MEDICAL BOARD OF AUSTRALIA

update

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Medical Board of Australia

Message from the Chair

For the first time the National Registration and Accreditation Scheme allows us to look at comprehensive data about the major health professions in Australia. There are more than 530,000 health practitioners registered in the 10 professions in the National Scheme. This represents one in 44 people in Australia, or one in 20 working Australians. Medicine is the second largest profession after nursing and midwifery, with just over 88,000 practitioners – about 17% of all registrants. The annual report recently published by the Australian Health Practitioner Regulation Agency (AHPRA) provides a detailed breakdown of the professions by age, gender, state and specialty (see www.ahpra.gov.au).

In the first year of the National Scheme, just over half of all notifications about health practitioners were about doctors; 1,455 in NSW and 2,667 across all other states and territories. This rate is broadly consistent with complaints rates recorded by previous state and territory medical boards. On the registration side, the work is more complex for medicine than most of the other professions because we have specialist registration, provisional registration (interns) and large numbers of international medical graduates with limited registration in areas of need and training positions. So while medicine is not the largest profession, regulating medical practice is a major part of the work of the National Scheme.

Almost eighteen months into the National Scheme, many people are still confused about how it all fits together: what AHPRA does, what the Boards do, what happens nationally and what happens in state and territory offices.

AHPRA and the National Boards work in partnership to deliver the National Scheme. They each have a set of responsibilities and functions set out in the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory. The National Law sets out the objectives, guiding principles and architecture of the National Scheme and defines the types of registration available and the processes for handling notifications about practitioners' health, performance and conduct.

The Medical Board of Australia sets policy and develops standards. National Board members are appointed by the Australian Health Workforce Ministerial Council (the Ministerial Council). There are eight practitioner members, one from each state and territory, and four community members. The National Board meets monthly and publishes a communiqué on its website after each meeting.

For medicine there is a state or territory board in each jurisdiction. Decisions about the registration, health, conduct and performance of individual practitioners are made at this level. State and territory board members are appointed by the Health Minister in each jurisdiction and these boards are committees of the National Board. Each state and territory board has a number of committees overseeing registration, notifications assessment, performance and professional standards and health. These committees' members include state and territory board members and external members. The National Law defines the composition of the National Boards as requiring at least half, and not more than two thirds, as practitioner members and the balance being community members. The state or territory boards and their committees also reflect this balance of practitioner and community membership. Information about the members of state and territory boards is published at www.medicalboard.gov.au.

AHPRA is the national agency that supports the National Boards and their delegates. AHPRA has a national office in Melbourne and an office in each state and territory. It employs the staff and administers the processes for registration and for investigation of notifications and is responsible, with the Boards, for keeping up-to-date and publicly-accessible registers for each profession.

In this second year of the National Scheme the initial hurdles, inevitable in such a major change, have been overcome. Our challenge now is to focus on ensuring that medical regulation plays its proper role in ensuring high standards of medical practice in Australia.

Dr Joanna Flynn AM
Chair
Medical Board of Australia

Contents

Bulletin Board

Sexual boundaries

The Board has released new guidelines on sexual boundaries, after consultation with the medical profession.

The guidelines confirm that good medical practice relies on trust between doctors and patients and their families. They state that it is always unethical and unprofessional for a doctor to breach this trust by entering into a sexual relationship with a patient, regardless of whether the patient has consented to the relationship.

The guidelines provide nationally-consistent advice to medical practitioners, replacing advice issued by previous regulatory authorities in each state or territory. In general, the national guidelines do not change the standards expected by previous state and territory boards, but they do make explicit the Board's expectations on this important issue.

The guidelines confirm that it may also be unethical and unprofessional for a doctor to enter into a sexual relationship with a former patient, an existing patient's carer or a close relative of an existing patient, if this breaches the trust the patient placed in the doctor.

The Board will investigate any medical practitioner who is alleged to have breached the guidelines and, if the allegations are substantiated, the Board will take necessary action under the National Law. The guidelines are published on the Board's website at www.medicalboard.gov.au under *Codes, guidelines and policies*.

Audit

All health practitioners registered under the National Law are required to comply with registration standards for English language skills, criminal history, recency of practice, continuing professional development and professional indemnity insurance.

Practitioners must retain the necessary documentation to demonstrate their compliance. The registration standards were developed by the Board after wide-ranging consultation and were approved by the Ministerial Council. They are published at www.medicalboard.gov.au under *Registration standards*.

