



Medical Board of Queensland

BULLETIN

ISSUE 17

SEPTEMBER 2003

Dear Colleagues

This edition of the Medical Board Bulletin contains a wide range of articles. There is a common theme although this may not be evident initially. The majority of articles arise from concerns or complaints which have come to the Board's attention, and where it is hoped that advice will be of assistance to practitioners.

The topic of patient confidentiality has been highlighted by a recent Court ruling (in another State). The Board receives a steady trickle of complaints about confidentiality, a significant percentage of which relate to Family Court matters. If practitioners have any doubts in these areas, they would be wise to consult their medical indemnity organisation before proceeding.

Practitioners will recall that a previous Bulletin article highlighted the unforeseen difficulties caused to retired doctors, and the use of the title Doctor, by the provisions of the Medical Registration Act. The Minister acted promptly and the Act has been amended to include a new category of registration designated 'non-practising'. This will replace the previous practice of the Board in waiving the registration fee for retired practitioners. The details of the new category are provided in an article in this Bulletin.

Practitioners will be required to register in the category, rather than simply transferring from their current category. However, payment of an initial fee is all that is required for the practitioner to stay on the Register indefinitely. The important issue for practitioners in this category is that it precludes any form of medical practice including prescribing and writing of referrals to specialists.

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REMINDER:
**General and
Specialist
registration
renewal payments
are due
no later than
30 September 2003**

**Renewal notices can be
downloaded from
[www.medicalboard.
qld.gov.au](http://www.medicalboard.qld.gov.au)**

Medical Board of Queensland: 19th Floor, Forestry House, 160 Mary Street, BRISBANE 4000.
Postal Address: PO Box 2438, BRISBANE 4001
Inquiries/Registrations: (07) 32252503 Fax: (07) 3225 2522
Complaints: (07) 3234 0187 Fax: (07) 3225 2527
Impairments: (07) 3234 1345 Fax: (07) 3247 3267

www.medicalboard.qld.gov.au
medical@healthregboards.qld.gov.au
medicalcomplaints@healthregboards.qld.gov.au
healthassessment@healthregboards.qld.gov.au

Currently, there is an Australian Health Ministers Advisory Council ('AHMAC') Working Party considering a model for a nationally consistent approach to medical registration.

The principles behind the Working Party's task are listed as:

- Improvement of current portability arrangements to ease movement of practitioners across jurisdictions
- Nationally consistent categories of registration
- Maintenance of competency and skills
- A nationally consistent approach to public access of register information
- Development of an Australian Index of Medical Practitioners

To enable all these topics to be drawn together and work successfully on a national basis, there needs to be an accurate national database or index.

Each of these subjects comprises the topics of five expert working groups. It is hoped that the outcome will allow for much greater harmony amongst regulatory authorities in Australia and as a consequence, a better 'deal' for practitioners and the public.

Through the enhancement of the mutual recognition system it is hoped to overcome the problems of interstate locums, telemedicine and interstate consulting by specialists such as pathologists.

Categories of registration considered will include non-practising doctors and medical students.

Public access to information on registers varies significantly between jurisdictions and is obviously a contentious issue.

The Working Party has a tight time frame, and its report is expected to be considered by Health Ministers in the first half of 2004.

Dr Lloyd Toft
Chairperson

Profile of New Board Member – Dr Gerry FitzGerald

Dr Gerry FitzGerald graduated from the University of Queensland in 1976. After two years at the Mater Hospital, he worked as Medical Registrar and subsequently became the Director of the Emergency Department at Ipswich Hospital for over ten years. He joined the Queensland Ambulance Services as Medical Director in 1990 and afterwards became Commissioner, a position he held for almost ten years. Gerry took up his current position of Chief Health Officer (CHO), Queensland Health in January this year.

Gerry is a Foundation Fellow of the Australasian College for Emergency Medicine and is a Fellow of the Royal Australian College of Medical Administrators and the Australian College of Health Service Executives. He also holds a Bachelor of Health Administration and a Doctor of Medicine Degree from the University of Queensland.

