the United States of America. In Australian health law, important developments have been influenced by case law from these countries.

24.2 LEGISLATION

Legislation, or statute law, will always prevail over the common law, however ancient and celebrated [2]. This is a clear expression of the democratic foundations of the United Kingdom, the Australian states and the Australian Commonwealth. A statute of the United Kingdom Parliament was defined as a document that had received the threefold assent of the Sovereign, Lords and Commons. The Constitution of the Commonwealth of Australia established a similar law-making trinity comprising the Governor-General, the Senate and the House of Representatives. Thus legislation must be passed by both houses and then assented to by the Governor-General before it becomes law. Similarly, the constitutions of the states (other than Queensland, which abolished its upper house in 1922) established comparable trinities in the Governor, the Legislative Council and the Legislative Assembly.

24.3 THE AUSTRALIAN FEDERATION

Australia is a federation of self-governing states and territories and has nine legislatures that generate large quantities of laws each year. The federal constitution that establishes the Commonwealth gives to the Australian Parliament capacity to make laws 'with respect' to a designated list of subject matters, for example trade and commerce, taxation, naval and military defence, post and telegraphs, copyright and divorce. A law made by the Australian Parliament is valid only if it can be characterised as a law 'with respect' to one of those subjects.

By contrast, the constitutions of the states and territories give their parliaments power to make law on any subject, usually expressed as laws 'for the peace, order and good government' of the jurisdiction. In response to the prospect of inconsistency between state and Commonwealth laws, the Australian Constitution provides that, in the event of conflict, Commonwealth laws prevail to the extent of the inconsistency. In the health field, the Federal Parliament has no explicit power to make laws, other than with respect to pharmaceutical, sickness and hospital benefits, leaving the substantive regulation to the states and territories. At the same time, the Commonwealth exercises control over provision of financial assistance to the states and territories and through this exercises significant influence.

The constitutional structure has been the source of much litigation, especially in challenging the validity of Commonwealth legislation. In more recent years, cooperative arrangements such as the Council of Australian Governments (COAG) and the Australian Health Ministers Conference and its advisory body, the Australian Health Ministers Advisory Council, as well as the Standing Committee of Attorneys-General have addressed issues of shared state, territory and Commonwealth significance.

24.4 CODIFICATION

Codification is the term applied to legislation that is intended to cover all the law on a particular subject, replacing all previous statutes and common law on the matter. Australian examples are the criminal codes of Queensland, Western Australia, Tasmania and the Northern Territory. These codes replace all previous common law and consolidate all the pre-existing legislation on such matters, and the jurisdictions are referred to as the 'code jurisdictions'. By contrast, the criminal law of the other states and territories, referred to as 'common law jurisdictions', is contained both in statutes and common law.

24.5 SUBORDINATE LEGISLATION

Although parliament is the source of legislation, its practice is to delegate the making of some of its legislation to other bodies. Parliaments do not ordinarily include comprehensive detail in Acts, which usually state broad matters of policy and delegate power to another person or body to make regulations (subordinate legislation) that supply the necessary operational detail. Acts usually empower the Governor-in-Council, or the appropriate minister, to make subordinate legislation to facilitate the enforcement of the provisions of the Act. Subordinate legislation has the same force and effect as the Act itself and overrides the common law. It may be called by various names, but those commonly used are regulations or statutory rules. These regulations and rules must be made within the limits of the authority given in the Act itself, otherwise they can be declared by a court to be *ultra vires* ('outside the powers') and invalid. Acts that establish statutory authorities for the control of particular governmental undertakings confer on those authorities the power to make regulations or by-laws for specific purposes related to such undertakings [2]. Examples of some such authorities are city councils, hospital boards, electricity trusts and water supply commissions.

24.6 SCHEDULES

While the individual sections of an Act usually deal with matters of more or less broad principle, there are times when it is necessary to include considerable detail within an Act. For these purposes it is a common practice to use a schedule as part of an Act or a set of regulations. An example of this practice is the 700-page Medical Benefits Schedule containing the details of medical benefits payable that is part of the Commonwealth *Health Insurance Act*. Schedules are often used to set out the forms of certificates or other documents prescribed under an Act or its regulations.

24.7 COMMON LAW: COLONIAL ORIGINS

When the colonies that later became the states of the Australian federation were first established, the law that was declared by the colonial power, England, was as much of the common law of England as was suitable to the colonial situation. This body of law was referred to as 'common law' because it applied to all people, as opposed to those laws made in England that applied only to specific categories of the English population.

At their commencement, the colonies had no power to make their own laws; this came later with self-government. Thus the courts established by the colonial power used and developed this body of law applying the same techniques and approaches they had learned in England. After self-government, the common law remained part of the laws, and as developed by the courts of the colonies, later the states, continues to be part of Australian law. It is still referred to as the common law, on the basis that it is applicable across the nation, although from time to time, through judicial response to the endless variety of case situations, some minor differences have emerged between states and territories.

24.8 COMMON LAW: THE PRACTICE OF PRECEDENT

For several centuries English judges in handing down judgments have set out in some detail the reasons for their decisions. At first, simple records were kept of the more important decisions, but this developed into an elaborate system of law reporting to ensure the preservation of the facts of the case and the reasoned judgments given, from which the principles of law were developed. When a new case came before a judge for decision, and it resembled one that had been decided before, the earlier decision was used as a guide. In time, this reliance on prior decisions became an identifying characteristic of the common law system. At the same time, and in order to retain a balance among consistency, predictability and flexibility to respond to new situations, the practice involved the development of a sophisticated and complex form of argumentation and justification. These features are tied in complex but essential ways to the adversary process of adjudication, also a distinguishing feature of the common law, discussed in Chapter 25.

Judges who have to decide cases generally regard themselves as bound to follow earlier decisions (precedents) of courts of higher authority. This has obvious advantages as unrestricted ad hoc judicial decision making could produce chaos. Close adherence to established rules permits a measure of predictability and planning for the future. It is not surprising, therefore, that the courts have developed rules of precedent, which set out how judges are to take account of the reasoning and conclusions of earlier decisions.

24.9 COMMON LAW: THE STRUCTURE OF PRECEDENT

In each Australian jurisdiction there is a hierarchy of courts. What is distinctive about the doctrine of precedent in common law is that not only are the reasoning and decisions in earlier cases considered in the course of deciding later similar cases, but also, within a hierarchy of courts, decisions by courts higher in that hierarchy are regarded as binding authorities and must be followed by the courts lower in that hierarchy. By contrast, the reasoning and decisions of other courts at the same level in the hierarchy, or in similar courts in other states or common law jurisdictions such as the United Kingdom, Canada and the United States of America, are treated as persuasive authorities. For example, a decision of the Supreme Court of Victoria will be binding on a County Court and Magistrates' Court of that state, but will only be of persuasive authority in such courts in other states of Australia. Similarly, the Supreme Court of Victoria is generally bound by decisions of the High Court, but will regard decisions of the English High Court, Court of Appeal or House of Lords as only of persuasive authority.

Where an injustice may result from following a binding precedent that is argued to be applicable, the court may find that the facts in the new case are sufficiently different from those on which the precedent was based for it to be able to distinguish the two cases 'on the facts'. The common law practice and structure of precedent apply in both civil and criminal divisions of the law. However, it would not be practical to rely on the common law system as the sole source of law for a nation as the development of the law depends on the issues in the cases that are brought to the courts. The fact that the origins of the common law lie in the past and that some of its rules are the product of different societies from our present one is in judges' considerations when they decide cases. Over time, precedent is gradually adapted to contemporary conditions, admittedly often lagging some way behind. Increasingly, in modern Australia, where the common law system diverges sufficiently from contemporary attitudes, legislative action is taken by parliament.

24.10 TYPES OF AUSTRALIAN LAW: CIVIL AND CRIMINAL LAW

In Saxon England no clear distinction was made between private and public wrongs. During and after the Norman era, a distinction came to be drawn between the civil law, which dealt with disputes between private people, and the criminal law, which dealt with offences against the King's Peace. In general terms, the civil law protected rights, while the criminal law punished wrongs. Civil law in its most common use means all that law which is not primarily related to crime. Criminal law is concerned with what are called criminal offences or crimes. Its purpose is

to regulate society by specifying that certain acts and omissions are unlawful and punishable. The historical echo of being offensive to the King's Peace is retained in that criminal offences are so characterised because they are offensive to any member of a society. The criminal courts are mainly concerned with adjudicating on the prosecution of offences and determining suitable punishment. On the other hand, courts acting in their civil jurisdiction adjudicate on whether there has been an infringement of the rights of the claimant and, if so, the appropriate remedy, often the award of damages as compensation. Some conduct can give rise to both criminal prosecution and civil action.

24.11 COMMON LAW AND EQUITY

Another distinction that remains important is that between common law and equity. Historically, the practice emerged whereby by the king, and later his Lord Chancellor, intervened in the outcomes of court processes that had been gained by conduct that may have been technically lawful but was unconscionable or against good conscience. Slowly, a separate body of legal principles called equity grew, as did the court in which those principles could be relied on, namely the Chancery Court. When the Australian colonies were established, equity principles were applied in those colonies as were deemed suitable to the local situation. In all Australian jurisdictions, there are no longer separate equity courts, but the principles of equity remain important and find their modern expression in such issues as confidentiality, fiduciary obligations, unjust enrichment and undue influence.

24.12 STANDARDS OF PROOF

One important distinction between the civil and criminal jurisdictions is the different standard of proof. In criminal proceedings, the Crown, which prosecutes alleged breaches of the law, must prove the guilt of the accused 'beyond reasonable doubt', and the judge, magistrate or jury decides whether guilt has been so established. In civil proceedings, the decision is reached on the 'balance of probabilities' – that is, that a fact is accepted as true if it is more probable than not that it occurred. This civil standard of proof also applies in disciplinary tribunals such as medical tribunals (see Chapter 8).

24.13 CIVIL WRONGS: CONTRACT AND TORTS

Civil wrongs most commonly occur in contracts or torts and are 'wrongs' in the sense that they infringe upon or deny the established rights of the aggrieved party. Contracts are agreements made between two or more parties whereby enforceable legal rights and obligations are created. Contracts may be written or oral, and

express or implied. An oral agreement may be just as binding as a written one, provided it can be proved, which may be more difficult than when documentary evidence can be produced. In an express contract, the terms are spelt out in detail when the parties enter into the contract; in an implied contract, they are implied from the conduct of the parties or the customs usually adopted in such transactions. It is generally assumed that the creation of a doctor–patient relationship brings into existence an implied contract. The doctor impliedly promises to treat the patient with reasonable care and skill and to respect the professional confidentiality of information given to him or her by the patient. In return for this, the patient impliedly promises to pay the doctor a professional fee.

Torts are civil wrongs arising quite independently of any contract. Examples include negligence, defamation, nuisance and trespass. It is possible for the same circumstances to give rise both to an action in tort and an action for breach of contract. For example, doctors who have treated a patient negligently may have broken an implied term in their contract to take reasonable care, and could be liable also in an action for negligence because of a breach of their duty of care to the patient. The law of torts comprises rules that specify certain kinds of consequences of conduct and provide for compensation for those injured as a result of those consequences. One effect, similar to criminal law, is the deterrence of the behaviour, but the deterrents employed are not those of conviction and punishment, rather the threat of liability to pay damages. The essential aim of the law of torts is to compensate those who have suffered harm through the infringement of their rights by the conduct of others [2]. The elements of the tort of negligence are described in Chapter 7.

24.14 CRIMES

Crimes are divided into summary offences and indictable offences. Summary offences are those defined in legislation and are usually minor offences heard and decided by a magistrate without a jury in a Magistrates' or Local Court. Summary offences include breaches of traffic regulations, being drunk and disorderly, offences against public order or safety, some drug offences, obscene publications and some assaults. Where an Act provides for a fine, forfeiture or imprisonment for an offence and does not state in which court it may be imposed, then a court presided over by a magistrate may deal with it.

