Working in Victoria's Healthcare System

An Orientation Manual for International Medical Graduates

pmcv

18th edition, 2019

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Please note: information in this manual may need to be updated from time to time. If you have a CD-ROM copy of this manual it is important to consult the electronic version on the PMCV website to access the most current information.

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The PMCV acknowledges that some of the material used in this Manual has been sourced from the Rural Workforce Agency, Victoria's "Orientation Manual for OTDs working in rural GP".

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Contact details:
Postgraduate Medical Council of Victoria
Telephone: +61 3 9670 1066
Web: www.pmcv.com.au
Email: pmcv@pmcv.com.au

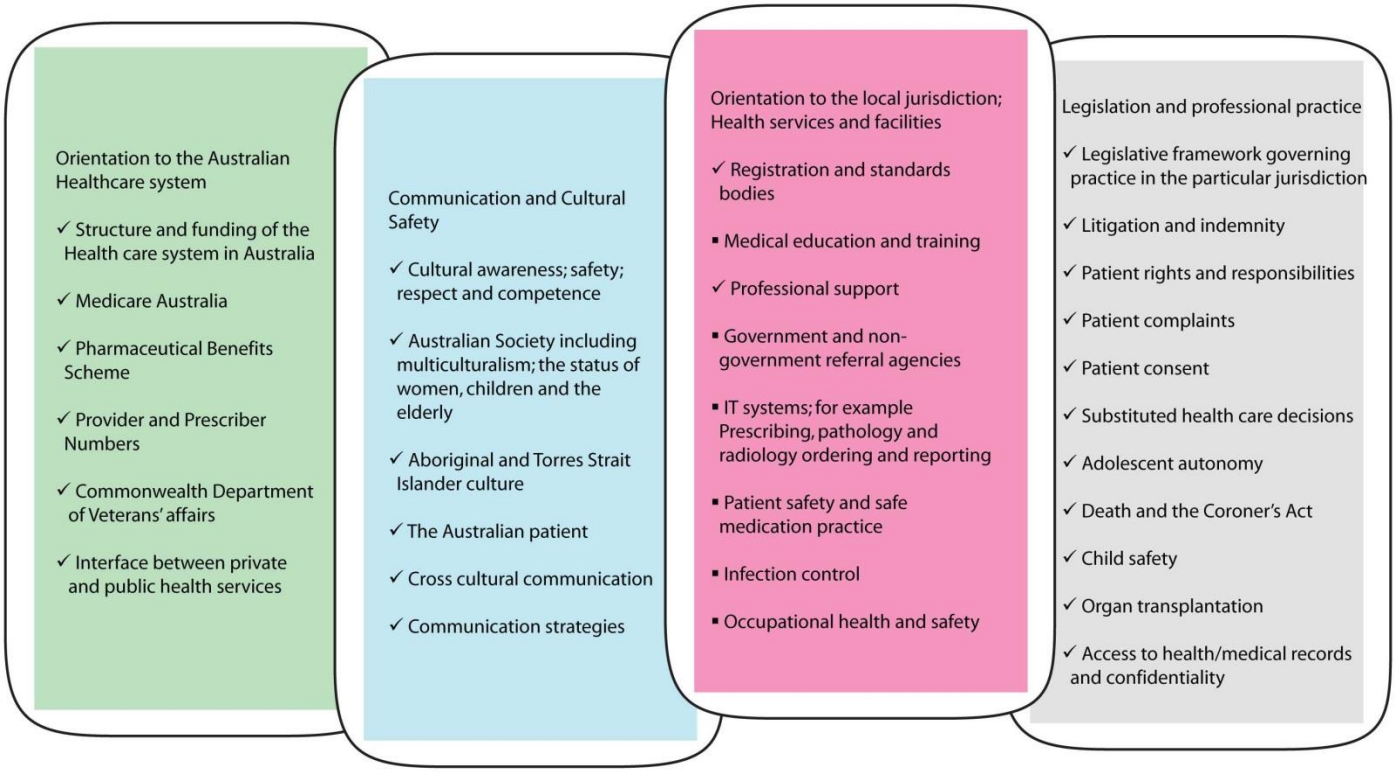
Introduction

This Orientation Manual has been developed and written for International Medical Graduates (IMGs)[1] who are new to Australia and who are entering hospital-based or general practice in Victoria.

It is intended to assist integration into the Australian heath care system. Obtaining medical registration and finding employment is the responsibility of the IMG and will only be achieved by approaching individual hospitals.

The Manual has been developed by the Postgraduate Medical Council of Victoria (PMCV), initially drawing on a range of material prepared by the Rural Workforce Agency Victoria (RWAV) for IMGs working in general practice in rural areas in Victoria. The PMCV also acknowledges reference to the Queensland Health document *Transition to clinical practice in Queensland Health: Orientation manual for international medical graduates.* Advice and input has been obtained from a range of individuals, including Australian trained doctors in Victorian hospitals, IMGs, medical administrators and clinicians who work with pre-vocational trainees in hospitals, junior medical staff and other individuals involved with hospital-based medicine in Victoria.

Following a decision of the Council of Australian Governments (COAG) in July 2006 regarding the assessment of IMGs, the Australian Medical Council (AMC) has defined mandatory content for IMG orientation. Subsequently, the manual has been updated to reflect these guidelines.



AMC Orientation Guidelines (2007)

[1] There is a growing tendency in Australia to use the term 'International Medical Graduate' (IMG) when referring to medical practitioners who obtained their medical qualifications outside of Australia. However the term 'Overseas Trained Doctor' (OTD) is still widely used, and is incorporated in some legislation and training schemes. In particular, the AMC continue to use the term Overseas Trained Doctor. In general, this manual refers to IMGs, unless the term OTD is specifically required.

This resource is reviewed annually via the consultation with a number of groups representing IMGs, employers and professional bodies and is now in its **18th version**.

The Manual has been developed to provide hospital-based doctors with a good basic overview of the Australian, and in particular, the Victorian medical system and environment. It has been designed as a resource and reference document. Due to the enormous amount of material covered we have not gone into great detail on many subjects. Instead, we have provided details and active links to access further information so that readers can research subjects of particular interest. Also, because the environment is constantly changing we would urge all readers to check websites and relevant bodies to ensure they have the latest information.

It would be valuable if, as you are using the Manual and you note any changes, these could be communicated to the Postgraduate Medical Council of Victoria, for incorporation into updates of the Manual.

We wish you well using this Manual and hope that it makes your arrival and integration into the Victorian health system easier and more enjoyable.

Ms Lynne Ticehurst
Chair, IMG subcommittee,
Postgraduate Medical Council of Victoria.

Ms Kylie Nicholls
IMG Manager,
Postgraduate Medical Council of Victoria.

How to Use the Manual

The Manual is divided into the following sections:

- Orientation to the Australian Healthcare System
- Communication and Cultural safety
- Orientation to Local Health Services and Facilities
- Legislation and Professional Practice
- Living in Victoria

There are also a number of Appendices which provide the following additional information:

- Health Industry and Clinical Acronyms
- Victorian Public Hospital Websites

You should familiarise yourself with the content and format and use the Manual as a reference and resource document.

The Table of Contents is hyperlinked to the relevant pages/sections of the document

Key

 **Indicates a link to relevant web-based information**

Indicates a link to a related PDF document

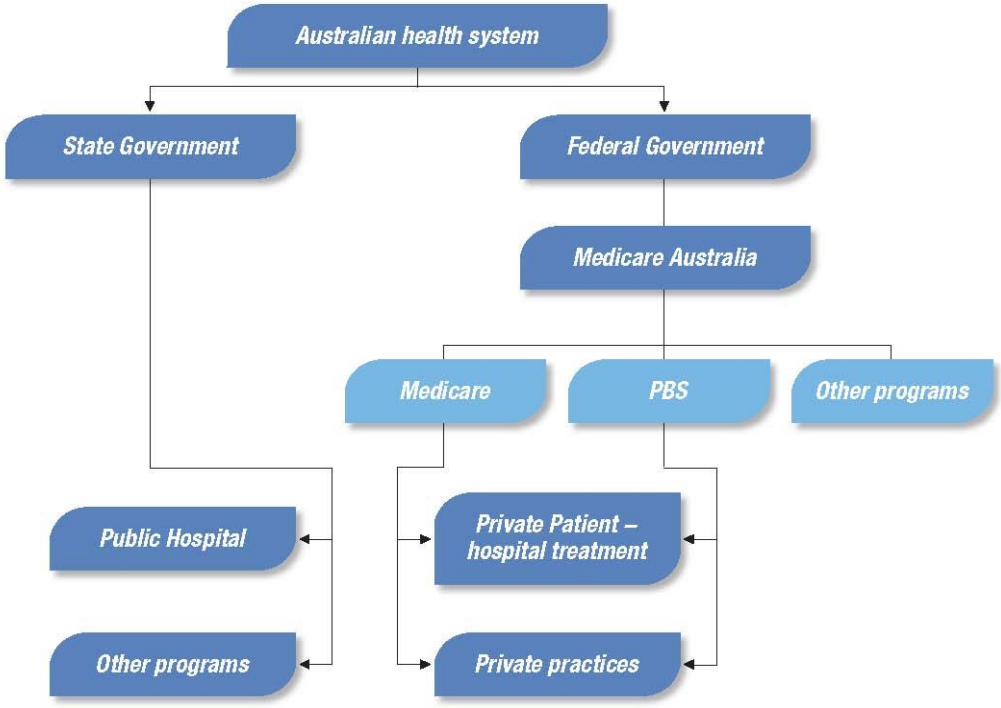
Feedback

The Postgraduate Medical Council of Victoria (PMCV) invites your feedback on the Manual and would appreciate your comments or suggestions regarding the content and format of the Manual. Please provide any feedback via email: pmcv@pmcv.com.au

Section 1 – Orientation to the Australian Healthcare System

This section of the Manual focuses on those parts of the Australian Medical system that IMGs need to know about in their dealings with patients. In particular, it provides an overview of the key aspects of the Australian Healthcare system.

OVERVIEW OF THE AUSTRALIAN HEALTH SYSTEM



Source: Medicare and You Online Learning Module – Medicare Australia

The aim of the national health care funding system is to give all Australian residents, regardless of their personal circumstances, access to health care at an affordable cost or at no cost, while allowing choice for individuals through substantial private sector involvement in health care delivery and financing.

The Australian Federal Government has the primary role of developing national policies, regulations and funding.
The Australian Federal Government funds three major national subsidy schemes:

1. **Medicare**—providing free or subsidised treatment by health professionals including medical practitioners, participating optometrists, dentists (specified services only) and eligible allied health professionals, and free treatment as a public (Medicare) patient in a public hospital.
2. **The Pharmaceutical Benefits Scheme (PBS)**—subsidises a significant proportion of the cost of prescription medicine.

3. **The 30 per cent Private Health Insurance (PHI) Rebate**—supports people's choice to take-up and retain private health insurance.

Australia's public hospital system is jointly funded by the Australian Federal Government and State and Territory governments, and is administered by State and Territory health departments. State, Territory and Local Governments are responsible for the delivery and management of public health services and for maintaining direct relationships with most health care providers, including the regulation of health professionals and private hospitals.

MEDICARE AUSTRALIA

Delivering Australia's universal health funding program

Medicare Australia works in partnership with the Department of Health and Ageing (DoHA) to achieve the Australian Government's health policy objectives.

DoHA is responsible for the:

- policy development of Medicare
- production of the *Medicare Benefits Schedule* (MBS).

Medicare provides access to:
• treatment as a public patient in a public hospital
• subsidised treatment by health professionals.

Medicare benefits are paid for professional services provided by medical practitioners, participating optometrists, dentists (specified services only) and eligible allied health professionals. Health professionals must meet legislative requirements before their professional services can attract a Medicare benefit.

Medicare Australia is responsible for:

- making sure Medicare benefits are paid to eligible Australian residents for services provided by eligible health professionals.
- assessing and paying Medicare benefits for a range of medical services—provided in or out of hospital, based on a schedule of fees determined by DoHA in consultation with professional bodies.

Medicare Australia

Provider Numbers

What is a provider number?

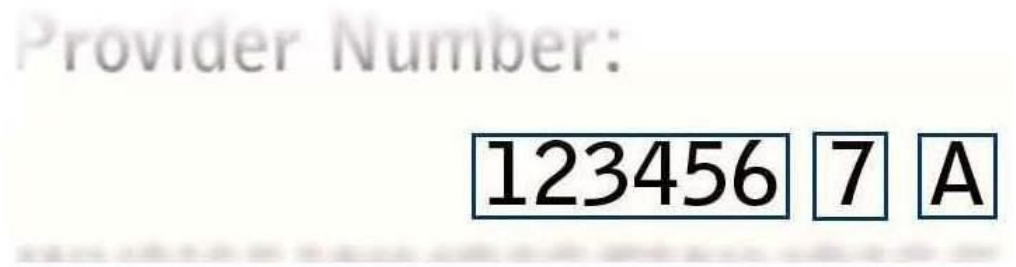
Provider numbers are unique numbers issued by Medicare Australia to registered health professionals including medical practitioners, optometrists and allied health professionals.

Medicare Australia uses provider numbers to identify health professionals and the location from which the health professional renders services. As a health professional you must have a provider number for every

location at which you practise. If you move to a new practice location, you must apply for a provider number for that new location.

A provider number consists of:

- six numbers referred to as the provider stem (e.g. 123456)
- an alpha or numeric character that identifies the practice location (e.g. 7)
- an alpha check digit (e.g. A)



How do I apply for a provider number?

Before you apply for a provider number with Medicare Australia, you must have current medical registration. You should send a copy of your registration certificate or confirmation from the registration board, advising your current registration status to Medicare Australia with your application for a provider number.

pdf
Click to View

Application for an initial Medicare provider number (medical practitioner)

If you already have a provider number and want to apply for a provider number for a new location, you can complete the following form:

pdf
Click to View

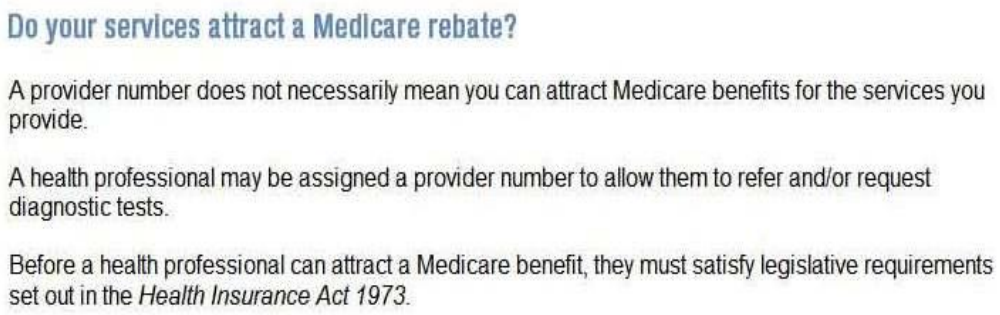
Application for a Medicare provider number for a new location

If you have questions about your eligibility to access Medicare benefits for services you provide call the Medicare provider enquiry line ***132 150***

How is your provider number used?

Apart from uniquely identifying you and the physical location from which you practise, a provider number is used to:

- refer your patient to another health professional (usually a specialist, consultant physician, allied health professional or to request diagnostic imaging or pathology services)
- determine whether you attract Medicare benefits for your services at particular practice locations or all practice locations (legislative requirements must be met).



Source: Medicare and You Online Learning Module – Medicare Australia

Medicare Provider Number Restrictions

Eligibility to access Medicare benefits is determined by the *Health Insurance Act 1973* and related Regulations. In particular, the requirements of sections 19AA and 19AB of the *Health Insurance Act 1973* must be satisfied before access to Medicare benefits can be granted.

Section 19AB of the Health Insurance Act 1973

Section 19AB of the Act applies to overseas trained doctors (OTDs) and foreign graduates of an accredited medical school (FGAMS) who gained their first medical registration on or after 1 January 1997. Section 19AB of the Act restricts their access to Medicare provider numbers and requires them to work in a *'district of workforce shortage'* (DWS) in order to access the Medicare benefits arrangements. OTDs and FGAMS who are subject to section 19AB of the Act are generally required to work in a DWS for a minimum period of ten years from the date of their first medical registration.

Overseas trained doctor: means a person:
(a) whose primary medical qualification was not obtained from an accredited medical school

Foreign graduate of an accredited medical school: means a person:
(a) whose primary medical qualification was obtained from an accredited medical school;
and
(b) who was not one of the following when he or she first enrolled at an accredited medical school:

(i) a permanent Australian;
(ii) a New Zealand citizen'
(iii) a permanent resident of New Zealand

An **accredited medical school** means a medical school that is:

(a) accredited by the Australian Medical Council; and
(b) located in Australia or New Zealand.

Definitions as per s19AB of the *Health Insurance Act 1973* (the Act)

New Zealand permanent resident and/or citizen
Persons who enter Australia under a New Zealand passport are considered to be a temporary resident of Australia under the *Migration Act 1958*.
From 1 April 2010 those doctors that were New Zealand permanent resident or citizens at the time that

they enrolled in an Australian Medical Council accredited medical school in Australia or New Zealand **will no longer be classified as overseas trained doctors**, and therefore will not be subject to s19AB of the Act.

How do I know if I am an overseas trained doctor or foreign graduate of an accredited medical school to which section 19AB of the Act applies?