He has held numerous positions within the College for Emergency Medicine and the Journal of Emergency Medicine, and as part of his current position represents the Department of Health on a number of Councils and Boards including the NHMRC and ACHS.

As CHO, he is responsible for the provision of advice to the Minister and the Director-General on health matters. He is also the regulator of private hospitals and provides leadership in the areas of clinical quality, research and education.

Dr FitzGerald's main interests lie in health care systems and in particular Emergency Medical Systems.

Non-Practising Registration

A new category of registration is available, for use principally by retired doctors, following amendments to the *Medical Practitioners Registration Act 2001*, which took effect on 28 March 2003. The category permits registration without practice rights for suitable persons who are or have been registered as a medical practitioner in Queensland, or elsewhere.

The non-practising category of registration was introduced in response to concerns expressed by retired doctors to the Minister for Health last year regarding removal of the fee waiver provisions, and the impact of proposed recency of practice requirements on such doctors. The Minister took steps to restore the fee waiver provision for retired doctors as an interim measure, while an appropriate strategy was pursued which would ensure retired doctors could continue to use the title 'Dr' and retain the status of a medical practitioner.

Eligible doctors who wish to be registered in the non-practising category must submit an application in the approved form together with a once only application fee. If the application is approved, the doctor's name will remain on the register as a non-practising registrant on an ongoing basis, without the necessity for annual application for renewal of registration.

The legislation provides that a standard condition of such a registration is that the registrant does not practise the profession. The Board interprets this to mean the cessation of all medical practice activities including, but not limited to, the writing of remunerated or unremunerated prescriptions or specialist referrals. A breach in this respect can attract a maximum penalty of \$7,500.

A non-practising registrant may take or use the title 'doctor', or a title, name, initial, symbol, word, or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate a medical qualification held by the registrant.

The fee waiver provision for retired doctors, which was available again last year, has now been revoked.

Confidentiality

Recently the Medical Board considered a complaint from a patient about a breach of confidentiality. The patient had been involved in a Family Court matter as a result of which she lost custody of her child.

The patient had attended a general practitioner on several occasions and had been prescribed medication. The solicitor for another party in the matter contacted the practitioner and asked for some information about the patient's treatment.

The practitioner was reluctant to provide any information without the patient's consent or a subpoena. Believing that the solicitor already had the information and that a subpoena would be issued, the practitioner gave the solicitor some fairly general information about the patient.

The solicitor did not obtain a subpoena but submitted an affidavit to the court which contained the general information provided by the practitioner.

Disclosure of information about a patient can be excused where there is a serious and imminent threat to health. Concern for the welfare of the child may have influenced the solicitor and the practitioner to act as they did but the Board did not accept that the circumstances justified the disclosure.

The Board made a finding of unsatisfactory professional conduct and reprimanded the practitioner.

This incident occurred before the December 2000 amendments to the Commonwealth Privacy Act and the practice concerned has since adopted a written Privacy Policy and has a Patient Information Sheet on its privacy policy.

Medical practitioners in private practice are required to comply with the Privacy Act and should by now have reviewed their privacy policy and practices. There are publications of assistance including the Australian Medical Association's *Privacy Resource Handbook for Medical Practitioners in the Private Sector* and the *Handbook for the Management of Health Information in Private Medical Practice* published by the Royal Australian College of General Practitioners.

Ganglions of the Hand and Wrist

A recent complaint to the Board concerned complications following an attempted surgical treatment of a ganglion of the wrist as an office procedure.

Ganglion is the most common soft tissue tumour of the hand and wrist. Treatment options include observation, aspiration and surgical incision. A conservative approach is commonly appropriate. Indications for surgery include pain, interference with activity and nerve compression.