Indictable offences are also defined in legislation. They are serious offences which must be heard by a judge and jury in a superior court after a committal hearing in a Magistrates' Court. In the common law criminal jurisdictions, these offences may be a breach of either common law or statute law and include such crimes as armed robbery, rape, aggravated assault and homicide.

24.15 COURTS OF LAW IN AUSTRALIA

The *Commonwealth of Australia Constitution Act 1900* established a 'Federal Supreme Court' to be called the High Court of Australia and provided for other federal courts. All other courts of law in Australia have been created or continued in existence by an Act of a federal, state or territory parliament. The courts of law in the states and territories form a hierarchy with the courts of summary jurisdiction (the Magistrates' Courts) at the base, then courts of intermediate jurisdiction (County or District Courts) as 'inferior courts', and the state Supreme Courts and federal courts such as the Family Court and the Federal Court as 'superior courts', with the High Court of Australia at the apex [2].

24.15.1 State and territory courts

Courts of summary jurisdiction

These are courts established by state and territory legislation and are presided over by full-time paid judicial officers, who are qualified legal practitioners known as stipendiary magistrates. They are open courts and provide a relatively quick and cheap resolution of less serious civil and criminal matters. Magistrates are addressed in court as 'Your Worship'. In the territories and all states other than New South Wales these courts are called Magistrates' Courts. In New South Wales the courts are called Local Courts. Civil and criminal jurisdictions of these courts vary between the states and territories and are defined by statute. As an example, the offences triable summarily in Victoria are set out in the 4th Schedule of its *Magistrates' Court Act 1989* and among a very long list include theft where the amount or value of the property does not exceed $100 000 or is a car, handling stolen goods where the amount or value of the property does not exceed $100 000, and some indictable offences under the *Drugs, Poisons and Controlled Substances Act 1981*. In all jurisdictions, statutes ensure that defendants are not deprived of their rights to trial by jury in a higher court if they so wish.

Criminal jurisdiction: preliminary committal hearings

Courts of summary jurisdiction conduct preliminary or committal hearings to determine whether there is sufficient evidence to support the prosecution of a defendant who is charged with a serious indictable offence such as murder, theft or conspiracy. All the evidence is recorded, but publication of the proceedings may be prohibited by the magistrate if it is considered that the subsequent trial might be prejudiced. If the court is satisfied that there is sufficient evidence to warrant the accused being tried, or that it raises a strong or probable presumption of guilt, it will direct that the accused be tried in either a Supreme Court or a District (County) Court. In the interim the accused may be remanded in custody or released

on bail. If it is not so satisfied, it will discharge the accused. Committals are used to protect accused people from being put to the considerable risk and expense of defending a jury trial when there is reasonable doubt whether there could be a conviction on the available evidence. The accused rarely give evidence or call witnesses at preliminary hearings.

Children's Courts

Children's Courts are either dedicated courts or divisions of Magistrates' Courts and have jurisdiction over criminal matters involving offenders who are under 18 years of age, and determinations about the care and protection of children at risk. Only in Victoria and the Northern Territory are these courts open to the public when dealing with criminal matters. In all the states and territories, with the exception of Tasmania, the media are permitted into the court room but reports of the proceedings must not directly or indirectly reveal the identity of the child. The courts have considerably wider discretionary powers than other courts of summary jurisdiction and are not bound to observe all legal formalities in pursuit of the best outcomes for children.

Criminal charges can be brought against children from the age of criminal responsibility to 17 or 18 years of age. The age of criminal responsibility is 10 years in all states and the Northern Territory but is 8 years in the Australian Capital Territory. The types of orders that can be given include reprimands, bonds, fines, community service work, training courses, supervision or suspended sentences. The advantages of these types of orders are that they empower the courts to impose reasonable conditions and directions on parents, guardians and children without the stigma of a recorded conviction.

One important function of the Children's Court is to attempt to rehabilitate and reform offenders. Most first-time offenders receive bonds or verbal reprimands or are released on probation for periods between 12 months and 3 years, but can extend until the child reaches 18 years on the discretion of the magistrate. The court may also impose a supervision order that empowers the supervising probation officer to impose reasonable conditions and directions on the parents or guardians, as well as on the child. As a last resort, children under the age of 15 years may be admitted to the care of the Community Welfare Services Department of a state, and those aged 15 years or over may be detained in a youth training centre for a specified period of time.

The power of Children's Courts to hear indictable offences differs in each state and territory, but in most jurisdictions it is usual for indictable offences to be passed on to a higher court. Care and protection matters typically relate to children of all ages. The types of orders that may be given include supervision, custody to a third party, an interim protection order, or a permanent care order.

Coroner's Courts

Coroners and Coroner's Courts are established by legislation in all states and territories and continue the office of Coroner, one of the oldest known in English law. Coroner's Courts do not strictly fit into the hierarchy of the other courts, but are on a level with courts of summary jurisdiction.

In present-day Australia the primary function of a coroner is to investigate the cause and circumstances of death (and, in some states, fires) in a wide variety of situations, most of which do not have any criminal or even suspicious overtones. Increasingly coroners are coming to see themselves as serving a preventative function by identifying hazards in the community. In pursuit of this and for accurate information about causes of death, coroners are heavily reliant on post-mortem examinations (see also Chapter 19). Coroners have the power to order such examinations. Further functions of coroners include the formal identification of deceased people when necessary. Coroners make no final determinations on the criminal liability or otherwise of people involved in the death, but have authority to refer their findings to Crown prosecution authorities.

The conditions of appointment and the jurisdiction of coroners vary between the various states and territories. In general, all stipendiary magistrates are coroners *ex officio* for their respective states or territories. All jurisdictions have state and deputy state coroners who are required to be legal practitioners.

The coroner's inquiry is not a trial but a fact-finding inquiry. A coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner that he or she reasonably thinks fit. The coroner formally determines who may participate in the inquiry, so that lawyers acting for interested parties formally request the coroner's leave or permission to appear. The coroner sometimes appoints a lawyer to assist the inquiry. Despite this, the conduct of most inquiries resembles fairly closely that of the adversarial procedure of other courts. While inadmissible in other jurisdictions, hearsay evidence is admissible in coroners' courts.

Doctors are frequently required to attend inquests and, unless it is obvious that their conduct will not be called into question, it is probably wise for them to inform their medical defence organisation of their attendance. This action should ensure that their reputations will be properly protected should the proceedings take an unforeseen tack.

Courts of intermediate jurisdiction

The names and jurisdiction of the courts of intermediate jurisdiction vary between states. In Queensland, New South Wales, Western Australia and South Australia they are called District Courts; in Victoria they are known as County Courts. These courts are presided over by a judge sitting with a jury. Criminal cases require a jury of twelve people. The number of jurors in civil cases varies between states but is four or six people in Queensland and Victoria. In each state these

courts are headed by a chief judge. Tasmania, the Northern Territory and the Australian Capital Territory do not have courts of intermediate jurisdiction.

The jurisdiction lies between and sometimes overlaps that of the courts of summary jurisdiction and the unlimited jurisdiction of the Supreme Courts of the states and territories. In their criminal jurisdiction, the courts can try most indictable offences when accused people are committed for trial from a Magistrates' Court, but cannot try people committed for treason, murder or attempted murder. Courts of intermediate jurisdiction may also hear appeals from a Magistrates' Court.

Supreme Courts

These are superior courts and have jurisdiction over all matters, civil and criminal, within state or territory jurisdictions that have not been excluded by statute. The Supreme Courts have both an original jurisdiction to hear cases for the first time and an appellate jurisdiction to hear an appeal from a single judge who has exercised the original jurisdiction or from a court of summary or intermediate jurisdiction. In Western Australia, South Australia and the Australian Capital Territory appeals are heard before a full bench – that is, three nominated judges of the respective Supreme Courts. The court then becomes the Court of Appeal. The latter applies also for civil appeals in Victoria. Criminal cases in that state are heard in a separate Trial Division of the Supreme Court. New South Wales, Queensland and the Northern Territory have separate permanent Courts of Appeal with presidents for both civil and criminal appeals in their Supreme Courts.

Most judges of Supreme Courts are appointed from the ranks of practising barristers and are required to retire at the age of 72 years. The chief judge of the Supreme Court is the Chief Justice of that state or territory. The remaining judges are called puisne ('lesser') judges, have the title 'the Honourable Mr/Ms Justice . . . ' and are addressed in court as 'Your Honour'.

24.15.2 Commonwealth (federal) courts

High Court of Australia

The High Court of Australia sits above the highest state courts and federal courts and consists of the Chief Justice of Australia and six other High Court justices. It is the final court of appeal from the Supreme Courts of the states and territories but, in most cases, appellants must seek the court's permission (leave) to have their appeal heard. When hearing appeals, the High Court is composed of three, five or all seven of the High Court justices, depending on the importance of the questions at issue.

The High Court also has original jurisdiction in matters:

- arising under any treaty
- affecting consuls or other representatives of other countries

- in which the Commonwealth of Australia, or a person suing or being sued on behalf of the Commonwealth of Australia, is a party
- between states, or between residents of different states, or between a state and a resident of another state
- in which a writ of mandamus or prohibition or an injunction is sought against an officer of the Commonwealth of Australia.

Federal Court of Australia

This court has both an original and appellate jurisdiction in matters arising under federal law. It is a superior court of law and equity with jurisdiction extending throughout Australia.

The jurisdiction of the General Division is exercised by a single judge of the court on matters such as bankruptcy, taxation, administrative law (the body of law regulating decision making by government and government agencies), actions under the *Trade Practices Act 1974* (Cth), admiralty law and company law. There is a right of appeal from the decision of a single Federal Court judge to the 'full' Federal Court (three Federal Court judges) and from there to the High Court. It may also hear appeals from the Supreme Courts of the territories and from judges of state Supreme Courts exercising federal jurisdiction, as in taxation cases.

Industrial Relations Court of Australia

This court was established in 1994 and interprets awards and union rules, hears applications about unlawful termination or contracts, and determines cases about secondary boycotts. As a consequence of the *Workplace Relations and Other Legislation Amendment Act 1996* (Cth), the court's jurisdiction was transferred to other courts, mainly the Federal Court of Australia. In 1997 the staff and resources of the Industrial Relations Court of Australia were transferred to the Federal Court of Australia, but the Industrial Relations Court of Australia continues to exist at law until the last of its judges resigns or retires from office.

Family Court of Australia

This federal court was created to adjudicate serious disputes arising under the *Family Law Act 1975* (Cth) and to exercise the powers contained in that Act. It has original and appellate jurisdictions and has at least one registry in the capital of each state. Proceedings are heard in closed court. In most states neither the judge nor counsel wears formal court attire. (See also Chapter 20.)

The *Family Law Act 1975* (Cth) continues to use to a limited extent the state courts of summary jurisdiction for less serious matters. These courts can make consent orders for custody or access to children, grant injunctions, make orders for spouse and child maintenance, and enforce maintenance orders. Appeals from these decisions can be made to a judge of the Family Court of Australia and appeals from decisions of a single judge may be made to the Full Court, consisting

of three judges. There is a limited right of appeal from the Full Court of the Family Court of Australia to the High Court of Australia.

Federal Magistrates' Court

This court, established in 1999, is intended to provide a simpler and more accessible alternative to litigation in superior courts. It adjudicates on matters arising under Commonwealth law, such as family and child support, administrative law, human rights, consumer protection and trade practices, privacy, migration and copyright. The court shares premises with the Family Court and the Federal Court in each state and territory. In 2009, the Federal Government announced that this court would be discontinued and its functions assumed by the Federal Court.