AHPRA and the National Boards are developing a nationally-consistent approach to auditing the compliance of health practitioners with mandatory registration standards. A pilot will be held in early 2012 to trial the framework for auditing compliance to meet relevant legislative requirements, set the scope and terms of reference for the audit, and determine frequency, size and type of audits. It will also establish a methodology and process for reporting on findings.

Detailed information will be provided to practitioners in 2012 as the audit approach is further developed, informed by feedback from the pilot. The audit framework will be implemented by 1 July 2012.

Registration: renewals and certificates

More than 98% of medical practitioners who were due to renew their registration by the new national registration renewal date of 30 September, renewed on time. Nearly 85% renewed online.

The registration renewal processes was supported this year by an extensive communications campaign aimed at encouraging the profession to renew on time, online. The Board tried to strike a balance between making sure all practitioners were aware of their responsibility to renew, and over-supplying reminders. As practitioners become more familiar with the renewal cycle and the requirements of the National Law, AHPRA and the Boards will review the extent of reminders sent to practitioners.

There are significant consequences in the National Law for medical practitioners who do not renew within one month of their registration expiry date. If this happens, the practitioner's registration lapses so the individual cannot continue to practise medicine. A fast-track application process is open for one month after the late period ends. Fast-track applications can usually be assessed within 48-72 hours of receipt of a completed application; however, a criminal record check is required.

The Board has approved a new certificate of registration that will contain the same information as the current certificate but will be A5 (half A4) size which will reduce print and postage costs.

Medical practitioners can download, at no cost, a copy of their certificate of registration through online facilities at www.ahpra.gov.au under *Your account*.

Consultations

International criminal history checking

In December 2011 and January 2012, the Medical Board of Australia will be consulting on issues around international criminal history checks. Under the National Law, the Board is responsible both for protecting the public, and for enabling the continuous development of a flexible, responsive and sustainable workforce. International criminal history checking requires the Board to strike a balance between these two requirements by establishing a policy that provides appropriate safeguards without undue red tape.

Under the National Law, National Boards must check the criminal history of a person applying for registration. To do this, the Board may obtain a written report about the criminal history of the applicant from CrimTrac, a police commissioner and/or an entity in a jurisdiction outside Australia that has access to records about the criminal history of persons in that jurisdiction.

The National Law defines ***criminal history*** as:

- every conviction of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law
- every plea of guilty or finding of guilt by a court of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law and whether or not a conviction is recorded for the offence
- every charge made against the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law.

The current approach of the Board and AHPRA to checking criminal histories involves:

- seeking an Australian criminal history through CrimTrac and
- requiring the applicant to sign a declaration on the application form disclosing his or her criminal history in all countries including Australia.

The Board and AHPRA recognise that the lack of formal international criminal history checks is a weakness in the system. If a medical practitioner is found to have made a false declaration, the Board can take further action under the National Law.

AHPRA and the Board recognise that it is desirable to refine international criminal history checking beyond the current declaration–based approach, but are aware that all available options involve a number of logistical, practical and procedural issues.

A consultation paper on these issues will be published on the Board's website at www.medicalboard.gov.au in December and January. The Board welcomes feedback.

Definition of practice

The National Law does not define practice. The National Boards agreed to a common definition of practice and incorporated this into a range of registration standards that came into effect on 1 July 2010 with the start of the National Scheme, after a period of consultation.

Registered health practitioners work in various settings using their knowledge and skills as qualified health practitioners. The current definition of practice is broad. It takes into consideration the evolving nature of health care and the practice of the health professions, allowing for technological innovation and other changes to health care delivery. To limit the definition of "practice" to specified tasks, defined scopes of practice or only direct patient/client care relationships may inadvertently restrict the practice of the health professions and the delivery of health care services, contrary to the interests of the public.

The current definition of practice adopted by the Medical Board of Australia is:

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

The Board received feedback from stakeholders that the very broad definition of 'practice' used in the standards has caused practical difficulties and resulted in unintended consequences. Some other National Boards identified similar issues and have also consulted with their stakeholders, while others found the current definition useful and relevant to their profession.

In late 2011, the Medical Board and six other National Boards issued a consultation paper on the definition of 'practice' to address the issues that had been raised and to help them decide whether or not a change to the definition was necessary. Any change would require a change to the registration standards in which the definition is embedded and therefore approval of the Ministerial Council. A consultation paper was published on the Board's website in October and in November 2011, the Board held a stakeholder forum to understand in more detail the concerns held by some groups of practitioners.