Surgical excision is effective with a low rate of recurrence provided that the stalk of the cyst and the joint capsule at the origin of the stalk are excised. A good knowledge of the relevant anatomy, appropriate equipment, good

lighting and sterile conditions are required to minimise injury to adjacent structures and the risk of recurrence. A bloodless field is highly desirable.

The main complications are recurrence and injury to cutaneous nerves. There is a fairly high incidence of complications when these lesions are treated under local anaesthesia because a bloodless field cannot be achieved and the local anaesthetic itself can distort tissue planes increasing the risk of damage to cutaneous nerves.

Surgical treatment of a ganglion is not just a minor operation. A formal surgical environment is required.

Misuse of Thyroxine and Diuretics by Patients with Eating Disorders

Prepared by Dr Jacinta Powell, A/Principal Advisor in Psychiatry, Mental Health Unit, Queensland Health, at the request of the Board

Misuse of drugs, both licit and illicit, is common in patients with eating disorders. Certain substances are used with the thought that they will contribute to weight loss or curb appetite, including amphetamines, appetite suppressants, laxatives and diuretics.

In a survey of 275 patients with Bulimia Nervosa, Mitchell *et al* (1985) found that laxative abuse was reported in 60.6% and diuretic abuse in 33.1% of patients. Of these patients, 10.2% reported using diuretics on a daily basis as a means of weight control. Surveys by Halmi *et al* (1981) and Johnson *et al* (1984) of college and high school students found about 4% of students were using diuretics. Garner and Garfinkel (1997) suggested that diuretic use is not uncommon in late adolescent and young adult women, but is more frequent in patients with eating disorders.

Over the counter diuretics seem to be relatively weak. However, the use and misuse of prescription diuretics is of concern due to potentially serious adverse consequences, particularly hypokalaemia, dehydration, weakness and cardiac conduction abnormalities.

The misuse of thyroxine and thyroid medications has been described in case reports since the mid-1980s. Garner and Garfinkel noted that misuse of thyroid hormones, or withholding of appropriate anti-thyroid hormones, may occur with patients with thyroid disease to prompt weight loss or counteract weight gain. They also noted that some patients without thyroid disease may abuse thyroid medication and cited case reports of women surreptitiously using their mothers' thyroid medication and presenting with clinical signs of hyperthyroidism.

Wark *et al* (1998) reported a case of thyrotoxicosis in a young pregnant woman who had long standing Anorexia Nervosa. Kaplan (1998) detailed the case of a young man using up to 500 mg of thyroxine per day as a stimulant and weight loss agent. Webster *et al* (1991) in a case series found that it was not uncommon for women with eating disorders to receive prescriptions for thyroxine due to abnormal TFTs, which are secondary to eating disorders, in particular Anorexia Nervosa. The authors reported that

7% of the anorexic patients in this series reported having abused thyroxine.

It is important to consider the potential for misuse and abuse of commonly available prescription medications such as diuretics and thyroxine, particularly by females and males in late adolescence and early adulthood when eating disorders are at their peak. Requests for thyroid hormone prescriptions should be viewed cautiously in the absence of supporting clinical information. In addition, an awareness of the abnormalities in laboratory tests, particularly endocrine parameters, which accompany anorexia nervosa, is necessary to prevent the unwarranted prescription of medications such as thyroxine without the underlying cause being established.

References

- Garner, D.M., Garfinkel, P.E. 1997. *Handbook of treatment for Eating Disorders*, The Guildford Press, New York.
- Halmi, K.A., et al 1981. *Psychological Medicine*, 11, 697-706.
- Johnson, C.L., et al 1984. *Report of the Fourth Ross Conference in Medical Research*, September 1983, 14-18.
- Kaplan, R. 1998. 'Thyroxine Abuse', *The Australian and New Zealand Journal of Psychiatry*, 32(3), 464-465.
- Mitchell, J.E. et al 1985. *American Journal of Psychiatry*, 142:4, 482-485.
- Wark, H. 1998. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 38:2, 221-223.
- Woodside, D.B., et al 1991. *International Journal of Eating Disorders*, 10, 111-115.