24.16 TRIBUNALS

Administrative tribunals are established at state and federal level to determine matters on the administration of government. They have legal powers similar to those of a court but procedures are less formal. Generally the conduct of tribunals is informal, rules of evidence are less strictly interpreted and the required documentation is simpler. In some cases participants are encouraged to appear without representation. Tribunal members are not bound to follow precedent in their decision making. Compared with courts, tribunals provide easier access to the law and specialist expertise, and are cost- and time-effective.

The federal Administrative Appeals Tribunal (AAT) provides independent review of a wide range of decisions made by federal administrators. In a similar way, the Social Security Appeals Tribunal (SSAT) provides an independent review of the decisions of the Commonwealth social welfare agencies. Decisions of the SSAT may be appealed to the AAT.

States and territories have established similar bodies and there is a tendency to combine a number of tribunal functions into one body, such as the Victorian Civil and Administrative Tribunal (VCAT), with jurisdiction over a number of state or territory administrative areas. As an example, in some states doctors can apply to an administrative appeals tribunal from a decision made concerning registration or practice made by a medical board. Other tribunals include small claims tribunals, which resolve in an informal way disputes about debts below a prescribed amount, and crimes compensation tribunals, which determine the amount of compensation payable to victims of crime.

24.17 COMMONWEALTH OMBUDSMAN

The Commonwealth Ombudsman's office, established in 1976, investigates complaints about the administration of Commonwealth Government departments and agencies. Investigations are impartial, confidential and free of charge. The

Ombudsman may choose not to investigate for a variety of reasons stipulated in the Act, including a delay of more than 12 months in lodging the complaint, or that the complaint is frivolous.

The Ombudsman investigates the reason for the complaint, ensures that the agency or department is aware of all aspects of the complaint, and makes determinations as to the legality or reasonableness of the decision of action. The Ombudsman has the power to require information and summon people to give evidence, but does not have the power to force a government department or agency to overturn its decision. Instead the Ombudsman may make a recommendation, for instance that a government department reconsider its action or decision, change its procedures or pay compensation. If the recommendation is not implemented, the Ombudsman may report the matter to the prime minister or parliament.

There are state government ombudsmen and a growing number of industry scheme ombudsmen with similar functions and powers. Examples of industry ombudsmen include the Telecommunications and Banking Industry Ombudsman and the Private Health Insurance Ombudsman at the federal level, and the Victorian Electricity Ombudsman at a state level.

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25 MEDICO-LEGAL EXAMINATIONS AND REPORTS, COURT PROCEDURES AND EXPERT EVIDENCE

This chapter is designed to assist doctors in conducting medico-legal examinations and preparing medico-legal reports, and to advise doctors about appearing in court as ordinary or as expert witnesses. Problems that may arise at medico-legal examinations are first identified and advice is provided about the content and scope of medico-legal reports. After briefly describing the adversarial system used in Australian courts, the chapter is then structured around the usual sequence by which a doctor becomes aware that he or she may be required in court. Lastly, the matter of jury duty for doctors is touched upon.

25.1 MEDICO-LEGAL REPORTS

25.1.1 Treating doctors' reports

For doctors who are primarily in clinical practice, the most common involvement with the legal system will come via a request for a medico-legal report about a current or past patient, most often in the context of an insurance or workers compensation claim. The request should be accompanied by an original signed authority from the patient to release the medical information and by a letter from the solicitor describing what is requested.

In preparing medico-legal reports in regard to the diagnosis, care and treatment of a patient, doctors should take care to answer the questions asked of them and should strive to make the report factual, objective, complete and to the point. Material in the patient's records that is irrelevant to the request should not be included in the report. If the doctor has any doubt in this regard, advice should be sought from the doctor's medical indemnifier. A well-constructed medico-legal report may be sufficient for the solicitor and the court, and thus obviate the need for the doctor being called to give evidence.

A treating doctor's report is not required to contain an opinion regarding the patient's claim, although some solicitors may request comments on aetiology, diagnosis and prognosis. A treating doctor may decline to answer such

questions, especially should the doctor feel unqualified to give such an opinion. At the very least, the report should contain the patient's history, the physical findings, the investigations done, the results obtained and the treatment given. If the patient has been referred to another doctor, this should be mentioned, but it is not the task of the treating doctor to provide any report of another doctor. If the medico-legal report identifies to whom the patient was referred and when, the requesting solicitor will be able to make a decision about approaching that doctor for a report. Above all, no matter how much compassion the doctor might have for the patient, the report must not be written in a partisan manner. The weight and authority of a doctor's report lies in the professionalism with which it is composed, combining factual accuracy, medical expertise and dispassionate judgment. Some of the advice provided below in relation to expert witness reports is also relevant to treating doctors' reports.

A medico-legal report is legally privileged and must not be released to any other party without the permission of the solicitor who requested it. Despite this, doctors need to be aware that the report will usually be exchanged with solicitors for the other side and may be read by many authorised people, another reason why care and attention should be paid to the writing. Despite the pressures of medical practice, requests for reports should be handled promptly, so that a patient's claim is not jeopardised and that administrative justice is not delayed. Undue delay, unless justified, may result in medical board disciplinary action. Some medical boards have issued guidelines for medico-legal reporting [1–2], which address these professional issues and the problems that can arise from the doctor–patient interaction when medico-legal assessments are made (see below). The Australian Medical Association has also issued helpful guidelines [3].

25.1.2 Medico-legal examinations

Doctors are frequently requested by solicitors or insurers to examine patients for the purpose of providing a report that may be used to assist the solicitor or insurer in determining or pursuing a claim for compensation or the like. The cost of such examinations is not covered by Medicare and government benefits are not available. It is usual that appointments for medical examinations are first made by telephone and then confirmed by a solicitor's letter. The letter should contain a brief description of the circumstance in which the patient was harmed or injured, particulars of the harms or injuries alleged, copies of the relevant medical certificates and other medical reports, X-ray and pathology reports, and so on, together with details of the disabilities the patient claims arose out of the harms or injuries. There will usually be a series of questions included in the letter requesting advice on some or all of the following:

- the patient's physical condition with particular reference to the alleged injuries or disabilities

- whether the accident or condition could have caused the particular injuries or disabilities
- whether the patient's condition is stabilised or whether there is any prospect of further improvement or deterioration
- whether there is any residual disability and, if so, the extent of such disability
- whether any further medical treatment is indicated and, if so, an opinion concerning the probable outcome of such treatment
- whether the patient is fit for any work and, if so, what type of work
- if the patient is unfit for work, the cause of the loss of capacity for work and the degree incapacitated
- whether the doctor recommends that the patient be examined by any other specialists
- whether there are any other matters which the doctor considers relevant.

25.1.3 Content of medico-legal reports

Medico-legal reports for personal injury and negligence cases and general litigation should conform to court guidelines for expert witnesses (see below) and otherwise should include:

- the name and address of the doctor
- the solicitor's complete reference on the report and a list of all the materials relating to the report taken into account by the doctor
- a short paragraph to establish the doctor's relevant qualifications and expertise
- a written acknowledgment that any code of witness conduct (see below) provided has been read and adhered to
- the patient's full name, age, occupation and address
- the history of the patient relative to the illness or to injuries alleged to have arisen out of an accident
- the patient's present complaints
- the results of the examination of the patient
- the results of any tests or other investigations relied upon, identifying the person or service that conducted the tests
- the diagnosis of the patient's condition
- the prognosis of the patient's condition – where it is alleged that a pre-existing disease or condition has been aggravated, or that future disease or degeneration may occur, specific reference to this should be made
- the facts, matters and assumptions on which the opinion is based
- the reason(s) for the opinion
- references for any literature or other material relied upon
- the answers to the solicitor's questions
- a declaration that the doctor has made all enquiries believed to be desirable and that no matters of significance have been withheld from the court

- any qualification of an opinion expressed in the report
- whether any opinion expressed is not more than a tentative opinion because of insufficient research or lack of data or other reason
- whether any issues fall outside the area of expertise of the doctor
- a summary of the opinion.

In the interests of patients and in order to avoid duplication, it is desirable that certain specialised examinations such as X-rays, pathology, ECG, EEG and other special diagnostic investigations should be undergone by patients only insofar as it is necessary for their treatment. The plaintiff's solicitors should ensure that the plaintiff takes X-rays and any relevant reports to the examination or, if this is not possible, authorise the defendant's examiner to inspect such X-rays. In practice, the results of such diagnostic investigations will be made available to the defendant's medical advisers.

Doctors should not express opinions to patients about the quantum of damages that they are likely to recover as a consequence of their injuries, the likelihood of success, the conduct of the litigation or the likelihood of settlement. The doctor's opinion must be based solely on his or her independent assessment of the plaintiff's medical condition. Counsel and solicitors, however, must make a judgment on the issue of the defendant's liability. Settlements of personal injury claims are often concluded at amounts substantially less than the amount at which the plaintiff's injuries might have been otherwise assessed because they are in effect discounted by factors such as the risk that the plaintiff might lose the action, or the plaintiff's own contributory negligence.

Documents that are brought into existence for the purpose of prosecuting or defending an action or obtaining legal advice are privileged from disclosure and such privilege can be waived only by the party for whom they were created. Medical reports are privileged documents and therefore the contents may be disclosed only with the consent of the client or by court order. However, legislation and some rules of court require the parties to exchange reports in some cases, and medical reports are often revealed or exchanged during settlement negotiations. Accordingly, it would normally be improper for the plaintiff's and defendant's medical advisers to discuss the plaintiff's condition with each other without the consent of both parties through their respective solicitors. Some doctors understandably regard this as restrictive and conducive to confusion. Such doctors often refuse to accept instructions from solicitors unless it is agreed in advance that there can be such communication.

A solicitor may be required to disclose and discuss with the client the contents of any medical report received in the course of advising that client. In doing so, care should be taken not to interfere with the medical treatment of the client. When in doubt, the solicitor should discuss the matter with the treating doctor and vice versa. In their reports, doctors should be careful not to make gratuitous remarks about the patient or their colleagues, but should confine

themselves to medical fact and medical opinion. At times, medico-legal assessments may lead to the assessor identifying a need for urgent treatment or for recommendations for possibly more effective treatment. Australian Medical Association guidance on this subject advises the independent medical assessor who has serious concerns regarding the management of a patient to contact the treating doctor [4].

It is essential that doctors promptly provide reports to solicitors after the medical examination. Rules operating in the courts put additional pressures of time on solicitors to prepare cases for trial. It is recognised that doctors have the right to withhold a report until they have received their fee or a written acknowledgement that their fee will be met, either immediately or within a specified period. Such written acknowledgement will often be part of the letter confirming the appointment. Doctors who are unwilling to make an appearance in court should not accept requests to undertake medico-legal examinations.

The courts are very aware of the time pressures on doctors, particularly treating doctors, and generally go out of their way to minimise the interruption involved when doctors attend the court. However, where doctors have agreed to be expert witnesses and have accepted fees to provide an expert report, attendance at court is expected and pressure of clinical work should not be used to delay or avoid such responsibility.

25.2 PROBLEMS ARISING IN MEDICO-LEGAL EXAMINATIONS

In the usual medical consultation the doctor is acting only in the interests of the patient. In a medico-legal consultation the doctor is a neutral expert employed by a third party and expected to give an impartial opinion to the party requesting the opinion. To ensure accuracy and validity, the doctor's range of inquiry during history taking may appear to be and indeed frequently has to be different from that employed in usual clinical practice. This difference in the purpose of the examination should ideally have been explained to the patient by the solicitor or insurer arranging the appointment. Even when genuine attempts are made at explanation they are not always heard or understood.

In medical practice, when a patient attends a doctor's surgery for treatment, mutual honesty is assumed, and this assumption is usually well founded. This mutual trust may be modified in a medico-legal consultation where the doctor may feel an obligation to minimise the chances of being deceived. However, this should not be translated into an adversarial or aggressive method of questioning, or brusqueness in conducting the physical examination. The patient may also be somewhat estranged, recognising that the doctor is employed by another party to the litigation whose interests are opposed to those of the patient. Doctors should not be surprised if patients undergoing medico-legal examinations consider that

they may be biased in their medical assessments. For this reason, among others, many doctors do not wish to be involved in medico-legal work and others are not suited to it.