If you are:
(a) an overseas trained doctor; or
(b) a foreign graduate of an accredited medical school (a temporary resident when you first enrolled in medical school in Australia); and
(c) were first registered with an Australian State or Territory medical board on or after 1 January 1997 then you are considered restricted by section 19AB of the Act.

How is section 19AB of the Act assessed?
The Act sets out the basic tests to determine whether a doctor is restricted by section 19AB of the Act.
1. If you are:
(a) an overseas trained doctor; or
(b) a foreign graduate of an accredited medical school who gained their first medical registration before 1 January 1997; and you applied to the Australian Medical Council (AMC) before 1 January 1997 and you were deemed eligible by the AMC to sit the exam then you **may not be subject to the restrictions** associated with section 19AB of the Act. However, for a formal assessment, you must supply Medicare Australia with a copy of the AMC letter acknowledging receipt of your application and eligibility to sit the exam.

2. If you are:
(a) an overseas trained doctor; or
(b) a foreign graduate of an accredited medical school who gained their first medical registration on or after 1 January 1997 then you are considered **restricted** by section 19AB of the Act for a minimum period of ten years from the date of your first medical registration.

3. If you are:
(a) an overseas trained doctor; or
(b) a foreign graduate of an accredited medical school who gained their first medical registration on or after18 October 2001 then you are considered **restricted** by section 19AB of the Act for a minimum period of ten years from the date of your first medical registration.

What is the "ten year moratorium"?
This is the short hand name that is frequently applied to the restrictions under section 19AB of the Act.

When will my moratorium start?
Your moratorium will commence from the date that you obtain your first medical registration in Australia.

I was first medically registered in Australia in 2002, but am not yet a permanent resident, when does my 10-year moratorium start?
Previously a doctor's 10-year moratorium may not have commenced until the doctor became a permanent resident of Australia; now, after **1 April 2010**, a doctor's 10-year moratorium period starts from the date of their first medical registration in Australia.

If, however, you do not gain permanent residency by the time your moratorium is completed, you will continue to require a section 19AB exemption until such time as you gain permanent residency or Australian citizenship.

If section 19AB of the Act applies to me, how do I gain access to the Medicare benefits arrangements?
You will need to **apply for a Medicare provider number** from **Medicare Australia** who will apply to the Department for a section 19AB exemption on your behalf. The primary criteria for assessing section 19AB exemptions is that the applicant is working in a location that is deemed to be a district of workforce shortage (DWS). A location is deemed to be a DWS if it falls below the national average for the provision of medical services of the type provided by the applicant. Population needs for health care are deemed to be unmet if a district has less access to medical services than the national average.

 **DWS location database**

Section 19AA of the Health Insurance Act 1973

Section 19AA of the Act is applicable to medical practitioners who are Australian permanent residents or Australian citizens and doctors Section 19AA of the Act requires that, in order to access Medicare benefits, the practitioner must be a recognised GP, specialist, consultant physician or participate on an approved vocational training or workforce program.

IMG's who complete their commitment to section 19AB of the Act (also known as the 10 year moratorium) are subject to the restrictions under section 19AA of the Act. This means that if a doctor completes their 10 year moratorium and is a permanent resident of Australia but has not gained Fellowship or hold specialist recognition, they will still be subject to the restrictions under section 19AA of the Act.

What if I am no longer restricted by s19AB, but am restricted by s19AA, and do not have fellowship or a placement on a training program?
If you are deemed to be no longer restricted by s19AB, but have not gained fellowship with one of the relevant colleges, you will need to approach the most appropriate training provider for your situation and location. You are required to be on a training or workforce program to enable you to continue to access Medicare benefits.

 **Doctor Connect website** – for further details relating to Medicare Provider number restrictions.

PHARMACEUTICAL BENEFITS SCHEME (PBS)

Overview of the PBS

The PBS has been operating in Australia since 1948. It is designed to make sure all Australian residents and eligible overseas visitors have access to necessary and life saving medicine at an affordable price. About 80 per cent of prescriptions dispensed in Australia are subsidised through the PBS.

The current cost of the PBS is about $7 billion per year. In the 12 months to June 2008, around 171 million prescriptions were subsidised through the PBS - representing about eight prescriptions per person in Australia annually.

Prescriber Numbers

Prescriber numbers

A PBS prescriber number is required to prescribe medicine under the PBS. A prescriber number is allocated to medical practitioners, dentists and authorised optometrists. Medical practitioners working in public hospitals participating in the Pharmaceutical Reforms can also request a prescriber number, but they can only write PBS prescriptions for patients on discharge, day admitted patients and out-patients.

This prescriber number uniquely identifies you and remains the same throughout your career. It also tells pharmacists of your eligibility to prescribe PBS medicine.

Who is eligible for PBS medicine?

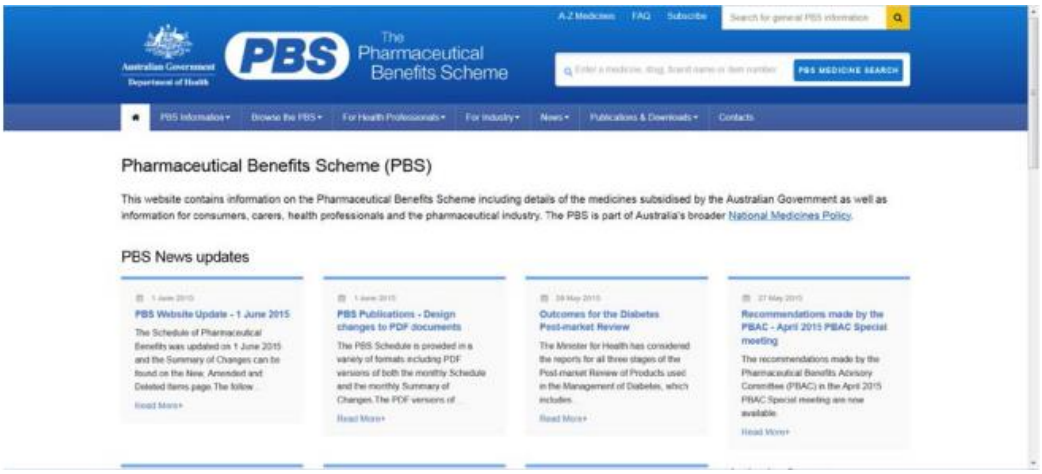
Australian residents must be current Medicare cardholders to access the PBS. Some patients may be eligible for further concessions if they hold an entitlement card which includes:

- Health Care card
- Pensioner Concession card
- Commonwealth Seniors Health card
- Safety Net concession/entitlement card.

Source: PBS and You Online Learning Module – Medicare Australia

The Schedule of Pharmaceutical Benefits

The Schedule of Pharmaceutical Benefits - referred to throughout as **the 'Schedule'** - lists all of the medicines available under the PBS, and explains the uses for which they can be subsidised.



'Search Schedule' - by the generic or proprietary brand name of your medicine.

The Schedule is produced monthly by the Australian Department of Health and Ageing (effective on the first day of each month).

It is vital therefore that doctors, dentists, optometrists and pharmacists remain up to date with information on which medicines are included in or excluded from the Schedule, which PBS prescribers may prescribe certain medicines, whether restrictions apply to the medicines, and how much patients should pay.

Prescribing Medicines – Information for PBS Prescribers

PBS prescribers
PBS prescription forms
Preparing general PBS prescriptions
Restrictions – *Unrestricted, Restricted and Authority required benefits*
Authority PBS prescriptions
Maximum quantities and repeats
Regulation 24
Urgent cases
Drugs of addiction
Emergency drug (doctor's bag) supplies
Availability of Methoxyflurane for emergency treatment only
Improving the capacity of the PBS to meet particular Aboriginal and Torres Strait Islander health needs

PBS prescriptions in public hospitals

Under the Australian Health Care Agreements the public hospital pharmaceutical reforms provide eligible patients in participating public hospitals with access to subsidised medicine under the PBS. A range of chemotherapy pharmaceuticals are also available via the Chemotherapy Pharmaceuticals Access Program (CPAP). Participating hospitals are required to adopt the Australian Pharmaceutical Advisory Council guidelines on the continuum of pharmaceutical care between the hospital and the community.

Currently prescribers at approved participating public hospitals in Victoria, Queensland, Northern Territory and Western Australia may write PBS prescriptions for:

- eligible outpatients
- day admitted or non-admitted patients receiving chemotherapy
- patients on discharge from hospital.

The medicine can be supplied from the participating public hospital pharmacy or from an approved community pharmacy.
CPAP medicine may only be supplied by an approved public hospital pharmacy.

When writing a PBS public hospital prescription:

- all medicine on the one prescription must be written by the same practitioner and if it is authority required medicine, approval sought by the prescribing practitioner
- there can be up to 10 items on one prescription and may include multiple authorities, PBS and non-PBS items
- it is acceptable to include authority required and non-PBS medicine together with PBS medicine on the one PBS public hospital prescription. However each authority required medicine must have its own unique authority approval number.

Download a copy of the Schedule of Pharmaceutical Benefits *(PBS Offline)*

The PBS Schedule is available to be downloaded to CD ROM or to your computer. This will give you the convenience of a current version of the Schedule with all the dynamic search capability of the website whenever you do not have access to the internet.

To keep PBS offline up to date, it should be downloaded fresh with the regular Schedule update that occurs on the first of each month.

Patient Charges

The Safety Net Scheme and Safety Net Thresholds

PBS Contacts for Health Professionals

Department of Health

Medicare Australia

Reciprocal Health Care Agreements

Eligible visitors from countries with a Reciprocal Health Care Agreement (RHCA) with Australia are also entitled to PBS medicine. Countries with a RHCA include:

- the United Kingdom
- the Republic of Ireland
- Finland
- Italy
- Malta
- the Netherlands
- Norway
- New Zealand
- Sweden
- Belgium (effective 1 September 2009).

REF

Source: PBS and You Online Learning Module – Medicare Australia

PBS Online Learning Modules

Medicare Australia has developed a series of:

PBS online e-learning modules for new health professionals

DEPARTMENT OF VETERANS' AFFAIRS (DVA)

The Commonwealth Department of Veteran's Affairs support those who serve or have served in defence of our nation and commemorate their service and sacrifice.

 **Further information and details can be accessed via the DVA website.**

TRANSPORT ACCIDENT COMMISSION (TAC)

The TAC is a Victorian Government-owned organisation that was set up in 1986.

Its role is to pay for treatment and benefits for people injured in transport accidents. It is also involved in promoting road safety in Victoria and in improving Victoria's trauma system.

Funding used by the TAC to perform these functions comes from payments made by Victorian motorists when they register their vehicles each year with VicRoads.

The TAC is a "no-fault" scheme. This means that medical benefits will be paid to an injured person - regardless of who caused the accident.

Legislation guides the TAC in the types of benefits it can pay and any conditions that apply. This legislation is called the *Transport Accident Act 1986*.

 **Further information and details can be accessed via the TAC website.**

WORKSAFE VICTORIA

WorkSafe Victoria is the manager of Victoria's workplace safety system. Broadly, the responsibilities of WorkSafe are to:

- Help avoid workplace injuries occurring
- Enforce Victoria's occupational health and safety laws
- Provide reasonably priced workplace injury insurance for employers
- Help injured workers back into the workforce

 **Further information and details can be accessed via website.**

Section 2 – Communication and Cultural Safety

With thanks to Judith Miralles & Associates and Dr Sean Fabri for their contribution to the following section of the manual.

CULTURAL AWARENESS; SAFETY; RESPECT AND COMPETENCE

You may hear the terms 'cultural awareness', 'cultural safety', 'cultural respect' and 'cultural competence' used in Australia, especially in the health care system. The following definitions will help you to understand what they mean as practical knowledge of these issues will mean safe, effective, and appropriate clinical communication at all times:

- **Cultural awareness** is sensitivity to the similarities and differences that exist between two different cultures and the use of this sensitivity in effective communication with members of another cultural group. It is also the awareness that one's own cultural values are not universal, nor automatically "better" than another set of values.

- **Cultural safety** involves actions that recognise, respect and nurture the unique cultural identity of a person and safely meets their needs, expectations and rights. It means working from the cultural perspective of the other person, not from your own perspective.

- **Cultural respect** can be defined as the 'recognition, protection and continued advancement of the inherent rights, cultures and traditions of a particular culture.'

- **Cultural competence** means becoming aware of the cultural differences that exist, appreciating and having an understanding of those differences and accepting them and being prepared to guard against accepting your own behaviours, beliefs and actions as the norm. Cultural competence includes the ability to translate awareness into a positive outcome from an exchange between yourself and a person from a different cultural background.

- **Personal cultural competence** is the actions we personally take to expand our knowledge of other cultures and how we use that to shape service to those people. This is especially important in effective doctor-patient relationships.

AUSTRALIAN SOCIETY

Practicing medicine in Australia can be very challenging especially for those doctors who come from countries where there is one culture, one religion and one language.

Australian society is multicultural, made up of people of diverse backgrounds. In all societies, there are sub-cultures, and important differences between rural (country/bush) and urban (city) groups, among different classes and genders. Even within these groupings, individuals vary in the extent to which they fit to a particular image. For example, with Indigenous people of the same tribe or family, those people living in the city are likely to be different in their beliefs and behaviours than those living in rural areas, while older people may differ from younger ones. Consequently, a person may not strongly identify with their cultural background. It is dangerous to assume that culture is the most important factor in making us who we are.

Historically Australians have expected people to assimilate into the dominant Anglo-Australian culture. We now celebrate cultural difference, and are becoming more attuned to the needs of individuals from different cultural backgrounds. Patient-centred care is now understood to mean that the doctor will take account of the patient's cultural values: for example, if a patient is unwilling to make decisions on his own because he comes from a culture where the family is involved in the treatment plan, then the doctor will organise a family meeting to ensure the patient can reach a decision in a culturally comfortable way. This approach is often called 'cultural safety'

A culturally competent clinician is also open to seeing value in other ways of doing things – not just merely tolerating differences. S/he is able to critically examine her/his cultural values and not just the values of other cultures.

Furthermore, although culture may be important, other factors may affect a person's health care and health seeking behaviour. These may include gender (of the patient and/or service provider), class (social-economic) position, education, knowledge of medicine, private health insurance arrangements, and access to money and transport.

While it is the aim of the Australian health care system to provide equal access to health care to all members of the community, this is not always easy to achieve. Many people from non-English speaking background and Australian Aboriginal and Torres Strait Islander people may be seriously disadvantaged by their inability to communicate effectively within a system that may seem daunting and unfamiliar. Medical emergencies can be traumatic for anyone. So imagine how much more traumatic this can be for those who cannot understand the health care system. It is the responsibility of the systems/clinicians as much as the responsibility of the patients to be able to communicate effectively within the Australian health care system.

ABORIGINAL AND TORRES STRAIT ISLANDER CULTURE

"Health does not mean just the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is the whole of life view and includes the cyclic concept of life-death-life. Health services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well being of their communities": (*Aboriginal and Torres Strait islander Health Policy, 1994*)

'Health to Aboriginal people is a matter of determining all the aspects of their life, including control over their physical environments, of dignity, of community self-esteem and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity' (*National Aboriginal Health Strategy, 1989*)

The importance of family and community wellbeing is based on the strengths of:

- traditional healing, socialisation and cultural practices
- self-determination in finding local solutions to local problems
- a level of control over those factors to ensure the welfare of families and children.

Health Status

In general Aboriginal and Torres Strait Islander populations compared with non-Indigenous populations:

- are younger and have a larger proportion of children – the median age is 19 years compared to 36 years for non-indigenous populations
- have higher birth rate and have children at a younger age, and a higher infant mortality rate
- continue to have a life expectancy approximately 20 years less than the wider Australian population – median age for indigenous death is 53.2 years
- experience illness, injury, hospitalisation and death at several times the rate of other Australians – circulatory, respiratory, endocrine and injury are the major causes of death and hospitalisations. Children are also prone to ear infections and resultant hearing loss.
- continue to have poorer heath compared with other Indigenous populations in New Zealand and Canada.

Working with Indigenous Patients

Specific issues in communicating or providing treatment may relate to:

- verbal communication – e.g. you should communicate in an open manner using plain language, be direct and explicit so that there is no room for misinterpretation. Use verbal communication in preference to written communication.
- indirect or non-verbal communication – e.g. expect less eye contact and use less eye contact.
- gender issues – women's health is only 'women's business' and men's health is only 'men's business' so your patient may prefer to see a doctor of the same gender as themselves
- taboo relationships – father-in-law, sister-in-law
- information gathering – exchanging information, open ended questions, tone of voice, silence, levels of literacy or understanding of medical jargon can cause confusion. Therefore you must speak very clearly at all times
- Speaking of death – to some communities, it is distressing and offensive to depict, refer to, write of, or name persons who have died
- Concept of time
- Sense of humour
- Fear of being alone
- Personal space

Resources for further information

Working with Aboriginal people and communities: A practice resource (NSW Department of Communities)

This resource provides general information to improve knowledge and understanding of the diverse cultural dynamics that exist within Aboriginal families and communities. It also contains practical engagement and communication strategies for working with Aboriginal people.

Improving the patient experience of Aboriginal people in the Emergency Department (Victorian Department of Health)

This report describes the findings of a project in which five Victorian health services undertook local projects to improve the experiences of Aboriginal people in their emergency departments. A number of strategies were used to engage the local Aboriginal communities to better understand their experiences of the emergency department. Initiatives to improve cultural safety, promote delivery of culturally-sensitive care and develop state-wide resources to assist care delivery to Aboriginal consumers in emergency departments were developed and implemented.