Communicable Diseases

Queensland Health has requested that medical practitioners be reminded of their responsibilities with regard to disease control and informed of some important conditions that may be relevant to their practice.

Certain diseases are notifiable diseases in Queensland. Under the *Health Act 1937*, medical practitioners are required to notify patients with these conditions to Queensland Health. In practice, most of these conditions will be notified automatically by the diagnosing laboratory. However, practitioners' diligence in notification of the following conditions will facilitate timely public health interventions:

- Suspected invasive meningococcal or Haemophilus influenzae type b (Hib) disease
- Suspected measles
- Suspected dengue
- Foodborne or waterborne illness in two or more associated cases
- Foodborne illness in a food handler
- Haemolytic uraemic syndrome
- Acute flaccid paralysis
- Acute viral hepatitis
- Pertussis

- Diphtheria
- Probable or confirmed Severe Acute Respiratory Syndrome (SARS)

Public Health Units are located in key areas of the state to coordinate the local response to these diseases. Practitioners' assistance in timely notification of these conditions will ensure that optimal preventive measures are put in place. These Units can assist doctors with any queries regarding these conditions.

A number of fact sheets and information are available online at: <http://www.health.qld.gov.au/HealthyLiving>

New practitioners to Australia are also advised that all Australian bats and flying foxes are considered to potentially carry Australian Bat Lyssavirus. This infection gives the same clinical presentation as rabies and has the same poor prognosis. Individuals who sustain a bite or scratch or have other percutaneous or percutaneous exposure to bat saliva or neural tissue should be brought to the immediate attention of the local Public Health Units to coordinate the provision of rabies prophylaxis.

Anti-Snoring Devices

Notice from Dental Board of Queensland

Following consideration of a complaint, the Dental Board of Queensland is satisfied that the provision of a mandibular advancement splint by any person other than a dentist, (including a registered dental prosthetist) is the illegal practice of dentistry.

The Dental Board of Queensland strongly advises that it is totally inappropriate for a dentist or medical practitioner to prescribe or refer a patient for an anti-snoring device to a dental technician or dental prosthetist. If the dentist or medical practitioner is not competent to provide this treatment then they should refer the patient to an appropriately trained general dental practitioner or specialist.

The Board's reasons for this decision are:

- the *Dental Technician and Dental Prosthetists Registration Act 2001* does not provide for Dental Technicians and Dental Prosthetists to provide anti-snoring devices;
- Anti-snoring devices are orthodontic devices;
- the literature outlines many clinical consequences for teeth and the temporomandibular joints following the use of anti-snoring devices;
- Anti-snoring devices should be provided by trained dental practitioners following assessment by specialist medical practitioners and their use should be monitored by both the dental practitioner and medical practitioner.

The Dental Board also advises that the clinical management of current patients using such devices should be immediately referred to an appropriately trained specialist or general dental practitioner.

It is the intention of the Dental Board to take all necessary steps to ensure that the public of Queensland are only treated by appropriately trained and competent dental practitioners.

Accordingly, the Dental Board will fully pursue any future complaint of a person, other than a dentist or a medical practitioner, undertaking clinical treatment of snoring or sleep apnoea with a dental device.

Doctors and Overseas Travellers

Included at the request of Queensland Health

A recent coronial inquiry concerned the case of a traveller who contracted a fatal infection whilst overseas, which caused diagnostic difficulties upon return to Australia. The patient had returned home from Indonesia, at which time he became unwell, and died as a result of confluent bronchopneumonia (melioidosis) caused by *Burkholderia pseudomallei*. The coroner found that the delay in diagnosing the condition may have contributed to the patient's death. The coroner's recommendations highlighted the need for medical practitioners to assist patients prior to overseas travel and to be aware of the greater range of diagnostic possibilities, should returned travellers become ill.