In addition to anger and accusations of bias when a medico-legal report is adverse to the patient's interests, a number of other complaints are frequently made by patients [1], including allegations:

- of rudeness or abruptness, or failure to listen
- that the physical examination caused undue pain or aggravated the existing condition
- that the patient's privacy was not respected, in relation to providing for undressing in private and to providing an appropriate gown or cover sheet.

Most of these problems could be averted by paying greater attention to communicating the nature of the consultation, explaining the extent and purpose of the physical examination, and explaining to the patient how the report will be used. The following problems may also be created by the doctors themselves when composing or attending to requests for medico-legal reports:

- unacceptable delays in responding to requests for reports
- providing poor-quality reports, aggravated by excessive charges
- failing to remain objective
- using judgmental or emotive language
- basing conclusions on inaccurate material, or inappropriately implying that the allegations of patients are facts
- failing to recognise that the report, once sent, is the property of the solicitor and cannot be used by the doctor for purposes other than for which it was created.

25.3 EXPERT WITNESS REPORTS

Expert witness reports most frequently originate following a medico-legal examination. Less commonly, doctors may be asked to provide a written opinion based on medical records, specialist reports and witness statements often relating to a pending civil action for alleged negligence by another doctor (or relating to a complaint before a health complaints commissioner). Although this will not involve seeing the patient in person, all the advice about medico-legal reports is pertinent to these situations.

Depending upon the jurisdiction, a request for a medico-legal report from an expert witness may be accompanied by a mandatory guideline issued by the relevant court. Such a guideline was first developed in 1998 by the Federal Court of Australia and the Law Council of Australia but it carries slightly different names in various states. For example in New South Wales and Victoria, it is referred to as the *Expert Witness Code of Conduct* while in South Australia it is referred to as *Practice Direction 46, Guidelines for Expert Witnesses in Proceedings in*

the Supreme Court of South Australia. In the County Court of Victoria, the code reads as follows [5]:

1. A person engaged as an expert witness has an overriding duty to assist the Court impartially on matters relevant to the area of expertise of the witness.
2. An expert witness is not an advocate for a party.
3. Every report prepared by an expert witness for the use of the Court shall state the opinion or opinions of the expert and shall state, specify or provide
   (a) the name and address of the expert;
   (b) an acknowledgement that the expert has read this code and agrees to be bound by it;
   (c) the qualifications of the expert to prepare the report;
   (d) the facts, matters and assumptions on which each opinion expressed in the report is based (a letter of instructions may be annexed);
   (e) (i) the reasons for;
   (ii) any literature or other materials utilised in support of;
   (iii) a summary of
   – each such opinion;
   (f) (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise;
   (g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;
   (h) a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate, and that no matters of significance which the expert regards as relevant have, to the knowledge of the expert, been withheld from the Court;
   (i) any qualification of an opinion expressed in the report without which the report is or may be incomplete or inaccurate; and
   (j) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason.
4. Where an expert witness has provided to a party (or that party's legal representative) a report for the use of the Court, and the expert thereafter changes his or her opinion on a material matter, the expert shall forthwith provide to the party (or that party's legal representative) a supplementary report which shall state, specify or provide the information referred to in paragraphs (a), (d), (e), (g), (h), (i) and (j) of clause 3 of this code and, if applicable, paragraph (f) of that clause.
5. If directed to do so by the Court, an expert witness shall
   (a) confer with any other expert witness; and

(b) provide the Court with a joint report specifying (as the case requires) matters agreed and matters not agreed and the reasons for the experts not agreeing.

6. Each expert witness shall exercise his or her independent judgment in relation to every conference in which the expert participates pursuant to a direction of the Court and in relation to each report thereafter provided, and shall not act on any instruction or request to withhold or avoid agreement.

As indicated by paragraph 5, in several jurisdictions, courts are using new approaches to how expert evidence is gathered by bringing medical experts from both sides together in conference to determine what is common ground and to narrow the evidentiary issues in question (for another example, see the Family Court website at http://www.familycourt.gov.au/wps/wcm/connect/FCOA/home/publications/All±Publications/D±to±M/FCOA_br_Conference_Experts).

25.4 COURT PROCEDURES

Doctors are called to give evidence as expert witnesses in civil, and occasionally criminal, matters. Doctors may also be asked to give evidence of the facts of their treatment of patients or to give evidence as defendants in civil court actions such as negligence. While the last of these instances is undoubtedly the most stressful, any appearance in court produces anxiety even in the most experienced doctors. Levels of stress and anxiety may be reduced by having a better understanding of court procedures, taking the trouble to be well prepared, and appreciating what is required of the doctor as a witness.

25.5 THE ADVERSARIAL SYSTEM

Legal proceedings in Australia are adversarial. The adversarial system prevails in most other countries where the legal system was derived from Great Britain. The adversarial system is in contradistinction to the inquisitorial system practised in most European countries where the legal systems are derived from Roman law. In the adversarial system, trials, whether criminal or civil, are effectively contests between opposing parties, with a judge acting as the umpire, deciding on points of law and procedure, and giving legal directions to the jury, which alone decides the issues of fact. In civil trials without a jury, the judge decides both issues of law and fact. In the adversarial system the burden of winning the contest usually rests upon the party who initiates the proceedings. In a criminal case it is the

Crown in the guise of either the Director of Public Prosecutions or the police who brings the case against an accused person, while in a civil case it is the plaintiff who brings an action against a defendant. This structure closely resembles that in medical disciplinary tribunals, although the barrister 'prosecuting' the case against a doctor plays a slightly different role as 'counsel assisting' the tribunal and has a duty to draw the attention of the tribunal to matters favourable to the doctor whose conduct is being examined.

In this system the conduct of the litigation until the point of trial is, with some exceptions, left largely in the hands of the opposing parties. In theory, this freedom is an incentive to explore all of the relevant facts and arguments to be tested at the trial. In practice, preparation for a trial is designed to establish the minimum essential matters on which the selected legal arguments for a claim or a defence can be based. Lawyers have duties to the court to draw its attention to any relevant matters of law, whether favourable or not. They do not have a corresponding duty as to matters of fact, so that, short of knowingly introducing false evidence, each side is free to select the facts that will strategically offer the strongest support for its legal arguments.

The trial procedure is structured to concentrate matters into one continuous oral hearing. In jury trials it is considered that, by leaving the jury to consider evidence in its oral form, the jury's discussion of the case in the jury room will be more open, the exchange of views among jurors will be easier, and the legitimate merging of opinions will more easily occur than if the evidence were given in writing, or if the jurors were each armed with a written transcript of the evidence.

At the trial, the evidence is established by answers given by witnesses to the questions asked, in turn, by opposing parties according to the rules of procedure (see below). The presiding judge is more an umpire than a referee, intervening to ensure and enforce these rules only when asked by one of the parties. Judges have only very limited powers to call witnesses in both civil and criminal trials. While judges may ask witnesses questions in the interests of clarifying answers to questions put by counsel, they may not examine witnesses in such a way as to join in the contest or even to appear to do so.

The jury is a body of sworn people – usually six in civil cases and twelve in criminal proceedings – who decide questions of fact in accordance with the relevant law as explained to them by the trial judge. Reliance on juries is controversial: some argue that the legal system would operate better without them while others hold that the jury system is invaluable because it brings the opinions of ordinary citizens to the delivery of justice, rather than delegating that role to lawyers.

The evidence of a witness in both civil and criminal trials falls into three main parts: evidence-in-chief, cross-examination and re-examination.

25.6 THE GIVING OF EVIDENCE

25.6.1 Evidence-in-chief

This is presented through the answers to questions asked by the party who has called the witness. In criminal trials, witnesses called by the Crown are first questioned by the prosecutor, while in civil cases witnesses called by the plaintiff are questioned first by the plaintiff's barrister. Witnesses are asked their names and addresses and, if relevant, their qualifications and experience. Before trials, witnesses are usually asked to prepare statements on the matters on which evidence is sought.

In courts of summary jurisdiction and Coroner's Courts, the prosecutors or coroner's assistants are usually experienced police officers, although in serious matters a barrister may be briefed by the Director of Public Prosecutions. In superior courts, a Crown Prosecutor (a barrister employed as a permanent prosecutor) or a barrister engaged for that case only will conduct the case.

Generally, answers to questions are given from the witness's unaided memory but doctors will usually be permitted to refer to notes, records or reports made by them, or made under their supervision. A witness must have leave of the court to use such material to refresh his or her memory, and lawyers for the other party may ask to see the documents. X-ray films and photographs may be used as documents to refresh memory and may also be tendered as evidence. The use of leading questions that, in effect, predetermine the answer is not permitted during the evidence-in-chief and the opposing barrister (counsel) will object to their use.

It is standard practice for counsel for one party to request the judge to order all prospective witnesses from the courtroom to prevent them hearing the evidence or cross-examination of earlier witnesses. The judge usually complies with such a request unless an application is made by counsel to allow a particular witness, such as an expert, to remain in court. Prospective witnesses must remain within the precincts of the court, so that they can respond promptly when called to appear.

25.6.2 Cross-examination

After evidence-in-chief has been given, the witness is usually examined by counsel for the accused or the defendant. In cross-examination the witness may be asked questions intended to clarify the evidence-in-chief, or to elicit information that is favourable to the accused or defendant. Questions may also be asked in order to cast doubt on the accuracy of the evidence previously given by the witness, or to attempt to discredit the witness in the eyes of the judge or jury, and so decrease the weight of the evidence given during the evidence-in-chief.

Cross-examination is often in the form of leading questions to which there can be no objection in this stage of the proceedings. The evidence of medical witnesses may be tested by rigorous cross-examination, particularly if the evidence-in-chief has been unfavourable to the cross-examiner's client.

25.6.3 Re-examination

After cross-examination counsel for the party that called the witness can ask further questions, usually to clarify any ambiguities that may have arisen from the cross-examination. Under the rules of evidence no new material may be introduced at this stage and re-examination is usually relatively short.

25.7 EVIDENCE OF FACT

The law distinguishes between evidence of fact and evidence of opinion. Ordinary witnesses are required to give evidence of fact, and opinions are generally inadmissible to prove fact whether such opinions are those of the witness or those of a third party (hearsay evidence). Doctors, like other citizens, may be ordinary witnesses to facts when they may have witnessed a road accident or a crime or as witness to what they have done in their work as a medical practitioner. The doctor in these circumstances is in exactly the same position as any other witness and is required to state what he or she saw, heard or did, and not give an opinion about events, except for commonplace observations such as the age or general appearance of the victim.

25.8 HEARSAY EVIDENCE

The 'hearsay rule' is that the oral or written statements of one who is not called as a witness but which are narrated to the court by a witness, or through a document, for the purpose of supporting other evidence, are inadmissible. The basis of the objection to hearsay evidence is that those people whose statements are repeated, or whose documents are produced, were not under oath when they made such statements or documents, nor are they available to be cross-examined about what they have said or written. There are exceptions to the rule including statutory exceptions, declarations of deceased people in certain circumstances, evidence given at previous trials, sworn depositions and certain confessions. The following exceptions to the hearsay rule may be relevant to doctors.

25.8.1 Some statements of patients

What patients say in response to their doctor's questions during the taking of a medical history can usually be repeated. It is not regarded as hearsay if it is not

used to prove the truth of the matters stated but simply as the basis upon which the doctor's opinion or evidence was formed.