The Board is now reviewing the feedback provided in the consultation process and will update the profession as decisions are made and future directions are set. Anyone with a specific interest in this issue should monitor the Board's website at www.medicalboard.gov.au and the Board's communiqués published after each Board meeting.

2010-11 annual report

The introduction of the National Scheme on 1 July 2010 represented an unprecedented change to medical regulation. The release of the 2010-11 annual report by AHPRA and the National Boards provides comprehensive data about the first year of operation of the National Scheme. It is published on the AHPRA website at www.ahpra.gov.au.

As well as profiling the professions and practitioners, the report provides the first national data on notifications involving health practitioners and the actions taken by the National Boards to protect public safety.

Important information about the medical profession published in the report includes:

- there are 88,293 registered medical practitioners in Australia, which is about 17% of all registrants in the National Scheme
- there are 16,839 registered medical students in Australia, which is 17% of the student register
- there are 6,221 medical practitioners with limited registration, most International Medical Graduates (IMGs) registered to practise in areas of need
- there are nearly 51,000 medical practitioners with specialist registration
- there were 4,122 notifications (complaints) against medical practitioners received during the year, representing about 51% of all notifications received under the National Law - these 4,122 notifications were made about 4% of all registered medical practitioners (see tables 13 and 14, annual report)
- the Medical Board of Australia (or the Medical Council of NSW) took immediate action on the registration of 62 practitioners during the year and as a result imposed conditions or accepted undertakings on the registration of about 75% of these practitioners (see table 21, annual report)
- there were 144 mandatory notifications received about medical practitioners, which is 33.6% of the 428 mandatory notifications received for all professions, and a rate of 16.3 per 10,000 practitioners (tables 22 and 23, annual report)
- of all mandatory notifications received, 59.1% were about a departure from standards, 29.9% related to impairment, 6.8% about sexual misconduct and 4.2% about drug and alcohol issues (table 24, annual report) and
- the Medical Board took immediate action in relation to 16 mandatory notifications and as a result imposed conditions, accepted an undertaking or suspended the practitioner's registration in all cases (table 27, annual report).

Comparisons with previous regulatory schemes should be approached with caution but the rate of notifications about medical practitioners appears broadly consistent with previous years.

The annual report is an important source of information about the Board's activities in 2010-11. The Board has also published a financial overview to explain in more detail the costs of national registration, the transition to the National Scheme and the Board's budget approach. This is published on the Board's website at www.medicalboard.gov.au.

Guidelines and conscious sedation

The Board recently received feedback that it should develop guidelines for medical practitioners who perform conscious sedation in dental surgeries. The Board was aware that the Dental Board of Australia was consulting on similar guidelines.

Under the National Law, the Board has a role in developing codes and guidelines for medical practitioners. These aim to clarify the Board's expectations of medical practitioners in relation to professional standards. In general, the Board does not believe that it has a role in developing clinical practice guidelines, which are developed by many reputable and highly-qualified groups including the National Health and Medical Research Council, specialist medical colleges and other statutory or government bodies.

The Board expects all medical practitioners to comply with its code of conduct, *Good Medical Practice*, regardless of their field of practice. The code states that good medical practice involves:

- recognising and working within the limits of your competence and scope of practice (2.2.1)
- ensuring that you have adequate knowledge and skills to provide safe clinical care (2.2.2)
- keeping your knowledge and skills up to date (7.2.1)
- participating regularly in activities that maintain and further develop your knowledge, skills and performance (7.2.2)
- ensuring that your practice meets the standards that would be reasonably expected by the public and your peers (7.2.3)

Good Medical Practice is published at www.medicalboard.gov.au under *Codes, guidelines and policies*.

Medical practitioners must work within their level of competence and training. The Board expects medical practitioners to be aware of relevant clinical practice guidelines about the areas in which they practise, produced by reputable sources.

When assessing a notification, the Board would measure a practitioner's conduct or performance against such guidelines, recognising that the definition of:

- *unprofessional conduct* includes conduct which is of a lesser standard than that which might be reasonably be expected by the public or the practitioner's professional peers and
- *unsatisfactory professional performance* means the knowledge, skill or judgement possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.

When medical practitioners are providing sedation and/or analgesia for diagnostic and interventional medical, dental or surgical procedures, the Board expects them to follow the guidelines of the Australian and New Zealand College of Anaesthetists, *Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures Professional Standards document PS9 (2010)*.