During the 1999/2000 financial year, more than 3.3 million Australians travelled overseas. One in five of these travelled for business reasons. With increasing business and tourism links to countries in the region, travellers are often travelling at short notice. For the majority of travellers, the experience proves to be worthwhile, and is generally free of adverse health consequences. However, given the proximity to tropical/developing countries, travellers from Australia may be exposed to a number of infectious diseases, as well as other hazards.

Travelling overseas: Consider health risks

Medical practitioners need to be aware of the health risks associated with overseas travel. These potential risks include:

- Health risks associated with air travel
- The impact of pre-existing health problems, ongoing need for medications
- Difficulty in accessing medical help in remote locations
- Risks associated with characteristics of the travel such as destination, purpose and duration of visit
- Local climatic conditions such as excessive temperature and humidity
- Potential exposure to disease vectors.

Forward planning, appropriate preventive measures and careful precautions can substantially reduce the risks of adverse health consequences. The medical profession and the travel industry can both provide information and guidance to travellers to enable them to understand the risks involved, and to take the necessary precautions for the journey.

Good planning pays off

The World Health Organisation, in its 2002 edition of 'International Travel and Health,' recommends travellers intending to visit a destination in a developing country, should consult a travel medicine clinic or medical practitioner before the journey. This consultation should preferably take place 4–6 weeks before the journey, particularly if vaccinations may be required. This consultation will determine the need for any vaccinations and/or chemoprophylaxis, as well as providing information on ways to reduce the risk of exposure to infectious agents. However, last-minute travellers can also benefit from a medical consultation, even as late as the day before travel. Signage in your surgery may encourage potential travellers to seek advice in a timely manner.

Pre-travel medical assessment can provide advice regarding risk-assessment based immunisation; malaria prophylaxis; advice regarding sexually transmitted infections (especially HIV and antibiotic resistant strains of gonorrhoea); reduction of risks regarding food and water; and management of underlying medical problems as a traveller. Exposure to potential infectious agents depends on the presence of infectious agents in the area to be visited. The risk of becoming infected will vary according to the purpose of the trip, the itinerary within the area, the standards of accommodation, hygiene and sanitation, as well as the behaviour of the traveller. In some instances, disease can be prevented by vaccination, but there are many infectious diseases, including some of the most important and most dangerous, for which no vaccines exist.

Unusual illness: Consider recent overseas travel

Medical practitioners are generally aware of the need to take a travel history from patients who present with a febrile illness, dermatologic conditions, or diarrhoea. The outcome of treatment in such cases may depend on the type of infectious agent, the natural history of infection, the timeliness of diagnosis and appropriate treatment, superimposed on patient-specific factors such as co-existing disease and medications. It is incumbent on all health providers to improve knowledge and skills in the management of tropical infectious diseases, and seek early assistance from appropriate specialist services if required, in order to expedite the diagnosis and treatment. Suspected or confirmed notifiable conditions such as measles and dengue fever, should also be promptly notified to the local Public Health Unit to facilitate prompt timely health action.

Community Education: Consider participation

Travel medicine is acknowledged as an area of special interest. Professional organisations, health practitioners in the public and private sector, and educational institutions, should aim to incorporate the enhancement of knowledge and skills in this discipline into their organisational strategies and curricula. Furthermore, there is a need for collaboration with industry and the wider community to ensure that valuable educational opportunities are not wasted. There is a need for both health practitioners and

the travelling public to be kept informed of the trends in travel and tropical medicine, particularly regarding problems such as malaria, vaccine-preventable diseases and other infections, and the risk of injuries such as road trauma. Public Health Units are available to provide timely responses to diseases of public health importance, including imported infections.

Useful references:

Looke D J and Robson J M B. 2002. Infections in the returned traveller. *The Medical Journal of Australia*. Vol 177 pp 212-219.