The Little Red Yellow Black Website & Book – An introduction to indigenous Australia

The perfect starting point for those who want to know about Australia's rich Indigenous cultures, but don't know where to begin. It's written from an Indigenous perspective and covers history, culture, arts, sport, languages, population, health, resistance and reconciliation.

THE AUSTRALIAN PATIENT

It is difficult to explain all of the complexities of the Australian culture and the expectations of the 'average' Australian patient. There are however some recognised characteristics that may help you to understand why your patient behaves in the way that they do and what they may expect of you.

Individuality

Most Australians prefer to be treated as individuals rather than being seen as members of a particular family, class, group or position. They also dislike being too dependent on others. The extended family therefore is not as dominant as in many other countries and cultures. This impacts particularly on our aging population and families with young children and helps to explain why many elderly patients live alone for example.

Equality

Most Australians are very tolerant people and believe that people are entitled to be treated with respect irrespective of their background, gender, age, economic status etc. Australians grow up believing that people, including women and children should have equal social, legal and political rights and the Australian constitution protects these rights. Anti-discrimination laws prevent discrimination on the grounds of race, gender and marital status, sexual orientation, and physical and intellectual disability. Australian women are treated equally to men. The majority of your patients would think of themselves as your equal, regardless of their socioeconomic status or position they will most likely call you by your first name and expect you to do the same. Many Australians are very well-informed and like to be partners in the management of their health. If you appear authoritarian and insensitive, they may challenge this either directly or indirectly (e.g. in writing).

Directness

It is considered quite normal in Australia to discuss issues, events and ideas openly with other people. In a consultation, your patients might bring up issues and events, which you may consider sensitive, embarrassing or rude. Be aware of your own reactions with your body language and also with what you say so that the consultation can continue without embarrassment and remain objective. You may not pick up all of the subtle and sometimes vital clues in a consultation if you don't.

Take the lead and be direct and welcoming in your introductions to your patient. The use of names throughout the consultation enables you to connect with your patient in order to establish and maintain rapport. If your patient is unsure of how to address you, then it will generally be difficult to form an effective partnership. Sometimes your names are as unfamiliar to Australians as theirs may be to you. Inform your patients how you would like to be called and also ensure that you ask them how they would like to be called too. Australian patients will probably call you by your first name or "Doc". If you are unsure how to pronounce a name, ask.

It is important to maintain eye contact with your white English-speaking Australian patients as this tells them you are interested, honest and sincere. However, not everyone feels like this for example, Australian Aborigines and Torres Strait Islander and patients from some Asian cultures do not like direct eye contact so you will need to adapt your consultation style to respect the cultural requirements of these patients in order to facilitate the best outcome possible. Patients will always expect that you are upfront, direct and honest with them. Moreover, if you are uncertain or do not know something, it is essential that you either seek clarification or explain that you do not know and will try to find the answer.

Whilst Australians are fairly direct, you will sometimes have patients from cultural backgrounds where indirectness is the norm and whilst the patient may respond positively to your questions, *it does not mean that they agree with or understand what you have said. In such cases you will need to probe the patient's understanding and ability to comply with the care plan.*

Australian English is also fairly informal and brief – Australians will often say 'get to the point' if you are taking too long. A Spanish-speaking doctor was heard to exclaim during a cross cultural training workshop: 'I realise I think in long sentences and in Australia I need to think in dot points.' The informality of spoken language means that a doctor is expected to use simple and non-medical terms.

Sense of humour

Australians love to joke and tell a joke. "Did you hear the one about…….?" is a very familiar opening to any joke. Colleagues and patients alike will love to tease or 'pull your leg' and if they do this to you, it is a form of acceptance and by no means meant to be an insult or form of discrimination. Smile and join in as laughter keeps work interesting and it is good for health. If at any time, you are offended by this, let them know that you are, and why you feel that way. "Being open" or upfront or honest means that you will have better relationships with your patients and your colleagues.

Patients may joke about conditions or illnesses that are often very serious. For example the Australian male often underplays serious symptoms by joking. Be aware of this underplay. In general, males do not go to see doctors often and when they do, you need to take it seriously. For example, recently, a 76 year –old patient who fell off the roof of his house, broke both legs, his collarbone, punctured his lung and had a blood pressure of 170/120 drove to the nearest hospital and when asked how he was feeling said, "Bloody fantastic!" This is a form of irony, or saying the opposite to what is true, which is very common, especially when the true situation is obvious. Australians also use a great deal of metaphor in their speech, so do not take everything literally. Instead be prepared to translate their comment into the context in which it was intended. For example, if a patient is asked how they have been since you last saw them, and they respond "It's been plain sailing," they are likely to mean that no problems have occurred, rather than that they have been in a boat.

Healthy scepticism

Australians are quite sceptical about governments, institutions, about politicians and often their doctors. Australian patients have access to a wealth of information from the internet, popular magazines and television programs about healthcare, some of this is material is highly credible, while others may be dubious in quality and/or reliability. You will sometimes need to work hard to negotiate with your patients, so asking what they know about their illness upfront can often shortcut a consultation for you. You can correct any misinformation and misperceptions for build on existing knowledge to maximise best use of your time.

Underpinning this background of culture and general characteristics is the language that is needed for your consultation. If you are from a non-English speaking background you will need to work hard on your English to constantly improve it, not just in terms of vocabulary, but also appropriateness of words in context, pronunciation, tone of voice, and the use of idioms and metaphors.

CROSS CULTURAL COMMUNICATION

In a health care environment, cultural differences take on a greater significance. Proficiency in English may not always be enough to remove any cultural barriers between doctors and patients. Different values and beliefs of Australian patients will affect their perceptions of appropriate treatment and behaviour. Your own training and background may lead you to have different expectations to those of your patients.

You need to be aware of your own cultural assumptions and the impact this may have on your interaction with your patients. It is important not to make assumptions about your patients. For example, a couple wanting to have a baby may not be married but in Australia this unmarried relationship is still formally recognised and protected by law. Another example might be a young unmarried woman seeking the oral contraceptive pill. In Australia, most doctors would prescribe the pill to an under aged teenage girl if she is competent and there are no contraindications. If you have strong moral objections, you must refer your patient on to another practitioner.

Be aware of your own "hot buttons". How do you react when?

- you try to help people and they take no notice, do not take their medicine, and continue to do things that make their physical condition worse?
- they are disrespectful to you and your staff?
- they come to your surgery drunk or drugged?
- they try to get prescriptions from you under false pretences?
- they are physically violent to their family?
- they believe spirits and curses are the cause of their illness?
- they are reluctant to take the medicine you have prescribed for them, but are willing to take herbal medicines or alternative therapies that have not been proven to have a benefit?

If you and your patient come from different cultures you need to be highly conscious of the possible communication pitfalls. For example, when your patient says "yes" are they giving consent, simply acknowledging that they have heard what you have said, or possibly simply repeating your words? Miscommunication affecting the doctor-patient relationship can arise in many ways; from attitudes towards the role of the medical profession in the treatment of illness, to the influence of religion to cultural differences in lifestyle, gender, discrimination and status.

Here are some basic principles for communicating with a person from a different culture, which may help:

- assume differences until similarity is proven
- check your assumptions in a culturally sensitive way
- emphasize description rather than interpretation or evaluation
- delay judgement until you have had sufficient time to observe and interpret the situation
- practice empathy – try and see the situation from the other person's perspective. Consider how you would behave if you had the same beliefs or values as your patient.
- treat your interpretation as a working hypothesis until you have sufficient data to support it.
- Be aware of your own cultural beliefs and prejudices. For example;
    - do you believe women are of equal value, intelligence, and maturity to men?
    - what is your attitude to physical violence, uncommon sexual habits, or poor personal hygiene?
    - how do you react when a family does not feed their children properly but they seem to have enough money for other things?

Whatever approach you take, the most important thing is keeping the patient's needs uppermost in your mind.

"*When a personal moral judgment or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere*" (Australian Medical Association (AMA) Code of Ethics)

The patient then needs to be supported by you to find alternative help.

In areas in which you have strong personal beliefs, conduct your research about alternative approaches more rigorously than usual and ask others for advice.

The following are common areas where your personal views and your role as a doctor may conflict strongly. Be aware of these areas of conflict to ensure your judgment is not clouded with emotion:

- Termination of a pregnancy
- IVF treatment for single women
- the process of dying
- treatment of pain
- prescription of contraceptives
- AIDS related care
- Sexual orientation
- Circumcision
- Organ donation
- Substance abuse
- Euthanasia

Ensure that all the evidence for alternative treatments is equally weighted in your judgment. Take legal and reporting requirements into account. In some cases where you are aware your judgment may be biased, you may need to refer the patient to a colleague.

"*Do not deny treatment to any patient on the basis of their culture, ethnicity, religion, political beliefs, sex, sexual orientation or the nature of their illness*". (AMA Code of Ethics)

COMMUNICATION STRATEGIES

How to show politeness

As you may be aware maintaining communication with others in your healthcare team in Australia is vital. Team members will be your greatest teachers. “Please” and “thank you’ are important words in our culture and will help you maintain effective relationships with all of your team.

If you do not use appropriate language, your simple questions and requests may unintentionally appear arrogant, demanding and/or very rude. This may have a negative effect on the person you are speaking to. The following are some suggested questions:

Would you mind if…(“*I came on grand rounds tomorrow?*”)

Would it be possible…(“*for you to take this patient down to X-Ray as soon as you can manage it?*”)

May I…(“*examine you*?”)

Do you mind…(”*explaining the procedure for …?*”)

Could you please…(“*unbutton the top few buttons of your shirt for me?*”)

In terms of stating your opinion, you can either state the situation as a fact, eg:

“If you don’t give up smoking, you will have another heart attack.”

Or as opinion:

“I think...” (“*your smoking is your biggest risk factor for having another heart attack.”)*
“In my opinion...”
“The way I see it...”

In general, if you state your opinion as fact, Australian’s will see this as meaning you are not open to negotiation on the subject, and it comes across as authoritarian. This may be appropriate, but in most cases, it is preferable to indicate that you are open to discussion.

The importance of admitting you don’t know and asking for clarification

In Australian it is acceptable or OK to tell a patient or a colleague that you do not know or understand something. Australian doctors are not expected to know everything and you will not be regarded negatively if you don’t know the answer or reply.

You don’t need to ‘save face’ in the Australian culture and pretend that you do know. Patients and colleagues alike value honesty, so if you don’t know, say “*I am sorry but I don’t know that but I will find out and get back to you.*” Similarly, it is alright to admit to your consultant that you haven’t done a task if you have been too busy rather than saying that you have. Importantly, it also means that you are less likely to make mistakes and will cause less harm to your patients.

Ask for clarification of what you do not understand. For example, if your patient says ‘doc I am feeling a bit wobbly on my pins today”, you will need to clarify what they mean. Rephrasing or clarifying parts of the consultation will help your communication.

If you do make a mistake, admit your error by saying: “*I am sorry*” but then find out where you went wrong and learn from your errors. You will have then the opportunity to learn something new and move on. This will enable you to make the most of all your learning opportunities and ensure a safe and effective health care environment for everyone.

The importance of the appropriate attitude

A doctors’ authority with regard to knowing what is best for their patients is respected in this culture. In response, it is expected that patients will also be given respect and not treated in an authoritarian manner by doctors and health care workers.

For example if you would like to examine a patient, ask permission first, explain what you are doing, why you are doing it and then thank them afterwards. Offer them the same respect that you would expect if you were in their position.

In the workplace, you will work in multidisciplinary teams where every person has equal value and respect. Every team member has an important role to play. In the hospitals, everyone from the switchboard operator and ward assistants to the most senior administrator is important. In some medical management teams the patient and patient’s family are also members of the team.

In Australian culture, it is expected that each team member will carry out their own roles and responsibilities i.e. “pull their own weight” and not leave tasks to other team members.

Being observant

Watch the response of your patient, their families and your colleagues when you are speaking to check misunderstandings, people often express non comprehension by frowning, for example. You will learn a lot from how people respond to you about how to say something or if you have said something that is inappropriate or not correct.

Slowing down your rate of speaking

If you normally speak fast and you have an accent most people will not understand you, especially on the phone or in a noisy ward. If you find that people misunderstand or do not respond to what you are saying then try to slowdown.

Coping with Australian idioms

Australians use a lot of idioms and slang (colloquialisms) when they speak to each other. Even within Australia, people who live in different regions can use different words to say the same thing, e.g. ‘bus’ versus ‘coach’ or ‘case’ versus ‘port’.

This may seem complicated, but don’t worry! Australians are generally a friendly lot and if you don’t understand, you can ask people to explain what they mean. Slang words are often just shortened versions of longer words, with ‘o’ or ‘ie’ added at the end, e.g., barbeque becomes ‘*barbie*’, afternoon becomes ‘*arvo*’, OK becomes ‘*Okie Dokie*”.

Teenagers, as in all countries, have their own ever-changing slang words which are often influenced by popular international culture. For example, the words '*sick*', '*filth*', '*wicked*' and '*cool*' have all been used at different times to express that something was '*great*'.
Swearing is also quite common – sometimes it is meant to be offensive and sometimes it isn't. Like all language though, it depends how something is said, rather than what is said, that often transfers the meaning. For example, the swear words 'crap' and 'bloody' said in the following consultations would not be said to offend the doctor.

Example:

Doctor: 'What can I do for you today, Ms McCullogh?'
Patient: 'Call me Alicia, Alistair, I feel like crap. I've had this bloody headache on and off now for a coupla weeks and nothin' I take will budge it.'

Doctor: 'Tell me a bit more about your nasty headache, Alicia.'

With thanks to Judith Miralles & Associates for their contribution to this section of the manual.

For further information, support and training refer to the DVD and discussion guide *Cultural diagnoses: A communication-based learning resource for international medical graduates and* visit the CultureMate website

AUSTRALIAN ENGLISH RESOURCES

Further information and resources can be found in the Australian Medical English section of the Doctor Connect website.

Section 3 – Orientation to the local jurisdiction: Health services and facilities

REGISTRATION AND STANDARDS BODIES

This section describes the requirements to practise as a medical practitioner in Australia.

Australian Health Practitioner Regulation Agency (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the registration and accreditation of 15 health professions across Australia.

AHPRA's operations are governed by the *Health Practitioner Regulation National Law*, which came into effect on 1 July 2010. This law means that for the first time in Australia, 14 health professions are regulated by nationally consistent legislation. In Victoria, the act is cited as Health Practitioner Regulation National Law (Victoria) Act 2009.

AHPRA supports the 15 National Boards that are responsible for regulating the 14 health professions. The primary role of the Boards is to protect the public and they set standards and policies that all registered health practitioners must meet.

Further information on the Australian Health Practitioner Regulation Agency

Medical Board of Australia (MBA)

Medical Registration

After 1 July 2010, every doctor practising medicine in Australia must be registered with the Medical Board of Australia.

The Board keeps up-to-date public registers:

- of all registered medical practitioners with general, provisional, limited and non-practising registration
- of all medical practitioners who are recognised as specialists

There is a range of different types of registration to match different levels of training and experience. Most doctors have general registration and there are specific categories for medical students, newly trained doctors and some international medical graduates.

National registration came into effect on 1 July 2010. Medical practitioners with general or specialist registration can practise in any state or territory in Australia.

Types of Medical Registration

Under the *Health Practitioner Regulation National Law Act 2009*, there is a range of registration categories under which a doctor can practise medicine in Australia. Different categories apply to different types of registration. More information about these categories is provided via the links below.

Categories of medical registration are:

 General registration

 Limited registration

 Specialist registration

 Provisional registration

 Non-practising registration

Renewal of Medical Registration

The Board can grant up to 12 months registration.

The registration renewal date for medical practitioners with general, specialist and non-practising registration is **30 September.** The registration renewal date for practitioners with limited or provisional registration is determined on a case by case basis.

Policies, Codes and Guidelines

The Medical Board of Australia has developed codes and guidelines to guide the profession. These also help to clarify the Board's expectations on a range of issues.

The Board has approved policies, codes and guidelines on the following:

Codes and Guidelines

 Good Medical Practice: a code of conduct for doctors in Australia

 Sexual Boundaries: Guidelines for doctors

 Guidelines for Mandatory Notifications

 Guidelines for Technology Based Patient Consultations

Guidelines for Advertising of Regulated Health Services

Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures

Guidelines - Short-term training in a medical specialty for international medical graduates who are not qualified for general or specialist registration (effective from 1 July 2016)

Guidelines – Supervised practice for international medical graduates

Policies

Social Media Policy

Posting guidelines: Options for revalidation in Australia online discussion

Registration

Medical Registration – What does it mean? Who should be registered?

Registration Standards

Registration standards define the requirements that applicants, registrants or students need to meet to be registered. The Medical Board of Australia has developed the following registration standards:

Mandatory registration standards

Continuing Professional Development Registration Standard

Criminal History Registration Standard

English Language Skills Registration Standard

Professional Indemnity Insurance Registration Standard

Recency of Practice Registration Standard

Limited registration

- Limited Registration for Area of Need Registration Standard
- Limited Registration for Postgraduate Training or Supervised Practice Registration Standard
- Limited Registration for Teaching or Research Registration Standard
- Limited Registration in Public Interest Registration Standard

General registration

- Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training
- Granting General Registration to Medical Practitioners in the Standard Pathway who hold an AMC Certificate

Specialist registration

- Registration Standard for Specialist Registration
- List of specialties, fields and related titles Registration Standard

Further registration information available on the website → Medical Board of Australia

The Australian Medical Council

The **Australian Medical Council (AMC)** was established by the Australian Health Ministers in 1984 as an independent national standards body for medical education and training. Its primary purpose is 'to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community'.