Registration standard on PII

Under the National Law, the Board must develop and recommend to the Ministerial Council one or more registration standards, including about professional indemnity insurance, criminal history, continuing professional development, English language skills and recency of practice.

The registration standards can be accessed on the Board's website at www.medicalboard.gov.au, under *Registration standards*.

The Board consulted widely on the standards which were approved by the Ministerial Council on 31 March 2010 and took effect on 1 July 2010.

Medical practitioners must comply with the standards and confirm that they have complied and/or will continue to do so at each renewal of registration. The Board can take action under the National Law if a practitioner does not comply with one or more of the registration standards.

The Board has received feedback from a professional indemnity insurer that some practitioners are confused about the registration standard for professional indemnity insurance (PII). In particular, it seems that some medical practitioners believe that they must hold their own PII, regardless of their employment situation.

The registration standard for PII takes into consideration that medical practitioners work in a range of settings and have a range of insurance arrangements in place. The registration standard is flexible enough to allow for this.

The registration standard states that all medical practitioners who undertake any form of practice must have PII **or some alternative form of indemnity cover** that complies with this registration standard, for all aspects of their medical practice.

If a medical practitioner is specifically precluded from cover for any aspect of practice under their insurance or indemnity arrangements, the practitioner must not practise in that area.

The registration standard describes a range of practice contexts and the usual nature of insurance cover that might be appropriate in the circumstances. These include:

(a) private practice

It would be usual for practitioners in private practice to have PII with an approved insurer. The PII must include run-off cover. The approved insurers listed here all meet the minimum product standards that apply to all medical indemnity insurers as defined in the *Medical Indemnity (Prudential Supervision and Products Standards) Act 2003* (Cth):

- Avant
- Invivo
- Medical Indemnity Protection Society Limited (MIPS)
- Medical Insurance Group (MIGA) and/or
- MDA National.

(b) employment in the public sector or contractual arrangements

It would be usual for practitioners employed in the public sector, or under certain contractual arrangements, to have cover under a master policy or legislation. Medical practitioners in these circumstances are complying with the registration standard.

(c) other indemnified employer

Medical practitioners who are employees or have contractual arrangements with a non-government employer, who holds the appropriate insurance to cover a medical practitioner, comply with this registration standard.

(d) statutory exemption from liability

A medical practitioner who is employed as a medical practitioner and is exempted from liability under a State or Commonwealth Act complies with the registration standard.

(e) practitioner working overseas

A medical practitioner registered in Australia but practising exclusively overseas is not required to provide evidence of PII.

The registration standard also states that when an individual medical practitioner's scope of medical practice does not include providing health care or medical opinion about the physical or mental health of any person, PII will not be required for the purposes of registration.

Medical practitioners who work in more than one setting may have different insurance arrangements covering each setting.

Panel hearings

An article on notifications was published in Issue 2 of the Medical Board *Update*. The article explained the process of investigating a notification, including the various actions that the Board can take.

The Board committed to publishing more information about panel and tribunal hearings in future editions of the Update. This article provides more information on panel hearings.

The Board has the power to take a range of actions after receiving a notification, after investigating a registered medical practitioner or after conducting a health or performance assessment.

These actions can include:

- a decision to take no further action
- referral to another entity such as a health complaints entity or
- to take immediate action if this is necessary to protect the health and safety of the public. More detail on this power was published in Issue 1 of *Update*.

If the Board believes that a practitioner's conduct or performance was unsatisfactory or that his or her health was impaired, it can:

- caution the medical practitioner and/or
- accept an undertaking from them and/or
- impose conditions on the practitioner's registration.

Alternatively, the Board may decide to refer matters to a health or performance and professional standards panel or a tribunal.

Health panels

The Board may establish a health panel if it decides it is necessary or appropriate and believes that a registered practitioner or student has or may have an impairment.

A health panel consists of at least three members, selected from a list of persons approved to be appointed as members of panels. In the case of medicine, at least two members must be registered medical practitioners. One of the medical practitioners must have expertise relevant to the matter that is the subject of the hearing. The third member must not be a registered medical practitioner.

Performance and professional standards panel

The Board may establish a performance and professional standards panel if it decides it is necessary or appropriate to do so and believes that because of a notification, or for any other reason that –

(a) the way a registered medical practitioner practises is or may be unsatisfactory or

(b) the registered medical practitioner's professional conduct is or may be unsatisfactory.