WHO. 2002. 'International Travel and Health,' available on-line at <http://www.who.int/ith/>

Control of Medical Records

Following a recent incident the following matter has been drawn to the attention of the Board by the Director, Professional Services Review. The *Health Insurance Act 1973*, in section 89B, gives the Director the power to require the production of specified medical records. The sanctions for non-compliance is exclusion from the Medicare arrangements until the records are produced.

The current case: A practitioner was required to produce a number of medical records under a section 89B notice. The response initially was that the practitioner did not have control of the identified records but a nominated company did, with a few records held by another medical practice.

Section 89B notices were issued to each of these entities. The other medical practice produced the records it held. The nominated company responded by advising that it did not control the records. It advised it was only a software company supplying software to medical practices in return for a monthly licence fee. The software was activated by a software 'key' supplied by the company on receipt of the fee. It also transpired that the medical practitioner and company were in a financial dispute over this arrangement.

In summary the medical records and practice information are claimed to be stored on the hard drive of the practitioner's computer but could only be accessed by the use of a 'key' supplied by the software company. It is apparent that this may be a convenient arrangement until problems arise between the separate parties.

The consequence is that practitioners or locums may not be able to guarantee access to patient records against the wishes of the service company. It is considered this could have significant implications for the practice of medicine and patient care, and this arrangement is therefore drawn to the attention of medical practitioners.

Approvals for the use of Amygdalin

Queensland Health has advised that recently there had been an increase in the number of inquiries relating to the

use of Amygdalin. Amygdalin, also known as Laetrile and Vitamin B17, is purported in "alternative" circles to be an effective agent in the treatment and prevention of cancer.

However, Amygdalin is listed in Appendix C of the Standard for the Uniform Scheduling of Drugs and Poisons (the Standard). Substances listed in Appendix C of the Standard are those poisons that are considered of such danger to health as to warrant prohibition of sale, supply and use. Accordingly, all Appendix C poisons of the Standard are regulated poisons under Queensland's *Health (Drugs and Poisons) Regulation 1996* and specific approval is required for them to be obtained, possessed and used.

The Queensland Health policy on the issue of approvals for Amygdalin (Vitamin B17/Laetrile) under the *Health (Drugs and Poisons) Regulation 1996* can be viewed on the Board's website at www.medicalboard.qld.gov.au, or alternatively the Queensland Health website at www.qheps.health.qld.gov.au/PHS/Documents/ehu/manual/19967.pdf.

Medical Practitioners are Mandated to Report Suspicions of Child Abuse and Neglect - s.76K Health Act 1937

Background:

The abuse and neglect of children is not uncommon in Queensland. It is probable that an individual medical practitioner should have cause to suspect child abuse and/or neglect (CAN) on multiple occasions in the course of a career.

The medical literature of the past half-century has clearly identified CAN as a cause of preventable mortality and morbidity. CAN is now identified in standard medical reference texts, and across a multitude of sub-speciality texts, as a legitimate and important part of the medical differential diagnosis for a diverse range of presenting symptoms and signs in infancy and childhood.

Research has clearly established that family members, care-givers and family friends are commonly responsible when children are abused and/or neglected. This has implications for the medical practitioner - this adult may be the person presenting the child for consultation, or potentially have a vested interest in concealing/minimising the circumstances surrounding the abuse and/or neglect.

In the context of pervasive peer-reviewed medical literature, there is a proportional expectation of competency for medical practitioners to identify and professionally manage presentations where CAN could reasonably be suspected in the circumstances of the child's presentation for medical care.

Reporting:

In Queensland, medical practitioners are mandated in law to notify suspected CAN. *Section 76K of the Health Act 1937* requires that:

- (1) “A medical practitioner who suspects on reasonable grounds the maltreatment or neglect of a child in such a manner as to subject or be likely to subject the child to unnecessary injury, suffering or danger shall, within 24 hours after first so suspecting, notify by the most expeditious means available to the medical practitioner a person authorised under a regulation to be so notified.”