The AMC:

- Acts as an external accreditation entity for the purposes of the Health Practitioner Regulation National Law
- Develops accreditation standards, policies and procedures for medical programs of study based predominantly in Australia and New Zealand and for assessment of international medical graduates for registration in Australia
- Assesses, using the approved accreditation standards, medical programs and the institutions that provide them – both those leading to general registration and those leading to specialist registration of the graduates to practise medicine in Australia
- Assesses other countries' examining and accrediting authorities to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by those

authorities have the knowledge, clinical skills and professional attributes necessary to practise medicine in Australia
- Assesses the knowledge, clinical skills and professional attributes of overseas qualified medical practitioners seeking registration to practise medicine in Australia
- Assesses the case for recognition of medical specialties.

For further information please refer to the following information on the AMC website:

Applying to the Australian Medical Council

MCQ Examination

Clinical Examination

Educational Support and Assistance

In Victoria, courses (commonly known as Bridging Courses) to assist international medical graduates with their AMC examinations are offered by:

Health Education Australia Limited (HEAL) - formerly VMPF

Alan Roberts International Medical Graduates Support and Advisory Service (ARIMGSAS)

English language proficiency

English Language Proficiency is a formal requirement for registration in Australia. From 1 July 2015, new registration standards for English language skills will come into effect.
The new standards introduce additional pathways for applicants to demonstrate evidence of their English language skills. These new standards apply to all applicants for initial registration, regardless of whether they qualified in Australia or overseas. For full details view the **AHPRA Registration Standard - English Language Skills.**

pdf
Click to View

English Language Skills Registration Standard

International English Language Testing System (IELTS)

Occupational English Test (OET)

PTE Academic

TOEFL iBT

Department of Home Affairs

Skilled Visa Changes 2018

Changes to the Skilled Visa programs came into effect on 18 March 2018.
No further applications under the Temporary Work (Skilled) visa (subclass 457) program can be lodged, with the new Temporary Skill Shortage (TSS) visa online forms available for use since 18 March 2018

The below is a link to the Department of Home Affairs skilled visa newsletter outlining changes as they are introduced:

Skilled visa newsletter

WORKING IN A VICTORIAN HOSPITAL

Working in a hospital can provide you with valuable learning experiences that enable you to consolidate and extend your theoretical knowledge and technical skills. If you are employed as a medical officer you will undertake rotations which will enable you to contribute positively to patient care as a member of the healthcare team while providing you with supervised training to support your career development and enable you to achieve full medical registration.

IMG employment pathways in Victoria: An overview

International medical graduates (IMGs) whose medical qualifications are from a medical school outside of Australia or New Zealand and who are seeking registration to practise medicine in Victoria must provide evidence of eligibility to undertake one of the following 3 assessment pathways: Standard Pathway; Competent Authority or Specialist Pathway.

IMG employment pathways in Victoria flow chart

The Hospital Structure

Hospitals have varied structures and you should be given a copy of your hospital's governance and organisational structure before you start working. You should note that you main contacts will other doctors in your Unit (Unit Head, nominated Supervisor, Registrar, junior doctor colleagues) and relevant ward staff.

As a doctor, there will be a range of people that you will interact with directly including:

- Patients and their relatives/friends
- Medical practitioners including other HMOs, Registrars and Consultants
- Other Health professionals including nursing and allied health
- Medical Clinical Educator & Directors of Clinical/College Training
- Medical Workforce and Medical Education staff
- General practitioners and other people involved in community services

Medical Workforce Unit

A Unit you will always have contact with is the Medical Workforce Unit of a health service. Recruitment of junior medical staff is generally coordinated by this Unit as well as:

- Orientation for medical staff
- Rotation allocation and roster preparation including leave management
- Development of position descriptions and link to Australian Junior Doctor Curriculum Framework
- Career advice and pastoral support for junior doctors
- Assistance with medical registration and immigration issues
- Other human resources and industrial issues including pays

The Role of a Junior Doctor (HMO)

You will play a central role in the day-to-day management of your patients. In your role as a Hospital Medical Officer (HMO) you should expect to:

- ensure high professional standards are maintained. You should practise professionally and ethically, in accordance with the expectations of the community, the medical profession and the Medical Board of Australia
- liaise with medical supervisors, nursing, allied health, and other relevant staff regarding patient management
- perform clinical duties including inpatient and outpatient services
- ensure appropriate communication is maintained to patients and other members of the patient care team, including external agencies such as general practitioners
- ensure adequate medical records and discharge planning systems are maintained
- be punctual and courteous and
- be responsible for your personal health and safety.

Interactions with Nursing Staff

Nurse Managers and other ward nursing staff can provide invaluable assistance about ward practices and hospital procedures. Please talk to them about relevant issues, particularly where you have concerns.

Always treat nursing staff with respect and remember that you share a primary goal – high quality patient care. Listen to their concerns, discuss the rationale for your clinical judgements and keep them informed of your whereabouts.

HMO Society

There is usually an active HMO Society at each hospital and you should consider becoming a member. These groups provide peer support and arrange social functions.

Commencement

Orientation to Hospital

The hospital's orientation program aims to familiarise you with the hospital environment. When you are appointed to a new position or a new location (including a secondment), the hospital should provide you with information on matters essential to the safe and efficient discharge of your responsibilities. You should receive written information that might include a "Unit Handbook" on the following:

- Governance and organisational structure.
- Hospital and Unit policies and procedures (eg emergency procedures, clinical protocols).
- Procedures for ordering supplies and tests.
- Job description including duties, responsibilities & lines of authority.
- Learning objectives (education and training goals).
- Assessment and feedback processes.
- Indemnity insurance details to cover you when you are caring for patients.
- How to handle medical emergencies.

It is also important that you speak with other doctors to help you develop a clear understanding of how the hospital and your unit work. This should include procedures and processes as well as a handover of all patients.

Conditions of Employment

The conditions of employment for hospital medical officers working in Victorian health services are subject to the current *Australian Medical Association (Victoria) Hospital Medical Officer Certified Agreement.* This Agreement sets out the minimum working conditions and covers things such as hours of work, conditions of secondment, termination of employment, rates of pay, superannuation allowances, leave.

A copy of the Award can be obtained from the Hospital website and the:

AMA Victoria website

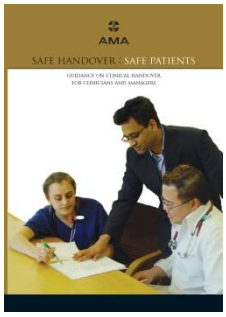
Rotations and Rosters

Most HMOs rotate through four or five units each year, with ten to thirteen weeks spent in a particular unit. As hospitals operate 24-hours, 7 days a week, all shifts must be filled and HMOs are expected to work a mix of day, weekend and night rosters. Hospitals try to give consideration to personal preferences and individual requests but HMOs need to remember that patient care remains the hospital's primary objective.

During your rotation you will be assigned a more senior medical practitioner who is responsible for supervising your work and for conducting mid-term and end of term assessment interviews. The supervisor is also responsible for working with you to determine your education goals and needs and to help you meet these.

Communication/Handover

Communication is an essential component of all junior medical staff jobs. Whether you are informing nursing staff of your wishes or ensuring that other HMOs covering your patients/ward when you handover know about your patients and are aware of any issues which must be monitored, effective communication is of the highest importance.



Australian Medical Association (AMA) publication: 'Clinical Handover Guide – Safe Handover: Safe Patients'

Discharge Planning

Discharge Planning should commence as soon as possible after admission as early referrals expedite discharges. Planning must take into account:

- The patient's medical, functional and psychological status, social circumstances and home environment.
- The availability of any necessary rehabilitation, social and long term care needs.
- Patient and family involvement wherever possible.
- Whether the patient requires transport on discharge.

In planning the discharge of patients, staff should consider the following:

Communication with GPs

- Inter Hospital Transfer
- Follow-up Appointments
- Pharmacy Requirements
- Geriatric Assessment (if applicable)
- Social Work Requirements

Internal Services

- Palliative Care
- Stoma & Prosthetic Care
- Coronary Disease
- Oncology
- Anti-Coagulant

Home Services

- Royal District Nursing Service
- Meals on Wheels
- Home Help
- Day Hospital

Allied Health Services

- Physiotherapy & Occupational Therapy
- Speech & Hearing

MEDICAL EDUCATION AND TRAINING

Informal and formal education programs

Medical practitioners in hospital medical officer 1 and 2 positions (HMO1/HMO2) can expect to take part in a range of formal education opportunities which are relevant to their needs, and to the clinical needs of their hospital. Valuable learning opportunities exist outside the structured training sessions and include discussion of particular clinical problems demonstrated by patients on the ward, department or unit meetings, Grand Rounds or other division or hospital-wide educational activity, Radiology and/or pathology demonstrations; mortality and morbidity audits, and clinical skills sessions. The hospital should provide you with a copy of the program to attend.

Australian Curriculum Framework for Junior Doctors (ACFJD)

The ACFJD outlines the knowledge, skills and behaviours required of prevocational doctors (PGY1, PGY2 and above) in order to work safely in Australian hospitals and other healthcare settings. The Curriculum Framework provides junior doctors with an educational template that clearly identifies the core competencies and capabilities that are required to provide quality health care. While it is expected that most of the competencies will be mastered by the end of internship, it is anticipated that a trainee will become more proficient and skilful in subsequent postgraduate years.

View the ACFJD

Medical Education Resources

Better Health Channel

Health Translations Online Directory

Clinicians' Health Channel (Department of Health Victoria)

Evidence Based Medicine

The essence of Evidence Based Medicine (EBM) is that decision making in healthcare should be influenced by the best available evidence and clinical experience.

The practice of EBM means integrating individual clinical expertise with the best external evidence from systematic research. Integral to this is access to, and interpretation of, the evidence in systematic reviews, meta-analyses, evidence-based practice guidelines and evidence databases. *(Source eMJA, 1999, Editorial, 170: 52-53)*

The EBM process - incorporating the best available research evidence in decision making - has four steps: asking answerable questions; accessing the best information; appraising the information for validity and relevance; and applying the information to patient care.

For a comprehensive and user-friendly guide to EBM, check out the eMJA article by Jonathon C Craig, Les M Irwig and Martin R Stockler, ***Evidence-based medicine: useful tools for decision making*.**

Continuing Professional Development

Continuing Professional Development (CPD) is critical to maintaining the high standards expected from the medical profession. It is essential that you maintain clinical skills and stay up-to-date through participation in continuing medical education and professional development activities.

Professional development by individual doctors is monitored by the medical professional organisations.

Specialist Vocational Medical Colleges

There are a thirteen specialist vocational Colleges in Australia. They are:

- **Australian and New Zealand College of Anaesthetists (ANZCA)**
- **The Australasian College of Dermatologists (ACD)**
- **The Australasian College for Emergency Medicine (ACEM)**
- **The Royal Australian College of General Practitioners (RACGP)**
- **College of Intensive Care Medicine of Australia and New Zealand (CICM)**
- **The Royal Australasian College of Medical Administrators (RACMA)**
- **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)**
- **The Royal Australian and New Zealand College of Ophthalmologists (RANZCO)**
- **The Royal College of Pathologists of Australasia (RCPA)**
- **The Royal Australasian College of Physicians (RACP)**
- **The Royal Australian and New Zealand College of Psychiatrists (RANZCP)**
- **The Royal Australian & New Zealand College of Radiologists (RANZCR)**
- **Australian College of Rural and Remote Medicine (ACCRM)**
- **Australian College of Sports Physicians (ACSP)**
- **Royal Australasian College of Surgeons (RACS)**

PROFESSIONAL SUPPORT

There are a number of organisations that are able to provide professional and personal support to doctors in Australia and offer a valuable source of experience and knowledge.

The major message is - do not be shy about using them. Asking for advice or help is not a sign of incompetence. It can be a way of building a rich network of learning and friendship.

Because Australia is such a large and diverse country, individual doctors cannot be expected to be expert in all the situations they may meet. Some situations doctors face will be uniquely Australian - for example spider bites or the impact of indigenous tribal beliefs on acceptance of medical treatment.

Australia conducts world class research and is in the forefront of some legal and ethical issues. Consequently new information and regulations are frequently being published.

The Hippocratic oath guides doctors to prolong life and reduce suffering. Asking for help and assistance to do this is part of being a good doctor. As well as providing the best level of care for your patients, it means you are continually learning and gaining wisdom – thus becoming a better doctor.

Australian Medical Association

AMA Victoria – Peer Support Service

AMA Victoria offers a **Peer Support Service** that is both anonymous and discreet. For the cost of a local call, you can call and talk to one of the trained counselors who are also experienced doctors.

The service will support you on issues including:

- dealing with a stressful incident
- violence and trauma in your workplace
- workplace issues such as bullying or harassment
- workload concerns\feeling of stress or inability to cope
- burnout
- your professional life
- your career plans
- personal issues
- your well being

You can contact the Peer Support Service on telephone: ***1300 853 338***, 365 days a year.

The Victorian Doctors Health Program

The Victorian Doctors Health Program (VDHP) is a confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use problems, or any other health issues.

You can contact the Victorian Doctors Health Program on telephone: *61 3 9280 8712*

Your Own Doctor

Doctors often put their duty of care to their patients first and work unrealistic workloads, often in isolation. Their health and wellbeing and that of their family around them can often be overlooked.

You should have your own medical practitioner from whom you can obtain care and medical treatment, including prescriptions and referrals.

GOVERNMENT AND NON-GOVERNMENT REFERRAL AGENCIES

The following section provides information and links to a number of Victorian and National based organisations, including:

- health support organisations and services
- emergency services/ patient transport/transfer services
- aged care and disability services
- government agencies

Health Support Organisations and Services

Community Mental Health

Community Mental Health services are available widely across Victorian communities. There are a number of categories of services provided:

- Adult Services
- Aged Person Services
- Child & Adolescent Services

Victorian Mental Health website

Drugs and Alcohol

Drugs and Poisons Regulation (DPR) in Victoria

Australian Drug Information Network

Alcohol and Other Drugs Services in Victoria

Alcohol and Drug Foundation

Turning Point Alcohol and Drug Centre

National Drugs Campaign

Needle and Syringe Program

Hearing Services

The Australian Government Hearing Services Program

Palliative Care

Palliative Care is the provision of holistic care to patients who have a life threatening illness and for whom active curative treatment is no longer the major treatment goal. Each region of Victoria has a designated palliative care service providing its own program of services to the person and their family. This may include nursing, medical consultancy to the person's GP, day care, counselling, diet advice, loan of equipment, physiotherapy, occupational therapy, social worker services, bereavement support, pastoral care and a wide range of support from trained volunteers.

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Palliative Care Victoria – Resources and websites

Very Special Kids

Very Special Kids (VSK) is a unique Victorian organisation that improves the quality of life for families who have a child with a progressive life-threatening illness. VSK is a place where families can go together for respite, secure in the knowledge that their sick child will be looked after and where they too can join in the special experience.

Families can share experiences with other families who understand how it feels to have a child with a progressive life-threatening illness. It offers palliative and respite care for children and parents, where children can stay, giving their parents an opportunity to rest and have some time to themselves, and a place where children can have a break from their parents. It is the first respite facility of its kind in Australia.

Melbourne Sexual Health Centre

The Melbourne Sexual Health Centre provides testing, diagnosis, treatment and counseling services for all sexually transmitted infections. Services are free and confidential.

Women's Health

 **Women's Health Victoria**

 **Breast Screen Victoria**

 **The Jean Hailes Foundation**

 **Family Planning Victoria**

Depression and Youth Suicide Prevention

Telephone counseling services include:

 **Kids Helpline** (***Telephone***: ***1800 551 800***) and

 **Lifeline** (***Telephone 13 11 14***)

Other support services include:

 **Beyond Blue**

 **Reach**

 **Life**

Emergency Services/Patient Transport/Transfer Service

Hospital Bypass

Guidelines for Hospital Early Warning Systems (HEWS) and hospital bypass for health service emergency departments

Ambulance Victoria

PIPER - Paediatric Infant Perinatal Emergency Retrieval

24 hour emergency number **1300 137 650**

Neo-Natal Resuscitation Guidelines - The Australian Resuscitation Council
Refer Section 13.

Adult Retrieval Victoria (ARV)

Adult Retrieval Victoria are providers of Adult Critical Care and Major Trauma Advice, Critical Care Bed Access, and Retrieval of Critical Care Patients State-wide.

This state-wide service is available 24 hours, 365 days a year.

ARV is part of Ambulance Victoria.

Contact: 1300 368 661

Aged Care and Disability Services

Home and Community Care (HACC)

The Home and Community Care (HACC) Program provides funding for services which support frail older people, younger people with disabilities and their carers. These services provide basic support and maintenance to people living at home and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care.

Hospital in the Home (HITH)

Hospital in the Home (HITH) provides hospital care in the comfort of the person's own home. Patients are regarded as hospital inpatients and remain under the care of their treating doctor in the hospital, and receive the same treatment that they would have received had they been in a hospital bed.

Patients may be able to receive all their hospital care at home or they may have a stay in hospital and then receive HITH in the latter part of their treatment. Participation in HITH is voluntary - both patients and their carers must agree to have their care provided at home.

Post-Acute Care (PAC)

Short-term supports facilitate a safe and timely discharge from hospital. The person returns home with an appropriate package of community-based supports. They are also linked up with ongoing long-term supports in the community, as required.