25.8.2 Complaints of sexual assault

A doctor may be asked to examine a person who is a victim of an alleged sexual assault. If during the course of such an examination the victim voluntarily gives an account of what happened, it may be received in evidence as a 'fresh' or 'early' complaint. It is given this name because the account of the event, or complaint, must be made by the victim at the first reasonable opportunity, and its admissibility substantially depends on this. Admissibility also depends upon its spontaneous nature, and a doctor should not at this stage prompt the patient nor ask questions to elicit the circumstances of the offence. The doctor should record the account given as far as possible in the exact words that were used. This sort of material cannot be used unless the victim has given, or will otherwise give, evidence of the incident.

25.8.3 Dying declaration

At common law, provision that a statement made by a victim of murder or manslaughter may be given in evidence, in a trial for the murder of the deceased, is an exception to the hearsay rule, if the statement is made in certain circumstances. To qualify as a dying declaration, the statement must relate to the death of the victim, and must have been made when the deceased 'had a settled, hopeless expectation of impending death, without any hope of recovery' [6]. For the evidence to be admissible, the victim must, if necessary, be made aware of the hopelessness of recovery and must be shown to have accepted this prognosis. The declaration must also have been completed; incomplete statements are not acceptable. The doctor to whom a dying declaration is made should, as soon as possible, record the victim's words in writing and, if circumstances permit, ask the victim to sign the record after it has been read to him or her. Any witness present at the time the statement is made should also be asked to sign the record as accurate. The basis for the acceptance of this declaration is the legal assumption that people who know they are about to die are likely to tell the truth. The declaration cannot be used if the person making it does not die.

25.8.4 Dying deposition

There is a statutory provision that a person who is dying may provide evidence if his or her testimony is recorded in the presence of a Justice of the Peace. This can be done only where the person is dangerously ill and, in the opinion of the attending doctor, is unlikely to recover.

25.9 APPEARING IN COURT

The welfare of patients may depend not only on expert medical treatment but also on a just award of damages. It is important to patients that the doctors who have treated them properly assist their legal advisers. While many doctors dislike becoming involved in litigation because of the demands on their time, they, like other citizens, have a duty to assist the courts in the administration of justice and are bound to appear in court to answer a subpoena.

Cases involving the determination of liability and the quantum of damages in relation to personal injuries arising out of accidents are fixed for hearing in the monthly lists of cases to be heard by courts and tribunals. Such cases are fixed to be heard on specific dates and cases that are fixed for hearing on the same date are heard in the order in which they appear in the court lists. However, contested cases frequently run for several days or more, and consequently the succeeding cases in the list are not heard until some days after they are initially fixed. Conversely, it sometimes happens that cases are settled shortly before they are due to be heard and consequently the succeeding cases in the list are heard sooner than was anticipated, although not before the date fixed. It follows that it is not possible for a solicitor to determine much in advance precisely when a witness will be required. The uncertainty surrounding the precise date on which a case will be heard is a constant source of inconvenience, not only to doctors but also to legal practitioners, the parties and all other witnesses. While most solicitors usually make every effort to maintain contact with medical witnesses, oversights do occur and doctors should not hesitate to contact a solicitor's office to confirm arrangements or to be informed of any delays to the case.

25.10 SUBPOENA

A subpoena is a form of summons that is served on a witness to attend a court, at a specified time and place, for a specific purpose. For a subpoena to be legally valid the witness must be given 'conduct money', which is based on the cost of travel by public transport to the court. Witness fees and travelling expenses are usually paid by the party calling the witness. Failure to respond without good cause to a valid subpoena is contempt of court, and a judge may order that the absent witness be arrested, or brought before the court. When witnesses cannot attend, they should advise the party calling them of the circumstances. Strictly, witnesses are required to remain in the precincts of the court for the duration of the trial, although professional witnesses such as doctors can usually make arrangements with the prosecutor or lawyers calling them so that they are not required to wait at courts for an excessive time before appearing.

Documents, including medical records, may also be the subject of subpoena from a court and may also be requested by some tribunals. Such a subpoena

must be answered. The subpoena should indicate whether the original record or a photocopy is requested. If the original file is requested, a copy should be kept by the doctor [7]. It is in the interests of patients that material in their files that is not relevant to the issues in the case to which the subpoena relates be withheld from disclosure. Subpoenas are orders of the court and documents are produced to the court and not to either party's lawyers. The judge has the power to decide what material is relevant and should be disclosed. In responding to a subpoena for a patient's complete file, doctors should, in their patient's interests, be willing to inform the lawyers acting for patients of material that appears irrelevant to the issues in the case, disclosure of which would be detrimental to the patient's interests.

25.11 THE DOCTOR AS A WITNESS

In their professional capacity, doctors will usually appear in courts as a witness, either as a treating doctor or as an expert witness and, less commonly, as a defendant in a medical negligence claim or other action. As treating doctors, they may give medical evidence of the condition of a plaintiff, or concerning injuries received in a motor vehicle accident, or as to the injuries suffered by a victim of an assault.

Once notified of the possibility of being called as a witness, good preparation should include as a minimum (1) making contact with the solicitor calling you as a witness to clarify what is required, to check the date and venue, to ensure that you will be readily contactable in case of delays or adjournments, and to clarify who is responsible for notifying whom if changes occur, (2) re-reading all the relevant material and (3) collecting the relevant medical records and copies of any statements prepared by yourself (and in the case of expert witnesses any reference material to be relied upon) to take with you to the court. In addition, at any hearing, the doctor should dress professionally, as appearances may affect the assessment of the evidence provided.

The expectations of the court reflect the nature of the evidence to be provided. For treating doctors who are not specialists or expert in the field in question, the evidence should be restricted to the care provided to the patient and the history and examination findings of relevance. At times, barristers may try to elicit expert evidence from such witnesses and doctors must be careful not to answer questions beyond the scope of their expertise. Apart from this qualification, much of the following advice for expert witnesses is applicable to the role of the treating doctor as a witness.

25.12 EXPERT EVIDENCE

The general rule of evidence at common law is that witnesses may only testify to what they personally saw or heard or encountered through their own physical

senses. Expert witnesses are set apart from the ordinary or lay witnesses in that they are permitted to express opinions as evidence. The privilege of the expert witness to give such evidence of opinion is dependent on the court deciding that an issue before it is such that expert evidence is required and that the witness has the appropriate qualifications or expertise to give that opinion.

The law in Australia as to expert evidence is complex and detailed. In states other than New South Wales and Tasmania and in courts other than federal courts, it is governed by five common law rules used to test the admission of expert evidence. Briefly, these are the:

1. 'expertise rule', which is satisfied if the witness has sufficient knowledge and experience to be treated as an expert
2. 'common knowledge rule', which is satisfied if the information the expert is to give is something that the courts needs help with and cannot rely on its own knowledge
3. 'area of expertise rule', which is satisfied if the expert's knowledge and expertise are recognised by others as a credible arena of expertise
4. 'ultimate issue rule', which is satisfied if the expert's opinion is going to take the place of the question that the court itself has to decide (and, if so, the evidence will not be admitted)
5. 'basis rule', which is satisfied if the expert's opinion is based on matters directly within the expert's own observations (knowledge that can be tested).

In the federal courts, the *Evidence Act 1995* (Cth) has affected some of these rules and legislation in New South Wales and Tasmania has had a similar impact.

Expert evidence is ordinarily called in matters concerned with an organised branch of learning, such as medicine or science, where a judge or jury would need some formal training to understand the significance of certain findings. It may also be admitted where a special occupational knowledge or skill is helpful. For example, a jeweller could express an opinion about the value or authenticity of a certain piece of jewellery, this being an opinion which probably all members of a jury would be unqualified to express. Before admission of such evidence or opinion, the expert witness proffered to the court must be 'qualified' as such. Whether the area upon which the expert is called to give evidence is an 'area of expertise' and whether the qualifications and/or expertise of the expert witness are sufficient are matters for the judge [8].

Consistent with the practices of the adversary system, experts are called by one or other party to the proceedings. However, as the guidelines quoted above show, the primary function of an expert witness is to assist the court by putting it in possession of material essential to its decision. While such evidence may be expected to favour the arguments of the party calling the expert, it is not the expert's task to undertake any partisan presentation of the medical issues. The doctor should be an expert, but not an advocate, whose objective view of the matters of expert knowledge happens to coincide with and support the

version that the party calling the expert wishes to advance. But by whomever they are called, experts must maintain their impartiality and be aware that their overriding duty is to assist the court.

In response to concerns expressed within both the medical and legal professions regarding the quality and neutrality of some expert witnesses, the medical profession, via the specialist colleges, and supported by the AMA, has moved to identify college fellows who are appropriately qualified to be expert witnesses [9]. Also in response to these concerns, and as described above, the courts have directed that expert witnesses adhere to a code of conduct that addresses their responsibilities in preparing medico-legal statements and reports and appearing in court.

Expert witnesses should be aware of the differences between fact and opinion, although at times the differences may be obscure. They should also avoid becoming advocates for, rather than simply exponents of, their own opinion. Partiality of an expert witness usually becomes evident to a judge or jury and may reduce the weight of the expert evidence given, even if the opinion evidence is soundly based. Journeys outside the doctor's particular field of expertise may be encouraged by experienced counsel with the aim of either discrediting or lessening the weight that may be given to the evidence. Such temptation is to be resisted. When called to court, doctors should not hesitate to seek advice from their professional bodies, senior colleagues or the lawyers involved, regarding any uncertainties they may have.

25.13 THE EXPERIENCE OF BEING A MEDICAL WITNESS

Medical witnesses may be upset by the adversarial nature of courts. A doctor-witness should not react in a hostile manner if this occurs, and the cross-examination should not be regarded as a reflection on the competence or integrity of the doctor. More usefully, the process should be viewed as one in which the doctor is made accountable for the views that he or she expresses. In particular, a witness should not attempt to competitively engage counsel, who are usually much more versed in and used to such encounters than are doctors and other lay witnesses. Sarcasm is out of place and attempts at humour should probably be avoided. A calm demeanour will add to the credibility of the evidence. Lawyers preparing for an important case are likely to have gone to considerable lengths to inform themselves on the subject matter of the case, and medical witnesses should not assume that they alone have all medical knowledge.

Doctors need to recognise that the scope of what is relevant to the strategy of lawyers in court may differ significantly from the scope of what a doctor would consider relevant to a patient's condition. It is the lawyers' strategic relevance that governs the questions that they ask and the answer that they seek. Doctors may

find it frustrating that they are not given the opportunity to contribute all that they know of the facts or all of their opinions as experts.

Every time doctors step into the witness box to give evidence, whether as a young doctor in the emergency department, an experienced general practitioner or a senior specialist, they should make a determined effort to perform well and appear to the court as being professional, well informed, objective and impartial. This involves not taking sides, not arguing or becoming personally hostile with counsel and being tolerant of apparently ill-informed questions. Witnesses should answer only the question asked, should not volunteer information beyond that and should speak directly to the judge and jury. If counsel objects to a question put to the witness, a witness should not attempt to answer the question until the judge has ruled on the objection. If the witness feels that important evidence or views are not being sought or are being misconstrued, the witness should address these concerns to the judge.

To be of greatest assistance to the court, medical witnesses should familiarise themselves with the relevant facts of the case and with recent professional literature in relation to the area in which they will be giving evidence. Preparation should include conferring with the barristers calling them prior to their appearance in court. When attending court they should bring all relevant medical documents such as clinical notes, X-rays and pathology reports with them. As hearsay evidence is admissible from expert witnesses (to explain the basis of their opinions), they may refer to medical or scientific literature to substantiate their opinions. This literature should be available to be produced in court if required. Medical and scientific evidence should be stated clearly and accurately but in terms likely to be understandable to the court, and medical and scientific jargon must be avoided whenever possible. Answers to questions should generally be brief and to the point. Medical witnesses should also avoid trying to second-guess barristers or trying to engage in debate or gamesmanship. The expert witness must be honest and attempt to make known to the court the limits of reliability of the evidence and the inferences that may be properly drawn from it.

Re-examination usually concludes the matter for expert medical witnesses who are usually formally 'excused' from further attendance. If not excused they may be required to remain in the court and may be recalled to the witness box.