“A person authorised under a regulation” in Queensland is:

- an officer of Department of Families (DoF);
- an officer of the Queensland Police Service (QPS);
- the medical officer appointed to the local *Suspected Child Abuse & Neglect (SCAN) Team*.

The state-wide system of *Suspected Child Abuse & Neglect (SCAN) Teams* was initiated by the Queensland government in 1980 to ensure an effective and co-ordinated, multi-disciplinary response to notifications of suspected child abuse & neglect in Queensland.

The medical officer appointed to the local SCAN Team is an important resource and touch-stone for medical practitioners in circumstances of suspected CAN. The appropriate management of suspected child abuse and/or neglect is a specialised area of medical practice. As such, the development of a clinical referral and consultation relationship between an individual medical practitioner - who may have limited expertise - and other practitioners with particular expertise in the field is an expectation of appropriate medical practice.

In regard to notification of suspected child abuse and/or neglect, *s.76K of the Health Act 1937 further requires that:*

- (2) “Where notification is given to an authorised person pursuant to subsection (1), the medical practitioner so notifying shall, within 7 days after doing so, forward to the chief executive a further notification in the approved form.”

The chief executive in regard to this Act is the Director-General of Queensland Health. For practical purposes, this power has been delegated to the Chief Health Officer (CHO). Therefore, **notification forms should be directed to the Office of the Chief Health Officer.**

Copies of the appropriate form are available through the Office of the Chief Health Officer (07 323 40537) and/or are available for electronic down-load from the Queensland Health Electronic Publications System (QHEPS) at: www.qheps.health.qld.gov.au.

Protections:

Section/s 76K(6),(7) of the Health Act 1937 give explicit protection in law to medical practitioners who make notification of suspected CAN in compliance with the Act:

- (6) *Where in compliance or purported compliance with this section a notification is given or a statement or further information furnished in good faith by a medical practitioner—*

- (a) *no liability at law is incurred in respect of the giving or furnishing thereof by the medical practitioner;*
- (b) *the giving or furnishing thereof shall not in any proceedings before any court or tribunal or in any other respect be held to constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct.*

- (7) *A person does not incur any liability as for defamation by the publication of any defamatory matter contained in a notification or statement or further information as aforesaid where such publication is made in good faith and pursuant to any provision of or otherwise in the execution of this division.*

There are further protections in relation to notification given under the *Child Protection Act 1999*.

Further Information:

In the first instance, medical practitioners should seek advice from their local Child Protection service provider/s. This expertise can usually be accessed via the local paediatric medical unit (QH), the local office of the Department of Families (DoF), and/or the local police station (QPS).

There is an on-call Child Protection paediatrician available at all times to provide timely advice to medical practitioners. This service can be accessed via the Royal Children’s Hospital (07 3636 8111) and/or the Mater Children’s Hospital (07 3840 8111) switch-boards.

The Office of the Chief Health Officer (07 323 41138) and or the Queensland Health Paediatric Adviser (Dr Richard Roylance) (richard_roylance@health.qld.gov.au / 0411 601 681) should be contacted if these strategies prove insufficient and/or further advice is required.

Summary:

- CAN has serious implications for present and future physical, intellectual and emotional health.
- Medical practitioners have an obligation to display competency in the identification and management of child abuse and neglect, as a legitimate part of a medical differential diagnosis.
- Family, care-givers and friends may be directly responsible for the abuse and/or neglect of an individual child. This has implications for medical practice.
- Medical practitioners in Queensland are mandated in law to report suspected CAN.
- The medical officer appointed to the local SCAN Team is an important resource and touch-stone for medical practitioners in circumstances of suspected CAN. The development of a clinical referral and consultation relationship between an individual medical practitioner - who may have limited expertise - and other practitioners with particular

expertise in the field is an expectation of appropriate medical practice.