Royal District Nursing Service

The Royal District Nursing Service (RDNS) is the largest and oldest provider of home nursing and healthcare services in Australia. The RDNS is a not-for-profit organisation, delivering 24 hour a day nursing care to people in their homes, schools and workplaces. This service is provided 7 days a week, 365 days of the year.

Meals on Wheels

Meals on Wheels is a community service for the frail, aged, younger people with disabilities and their carers in Australia. The delivery of fresh or frozen meals can be arranged direct to the person's own home.

Government Agencies and Support

Victorian Department of Health

Centrelink

Centrelink is an Australian Government statutory agency, delivering a range of Commonwealth services to the Australian community.

Health Translations Directory

The Health Translations directory links to online multilingual health resources from government departments, peak health bodies, hospitals, community health centres and welfare agencies. This is a great resource for health practitioners who work with culturally and linguistically diverse communities, you can use this directory to find reliable translated health information.

IT SYSTEMS – PRESCRIBING, PATHOLOGY AND RADIOLOGY ORDERING AND REPORTING

(Specific to hospital-based orientation)

PATIENT SAFETY AND SAFE MEDICATION PRACTICE

(Specific to hospital-based orientation)

Useful reference material:

Australian Prescriber

Australian Prescriber is an independent publication providing readily accessible information about drugs and therapeutics. It covers topics assisting doctors, dentists, pharmacists and students. This site provides full text versions of the publication with a search facility.

National Inpatient Medication Chart (NIMC)

In April 2004, Australian Health Ministers stated a commitment to the implementation of a national standard inpatient medication chart in public hospitals to reduce patient harm from medication errors.

INFECTION CONTROL POLICY

Hand washing

Hand washing should occur:

- Before and after each patient contact;
- After removal of gloves;
- If hands become contaminated;
- After using the toilet;
- Before handling food;
- After sneezing, coughing, using a tissue;
- After handling waste

Clinical hand washing (with anti-microbial soap) should be done prior to performing invasive or clinical procedures.

Wearing of gloves

Gloves should be worn when:

- Handling blood or body fluids
- Handling equipment or materials contaminated with blood or body fluids
- Touching mucous membrane
- Touching non-intact skin of any person
- Performing venipuncture
- Performing other invasive procedures

Infectious Diseases and Guidelines - Victorian Government Health Information

Infection Prevention in Health Services - Victorian Government Health Information

Immunisations – Victorian Government Health Information

OCCUPATIONAL HEALTH AND SAFETY

(Specific to hospital-based orientation)

Section 4 - Legislation and Professional Practice

LEGISLATIVE FRAMEWORK GOVERNING PRACTICE IN THE PARTICULAR JURISDICTION

This section of the manual provides guidance on professional behaviour expected of doctors working in Australia.

This is particularly important as the medical profession is largely self-regulated, creating a privilege which is heavily based on trust.

This special relationship dictates that medical practitioners are scrupulous in all aspects of their behaviour and practice.

Federal and State Government Legislation

A practicing doctor is subject to more than 30 different Acts of State and Federal Parliament. While no doctor can be expected to have a detailed working knowledge of all of these Acts, doctors are professionally obliged to be generally aware of them and to seek more information when necessary.

Doctors are regulated through Acts of Parliament in each State and Territory. The key acts governing medical practice in Victoria are covered under the following legislation:

- *Health Practitioner Regulation National Law Act 2009*
- The *Health Complaints Act* 2016
- *The Health Services Act 1988*
- *The Mutual Recognition Act 1992*

Most of this legislation concerns the registration and regulation of medical professionals and in particular establishing bodies and providing them with guidelines regarding roles and responsibilities.

Other relevant legislation relating to medical practice includes (but is not limited to):

- *The Health Records Act 2001*
- The *Mental Health Act* 2014
- Drugs, Poisons and Controlled Substances Act 1981

Australian Health Practitioner Regulation Agency (AHPRA)

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the registration and accreditation of 14 health professions across Australia.

AHPRA's operations are governed by the *Health Practitioner Regulation National Law*, which came into effect on 1 July 2010. This law means that for the first time in Australia, 14 health professions are regulated by nationally consistent legislation. In Victoria, the act is cited as Health Practitioner Regulation National Law (Victoria) Act 2009.

AHPRA supports the 15 National Boards that are responsible for regulating the 14 health professions. The primary role of the Boards is to protect the public and they set standards and policies that all registered health practitioners must meet.

pdf Click to View *Health Practitioner Regulation National Law (Victoria) Act 2009*

Further information on the Australian Health Practitioner Regulation Agency

Medical Board of Australia (MBA)

The Medical Board of Australia has developed codes and guidelines to guide the profession. These also help to clarify the Board's expectations on a range of issues. The Board has approved codes and guidelines on the following:

pdf Click to View

Good Medical Practice: a code of conduct for doctors in Australia

pdf Click to View

Sexual Boundaries: guidelines for doctors

pdf Click to View

Guidelines for mandatory notifications

pdf Click to View

Guidelines for technology based patient consultations

pdf Click to View

Guidelines for advertising regulated health services

Medical Board of Australia

Guidelines: Short term training in a medical speciality for international medical graduates who are not qualified for general or specialist registration

(effective from 1 July 2016)

Guidelines: Supervised practice for international medical graduates

The Health Practitioner Regulation National Law (Victoria) Act 2009

The *Health Practitioner Regulation National Law (Victoria) Act 2009* gives clear direction to medical practitioners on the standards of conduct expected in medical practice.

The *Act* includes the following definitions of 'notifiable conduct' in relation to a registered health practitioner:

- Practiced the practitioner's profession while intoxicated by alcohol or drugs; or
- Engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
- Placed the public at risk of substantial harm in the practitioner's practice of the profession in a way that constitutes a significant departure from accepted professional standards.

Other Relevant Acts and Regulations

There are a number of Acts of Parliament which affect privacy and confidentiality relevant to public health care agencies, including:

Cancer Act 1958

Charter of Human Rights and Responsibilities Act 2006

Freedom of Information Act 1982

Health Records Act 2001

Health Services Act 1988

Coroners and Human Tissue Acts (Amendment) 2006

Mental Health Act 2014

Other relevant Acts and Regulations are:

- *The Coroners Act 2008*
- *The Children, Youth and Families Act 2005*
- *The Crimes Act 1958*
- *The Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*
- *The Evidence Act 1958*
- *The Births, Deaths and Marriages Registration Act 1996*

Professional Conduct Guidelines

Guidelines developed by the **MBA** and the **Australian Medical Association (AMA)** form the basis of this section of the manual.

The AMA *Code of Ethics* provides a set of fundamental principles which should guide doctors in their professional conduct.

Please refer to:

Medical Board of Australia

Australian Medical Association

The remainder of this section is organised into the following three major themes:

i. The Doctor and Patient
ii. The Doctor and their Profession
iii. The Doctor and Society

The Doctor and Patient

Over the centuries, doctors have held to a body of ethical principles developed to guide their behaviour towards patients, their professional peers and society. The Hippocratic Oath was an early expression of such a code. These codes of ethics encourage doctors to promote the health and well-being of their patients and prohibit doctors from behaving in their own self-interest.

Standards of Care:

a) Practise the science and art of medicine to the best of your ability and within the limits of your expertise.
b) Continue self-education to improve your standard of medical care.
c) Evaluate your patient completely and thoroughly.
d) Maintain accurate contemporaneous clinical records.
e) Ensure that doctors and other health professionals who assist in the care of your patient are qualified and competent to carry out that care'.

(AMA Code of Ethics)

It is important that you know:

- your limits. If it seems necessary for you to act outside your area of competence, ask yourself whether that is the best treatment available for the patient at that point in time.
- that taking a full history and conducting a full examination may not always be easy. Some patients will not allow this. Respect their wishes. Carefully record what occurred and why.
- that keeping records is of the highest importance. Keep accurate records of what you and the patient said and did on each occasion. Be extra diligent in 'special' cases e.g. the prescription of addictive drugs to patients other than your own; home visits; new patients.

RESPECT FOR PATIENTS

a) Ensure that your professional conduct is above reproach.
b) Do not exploit your patient for sexual, emotional or financial reasons.
c) Treat your patients with compassion and with respect for their human dignity.'

(AMA Code of Ethics)

RESPONSIBILITIES TO PATIENTS

'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.

To help with these decisions, inform and advise your patient about the nature of their illness and its possible consequences, the probable cause and the available treatments, together with their likely benefits and risks.'

(AMA Code of Ethics)

The patient has the right to make decisions affecting their well-being, based on necessary information.

It is also your responsibility to ensure that your patients understand what you are saying. You may need to engage interpreters or members of the family to help. This may raise privacy issues, and you need to be particularly careful if using family members.

COMMUNICATION WITH PATIENTS

Clear and unambiguous communication is the most effective way for medical practitioners to both minimise complaints to the Medical Board or the Health Services Commissioner, and in some cases, even avoid litigation.

Trust and open communication are central to any effective medical consultation. These are lost when a doctor is perceived to be rude, arrogant or insensitive.

When the doctor's conduct fails to meet community expectations, individual patient care can be compromised and the reputation of the medical profession generally can be undermined.

RESPECT FOR PATIENTS FROM DIFFERENT CULTURES

Australia is made up of people from a variety of cultures, many of whom hold different values and beliefs about health and medical treatment. These different beliefs and values will impact on your patients' perceptions of appropriate treatment and behaviour.

In areas in which you have strong personal beliefs, conduct your research about alternative approaches more rigorously than usual and ask others advice. For example in the case of:

- Termination of a pregnancy
- The process of dying
- AIDS related care
- Euthanasia

These are areas where your personal views and your role as a doctor may conflict strongly. Be aware of these areas of conflict to ensure your judgment is not clouded with emotion. In some cases where you are aware your judgment may be biased, you may need to refer the patient to a colleague.

Do not deny treatment to any patient on the basis of their culture, ethnicity, religion, political beliefs, sex, sexual orientation or the nature of their illness.'

(AMA Code of Ethics)

CONSENT FROM PATIENTS

Before you take any medical action, you must get the patient's permission. The patient needs to understand what it is you intend to do, why it is necessary and how it will be performed.

PATIENT PRIVACY AND CONFIDENTIALITY

> *Keep in confidence information derived from your patient, or from a colleague regarding your patient, and divulge it only with the patient's permission.'*
>
> *(AMA Code of Ethics)*

Medical practitioners must at all times be sensitive to the needs of their patients for privacy. They should ensure that they offer a screen and/or a gown when patients are required to undress.

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'*.
>
> *(AMA Code of Ethics)*

The management of dying is an area of social, legal and ethical debate in Australia, and many cultures have their own processes for managing dying. Balancing the desires of the patient, their family, the law and society and your own personal values is sometimes difficult.

Palliative care recognises the special needs of a person who has a life-threatening illness. The focus is not on curing them but on treating their symptoms by making them comfortable, by controlling their pain and by helping them to make changes which will make their life easier.

Palliative Care Victoria

REFUSAL OF MEDICAL TREATMENT

> *'Remember the obligation to preserve life, but, where death is deemed to be imminent and where curative or life-prolonging treatment is futile, try to ensure that death occurs with dignity and comfort."*
>
> *(AMA Code of Ethics)*

In Victoria, a person of sound mind aged 18 or over has a common law right to refuse medical treatment including life-sustaining measures. A doctor who proceeds with treatment without the patient's consent if this can be obtained commits an offence. Refusing medical treatment is not voluntary euthanasia. Furthermore, there are no circumstances in which a doctor may act with the intention of terminating a patient's life.

Patients can now also refuse treatment in an advance care directive. A person may only create an advance care directive if they have decision-making capacity in relation to each statement in their advance care directive. This means they must understand the nature and effect of the treatment about which they are making decisions. The advance care directive will only take effect at a time when the person does not have capacity to make a medical treatment decision that needs to be made. Until this time, the person will continue to make their own medical treatment decisions at the time treatment is offered.

An advance care directive cannot contain any statement that would require an unlawful act to be performed or that would require a health practitioner to breach a code of conduct or professional standards. If an advance care directive contains such statements, these statements are void and have no effect, but the remainder of the advance care directive remains valid.

INSTRUCTIONAL DIRECTIVE

In an instructional directive a person may either consent to or refuse a particular medical treatment. If the person subsequently does not have capacity to make a decision about that treatment, the instructional directive will apply as though the person has consented to or refused the treatment.
An instructional directive must be expressly identified as such. This means that it must contain a heading or some other reference using the words 'instructional directive'. Any other statements in an advance care directive are values directives. If it is unclear how an instructional directive would apply in the circumstances, but it is still indicative of a person's preferences or values, it must be applied as a values directive.

VALUES DIRECTIVE

In a values directive a person may make more general statements about their preferences and values and what matters to them. If there is not an instructional directive then the health practitioner will need to obtain consent from a medical treatment decision maker to provide treatment. The medical treatment decision maker must consider a values directive.

COMMUNICATION WITH RELATIVES

Communication with the relatives of your patients is a necessary part of medical practice. When communicating with relatives you should always make sure you protect the privacy of your patient.

The Doctor and their Profession

PROFESSIONAL CONDUCT

> *'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.'*
>
> *(AMA Code of Ethics)*

You are not expected to know everything and it is quite acceptable to ask if you are unsure about anything. One of the greatest challenges in medical practice is having the insight to know when to seek assistance from your colleagues. Having access to a peer group, whether it is through one of the specialist colleges, a hospital or a practice, makes it easier to seek such assistance.

The Doctor and Society

Australian society is made up of many cultures and people of diverse backgrounds. In all societies, there are sub-cultures, and important differences between rural and urban groups, among different classes and genders. Even within these groupings, individuals vary in the extent to which they fit a particular image.

Respect the integrity of individual personal and cultural beliefs. Individuals' cultural explanations and beliefs about their ill-health and their expectations of health care may affect their acceptance of treatments and the eventual outcome of health care. Be alert to polite non-compliance – that is someone who is too polite to say they will not be following your advice.

At the same time, even people who do not share your explanations of the causes of their ill-health may accept conventional treatments - you don't have to 'convert' them to your way of thinking to get a good result.

You do not have to agree with every aspect of another's culture just as the other person does not have to accept everything about yours - effective and culturally-sensitive health care can still occur.

COMPLAINTS

Complaints to the MBA are usually made by a patient, relative or another representative of the patient.

Complaints also come from other doctors, lawyers, employers, insurance companies, the Coroner, the Police, the Department of Health and Human Services. Others are referred by the Health Complaints Commissioner (see Section 7).

The types of complaints received by the MBA cover almost all aspects of medical practice. Many complaints involve an underlying poor approach to communication by the doctor and most also criticise the doctor's standard of practice. Other common complaints relate to medico-legal examinations and sexual misconduct. The personal conduct of a doctor is often cause for complaint, as are wrong or delayed diagnoses.

OTHER AREAS OF MISCONDUCT

- Operations without proper consent
- Inadequate sterilization of equipment and management of needles
- The appropriate and inappropriate breaking of confidentiality
- Not conforming with mandatory notification requirements
- The abuse of the Medicare system
- Compromising patient safety
- Prescribing drugs over the phone without examining the patient
- Asking inappropriate people to administer drugs
- Falsifying patient records
- Incorrectly certifying death
- Births –problems resulting from induced births or forceps deliveries. Many doctors are moving out of gynecology because of the high cost of insurance.

The MBA takes every complaint seriously, whatever its source. Under the Act, it must conduct a preliminary investigation into every complaint, unless it is frivolous or vexatious.

Medical Practitioners have ethical and legal responsibilities to identify situations where the public may be at risk by their conduct or that of another colleague.

The MBA encourages medical practitioners to consider the issue of 'impairment' – either your own or that of a colleague. Examples of impairment are:

- Drug dependent medical practitioners
- Mentally ill medical practitioners
- Ageing medical practitioners
- Medical practitioners who may be incompetent through lack of professional development

It is understandable that some doctors feel uncomfortable about this. However, all treating doctors must be aware that there are both ethical and statutory obligations on doctors to protect the public from impaired

registered health practitioners by reporting them to the relevant registration body. The HPRC provides immunity from civil and criminal liability for a treating doctor, where a report is made in good faith.

The Board also receives notifications of medical practitioners who may be impaired from patients, family members, the Department of Health, the Department of Human Services, pharmacists and other health professionals and through the complaints process.

Medico-Legal Guidelines

Medical Board of Australia

The role of the MBA is to protect the community by ensuring doctors maintain professional standards and practice ethically and competently.

There are four key areas of the MBA's work:

- registering doctors
- investigating complaints about doctors' professional conduct
- investigating and monitoring the health of doctors whose health may be impacting on their practice of medicine
- investigating and monitoring medical practitioners whose professional performance has been unsatisfactory

The MBA has an important role to play in investigating and dealing with complaints about individual medical practitioners**.**

If specific issues relating to legal obligations arise, practitioners should seek advice from their medical defence organisation, a legal practitioner, the Health Services Commissioner, the Privacy Commissioner, the Coroner's Office, the relevant government Department or the MBA.

LITIGATION AND INDEMNITY

Medical Insurance and Indemnity

When working in a public hospital medical staff are indemnified by the Victorian Managed Insurance Authority (VMIA). This covers the treatment of all patients provided a bill is not rendered to the patient in your name. However, please be aware that the VMIA hospital indemnity does **NOT** cover representation at the MBA or Coronial inquests. It is therefore imperative that you take out basic (hospital-indemnified) insurance cover with an independent Medical Defence Organisation (MDO). This is not expensive, is tax deductible, and serves to offer the security of independent help and legal advice when required.