Finally, doctors appearing as expert witnesses need to appreciate that they are participating in a process that society has developed over centuries, and one that is very different from the scientific and experimental approach used to finding the 'truth' in science or medicine. Court procedures do change gradually. For example, both the Federal Court and the federal Administrative Appeals Tribunal now provide the opportunity in selected cases for expert witnesses to confer for the purpose of narrowing the contested evidence and then to give their evidence and be cross-examined in front of each other, and to be questioned by the presiding officer.

25.14 FEES FOR COURT APPEARANCES

In civil cases, doctors who have given evidence to the court should send an account for their services to the solicitor on whose behalf the doctor was called. Under legislation, courts and tribunals set scales of fees for court attendance and these are updated from time to time. They are not binding on doctors. When giving evidence upon request from a statutory agency, witness fees are normally prescribed and inflexible, although they are reviewed from time to time, with input from the medical professional associations. Information regarding the recommended fee scales may be obtained from your medical association or from the relevant agency.

25.15 DOCTORS AND JURY DUTY

In general, doctors are not automatically excused from jury duty simply because of their profession but when called for duty may be excused if they provide 'good reason'. This covers more obvious matters such as ill health or incapacity and, for rural doctors, undue time lost travelling, but also includes severe financial or personal hardship. On this last ground, prolonged absence from a medical practice might be argued as likely to cause hardship to current patients or financial hardship to a self-employed doctor [10].

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Additional reading

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26 OTHER LEGISLATION RELEVANT TO MEDICAL PRACTICE

The bulk of state and Commonwealth legislation that is of most direct and frequent relevance to medical practice has been addressed in previous chapters. The differences between the jurisdictions are more often in detail than in principle. This final chapter summarises some further legislation that may involve practising doctors and is written mainly to highlight the principles involved in these Acts. Doctors wishing to seek more detailed advice concerning their responsibilities under the legislation should consult the department or statutory body established to administer the relevant Act. These additional legal responsibilities emphasise that the community places great trust in the professionalism of doctors in such roles as:

- the provision of objective reports and certificates in relation to disabilities, injuries and accidents
- the notification of authorities where individuals or the community are at risk
- assisting in the care and protection of the disabled
- exercising a public role as a person of independence and reliability
- meeting specific obligations as laid down in other Acts of Parliament.

Failure by a doctor to fulfil these responsibilities will diminish the community's trust in the medical profession and may lead to censure of a doctor by a medical board. In some instances, doctors may face fines or even terms of imprisonment for failing to meet these responsibilities without adequate cause.

26.1 SOCIAL SECURITY LEGISLATION

Under social security legislation, people with illness or injury leading to temporary or permanent disability with incapacity to work are entitled to social security income in the form of sickness benefits, a disability support pension (DSP) or other payments. DSP entitlement is heavily dependent upon the treating doctor completing a medical report form provided by Centrelink (the

Commonwealth agency responsible for administering the legislation). This report may be used to decide which payment a patient is entitled to or to determine if the person could benefit from vocational rehabilitation. It should be completed promptly, fully, legibly and accurately. In general, Centrelink staff do not seek medical reports from specialists and treating doctors should assume that this will not happen. Although some applicants for DSP may also be assessed by independent doctors on behalf of Centrelink and by independent job capacity assessors, those doctors and assessors need to be informed fully of any applicant's illnesses and/or injuries by the treating doctor. Patients may be unfairly discriminated against if the medical information relied upon at these independent assessments is based predominantly on the patient's own understanding of their illness or injury.

26.2 TESTAMENTARY CAPACITY AND WITNESSING WILLS

Doctors are not infrequently asked to certify to the testamentary capacity of a person who is preparing or revising a will. This task must not be accepted if the doctor, or an organisation with which the doctor is associated, stands to be a beneficiary of the will. In assessing testamentary capacity, there are four essential elements. The doctor needs to make a sufficient assessment that the person [1]:

1. understands that he or she is giving instructions in regard to the disposal of assets after his or her death
2. is of clear mind and able to state the extent and nature of his or her assets
3. is able to recall and understand the claims of potential heirs
4. does not demonstrate any sign of serious mental illness, such as delusions or hallucinations, or the effects of medications, which could impair decision making.

26.3 STATUTORY DECLARATIONS

Registered medical practitioners along with a number of other professionals are authorised to witness statutory declarations. The authorisation is to be found in the legislation about giving evidence (for example, the Victorian *Evidence Act 1958*). In responding to such a request, the doctor is not attesting to the content of the declaration, but is attesting to the identity of the person and to the fact that the doctor physically witnessed the person sign the declaration. The person signing is asked to state 'I declare that this is my name and handwriting and that the contents of my declaration are true and correct'. As a witness, the doctor must print his or her full name, sign and date the document, and write his or her professional qualifications and address, which can be the practice address. In documents of more than one page, every page should be so signed.

26.4 RESPONSIBILITIES OF DOCTORS IN RELATION TO INJURY OR ACCIDENT

As most people who suffer an injury or accident seek medical attention, doctors are well placed to attest to the extent of the injuries, the apparent cause of the injuries, the resultant disability and the prognosis. Care must be taken by doctors to record all relevant findings, as this record is important to the patient who has been injured and to any agency that may be responsible for the cost of medical care or for compensation for the injuries. The professional obligation in regard to medical records and to providing prompt, clear and objective reports and certificates is highlighted in Chapter 6. Statutory provisions for schemes covering the cost of the medical care and compensation for people injured at work or in motor vehicle accidents are in place in most states. Their effectiveness, viability and integrity depend heavily upon the professionalism of doctors.

26.5 WORKERS COMPENSATION AND REHABILITATION

Although knowledge of the requirements for workers compensation insurance is relevant to doctors who are employers (see Chapter 16), this section focuses on the role of a doctor in treating injured workers. Workers compensation schemes are now generally 'no fault' in that entitlement is not conditional on proof of negligence. Compensation is normally paid where a work-related injury or disease is documented and there is evidence that the person was employed. The term 'work-related' implies being caused by, contributed to or aggravated by the person's work. In most states, work includes travel to and from work. Stress as a contributing or causative factor to compensable disease or disability under these schemes appears to be handled inconsistently.

The role of a treating doctor in workers compensation schemes is to objectively assess any person presenting for treatment and to provide accurate certification of the disease or injury and consequent disability. The assessment of disability will include such matters as degree and expected duration of disability, and subsequently fitness to return to part-time or full-time work. Some understanding of the type of work performed by the injured person should be obtained in order that certificates are not meaningless. Objectivity on the part of the doctor must be observed. Some err by acting too strongly as an advocate for the patient and overlook that there is also a responsibility to the community to ensure that the compensation schemes are not abused. Other doctors may err by too harshly denying certificates to injured workers or understating the degree of injury or disability. Doctors who are not the treating doctor may also be asked to examine and report on a person seeking workers compensation. Aspects of this

role, which does not have the dynamics of the usual doctor–patient relationship and frequently leads to complaints against doctors, are covered in Chapters 3 and 25.

In most states, when a worker makes a claim for compensation, the treating doctor is required to describe the illness or injury on a certificate provided by the workers compensation authority. When completing and signing such a certificate, the doctor is simply reporting the relevant medical findings and is not attesting to any belief formed as to whether the illness or injury is work-related. That decision is not one for the doctor to make, although the treating doctor's opinion, as well as the opinions of medical experts, may be considered should an employer contest the claim and the matter comes to formal determination.

Some doctors refuse to take on the care of people presenting with work-related injuries as they find the paperwork tedious and the possibility of a court appearance unappealing. As in any other field of medical practice, there is no ethical obligation to accept such patients, provided it is not an emergency and provided alternative sources of medical care are reasonably available.

The treating doctor may also be involved in the rehabilitation of the injured worker, requiring discussions with the employer or a rehabilitation counsellor or case manager and at times workplace visits. The patient's consent for the release for any medical information during these processes must be obtained. Doctors should be cooperative in answering telephone calls or inquiries from employers and rehabilitation providers, as courteous discussion will serve to identify the issues before seeking the patient's consent to release information (see also Chapter 5).

For prolonged illness and where recovery from injury appears to be unduly slow, doctors must ensure that patients are fully reassessed at appropriate intervals and should consider seeking second opinions. A second opinion protects the interests of the patient primarily, but also can protect the doctor from criticism and the community from expensive abuse of the compensation system.

Relevant legislation is the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998* of New South Wales; the *Occupational Health and Safety Act 1985* and the *Accident Compensation Act 1985* of Victoria; the *Workers' Compensation and Rehabilitation Act 2003* of Queensland; the *Workers Rehabilitation and Compensation Act 1986* of South Australia; the *Occupational Safety and Health Act 1984* and the *Workers Compensation and Rehabilitation Act 1981* of Western Australia; the *Industrial Safety Health and Welfare Act 1977* and the *Workers Rehabilitation and Compensation Act 1988* of Tasmania; the *Work Health Act 1986* of the Northern Territory; and the *Workers Compensation Act 1951* of the Australian Capital Territory. Commonwealth government employees are covered by the *Safety Rehabilitation and Compensation Act 1988* (Cth).

26.6 PRE-EMPLOYMENT MEDICAL EXAMINATIONS

Many employers now ask that potential employees submit themselves for pre-employment medical checks. While many such examinations will be straightforward, doctors need to be alert to the risk of breaching anti-discrimination laws whether at state or federal level (for example, in Victoria the *Equal Opportunity Act 1995*). The Human Rights and Equal Opportunity Commission in Victoria has issued guidelines, which emphasise the need for the doctor to be informed by the employer about the 'genuine and reasonable job requirements for the particular position and the capacities required to perform these'. Doctors should be familiar with the process of pre-employment assessments. They need to explain to the job applicant the nature of any assessment and its relationship to the job requirements, and to assure the applicant that only health information relevant to their job capacity will be conveyed to the employer.

Questions must relate only to health issues relevant to the job. Thus questions about past compensation claims or sick days away from a previous job may not be asked. A preferred approach is to outline the job requirements and ask the applicant, or test the applicant, to see if there are any conditions that will affect their ability to do the job. The report to the employer must not contain information about a disability or impairment unrelated to the job requirements. Employers cannot refuse to employ a person on the basis of such information and anti-discrimination actions leading to significant compensation have been successfully pursued for this reason [2–3].

26.7 MOTOR VEHICLE ACCIDENTS

There are two principal roles for doctors. The first is similar to that in workers compensation schemes, namely the provision of medical care to the injured and the provision of objective reports and certificates to enable such people to receive appropriate compensation. No-fault schemes for such compensation exist in Victoria, Tasmania and the Northern Territory. The second role is quite different and concerns the taking of blood samples for testing for blood alcohol level. Doctors who care for people involved in motor vehicle accidents need to be familiar with the law in their state or territory pertaining to taking, dividing, labelling and storing of such blood samples.

In all jurisdictions, people involved in motor vehicle accidents who attend hospital for treatment must provide a blood sample. Testing is permitted without the consent of the person in New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, the Northern Territory and the Australian Capital Territory and the doctor taking the blood is granted protection from legal action. A doctor who fails to take, or fails to arrange the taking of, a

blood alcohol sample may be charged with an offence, except where the doctor believes that the taking of the sample would compromise patient care.

In most states, the road safety legislation provides police with the powers to arrest people in charge of motor vehicles who may be under the influence of drugs other than alcohol. When this occurs, the driver may be required to allow a doctor to take a blood sample.

Doctors also may be asked to express an opinion as to whether a driver is medically capable of participating in a breath alcohol test. After preliminary breath tests, if the subject requests it or if the breath sample has been insufficient, drivers may be brought by police for blood alcohol testing; this does not require the person's consent other than in Tasmania and the Australian Capital Territory.