- Initial notification of suspected CAN should be within 24 hours, and directed to a local authorised person - this is to ensure the immediate safety of the child. Notification forms should subsequently be directed to the Office of the Chief Health Officer within seven (7) days.
- Explicit protection in law is given to medical practitioners who make notification of suspected CAN in compliance with the *Health Act 1937*. There are further protections given under the *Child Protection Act 1999*.
- State-wide 24 hour access to clinical advice is available - the 'on-call' Child Protection paediatrician at the Royal Children's Hospital (07 3636 8111) and/or the Mater Children's Hospital (07 3840 8111) switch-board/s.

Security of Prescription Stationery

An increase in the incidence of forgery of computer generated prescriptions has recently been identified by Queensland Health. Based on the similarities between the forgeries, it appears that the activity may be limited to a single individual or a group in the coastal area extending from the Sunshine Coast to the Gold Coast. Prescription stationery, forgeries, or the drugs fraudulently obtained from such forgery are likely to be sold for substantial financial gains. The drugs obtained from these activities are frequently injected by drug users, and can cause significant morbidity and mortality.

The recent forgery incidents have involved the use of computer generated prescription stationery blanks removed from medical practices on both the Gold and Sunshine Coasts. It appears that the blanks are completed using a computer and printer.

Community pharmacies have been informed and asked to check any suspicious prescriptions with the issuing doctor. The medical practices from which the stationery was stolen were until recently unaware of the theft.

These incidents underline the need for doctors to review the security of their storage practices with regard to all prescription stationery including computer generated stationery and prescription pads.

Suggested areas for review include preventing opportunities for patients to obtain such prescription stationery when left alone in consulting rooms where such stationery is highly visible and also within other areas of the practice where patients may be able to access this stationery, such as unlocked storage cupboards. Doctors should also be equally vigilant in storing prescription papers at other times, such as in vehicles and at home. There have also been reports of the theft of prescription stationery from doctors homes and cars.

Please contact your local Public Health Unit or the Drugs of Dependence Unit (Tel: 3896 3900) if you require further assistance or would like to discuss these issues. The immediate reporting to local police of theft or attempted theft with a description of the suspect and/or vehicle is also advised.

Your cooperation in being security conscious at all times, will discourage the theft of prescription stationery and reduce the misuse of prescription medication.

Payment or Acceptance of a Benefit for Referrals

Attention is drawn to provisions in the *Medical Practitioners Registration Act 2001* which prohibit doctors from directly or indirectly paying or attempting to pay, or giving or attempting to give a benefit to a person in return for the referral of another person for a professional service. There is a further prohibition against the acceptance of a payment or benefit by a doctor for the referral of a patient to another medical practitioner, or to another health service provider. Similar provisions prohibiting such transactions are contained in the Acts regulating the other health professions.

If such an arrangement takes place between two registrants, each would have committed *prima facie* statutory offences. The breaches would occur on the one hand for the payment or benefit being made, and on the other for it being received. Equally if such an arrangement occurs between a registrant and a health practitioner other than a doctor, separate offences would have been committed by each party under the registration Acts for the respective professions.

Any consideration of whether an offence has been committed in a particular case would nevertheless require a close examination of the precise circumstances of the transaction. In this respect, the Board acknowledges that 'shared care' arrangements between doctors, and with other health practitioners do exist, and are regarded as legitimate collaborative activities between health practitioners. Such arrangements typically occur in co-treatment of patients by specialist registrants and general practitioners, and in cases such as pre-operative and/or post operative examinations conducted, for example, by optometrists for certain patients of ophthalmologists.

Any arrangement which could however be characterised as a payment or benefit arising specifically from a referral, might well be improper. The Board would be obliged to commence a prosecution in the Magistrates Court if an instance of making a payment, or giving a benefit, or accepting a payment, by a practitioner came to notice in circumstances which indicated a *prima facie* offence had been committed.

Such a matter, if proven, could result in a maximum penalty of \$15,000.00 being imposed.