A performance and professional standards panel consists of at least three members, selected from a list of persons approved to be appointed as members of panels. At least half, but no more than two-thirds of the members of the panel must be registered medical practitioners and at least one person must represent the community.

Notice of hearing

The practitioner or student who is the subject of a panel hearing must be given notice of the hearing. That notice includes the nature of the hearing and details of the matters to be considered at the hearing. A practitioner or student is given adequate notice of the allegations to be raised and sufficient time to be able to consider the allegations, prepare a response or arguments about the issues in question, or to make a counter-argument as to why, for example, the practitioner's conduct was reasonable in the circumstances.

The notice must also state:

- the day, time and place at which the hearing is to be held
- that the registered medical practitioner or student is required to attend the hearing
- that the registered medical practitioner or student may be accompanied by an Australian legal practitioner or other person
- that if the registered medical practitioner or student fails to attend the hearing, the hearing may continue and the panel may make a decision in the absence of the practitioner or student and
- the type of decision the panel may make at the end of the hearing.

Procedure of a panel

The National Law states that a panel may decide its own procedures, though it must observe the principles of natural justice.

The panel is provided with a copy of all relevant information supplied by the notifier and practitioner and gathered by the investigator. Panel members will have read all the material before the hearing. The medical practitioner or student who is the subject of the hearing will have been provided with the same material as the panel and will have had the opportunity to read all the material and to prepare a response.

Panel hearings are informal and inquisitorial. The panel will ascertain the relevant information by interviewing the notifier (in most cases) and the practitioner. Notifiers and practitioners or students are interviewed separately and arrangements are made to avoid them meeting at the hearing. It is usual for the practitioner to be interviewed for about 30 to 45 minutes.

At the start of the hearing, one of the panel members (usually the Chair) will introduce panel members, state the purpose of the hearing and explain the allegations to be considered. The Chair will also explain the procedures which will apply at the hearing. Before the practitioner is interviewed, the Chair will summarise for the practitioner the information provided by the notifier.

Practitioners and students are given sufficient opportunity to make submissions, but the panel is not required to give extensive time to arguments which it considers do not have merit.

The panel may have regard to a report prepared by an assessor about the practitioner or student and any other information it considers relevant to the hearing. During the hearing, the panel may decide it requires further information on a specific issue and it may be necessary to adjourn to obtain this.

Referral to a tribunal

The panel must stop hearing a matter and require the Board to refer the matter to a tribunal if:

1. the practitioner or student who is the subject of the hearing asks the panel for the matter to be referred to the responsible tribunal or
2. the hearing is about a registered medical practitioner and:
   (a) the panel reasonably believes the evidence demonstrates the practitioner may have behaved in a way that constitutes professional misconduct or
   (b) the panel reasonably believes the evidence demonstrates the practitioner's registration may have been improperly obtained because the practitioner or someone else gave the Board information or a document that was false or misleading in a material way.

Presence of others at the hearing

There are not usually witnesses at a panel hearing. Panels tend to rely on witness statements.

The National Law allows a practitioner to be accompanied by a legal practitioner or another person. The panel has the discretion to decide whether or not the legal representative or other person speaks for the practitioner at the hearing. The panel is likely to consider factors such as the practitioner's ability to participate in the process, the complexity of the material to be considered, the gravity of the allegations and the nature of the notification.

The practitioner and/or a representative of the practitioner cannot be present when the notifier is interviewed.

Panel hearings are not open to the public.

The standard of proof in a panel hearing

The standard of proof for a panel hearing is the civil standard known as 'satisfaction on the balance of probabilities' that the allegations occurred. This means that the panel must be reasonably satisfied that the facts disputed by the practitioner actually occurred.

Decision of a panel

After hearing a matter about a medical practitioner, the panel may decide that the practitioner has no case to answer and no further action is to be taken in relation to the matter. It can also decide one or more of the following:

(a) the practitioner has behaved in a way that constitutes unsatisfactory professional performance

(b) the practitioner has behaved in a way that constitutes unprofessional conduct

(c) the practitioner has an impairment

(d) the matter must be referred to a responsible tribunal and/or

(e) the matter must be referred to another entity for investigation or other action.

After hearing a matter about a student, a health panel may decide the student has no case to answer and no further action is to be taken; or that the student has an impairment; or that the matter must referred to another entity for investigation or other action.