Litigation in Australia does occur, and the effects on a medical practitioner can be quite devastating both emotionally and financially. However, many patients are unable to meet the required financial obligations or legal thresholds for litigation to proceed. Under such circumstances, they might take their grievances to the Health Service Commissioner and also to the MBA. Your MDO would provide assistance with your representation to the MBA.

Medical Negligence

Medical Negligence is a civil wrong known as a 'Tort'. There are three stages to this Tort. Plaintiffs must:

1. Establish a **Duty of Care**;
2. Prove a **breach** of this duty;
    a. Consider the relevant **standard of reasonable care** of the practitioner involved
3. Prove that they suffered a **damage/loss**;
4. Prove that the damage/loss was **caused** by the defendant's breach.

Courts base their decisions of what is acceptable and appropriate by the required standard of proof. In civil matters, the standard of proof is "**on the balance of probabilities**" rather than **"beyond reasonable doubt"** as occurs in criminal matters. The courts are often aided by expert opinion provided by appropriately skilled medical practitioners.

Litigation

Victoria does not have a high litigation rate. In the public healthcare sector, it is the hospital entity that is named in a causative action and not the individual medical practitioner. However, the individual practitioner will be called upon to assist the hospital with the defence of the claim. Because Victoria has a requirement for a mediation to occur prior to a court appearance, the majority of cases settle during this mediation process and never make it to court. This has the benefit of confidentiality and a much lesser impact on all concerned. Should settlement not be achieved at mediation, you will be required to assist the hospital with the defence of the claim in the courts. The VMIA will provide the legal representation; however, should you feel that a conflict might arise during the legal processes, this is where your MDO would assist you as well.

The impact of litigation and increasing MDO premiums have led to the withdrawal of practitioners from selected areas of clinical practice. The State and Federal Governments have strategies in place to try to overcome this occurring.

Examples of types of litigation:

- *Delayed or missed diagnoses.* In many instances this may well be related to the incorrect interpretation of an investigation or even failure to act upon the result of an investigation.
- *Failure to warn.* Consent issues keep recurring. Doctors need to be **proactive** with regards the information they provide to their patients undergoing procedures and treatment. In addition, they need to be **reactive** to individual patients' concerns.
- *Adverse outcomes of treatment.* In many circumstances, this can be tied in with consent issues as well. However, it is the doctor's reaction and poor communication with the patient that is often the precipitating issue that gives rise to the litigation.

Risk Management Strategies

Often claims arise because the patient or their family has not been sufficiently informed about the circumstances of their care. Undertaking litigation is perceived as a means of getting the required information as well as attempting to encourage changes to perceived inadequate procedures to ensure such an issue does not occur with anybody else.

Understanding the relevant protocol for managing patient dissatisfaction is encouraged. Many issues can be resolved early before entrenched positions are taken. With the introduction of the "Open Disclosure Standard", hospitals now have a communication procedure for dealing with the patient and their family in the event of an adverse outcome. You should make yourself familiar with this Open Disclosure Standard and the policies of the hospital where you will be working.

The two key issues that are central to minimising the risk of patients' complaints are:

1. **Communication.** Many of the incidents that lead to complaints or litigation could be prevented if there is a good relationship with the patient. Good communication also refers to not only providing explanations as well as offering patients the opportunity to ask questions, but being mindful of patients' privacy and understanding of medical terms.
2. **Documentation.** Good record keeping is reflective of good communication and clinical practice. It is essential for continuity of patient care (for your colleagues to provide ongoing care when you are not there) and also serves as the only contemporaneous record available to you into the future should litigation arise. It is vitally important to make sure that all entries are: dated and signed, legible, contain a note regarding discussions and warnings pertaining to treatment options, detailed with respect to follow up requirements, and contain notes of any telephone advice. Operation notes are to be detailed and no alterations of the notes should be made – any corrections need to be crossed out, identified as such and a new note written with the appropriate date and time – not back-dated.

Medical Defence Organisations (MDO)

In Victoria, there are a number of organisations that provide Medical Indemnity. The major ones being Avant, MDA National, Medical Insurance Group Australia (MIGA) and MIPS. These insurers are represented by a peak body, Medical Indemnity Insurance Association of Australia (MIIAA).

 **MIIAA**

Victorian Managed Insurance Authority (VMIA)

VMIA provides insurance to the public hospitals. By virtue of the fact that you are an employee of a public hospital and you are providing care to public patients attending a public hospital, you are afforded coverage under the VMIA policy. *Should you however, render a bill to the patient in your own name (Not via a special purpose fund arrangement); you will not be covered under the VMIA policy.* Please be aware that the VMIA policy does not cover you for representation to the Medical Board nor does it cover representation at a Coroner's Inquest (unless the VMIA elects to do so). As mentioned earlier, it is for these reasons you **must** take out a basic level cover with an MDO (see below).

 **Avant**

 **MDA National**

 **Medical Insurance Group Australia (MIGA)**

 **Medical Indemnity Protection Society (MIPS)**

PATIENT RIGHTS AND RESPONSIBILITIES

Patients in Australian public hospitals are entitled to expect and receive high quality services. Patients' rights and responsibilities are described in the Public Hospital Patient Charter

Australian Charter of Healthcare Rights

In relation to involuntary psychiatric patients, pursuant to section 13 of the *Mental Health Act* 2014, on becoming a compulsory patient under the Mental Health Act, every person must be given an appropriate printed statement advising the patient of their legal rights and other entitlements of patients under the Act, including the right to obtain legal representation and to have a second psychiatric opinion, and containing other information relating to the treatment and care of the patient that the Department of Health and Human Services considers relevant.

pdf
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Mental Health Act 2014

Not for Resuscitation (NFR) Orders

A decision not to resuscitate a patient who has had a cardiopulmonary arrest usually flows from a clinical judgment about the reversibility of the patient's condition and the likely prognosis.

An **"NFR Order"** (*Not for Resuscitation Order*) is to be issued in consultation with the patient, their agent/guardian where appropriate, senior medical staff of the referring/treating units and senior nursing staff. An "**NFR Order"** can be revoked at any time at the request of the competent patient, or their agent/guardian in the case of the incompetent patient.

PATIENT COMPLAINTS

Patients who are dissatisfied with any aspect of their treatment are entitled to make a formal complaint. All hospitals have staff who deal with complaints from patients. If you have a patient who wishes to make a complaint you can refer them to these staff and you can also seek advice from the Complaints Department if a complaint is made about you. Medical Administration is available to assist you in these circumstances.

Health Complaint Commissioner (HCC)

From February 2017, the Health Complaints Commissioner replaced the Health Services Commissioner. The HCC has greater power to take action against dangerous and unethical health providers and deals with complaints about the provision of health services.
The purpose of the new Act is to provide for a complaints process and other processes about health service provision and related matters, to establish the office of Health Complaints Commissioner and the Health Complaints Commissioner Advisory Council, to repeal the Health Services (Conciliation and Review) Act 1987 and to provide for related matters.

The responsibility of the HCC is not limited to complaint resolution. This is because the legislation contains the following “guiding principles” of health care:

- that a health service is able to be accessed;
- that a health service is safe and of high quality;
- that a health service is provided with appropriate care and attention;
- that a person seeking or being provided with a health service and the person's carer are treated with respect, dignity and consideration;
- that adequate and clear information is provided about a health service in respect of the treatment, options and costs in a transparent manner;
- that an inclusive approach is applied in the making of decisions about a health service;
- that the privacy and confidentiality of health information and personal information is respected;
- that a health service provider makes provision for the person seeking or being provided with a health service to make comments or complaints and that those comments or complaints are addressed.

The guiding principles establish a framework of responsibilities within which health service providers are expected to operate. At the same time, the principles provide a basis on which complaints may be made against health service providers.

Complaints can be made about any health service provided in Victoria, or a health services that's been requested even if not delivered. You can also make a complaint about anyone who holds your health records, including schools, gyms and other non-health service providers, about how they handle your information.

The HCC manages complaints about:

- access to services
- quality and safety
- care and attention

- respect, dignity and consideration
- communication about treatment, options and costs
- the level of involvement in healthcare decisions
- access, privacy and confidentiality of personal health information
- complaint handling by the health service provider.

Individuals may complain about health service organisations such as a public or private hospitals, GP clinics or community health services, or about an individual health practitioner. You can complain to us about both registered and non-registered, or general, health service providers.

PATIENT CONSENT

Consent to Treatment

Good communication is an essential part of good medical care and provides patients with the information they need to make decisions about their treatment. Medical practitioners are required to provide information to patients to enable them to understand:

- their treatment options,
- the foreseeable consequences and side-effects of any proposed therapy or intervention,
- the consequences of not proceeding with treatment, and
- your opinion of the best course of treatment and your reasons for holding this opinion.

What is consent?

Medical practitioners can only undertake procedures or provide treatment to patients who give consent, unless in the case of an emergency. For this purpose, consent is the voluntary agreement by a patient (with consent) to a proposed procedure of treatment. A patient can only give such agreement after he or she has been provided with sufficient information to enable him or her to make an informed decision.

HMO's are encouraged to ensure a detailed entry in the patient's medical record concerning the consent process; that is, make a note of the discussion of the risks and benefits of the procedure.

Where available & appropriate refer to patient information sheets which include diagrams and lay terms to explain the proposed procedure/treatment/examination. Provide the patient with the opportunity to ask questions or seek clarification before asking for written consent.

A Consent form should only be signed immediately after a discussion between, ideally, the treating doctor and the patient about the proposed treatment/ procedure/ examination including its material risks (including the risk of failure).

The doctor can only sign the consent form after having the discussion. The patient should sign their section of the form immediately after. Having obtained written consent it should be noted that the consent may become invalid, if for example the procedure/examination/treatment is postponed or there is a change in the patient's clinical condition which necessitates a fresh discussion of the risks and fresh consent form.

HMOs should not be taking 'consent to treat' from patients for procedures they do not understand in detail. If you are asked to take consent and do not know the procedure in sufficient detail, you should seek the assistance of a senior clinician involved.

Remember to use the service of a <u>professional</u> interpreter for consent when patients are not fluent in English or don't understand the medical jargon you may need to use. <u>It is not wise to use the services of staff or family in the doctor/patient relationship.</u>

A health professional who examines a person against his will and without statutory authority to do so, and a surgeon who performs an operation or part of an operation without the patient's express or implied consent, are each liable in *trespass*.

A health professional may also be liable in damages if he is negligent in failing to inform the patient of the *material risks* involved in the treatment, and if the patient having been so informed, would not have consented.

If treatment is given without consent the offence of *battery* may also be considered.

It goes without saying, therefore, that consent needs to be obtained **before** administering any treatment, or performing any examination or procedure unless there is legal justification for not doing so, for example, in an emergency.

Requirements for consent

The requirements for consent are listed below:

- **VOLUNTARY**: It is given voluntarily. It must not be given as a result of fraud or deceit of under pressure or duress.
- **SPECIFIC**: It relates to the specific procedure or treatment to be undertaken
- **CAPACITY**: The person giving the consent must have the legal capacity to provide it – for example a young person or a person with cognitive impairment may not have such capacity,
- **INFORMED**: The patient must be informed. This means they should have a general level of understanding of the proposed procedure of treatment, including its risks and side effects.

Practitioners should:

- Use plain, non-technical language to communicate information about proposed procedures and treatment to patients.
- Assure themselves about their patient's understanding of proposed procedures and treatment
- Not rush patients. They should give their patients the time and opportunity, when possible, to reflect on the information provided and their options ask questions and discuss issues with persons close to them and
- Use and appropriately skilled interpreter when this is necessary.

Exceptions to the need for consent

There are three exceptions to the need for doctors to undertake procedures or treatment only with due consent:

- **In an emergency, this is when the treatment given is necessary to avert a serious and imminent threat to a patient's life or physical or mental health;**

- **When authorised specifically under statute or by court order; and**

- **When another person is able to provide consent on the patients behalf. This includes parents in relation to a child who is not sufficiently mature to make these decisions.**

The emphasis on a *patient's autonomy* in current law, leads naturally to the conclusion that if a patient is unable to consent to treatment and no guardian, attorney or agent has been appointed to consent on the patient's behalf, then health professionals may have no lawful authority to administer treatment or perform an examination or procedure.

Common accepted medical practice however, demonstrates that doctors do treat in situations where there is no-one who has been legally appointed to consent on the patient's behalf.

For example, where the patient's condition is life threatening and immediate emergency action is needed, doctors may treat and rely upon the *doctrine of necessity as a defence to any claim.*

However, health professionals are warned that to treat a patient, claiming that it was in the best interests of the patient, is to enter a "grey area" in which the health professional runs the risk of allegations of assault and battery being made. Also, the defence of *necessity*, and probably the doctrine of emergency, do not apply if an adult competent patient has *refused*, rather than not consented to treatment.

If health professionals decide that a patient is not competent to decide about and consent to the treatment in question, either because of limited cognitive capacity or insufficient understanding about the proposed procedure, or that the patient's refusal does not cover the circumstances that have arisen, they are advised to consult with the **Victorian Civil & Administrative Tribunal (VCAT) Guardianship List, or the Public Advocate.**

Office of the Public Advocate

Victorian Civil and Administrative Tribunal

Application forms
Information on the Guardianship List

Who can give consent when the patient cannot?

Guardianship and Administration Act 1986

Medical Treatment Planning and Decisions Act 2016

Medical treatment decisions
If a person does not have decision-making capacity to make a medical treatment decision, the *Medical Treatment Planning and Decisions Act* 2016 specifies who has authority in Victoria to make such decisions. If there is no one, Victoria's Public Advocate can make significant treatment decisions without the need for a guardianship order.

Patients with a disability
Guardianship is a last resort, if there is no less restrictive alternative to safeguard the interests of an adult with disability.

All adults have the right to make their own decisions. People with disability should be encouraged and supported to make decisions for themselves. However, if a person is unable to make reasonable judgements because of their disability and there are concerns about the decisions they are making, or others are making for them, the Victorian Civil and Administrative Tribunal (VCAT) can appoint a guardian to make decisions for them. Guardianship may also be needed if there are different views which cannot be resolved about what is in the person's best interests, and a decision needs to be made.

Material Risks
All health professionals have a duty to warn a patient of a material risk involved in any proposed treatment procedure or examination.

A risk is material, if in the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the doctor is or should be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

It follows that there is not only a duty to warn of the possible complications of surgery, but *also* of the ***risk of failure*** as to the intended end result. [2]

National Health and Medical Research Council (NH&MRC)

To quote from the National Health and Medical Research Council (NH&MRC) "Guidelines for medical practitioners on providing information to patients",

> *"doctors should give information about the risks of any intervention, especially those that are likely to influence the patients decisions, and known risks should be disclosed when an adverse outcome is common, even though the detriment is slight, or where an adverse outcome is severe, even though its occurrence is rare".*

Therapeutic Privilege

Whilst a doctor has a *therapeutic privilege* to withhold information (say in the case of an unusually nervous, disturbed or volatile patient) you must note that in recent times there have been several cases which have discussed the dilemma that doctors find themselves in not wishing to "scare the patient off" on the one hand and giving full advice on the other. To quote from the decision of the Supreme Court of New South Wales in ***McKellar v Blake (30 October 1998)***

> ***"****Doctors themselves are in a difficult position. They will often, as appears to have been the case here, take the view that there is minimal risk and that the procedure will be of substantial benefit to the patient. They wish to avoid over-emphasising a warning in case it deters a nervous patient from undergoing a procedure which is likely to be beneficial. Nevertheless, the patient is entitled to know the risks which are involved and must be told".*

Assistance in obtaining informed consent from non-English speaking patients should **not** be obtained from relatives who are unlikely to provide a professional independent interpreting service for the attendant

[2] See F v R (1983) 33 SASR 189

medical practitioner. Check when the hospital's Interpreting Service is available and what the arrangements are for out-of-hours. There can be no excuse for not obtaining informed consent from a patient who does not speak or understand English.

Whilst a written informed consent form will not prevent actions in negligence from being mounted against a hospital and its staff, good documentation of the consent process, that is, discussion of risks and benefits, will provide material from which a defence to any such claim might be drawn, and will stand both the hospital and the medical practitioner involved in good stead in defending proceedings in which negligence is alleged.

Office of the Public Advocate

November 2017

Medical decision making

Applies from 12 March 2018

Health practitioners need a patient's consent before providing medical treatment.

New laws commencing on 12 March 2018, set out steps for health practitioners to follow when a patient is unable to consent. (See flowchart overleaf explaining the steps under the new *Medical Treatment Planning and Decisions Act 2016*).

The Act applies to health practitioners

The Act applies to all registered health practitioners in the following professions:

- medical
- dental
- physiotherapy
- occupational therapy
- chiropractic
- pharmacy
- optometry
- podiatry
- psychology
- nursing and midwifery
- medical radiation practice
- osteopathy
- Chinese medicine
- Aboriginal and Torres Strait Islander health practice.

In addition, the Act applies to the following, who are also health practitioners under the Act:

- paramedics
- non-emergency patient transport staff.

Medical treatment

Medical treatment is treatment by a health practitioner that is for one or more of the purposes and one of the forms of treatment listed below.

Purpose	Treatment
• diagnosing a physical or mental condition • preventing disease • restoring or replacing bodily function in the face of disease or injury • improving comfort and quality of life.	• treatment with physical or surgical therapy • treatment for mental illness • treatment with – prescription pharmaceuticals – an approved medicinal cannabis product • dental treatment • palliative care.