Relevant legislation is the *Road Transport (Safety and Traffic Management) Act 1999* (NSW); *Road Safety Act 1986* (Vic); *Transport Operations (Road Use Management) Act 1995* (Qld); *Road Traffic Act 1961* (SA); *Road Traffic Act 1974* (WA); *Road Safety (Alcohol & Drugs) Act 1970* (Tas); *Traffic Act 1987* (NT) and *Road Transport (Alcohol & Drugs) Act 1977* (ACT).

26.8 FITNESS TO DRIVE A MOTOR VEHICLE

People applying for a licence to drive a motor vehicle are required to inform the licensing authority of any illness or disability (including treatment thereof) that might impair their ability to drive. Doctors may then be approached by the licensing authority to provide a medical report, usually according to a pro forma, as to the individual's fitness to drive. People holding current licences, or people whose licences have been suspended or cancelled, also may be asked by the licensing authority to provide a medical report. In addition, treating doctors have ethical and legal duties towards their patient and the community if a patient has an illness that places the person and the community at risk if driving [4–5]. A recent survey indicates that many doctors are unfamiliar with their ethical and legal responsibilities in this regard and may thus be placing the community and their own professional status in jeopardy [6].

In making an assessment of fitness to drive, doctors are performing a duty on behalf of both the community and the patient, and must be objective and honest in their assessment. As the request for assessment is frequently based on the observations of police or others who have concern for the safety of the public, the task must be undertaken with care and caution. A treating doctor who forms a view that a patient may be unfit to drive should inform the patient of the legal requirements on both the patient and the doctor and advise the patient to notify the licensing authority of this unfitness. In the Northern Territory and South Australia, doctors have a mandatory obligation to so report, while in the other jurisdictions (except Western Australia) doctors who notify the licensing authority

in good faith are immune from civil action. Notification by the doctor without the consent of the patient may need to be considered as a last resort [7]. The national guidelines recommend such reporting where the doctor believes there is an imminent risk to road safety and the patient has continued to drive despite repeated advice to the contrary [5]. In this situation, privacy legislation provides protection to the doctor as does the relevant licensing legislation in all states and territories other than Western Australia. Advice is available from the state licensing authority and its medical advisers, who have access to formal testing facilities where ability to drive can be objectively assessed in marginal cases.

Requirements for obtaining private and commercial driving licences are laid down in a guide, *Assessing Fitness to Drive*, issued by Austroads [5]. This guide not only provides advice and guidance in regard to the medical assessment of drivers but also covers specific standards for all medical conditions which have the potential to affect driving capacity and the details of the ethical and relevant legal responsibilities of doctors in each state. When last revised in 2005, a copy was provided to every general practitioner in Australia.

State and territory legislation relating to reporting by doctors includes the *Road Transport (General) Act 2005*, the *Road Transport (Driver Licensing) Act 1998* and the *Road Transport (Driver Licensing) Regulation 1999* of New South Wales; the *Road Safety Act 1986* of Victoria; the *Transport Operations (Road Use Management) Act 1995* of Queensland; the *Motor Vehicles Act 1959* of South Australia; the *Road Traffic Act 1974* of Western Australia (note that a bill to amend this Act was before the Western Australia Parliament at the time of writing); the *Vehicle and Traffic Act 1999* of Tasmania; the *Motor Vehicles Act 1999* of the Northern Territory; and the *Road Transport (General) Act 1999*, the *Road Transport (Driver Licensing) Act 1999* and the *Road Transport (Driver Licensing) Regulation 1999* of the Australian Capital Territory.

26.9 DOCTORS' RESPONSIBILITIES TO OTHERS AT RISK

As discussed in Chapter 5, doctors are normally expected to keep confidential the information they obtain when attending their patients. However, the law and the community recognise that there are times when the protection of other members of society can take precedence over patient confidentiality. This responsibility is clearly recognised by legislation that compels doctors to breach patient confidentiality, as in reporting suspected child abuse and notifying authorities of people who have infectious diseases, as described below. Beyond these situations, the legal basis for a disclosure that otherwise breaches confidentiality is that it is in the public interest. However, the scope of what counts as being in the public interest is uncertain. In some jurisdictions, notably New South Wales, Queensland and Western Australia, legislation establishes offences for concealing information about serious crimes. Doctors considering disclosure of confidential information

in circumstances where there is no clear statutory duty to do so can find some justification in privacy law. Doctors who consider that they should notify police of information derived from a doctor–patient relationship, for example where a patient has disclosed serious crimes or serious criminal intent, will be wise to first seek advice from their medical defence organisation.

26.10 CHILD ABUSE

Abuse of children may be physical, emotional or sexual or may involve neglect or lack of care. Doctors need to be alert to the possibility that children presenting with repeated, unusual or poorly explained injuries or even illness may be the victims of abuse. Failure to identify reasonably evident abuse has been the cause of the criticism of doctors by coroners (see also Chapter 19). When possible abuse is recognised, doctors have a statutory obligation to inform the relevant child protection agency. Doctors reporting in good faith are not liable to civil action. The relevant legislation is the *Children and Young Persons (Care and Protection) Act 1998* of New South Wales; the *Children, Youth and Families Act 2005* of Victoria; the *Public Health Act 2005* of Queensland; the *Children's Protection Act 1993* of South Australia; the *Children and Community Services Act 2004* of Western Australia; the *Children, Young Persons and Their Families Act 1997* of Tasmania; the *Care and Protection of Children Act 2007* of the Northern Territory; and the *Children and Young People Act 1999* of the Australian Capital Territory.

26.11 INFECTIOUS DISEASES

Legislation exists in all states for the purposes of controlling the spread of infectious diseases and encompasses such matters as the responsibility of doctors and pathology laboratories to notify authorities about individuals diagnosed with infectious diseases, the powers of the state or territory to test, treat or quarantine such individuals, and the responsibility of patients to seek treatment and to avoid behaviour that might result in spread of infection. Broadly, the legislation covers HIV/AIDS, other sexually transmitted diseases and other infectious diseases.

26.11.1 HIV/AIDS

Public health legislation has been enacted in all Australian jurisdictions in an effort to reduce the spread of HIV/AIDS. The laws are complex and vary between the states; the differences at times reflect the conflict between proponents of traditional coercive public health measures and those who argue that, because of its limited mode of transmission and the risk of discrimination, the legislation should be framed so as to encourage behavioural change and voluntary testing.

The legislation is far-reaching, covering not only the requirements of notification but also such matters as counselling prior to testing, powers of detention and isolation, the power to compel testing, and tracing of sexual contracts. In some states, the law creates offences of knowingly transmitting infections or exposing others to the risk of infection. The law also addresses the issue of privacy and confidentiality (see Chapter 5). Two detailed reviews of this legislation have been published [8–9]. In all states and the territories, doctors who diagnose AIDS or HIV infection have a legal obligation to notify their respective health departments. This responsibility rests also with pathologists and pathology departments in New South Wales, Victoria, Queensland, Tasmania and the Australian Capital Territory. Various other legal obligations, special powers and offences are prescribed in the different state and territory Acts.

The relevant Acts are the *Public Health Act 1991* and the *Public Health Regulations 1991* in New South Wales; the *Health (Infectious Diseases) Regulations 2001* in Victoria; the *Public Health Act 2005* of Queensland; the *Public and Environmental Health Act 1987* of South Australia; the *Health Act 1911* of Western Australia; the *Public Health Act 1997* and *HIV/AIDS Preventative Measures Act 1993* of Tasmania; the *Public Health Act 1997* of the Australian Capital Territory; and the *Notifiable Diseases Act 1981* of the Northern Territory.

26.11.2 Other sexually transmitted diseases

Doctors and pathologists are obliged under law to notify their state health department when certain sexually transmitted diseases (STDs) are diagnosed. In Victoria, Tasmania and the Australian Capital Territory, the patient's full name is not required. The STDs other than HIV/AIDS that are notifiable include chlamydia only in Western Australia and Australian Capital Territory; syphilis and gonorrhoea in New South Wales and South Australia; and syphilis, gonorrhoea, chancroid, donovaniasis, lymphogranuloma venereum and chlamydia in Victoria and Tasmania. Genital herpes is also notifiable in the Northern Territory. In New South Wales, it is an offence if a doctor fails to advise a patient with an STD of the patient's responsibilities under the *Public Health Act 1991*.

26.11.3 Infectious diseases that are not sexually transmitted

In every state and the territories there are either schedules or regulations published in the *Government Gazette* or promulgated to doctors listing a large number of infectious diseases that must be notified to the respective health departments. A list of these diseases and appropriate notification forms are available from the relevant health departments. Infectious diseases are also covered by the *Quarantine Act 1908* (Cth), which provides that people, animals, goods and the transport that has brought them to Australia may be detained if there is believed to be a risk of

quarantinable disease, including smallpox, plague, cholera, yellow fever, typhus and leprosy.

Relevant infectious diseases legislation are the *Public Health Act 1991* and the *Public Health Regulations 1991* of New South Wales; the *Health Act 1958* and the *Health (Infectious Diseases) Regulations 2001* of Victoria; the *Public Health Act 2005* and the *Public Health Regulations 1996* of Queensland; the *Public and Environmental Health Act 1987* of South Australia; the *Health Act 1911* and the *Health (Infectious Diseases) Order 1993* of Western Australia; the *Public Health Act 1997*, the *HIV/AIDS Preventive Measures Act 1993* and the *Public Health (Notifiable Diseases) Regulations 1995* of Tasmania; the *Notifiable Diseases Act 1981* of the Northern Territory; and the *Public Health (Infectious and Notifiable Diseases) Regulations 1983*, the *Public Health (Infectious and Notifiable Diseases) Regulations (Amendment) 1992* and the *Sexually Transmitted Diseases Act 1956* of the Australian Capital Territory.

26.12 DOCTORS AND THE INTELLECTUALLY DISABLED

The rights of adult people who are permanently or temporarily unable to care for themselves are generally laid down in statute. The rights of the mentally ill and the responsibilities of doctors in their care are described in Chapter 23. There is legislation in most states and the territories which guides the care of the intellectually disabled. The rights of intellectually disabled people were spelt out in 1971 in the United Nations *Declaration on Rights of Mentally Retarded Persons*. This declaration emphasises equality of rights with normal citizens in relation to medical care; adequate living standards and living with their family where possible; the right to a guardian; and protection from exploitation and abuse. Legislation throughout Australia incorporates these principles.

Guardianship boards or their equivalent with powers to appoint guardians for people who are unable to care for themselves because of intellectual, mental or physical disability exist in all states and the territories. A Guardianship Board is established under the *Mental Health Act 1963* in Tasmania but, in other states and the territories where there is more recent guardianship legislation, the care and rights of the disabled are dealt in statutes separate from those concerning the care of the mentally ill (see Chapter 4).

26.13 NOTIFICATION OF CANCER

All states and the territories have developed cancer registries to assist in research into the causes and prevention of cancer. In addition to these registries there are also registries for Papanicolaou smear tests for cervical cancer responsible for regular reminder notices to females on the register. The responsibility for notifying new cases of cancer rests with public and private hospital authorities in New South

Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania and the Australian Capital Territory, with pathologists in Victoria, Queensland, South Australia, Western Australia, the Northern Territory and the Australian Capital Territory, with doctors in Tasmania and with radiologists in Western Australia.

Relevant specific legislation includes the *Public Health Act 1991* in New South Wales, the *Cancer Act 1958* and the *Cancer (Reporting) Regulations 2002* in Victoria; the *South Australian Health Commission (Cancer) Regulations 1991* and the *Public and Environmental Health (Cervical Cancer Screening) Regulation 1993* in South Australia; the *Health (Notification of Cancer) Regulations 1981* and the *Health (Cervical Cytology Register) Regulations 1991* in Western Australia; the *Cancer (Registration) Act 1988* in the Northern Territory; and the *Public Health Regulations 2000* in the Australian Capital Territory.