If a panel decides that a registered medical practitioner or student has an impairment, or that the practitioner has behaved in a way that constitutes unsatisfactory professional performance or unprofessional conduct, the panel may decide to do one or more of the following:

1. impose conditions on the registration of the practitioner or student
2. for a health panel, suspend the registration of the practitioner or student and/or
3. for a performance and professional standards panel, caution or reprimand the practitioner.

Notice to be given about a panel's decision

In some cases, the Chair of the panel may provide verbal feedback to the practitioner on the panel's decision. The panel must give notice of its decision to the Board as soon as practicable after making the decision.

The Board must, within 30 days after the panel makes its decision, give written notice of the decision to the registered medical practitioner or student who is the subject of the hearing. This includes the decision made by the panel, the reasons for the decision, that the practitioner or student may appeal against the decision, information about how an application for appeal may be made and the period within which the application must be made.

Referrals from coroners

From time to time, a state coroner may refer a finding of an inquest to AHPRA or the Board to bring to the attention of the profession.

AHPRA will publish a case summary of each referral from the coroner on its website, naming the deceased person, with the coroner's recommendations in full. A link will also be provided to the coroner's website. Medical practitioners are encouraged to access the AHPRA website at www.ahpra.gov.au to keep up to date with these cases and the coroners' recommendations.

When the Board decides that a referral from the coroner has wide-reaching implications for medical practitioners, it may publish a summary of the case, and highlight particular issues in the *Update*. The following case has been summarised for the education of all medical practitioners.

Oxycontin toxicity and IMG supervision

The deceased was a 28 year old woman with a complex past history that included anorexia nervosa, bulimia, asthma, borderline personality disorder and depression. At the time of her death, she weighed around 30 kg. The cause of death was bronchopneumonia complicating oxycodone toxicity.

The woman had suffered a fall and had soft tissue injuries. She had ongoing pain from her injuries and had asked her regular general practitioner to prescribe oxycontin, a slow-release, long-acting version of oxycodone (an opioid). The GP declined to prescribe the oxycontin, though he prescribed other analgesia for the patient.

Another GP working at the same clinic prescribed oxycontin for the patient two days later. The GP who prescribed the oxycontin was an international medical graduate who had started practising in Australia that day. At the inquest, he told the coroner that he was unfamiliar with oxycodone, and its slow release version, oxycontin. He had limited knowledge about how to access information that was available at the clinic about the woman.

The GP initially prescribed 40 mg oxycontin twice daily. The coroner noted that the usual starting dose for oxycontin was 10 mg twice daily. The medical practitioner told the coroner that the woman had reported to him that she had been prescribed this medication previously, at this dose. He therefore believed that she had already developed sufficient tolerance to enable her to be prescribed 40 mg twice daily.

A week later, the GP again prescribed oxycontin for her. He did not see the patient as there were discussions about a hospital admission. The GP prescribed oxycontin 80 mg daily. The GP told the coroner that at the time, he probably thought that this would provide a longer period of pain relief. This was an incorrect approach as regardless of the dosage, the drug is released at the same rate and analgesia is only experienced over a period of 12 hours.

The patient was hospitalised for two days, which she spent in the short stay ward of a hospital. The patient self-medicated for part of her admission. There was no review of her medications and she was discharged on 80 mg oxycontin. While in hospital, she was advised not to take a full dose but to take a half a tablet of oxycontin. This advice was incorrect, as cutting the tablet interfered with the slow release of the medication and allowed for faster release.

The coroner's recommendations include that all medical practitioners supervising the training of medical practitioners trained overseas and working in general practices should specifically supervise and oversee the prescription of opiate-based medication that an overseas-trained practitioner might wish to prescribe. This was especially true when the practitioner trained overseas is not familiar with the relevant medication. The coroner found that overseas-trained medical practitioners, during the course of their training, should be instructed to seek the advice of their supervisor before prescribing such medication.

The coroner also made recommendations to the particular hospital where the patient was admitted. These recommendations are relevant to other hospitals and include that when patients are kept in an emergency department for an extended period:

- medical staff should review the medication requirements of patients, particularly when a patient has been prescribed opiate-based medications and has exhibited signs of excessive sedation
- nursing and medical staff should be instructed to inspect visually any medication in the possession of a presenting patient and to remove any medication from the possession of the patient when the patient is admitted either to a general ward or to the short stay ward and
- necessary steps should be taken to prevent patients from self-medicating.

The coroner also recommended that clinical staff be made aware that it is not appropriate to advise patients that they may break slow-release medications such as oxycontin before consumption.