Emergency treatment

Consent is not needed in an emergency.

Emergency treatment must not proceed if the health practitioner is aware that the patient has refused the particular treatment in an instructional directive (one kind of advance care directive), or there is a relevant refusal of medical treatment certificate made before 12 March 2018.

In an emergency, a health practitioner is not required to search for an advance care directive that is not readily available.

Recovery within a reasonable time

If the patient is likely to recover decision-making capacity for the medical treatment decision within a reasonable time, the health practitioner should wait for the patient to be able to make the decision, unless a further delay would result in a significant deterioration of the patient's condition.

Record-keeping

A health practitioner needs to record on the patient's clinical records the reasons they were satisfied the patient did not have decision-making capacity.

The medical treatment decision maker

If a patient is unable to make a medical treatment decision, their medical treatment decision maker can do this on their behalf.

The Act specifies a list of people who can be a patient's medical treatment decision maker. (See flowchart for hierarchy).

A health practitioner can disclose health information about the patient to their medical treatment decision maker where it is relevant to a medical treatment decision they will make.

A patient's medical treatment decision maker must make the decision they reasonably believe is the decision the patient would have made. The Act sets out how they do this.

Turn to back page for more information ▸

Advance care directives

A person is able to make a legal document called an advance care directive. It can include an instructional directive with legally binding instructions to health practitioners about future treatment. If the patient currently does not have decision-making capacity to make a medical treatment decision, and previously made a relevant instructional directive, the directive takes effect as if they had consented to, or refused, the treatment.

A patient's advance care directive must not include any instructions that are unlawful or would require an unlawful act to be performed or that, if given effect to, would cause a health practitioner to contravene a professional standard or code of conduct.

In addition to an instructional directive, an advance care directive can include a values directive which documents the person's values and preferences for future medical treatment. It is considered by their medical treatment decision maker when making a decision on their behalf.

Refusing to comply with an instructional directive

A health practitioner should make an application to the Victorian Civil and Administrative Tribunal (VCAT) if they believe:

- circumstances have changed since the patient made their instructional directive and
- this means that the practical effect of the instructional directive would no longer be consistent with their preferences and values.

If a health practitioner reasonably believes that the delay in making the application would result in a significant deterioration of the patient's condition, they may refuse to comply with the instructional directive. This means the patient's medical treatment decision maker (or the Public Advocate) makes the decision, unless emergency treatment is required.

Palliative care

A health practitioner is able to administer palliative care to a patient who does not have decision-making capacity for that care, despite any decision of their medical treatment decision maker (or any statement in an advance care directive). However, the health practitioner must have regard to the patient's expressed preferences and values and must consult with their medical treatment decision maker, if any.

Futile treatment

Health practitioners assess whether or not to offer a particular medical treatment, and whether a particular treatment is futile or non-beneficial.

Significant and routine treatment

A health practitioner must seek consent from the Public Advocate to provide significant treatment to a patient who:

- does not have decision making capacity for the medical treatment decision and
- does not have:
  - a medical treatment decision maker or
  - an advance care directive with a relevant instructional directive.

See the Office of the Public Advocate (OPA) website for clinical guidelines about what constitutes significant treatment.

Routine treatment is any treatment that is not significant treatment under the Act. A health practitioner can administer routine treatment without consent if there is no medical treatment decision maker. If they do so, the health practitioner will need to set out in the patient's clinical records the details of:

- the health practitioner's attempts to locate an advance care directive and a medical treatment decision maker
- the exact nature of the routine treatment and the reason for the decision to administer it.

Notifications to the Public Advocate

A health practitioner must notify the Public Advocate if:

- the medical treatment decision maker of a patient refuses significant treatment and
- the health practitioner reasonably believes that the preferences and values of the patient are not known, or are unable to be known or inferred.

The health practitioner then awaits the response of the Public Advocate.

Special medical procedures

Only VCAT can consent to a special medical procedure for a patient who does not have decision-making capacity for the decision.

A special medical procedure is:

- any procedure that is intended, or is reasonably likely, to have the effect of rendering the patient permanently infertile
- termination of pregnancy or
- any removal of tissue for the purposes of transplantation to another person.

More information

For more information about the Medical Treatment Planning and Decisions Act, visit the OPA website from 12 March 2018 at www.publicadvocate.vic.gov.au

Can your adult patient CONSENT?

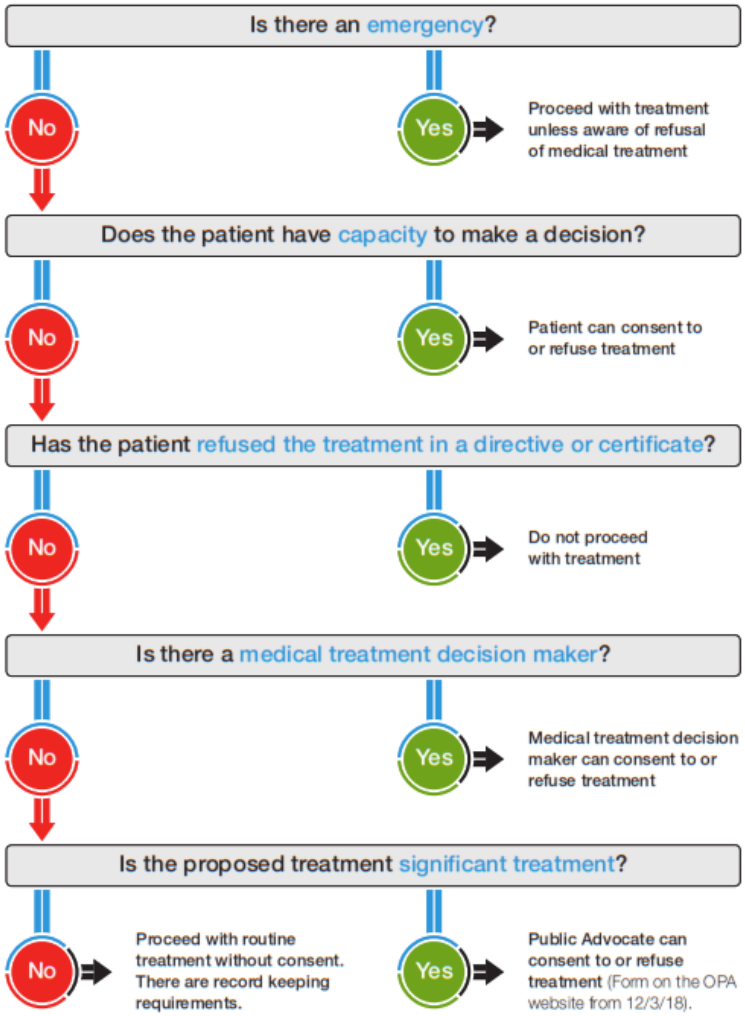
Office of the Public Advocate

Can your adult patient consent?

Process from 12 March 2018

www.publicadvocate.vic.gov.au

Download the app. Available 12 Mar 18



Emergency treatment

Medical treatment that is necessary as a matter of urgency to save the person's life, prevent serious damage to the person's health, or prevent the person from suffering or continuing to suffer significant pain or distress. A health practitioner may administer emergency treatment to a patient without consent, unless they are aware that the patient has refused the treatment in a directive or certificate (see below).

Decision-making capacity

The patient is able to understand the information relevant to the decision, retain that information to the extent necessary to make the decision, use or weigh that information as part of the process of making the decision, and communicate their decision in some way. Sometimes a relevant specialist may be required to make a capacity assessment.

Directive or certificate refusing treatment

Treatment must not proceed if:

- there is a valid refusal of medical treatment certificate made prior to 12 March 2018 in accordance with the *Medical Treatment Act 1988*
- the patient has refused the particular medical treatment in an instructional directive (in an advance care directive) in accordance with the Medical Treatment Planning and Decisions Act.

A health practitioner must make reasonable efforts in the circumstances to ascertain if the person has an advance care directive. There are some circumstances where they can refuse to comply with a directive.

Significant treatment

Medical treatment that involves any of the following:

- a significant degree of bodily intrusion
- a significant risk to the person
- significant side effects
- significant distress to the person.

See the OPA website for clinical guidelines.

Medical treatment decision

A decision to consent to, or refuse the commencement or continuation of, treatment.

Medical treatment decision maker

Where a patient is unable to consent to treatment, consent can be obtained from the medical treatment decision maker in the following order.

1. A medical treatment decision maker appointed by the patient
2. A guardian appointed by VCAT to make decisions about medical treatment
3. The first of the following people who is in a close and continuing relationship with the patient. If more than one, the eldest.
   a. the patient's spouse or domestic partner
   b. the patient's primary carer (an adult who is in a care relationship with the person and has principal responsibility for the person's care)
   c. an adult child of the patient
   d. a parent of the patient
   e. an adult sibling of the patient.

The person needs to be reasonably available, and willing and able, to make the decision.

Appointed medical treatment decision makers

A patient may have appointed someone under the Medical Treatment Planning and Decisions Act. Legal appointments made prior to the commencement of the Act are recognised. This means they may also have appointed them in an:

- enduring power of attorney (medical treatment) made before 12 March 2018
- enduring power of attorney appointing an attorney for personal matters made between 1 September 2015 and 11 March 2018
- enduring power of guardianship appointing an enduring guardian with healthcare powers made before 1 September 2015.

Note: Valid appointments in other Australian states and territories are recognised in Victoria.

Note: * If a person is a compulsory patient under the *Mental Health Act 2014*, that Act applies.
** There is a different consent process for medical research procedures.

Involuntary treatment of people under the *Mental Health Act 2014*

Mental Health Act 2014

The Mental Health Act 1986 has been repealed, and replaced with the new Mental Health Act 2014 (the MHA), which has seen reform to the delivery of mental health services whereby individuals and their families are now at the centre of decision-making about their treatment and recovery. The new Act has introduced reforms around:

- Establishing a recovery oriented framework and embedding supported decision-making processes;
- Minimizing the use and duration of compulsory orders;
- Increasing safeguards to protect the rights and dignity of people with a mental illness; and
- Enhancing oversight and encouraging service improvement

Patients who are treated on a compulsory basis are treated under the MHA. Psychiatric treatment for compulsory patients is delivered by health care professionals at approved mental health services located in inpatient units attached to public hospitals and community mental health clinics. The legislation permits treatment of compulsory patients without their consent when the criteria in section 5 of the MHA have been met.

Treatment Criteria

The section 5 criteria are:

(a) the person has mental illness; and
(b) because the person has mental illness, the person needs immediate treatment to prevent –
  (i) serious deterioration in the person's mental or physical health; or
  (ii) serious harm to the person or to another person; and
(c) the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and
(d) there is no less restrictive means reasonably available to enable the person to receive the immediate treatment

Mental illness defined

Mental illness is defined in section 4 of the MHA as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

The MHA also provides that a person is not to be considered mentally ill by reason only of any of one or more of the criteria outlined in section 4(2) of the MHA.

Treatment defined

Treatment is defined in section 6 of the MHA as follows:

(a) a person receives treatment for mental illness if things are done to the person in the course of exercise of professional skills-

(i) to remedy the mental illness; or
(ii) to alleviate the symptoms and reduce the ill effects of the mental illness; and

(b) treatment includes electroconvulsive treatment and neurosurgery for mental illness.

Assessment Orders

Assessment Orders are defined in section 28 of the MHA as an order made by a registered medical practitioner or mental health practitioner that enables a person who is subject to an Assessment Order to be compulsorily -

(a) examined by an authorised psychiatrist to determine whether the treatment criteria apply to the person; or
(b) taken to, and detained in, a designated mental health service and examined there by an authorised psychiatrist to determine whether the treatment criteria apply to the person.

Criteria for an Assessment Order

The criteria for an Assessment Order are located in section 29 of the MHA and are-

(a) the person appears to have mental illness;
(b) because the person appears to have mental illness, the person appears to need immediate treatment to prevent-
(i) serious deterioration in the person's mental or physical health; or
(ii) serious harm to the person or another person; and
(iii) if the person is made subject to an Assessment Order, the person can be assessed; and
(iv) there is no less restrictive means reasonably available to enable the person to be assessed.

Making an Assessment Order

Before a registered medical practitioner or a mental health practitioner can make an assessment order, they must to the extent that is reasonable in the circumstances-

(a) inform the person that they will be examined by the practitioner;
(b) explain the purpose of the examination; and
(c) examine the person.

A registered medical practitioner or a mental health practitioner can make an Assessment Order pursuant to section 30 of the MHA if-

(a) the registered medical practitioner or the mental health practitioner is satisfied that the criteria specified in section 29 of the MHA (and outlined above) apply to the person; and
(b) not more than 24 hours have passed since the registered medical practitioner or the mental health practitioner have examined the person.

When deciding whether to make an Assessment Order, the registered medical practitioner or the mental health practitioner may consider information communicated to them by a person other than the person being assessed (s30(3)).

The Assessment Order must state whether it is a Community Assessment Order or and Inpatient Assessment Order, and must include information prescribed in section 32 of the MHA.

If a person is subject to an Inpatient Assessment Order, they must be taken to a designated mental health service as soon as practicable, **but not less than 72 hours** after the order is made.

Duration of Assessment Orders (section 34)

A Community Assessment Order remains in force for 24 hours. An Inpatient Assessment Order remains in force for the a period of (whichever is shorter) either 24 hours after being received at a designated mental health service, or 72 hours of the person has not been received at the designated mental health service.

Extending Assessment Orders (section 34(2))

If on examining the person the authorised psychiatrist is no able to determine whether the treatment criteria apply to the person, they may extend the duration of the order for a period not exceeding 24 hours from the time the order is extended.

Variation of Assessment Orders (section 35)

A mental health practitioner or a mental health practitioner may vary an assessment order before an authorised psychiatrist completes an assessment of a person who is subject to an assessment order. They can vary an Assessment Order from a Community Assessment Order to an Inpatient Assessment order, or from an Inpatient Assessment Order to a Community Assessment Order.

Before varying an Assessment Order, the registered medical practitioner or mental health practitioner must:

(a) notify the authorised psychiatrist of the variation;
(b) give the authorised psychiatrist a copy of the Assessment Order that has been varied; and
(c) ensure that reasonable steps are taken to –
    (i) inform the person who is subject to the varied Assessment Order that the Order has been varied; and
    (ii) give the person a copy of the varied Order and a copy of the relevant statement of rights; and
    (iii) explain the purpose and effect of the variation.

Assessment of a person subject to an Assessment Order by authorised Psychiatrist (section 36)

An authorised psychiatrist must examine a person who is subject to an Assessment Order as soon as practicable after –

(a) the Order is made, in the case of a Community Assessment Order; or
(b) the person is received at the designated mental health service, in the case of an inpatient Assessment Order.

The authorised psychiatrist must explain the purpose of the examination to the person being examined, and must determine whether the treatment criteria apply to the person before the Assessment Order expires.

Revocation or expiry of Assessment Order (section 37)

The authorised psychiatrist must immediately revoke an Assessment Order if, after assessing the person subject to the order, the authorised psychiatrist is satisfied that the treatment criteria do not apply to the person.

An Assessment Order expires at the sooner of the following-

(a) at the end of the relevant period referred to in section 34;

(b) the person is made subject o a Temporary Treatment Order

Treatment During an Assessment Order (section 38)

A person subject to an Assessment Order must not be given treatment unless the person gives informed consent to the treatment, or a registered medical practitioner employed or engaged by the designated mental health service is satisfied that the urgent treatment is necessary to prevent –

(i) a serious deterioration in the mental or physical health of the person; or
(ii) serious harm to the person or another person.

Temporary Treatment Orders (sections 45-51)

Temporary treatment orders are defined in section 45 of the MHA as an order made by an authorised psychiatrist after assessing a person (in accordance with an Assessment Order or Court Assessment Order) that enables the person who is subject to the Temporary Treatment Order to be compulsorily-

(a) treated in the community; or
(b) taken to, and detained and treated in, a designated mental health service

When making a Temporary Treatment Order, the authorised psychiatrist must make a decision as to the treatment setting (either in the community or as an inpatient). When making a decision as to the treatment setting, the authorised psychiatrist is required to have regard to-

(a) the persons views and preferences about treatment for their mental illness, including any recovery outcomes they would like to achieve;
(b) the views expressed by the person in their advance statement
(c) the views of the person's nominated person, guardian and/or carer
(d) the views of the person's parents if the person is under 16 years of age
(e) the views of the Secretary to the Department of Human Services if the person is subject of a custody to Secretary order or a guardianship to Secretary Order.

The authorised psychiatrist can only make an Inpatient Temporary Treatment Order if treatment cannot occur within the community setting.

Treatment Orders (section 52)

Treatment orders are defined in section 52 of the Act, and are orders made by the Mental Health Tribunal that enable a person to be compulsorily –

(a) treated in the community (a Community Treatment Order); or
(b) taken to, and detained and treated in, a designated mental health service (an Inpatient Treatment Order)

Duration of Treatment Orders (section 57)

The maximum period that may be specified in a Treatment Order –

(a) in relation to a person who is of or over the age of 18 years and is subject to –
    (i) a Community Treatment Order, 12 months; or
    (ii) an Inpatient Treatment Order, 6 months; or

(b) in relation to a person who is under the age of 18 years and is subject to-

(i) a Community Treatment Order or an Inpatient Treatment Order, 3 months

Mental Health Tribunal

The Mental Health Tribunal was established under the MHA, and replaced the previous Mental Health Review Board. It is comprised of a full time President, Deputy President, Senior Members, and sessional members in membership categories (legal, medical and community members).