26.14 ALCOHOL AND DRUG-DEPENDENT PEOPLE

The state and territory laws relating to drugs of dependence are described in Chapter 18. In addition New South Wales, Victoria and South Australia have legislation to guide the care of people affected by alcohol or drug dependence. The *Inebriates Act 1912* of New South Wales provides for the establishment of public institutions and the licensing of private services for the assessment and treatment of people dependent on alcohol or narcotics. More recently in New South Wales, this Act has been complemented by the *Drug and Alcohol Treatment Act 2007*, which provides for an accredited doctor to issue a dependency certificate. The *Alcohol and Drug-Dependent Persons Act 1968* of Victoria makes provisions for the treatment and rehabilitation of people who are dependent. It also provides for voluntary admission to assessment and treatment centres and for court-ordered and medically ordered committal. A doctor who signs a medical certificate supporting a committal must not be a relative or guardian of the patient and must not have an interest in any private treatment centre to which the patient is to be committed. The *Public Intoxication Act 1984* of South Australia provides for the establishment of centres for the care and treatment of people affected by alcohol or drugs. In the other states and the territories these issues are dealt with in mental health legislation.

26.15 BLOOD SAMPLES FROM PEOPLE ACCUSED OF SERIOUS CRIME

All Australian states and territories have legislation enabling the collection of biological samples from people suspected of committing a range of criminal offences. Specifics of the legislation vary between jurisdictions but cover the type of sample (for example, hair, blood or buccal swab), consent, the use of force and the role of the courts in issuing orders.

26.16 TRADE PRACTICES LEGISLATION

The Commonwealth *Trade Practices Act 1974* was extended to cover the medical profession in 1997. The object of the Act is 'to enhance the welfare of Australians through the promotion of competition and fair trading and provision for consumer protection'. Its principle relevance for doctors relates to the setting of professional fees and possible anticompetitive actions such as price fixing and boycotts by groups of doctors who are deemed under the legislation to be competitors. The Act also provides powers for consumer protection from misleading advertising. The Act is administered by the Australian Competition and Consumer Commission (ACCC) (http://www.accc.gov.au/content/index.phtml/itemId/142).

The Act has public interest provisions, which allow the ACCC to authorise certain agreements that otherwise would be deemed to be anticompetitive. The best known to date has been the ACCC's authorisation of the training program of the Royal Australasian College of Surgeons [10], but several applications for authorisation in regard to fee arrangements on behalf of various groups of doctors and groups of hospitals have had mixed outcomes [11]. In its consumer protection role, the ACCC may request that organisations desist from misleading advertising but can also take action to enforce such requests via the Federal Court [11].

26.17 FIREARMS LEGISLATION

Legislation in some states (such as the Victorian *Firearms Act 1996* and the South Australian *Firearms Act 1977*) places a responsibility upon doctors to notify the police if a person under their care may not be a fit and proper person to possess, carry or use a firearm, where the doctor has reason to believe that the person has or intends to apply for a firearm licence. The legislation provides immunity from civil action for doctors who report in good faith.

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APPENDIX 1

AMA CODE OF ETHICS – 2004

Editorially revised 2006 (reproduced with permission)

Members are advised of the importance of seeking the advice of colleagues should they be facing difficult ethical situations.

A1.1 PREAMBLE

The Australian Medical Association (AMA) Code of Ethics articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues and society.

This Code has grown out of other similar ethical codes stretching back into history including the Hippocratic Oath.

Because of their special knowledge and expertise, doctors have a responsibility to improve and maintain the health of their patients who, either in a vulnerable state of illness or for the maintenance of their health, entrust themselves to medical care.

The doctor–patient relationship is itself a partnership based on mutual respect and collaboration. Within the partnership, both the doctor and the patient have rights as well as responsibilities.

Changes in society, science and the law constantly raise new ethical issues and may challenge existing ethical perspectives.

The AMA accepts the responsibility for setting the standards of ethical behaviour expected of doctors.

A1.2 THE DOCTOR AND THE PATIENT

A1.2.1 Patient care

- Consider first the well-being of your patient.
- Treat your patient with compassion and respect.
- Approach health care as a collaboration between doctor and patient.
- Practise the science and art of medicine to the best of your ability.

- Continue lifelong self-education to improve your standard of medical care.
- Maintain accurate contemporaneous clinical records.
- Ensure that doctors and other health professionals upon whom you call to assist in the care of your patients are appropriately qualified.
- Make sure that you do not exploit your patient for any reason.
- Avoid engaging in sexual activity with your patient.
- Refrain from denying treatment to your patient because of a judgement based on discrimination.
- Respect your patient's right to choose their doctor freely, to accept or reject advice and to make their own decisions about treatment or procedures.
- Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests.
- Upon request by your patient, make available to another doctor a report of your findings and treatment.
- Recognise that an established therapeutic relationship between doctor and patient must be respected.
- Having initiated care in an emergency setting, continue to provide that care until your services are no longer required.
- When a personal moral judgement or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere.
- Recognise that you may decline to enter into a therapeutic relationship where an alternative health care provider is available, and the situation is not an emergency one.
- Recognise that you may decline to continue a therapeutic relationship. Under such circumstances, you can discontinue the relationship only if an alternative health care provider is available and the situation is not an emergency one. You must inform your patient so that they may seek care elsewhere.
- Recognise your professional limitations and be prepared to refer as appropriate.
- Place an appropriate value on your services when determining any fee. Consider the time, skill, and experience involved in the performance of those services together with any special circumstances.
- Ensure that your patient is aware of your fees where possible. Encourage open discussion of health care costs.
- When referring your patient to institutions or services in which you have a direct financial interest, provide full disclosure of such interest.
- If you work in a practice or institution, place your professional duties and responsibilities to your patients above the commercial interests of the owners or others who work within these practices.

- Ensure security of storage, access and utilisation of patient information.
- Protect the right of doctors to prescribe, and any patient to receive, any new treatment, the demonstrated safety and efficacy of which offer hope of saving life, re-establishing health or alleviating suffering. In all such cases, fully inform the patient about the treatment, including the new or unorthodox nature of the treatment, where applicable.

A1.2.2 Clinical research

- Accept responsibility to advance medical progress by participating in properly developed research involving human participants.
- Ensure that responsible human research committees appraise the scientific merit and the ethical implications of the research.
- Recognise that considerations relating to the well-being of individual participants in research take precedence over the interests of science or society.
- Make sure that all research participants or their agents are fully informed and have consented to participate in the study. Refrain from using coercion or unconscionable inducements as a means of obtaining consent.
- Inform treating doctors of the involvement of their patients in any research project, the nature of the project and its ethical basis.
- Respect the participant's right to withdraw from a study at any time without prejudice to medical treatment.
- Make sure that the patient's decision not to participate in a study does not compromise the doctor–patient relationship or appropriate treatment and care.
- Ensure that research results are reviewed by an appropriate peer group before public release.

A1.2.3 Clinical teaching

- Honour your obligation to pass on your professional knowledge and skills to colleagues and students.
- Before embarking on any clinical teaching involving patients, ensure that patients are fully informed and have consented to participate.
- Respect the patient's right to refuse or withdraw from participating in clinical teaching at any time without compromising the doctor-patient relationship or appropriate treatment and care.
- Avoid compromising patient care in any teaching exercise. Ensure that your patient is managed according to the best-proven diagnostic and therapeutic methods and that your patient's comfort and dignity are maintained at all times.
- Where relevant to clinical care, ensure that it is the treating doctor who imparts feedback to the patient.

- Refrain from exploiting students or colleagues under your supervision in any way.

A1.2.4 The dying patient

- Remember the obligation to preserve life, but, where death is deemed to be imminent and where curative or life-prolonging treatment appears to be futile, try to ensure that death occurs with dignity and comfort.
- Respect the patient's autonomy regarding the management of their medical condition including the refusal of treatment.
- Respect the right of a severely and terminally ill patient to receive treatment for pain and suffering, even when such therapy may shorten a patient's life.
- Recognise the need for physical, psychological, emotional, and spiritual support for the patient, the family and other carers not only during the life of the patient, but also after their death.

A1.2.5 Transplantation

- Recognise that a potential donor is entitled to the same standard of care as any other patient.
- Inform the donor and family fully of the proposal to transplant organs, the purpose and the risks of the procedure.
- Exercise sensitivity and compassion when discussing the option to donate organs with the potential donor and family.
- Refrain from using coercion when obtaining consent to all organ donations.
- Explain brain death to potential donor families. Similarly explain that continued artificial organ support is necessary to enable subsequent organ transplantation.
- Ensure that the determination of the death of any donor is made by doctors who are neither involved with the transplant procedure nor caring for the proposed recipient.
- Recognise the important contribution donor families make in difficult circumstances. Ensure that they are given the opportunity to receive counselling and support.

A1.3 THE DOCTOR AND THE PROFESSION

A1.3.1 Professional conduct

- Build a professional reputation based on integrity and ability.
- Recognise that your personal conduct may affect your reputation and that of your profession.

- Refrain from making comments which may needlessly damage the reputation of a colleague.
- Report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body.
- Where a patient alleges unethical or unprofessional conduct by another doctor, respect the patient's right to complain and assist them in resolving the issue.
- Accept responsibility for your psychological and physical well-being as it may affect your professional ability.
- Keep yourself up to date on relevant medical knowledge, codes of practice and legal responsibilities.

A1.3.2 Advertising (editorially revised in November 2006)

- Confine advertising of professional services to the presentation of information reasonably needed by patients or colleagues to make an informed decision about the availability and appropriateness of your medical services.
- Make sure that any announcement or advertisement directed towards patients or colleagues is demonstrably true in all respects. Advertising should not bring the profession into disrepute.
- Do not endorse therapeutic goods in public advertising.
- Exercise caution in endorsing non-therapeutic goods in public advertising.
- Do not have any public association with products that clearly affect health adversely.
- Ensure that any therapeutic or diagnostic advance is described and examined through professional channels, and, if proven beneficial, is made available to the profession at large.

A1.3.3 Referral to colleagues

- Obtain the opinion of an appropriate colleague acceptable to your patient if diagnosis or treatment is difficult or obscure, or in response to a reasonable request by your patient.
- When referring a patient, make available to your colleague, with the patient's knowledge and consent, all relevant information and indicate whether or not they are to assume the continuing care of your patient during their illness.
- When an opinion has been requested by a colleague, report in detail your findings and recommendations to that doctor.
- Should a consultant or specialist find a condition which requires referral of the patient to a consultant in another field, only make the referral following discussion with the patient's general practitioner – except in an emergency situation.

A1.4 PROFESSIONAL INDEPENDENCE

- In order to provide high quality healthcare, you must safeguard clinical independence and professional integrity from increased demands from society, third parties, individual patients and governments.
- Protect clinical independence as it is essential when choosing the best treatment for patients and defending their health needs against all who would deny or restrict necessary care.
- Refrain from entering into any contract with a colleague or organisation which may conflict with professional integrity, clinical independence or your primary obligation to the patient.
- Recognise your right to refuse to carry out services which you consider to be professionally unethical, against your moral convictions, imposed on you for either administrative reasons or for financial gain or which you consider are not in the best interest of the patient.

A1.5 The doctor and society

- Endeavour to improve the standards and quality of, and access to, medical services in the community.
- Accept a share of the profession's responsibility to society in matters relating to the health and safety of the public, health education and legislation affecting the health of the community.
- Use your special knowledge and skills to minimise wastage of resources, but remember that your primary duty is to provide your patient with the best available care.
- Make available your special knowledge and skills to assist those responsible for allocating healthcare resources.
- Recognise your responsibility to give expert evidence to assist the courts or tribunals.
- When providing scientific information to the public, recognise a responsibility to give the generally held opinions of the profession in a form that is readily understood. When presenting any personal opinion which is contrary to the generally held opinion of the profession, indicate that this is the case.
- Regardless of society's attitudes, ensure that you do not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or convicted.

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