Pursuant to the MHA, the Tribunal must conduct a hearing to determine whether to make a Treatment Order in relation to a person who is subject to a Temporary Treatment Order.

After conducting a hearing, the Tribunal must –

(a) make a Treatment Order in respect of a person if the Tribunal is satisfied the treatment criteria apply to the person and determine –
   (i) the duration of the order; and
   (ii) whether the order is a Community Treatment Order or an Inpatient Treatment Order
(b) revoke the Temporary Treatment Order if the Tribunal is not satisfied that the treatment criteria apply to the person.

The Tribunal must also hear applications for revocation of Temporary Treatment Orders, or Treatment Orders and must conduct these hearings and determine the application as soon as practicable.

ADOLESCENT AUTONOMY

Medical Procedures Involving Children

The age of majority in Victoria is 18 years.[3] In some states in Australia, a minor's capacity to give informed consent to medical treatment is regulated by statute. Victoria is however, governed by the common law in this area and following the decision in *Gillickv West Northechand Wisbech Area Health Authority,* decided by the House or Lords in 1986, and supported by the Australian High Court.

The Court's decision in *The Secretary, Department of Health and Community Services v JWB and SMB (commonly referred to as Marion's case)*[4]established that it is now clear that if a child has achieved a significant understanding and intelligence to enable him or her to understand fully what is proposed, then the child may be said to have the capacity to consent to medical treatment.

In *Marion's* case, the question before the court was whether or not to sterilise a minor suffering profound permanent intellectual incapacity. The court determined that the parents, as guardians, could not authorise the sterilisation of their child and that in order to ensure the best protection for the interests of the child, the decision as to whether or not the child would be sterilised should come from the Family Court of Australia.

The Family Court of Australia has jurisdiction to decide whether or not to authorise non-therapeutic medical treatment, where this treatment is said to be in the best interests of the child.

It is the court's responsibility to protect the welfare of children, and any medical treatment involving treatment in non-therapeutic procedures should be brought before the Family Court for authorisation.

In considering whether a minor has the capacity to consent to medical treatment, a doctor must be satisfied when undertaking a competency assessment that a young person has sufficient understanding and intelligence concerning:

- the nature of the clinical problem;
- the nature and purpose of the proposed treatment;
- the effects of the treatment including side-effects;
- the consequences of non-treatment;
- other treatment options;
- possible repercussions of the treatment (for example, the consequences if parents found out) and;
- how to carry through the proposed treatment.

As outlined above, it is accepted law that a minor is capable of giving informed consent when he or she achieves a significant understanding and intelligence to enable him or her to fully understand what is proposed. This is known as the mature minor concept.

Note that historically, law has generally not upheld the ability of a minor to *refuse* medical treatment, even where the minor may be of mature years, see for example *Re W (a minor) Medical Treatment*[5], where the English Court of Appeal ordered a sixteen year old girl with anorexia nervosa be feed by a naso-gastric tube, despite a refusal to consent to treatment for her condition.

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[3] See Section 3 of *Age of Majority Act 1977*
[4] (1992) 175 CLR 218
[5] 1992 4All ER 627

Need for court authorisation

A child is unable to give a valid consent to a serious and significant procedure if:

- He or she lacks the capacity and is unable to understand the nature and consequences of the treatment or procedure.
- He or she lacks the legal capacity to make a particular decision because the procedure is so grave, serious or complex in its consequences.
- Their capacity is affected because the parents or guardians cannot agree on whether to consent to the procedure and the child is caught in the dispute and influenced by the wishes of others.

The Supreme Courts of each state and territory have parens patriae power as part of their inherent jurisdiction which enables the court to make orders concerning the welfare of minors. In a medical context, the parens patriae power enables a court to authorise medical treatment in circumstances where it is satisfied that the provision of treatment would be in the child's best interests.

DEATH AND THE CORONERS ACT

Certification of Cause of Death

Births, Deaths and Marriages Registration Act 1996

Section 37 of the ***Births, Deaths and Marriages Registration Act 1996*** requires that a doctor who is responsible for a person's medical care immediately before death, or who examines the body of a deceased person must notify the Registrar. This must occur within 48 hours of a persons' death, must contain information about the cause of the death, and be reported in a manner that is acceptable to the Registrar. Note that when giving notice to the Registrar the doctor must also give notice in an approved manner to the funeral director or other person who will be arranging for the disposal of the body. Of course, a doctor must not give notice of death if a coroner or police officer is required to be notified of the death under the Coroner's Act 2008.

There is a Statutory obligation for medical practitioners to:-

- accurately and completely fill out details required on every part of the Standard Death Certificate concerning the death of a person aged 28 days or over; or
- fully complete death certificates titled "Medical Certificate of Cause of Perinatal Death" for infants aged less than 28 days.

To submit an electronic medical certificate of cause of death or perinatal death, visit the Medical Practitioners Online page on the Birth, Deaths and Marriages website.

If you require hard copy MCCD or MCCPD forms, email bdmmedicals@justice.vic.gov.au

A penalty unit applies if a doctor does not meet the requirements of the legislation.

It is recommended that, in the case of reportable deaths, no death certificate be completed without first discussing the matter with the State Coroner's Office.

Coroner's Cases must be reported immediately regardless of the time of day or night.

It is recommended that, in ALL instances of reportable deaths, the State Coroner's Office is also informed immediately by telephone. This is a 24 hour service.

- Telephone Numbers: ***+61 3 9684 4444***
- Free call for country callers ***1800 136 852***
- Facsimile Number: ***+61 3 9682 1206***

The State Coroner will then make all the necessary local arrangements.

IF THERE IS ANY DOUBT AS TO WHETHER A CASE SHOULD BE REPORTED OR NOT, THE ADVICE OF THE CORONER SHOULD BE SOUGHT.

Deaths Reportable to the Coroner

Section 13 of the ***Coroners Act 2008*** *places* obligations on medical practitioners to report a death.

A doctor who is **present** at or after the death of a person must report the death as soon as possible to the Coroner if -

- the death was unexpected; or
- the death was violent or unnatural; or
- the patient was involuntary (under the Mental Health Act); or
- the death occurred in custody or care; or
- the death happened during or as a result of a medical or surgical procedure; or
- it was due to any kind of accident or injury; or
- the body can't be identified; or
- a medical certificate of cause of death has not been signed and is not likely to be signed.

Information for Health Professionals – Coroners Court of Victoria

Reviewable-Deaths

The Victorian Government introduced a system for dealing with multiple child deaths in one family. The legislation came into effect on 1 January 2005. The intention of the legislation is to ensure that Victorian systems and processes are capable of dealing effectively and humanely with all cases of multiple child deaths within a family.

Definition
A “reviewable death” is the second or subsequent death of a child of a parent.

Reporting
Health professionals and police must report a reviewable death to the State Coroner. Notification of the State Coroner does not imply that the death of a child is suspicious or avoidable. All families who have experienced the loss of more than one child, regardless of the circumstances, will have contact with the Coroner's process.

Counselling and support service
The death of a child is perhaps the most devastating event a family may endure. This grief is compounded when a family experiences the death of more than one child. The State Coroner's Office has experienced staff who can explain the coronial process and provide assistance with short term counselling. The phone number for Coronial Services reception is +***61 3 9684 4444,*** or the Counselling Services can be contacted directly on +***61 3 9684 4395***.

Investigation of the reviewable death by the Coroner

The Coroners Act 2008 empowers the State Coroner to investigate the second death of a child in a family to determine, if possible, the identity of the deceased, how the death occurred and the cause of death. The State Coroner has the same powers of investigation in relation to a reviewable death as he has in relation to a reportable death (i.e. a death that is unexpected, unnatural or violent or has resulted from injury: see section 3 of the *Coroners Act 2008*).

Investigation of the needs of the family by the Victorian Institute of Forensic Medicine

The State Coroner may refer a reviewable death to the Victorian Institute of Forensic Medicine (“VIFM”) for investigation. The primary focus of the investigation is to assess and make recommendations regarding the health of parents and the health and safety of siblings. The aim of the process is to ensure a coordinated delivery of support services to a family.

VIFM has appointed a Paediatric Liaison Coordinator to carry out the investigation and assessment of the needs of a family. The Paediatric Liaison Coordinator will speak to a family who has experienced the death of more than one child to explain the investigation and assessment process and to ask about the family's support needs. As part of the investigation process, the coordinator may speak with the family's treating doctor.

Families are invited to nominate a doctor they would prefer to be contacted.

Death in Hospital (where the death is a reportable death)

Where the death is, or may be, a reportable death to the Coroner, certain additional actions are required:

- The Coroner should be notified immediately.
- A Coroner's Medical Deposition should be completed. No death certificate should be completed without prior consultation with the State Coroner's Office; and no cremation certificate should be completed.
- When last offices are being performed, particular attention should be paid to:-
- intravenous lines
- nasogastric tubes
- endotracheal tubes
- drain tubes
- indwelling catheters
- other extraneous items

NONE SHOULD BE REMOVED

Note that:

- IV tubing should be tied and cut approximately 30cm from the body;
- Nasogastric tubes should be spigotted;
- Catheters should be disconnected from drainage bags and tied;
- Other tubing should be secured so as not to allow leakage.

Where hospitals wish certain items of equipment to be returned, the Coroner's Office should be notified and every assistance shall be given.

Valuables and belongings should be processed as in Section 6 Death in Hospital (where the death is not a reportable death to the Coroner) below and the police notified that they are being held temporarily at the hospital.

Depending on instructions from the Coroner the body is removed to the mortuary in line with Section 6(iii), (iv) and (v). An entry in the mortuary register should indicate the death has been reported to the Coroner.

Dead on Arrival (Reportable Deaths)

(This section relates specifically to country hospitals: D.O.A.s in the metropolitan area are immediately transferred to the State Coroner's Facility following pronouncement of death.)

a Bodies are received into the care of the Police Force and should be conveyed to the mortuary accompanied by a member of the Police Force.

b A member of the Police Force should be present when the body is pronounced "life extinct" by a medical practitioner and it is the responsibility of that member to make the necessary arrangements with the doctor concerned.

c It is the responsibility of the accompanying member of the police force to search the body for valuables and to take all valuables to the police station and enter them into the Property book.

d It is recommended that two members of the police force be present when the body is certified and the body and clothing searched.

e The clothing remains on the body and is removed on the authority of the police or pathologist. Police advice should then be sought as to the disposal of clothing.

f The Police Officer is responsible for entering all details in the mortuary book and providing a copy of Form 83 "Report of Death" to the Coroner and a copy for the information of the pathologist.

g Items for transmission to Forensic Science or the Coroner's Court for analysis should be secured in the mortuary refrigerator.

h Identification of the body is carried out in the presence of the Police. Should the body be in such a state as not to be suitable for viewing, a member of the police force should contact the pathologist who will make the body as presentable as possible.

i On clearance of the body a certificate permitting burial, cremation or other disposal will be issued by a Coroner or Coroner's Clerk and delivered to the Funeral Director involved.

Confirmation of Death

It is recognised practice that a legally qualified medical practitioner (not necessarily the attending doctor) must confirm that life is extinct prior to last offices being performed and the body transferred to the mortuary.

However, in a number of instances there may be considerable delay between the death of a patient and the attendance of a medical practitioner to confirm death.

This places ward nursing staff in the unpleasant position of having to decide how best to deal with the body unless such confirmation can be made.

In the context of these guidelines it cannot be recommended that bodies, which have not been confirmed as dead, be removed to the mortuary.

This does not solve the dilemma of nursing staff who do not have adequate physical facilities at their disposal to hold bodies in a separate area of the ward. That issue, and the instructions given to medical officers are for each hospital to address.

It must be advised, however, that, in the event, as unlikely as it may be, of a patient not confirmed dead being found alive once removed to the mortuary, the hospital and its nursing staff may face legal proceedings instituted by the patient and/or family.

Death in Hospital (where the death is not a reportable death to the Coroner)

Once death has been pronounced by a legally qualified medical practitioner, the nurse in charge of the ward should:

a ensure that appropriate last offices are performed;

b collect valuables and belongings and process thus -
- valuables should be documented and verified by another member of nursing staff, sealed in a valuables envelope and deposited with the appropriate hospital officer.
- In some circumstances, however, wedding rings cannot be removed or relatives specifically ask that the ring remain with the deceased. In such instances the ring should be taped on, the details noted in the appropriate registers and the relatives notified.
- belongings, other than valuables, should be listed and sealed in a bag ready for collection by the next of kin.

c When the body has been prepared for removal to the mortuary, the charge nurse should complete an entry in the ward mortuary book and ward register.

d The member of staff conveying the body to the mortuary will sign the ward mortuary book to verify transfer of the body.

e The officer in charge of the mortuary shall keep a register in which the following details are recorded –

- Name of deceased
- Identification number
- Medical Officer
- Date and time of death
- Time of Receipt into mortuary
- Accompanying documentation
- Whether a post-mortem was performed
- Name of Funeral Director
- Time of collection by Funeral Director
- Signature of Funeral Director
- Signature of mortuary officer

f Valuables should only be surrendered to known next of kin or relatives on production of a copy of the Will, a copy of letters of administration or other such documentation which is satisfactory for the release of valuables.

Consent for Post-Mortem Examinations

If the death is a reportable death, only the Coroner can direct that an autopsy be performed. This extends to those cases where the Coroner has released a body without directing that an autopsy be performed but the hospital wishes, and has gained consent under the ***Human Tissues Act 1982***, to perform its own post-mortem examination. In such cases, the Coroner's authority must be obtained.

In deaths not reportable to the Coroner, the *Human Tissues Act 1982* requires that appropriate consent be obtained before any post-mortem examination can be conducted.

The ***Human Tissues Act*** empowers a "designated officer" for a hospital to authorise post-mortem examinations. The authorisation must be in writing.

Coroners and Human Tissue Acts (Amendment) Act 2006

Prior to authorising a post-mortem examination, the designated officer must be satisfied that:-

a The senior available next of kin has agreed verbally to a medical practitioner, that a post-mortem examination of the body be performed. Consent may be given either before or after the patient has died; or

b That the patient has consented to a post-mortem examination prior to his death. In this circumstance consent must be in writing or be expressed orally in the presence of two witnesses; or

c That the wishes of the patient are not known, and either there are no surviving relatives, or, after making reasonable enquiries, the next of kin cannot be found.

The designated officer will give authority for a post-mortem examination if he has reason to believe that the deceased person had at any time expressed an objection to a post-mortem examination of his body.

The requirements of this Act will be fulfilled if a "Necroscopy Request Form" is completed by a medical practitioner involved with the care of the deceased patient.

Cremation

Cemeteries and Crematoria Act 2003.

The statutory requirements for cremation are outlined in section 131 of the ***Cemeteries and Crematoria Act 2003.***

Collection of Bodies from Hospital Mortuary

1 At all times the hospital should have a member of staff designated as being responsible for mortuary procedures.

2 It is through this person that all inquiries from police, funeral directors, relatives etc should be directed.

3 When unattended, the mortuary should be the responsibility of the authorised member of staff, who should hold the keys to the mortuary.

4 Bodies should not be released to Funeral Directors unless -
- There is a completed Death Certificate; or
- When the body is under the control of the Coroner, a completed certificate permitting burial, cremation, or other disposal is issued by a Coroner or Coroner's Clerk.

Funeral Directors should be required to complete the relevant sections of the Mortuary Register when collecting the body. Wedding rings remaining on bodies should be brought to the attention of the Funeral Directors who will acknowledge receipt.

CHILD SAFETY

Mandatory Reporting of Child Abuse

The Victorian ***Children, Youth and Families Act (2005)*** requires doctors who believe on reasonable grounds that a child is in need of protection from physical or sexual abuse to notify the Department of Human Services as soon as practicable. Statutory immunity is provided in circumstances where a doctor reports a case of suspected child abuse in good faith.

Statutory protection from liability also extends to doctors who report on reasonable grounds that a child between the ages of 10-15 years is in need of therapeutic treatment. However, reporting is **not** mandatory in this situation.

Multiple child deaths reporting provisions

The death of a child under 18 years of age in circumstances where another child (or children) of a parent has /have previously died, is classified as a "reviewable death". In the case of a reviewable death, a medical practitioner who is present at, or after, the death of a child **must** report the death to the coroner as soon as possible, regardless of the circumstances surrounding the death, including where the cause of death has been established. Failure to report a reviewable death is a statutory offence. The Coroner may investigate a reviewable death once reported. The Coroner may refer a reviewable death to the Victorian Institute of Forensic Medicine for an investigation and assessment of the health and safety needs of surviving siblings and the health needs of the parents of the deceased children. During, or following an investigation the Victorian Institute of Forensic Medicine, the may:

- refer the family to health and support services;
- notify child protection authorities in relation to any living siblings and/or
- advise the Coroner as to whether further investigation is warranted.

ORGAN TRANSPLANTATION

pdf
Click to View

The **Coroners and Human Tissue Acts (Amendment) Act 2006** governs the legal aspects of organ and tissue donation and use.

Donate Life Network

The Organ and Tissue Authority (OTA) manages the implementation of the national reform program through leadership of, and collaboration with, State and Territory Medical Directors, Donate Life Agencies (one in each state and territory) and hospital medical and nurse specialists in organ and tissue donation. These people and organisations comprise the Donate Life Network.

Donate Life

Consent

The legislation provides for adults to give consent to organ and tissue removal following their death:

a) at any time in writing; or
b) orally in the presence of two witnesses during the persons last illness.

Once consent has been obtained, the removal of tissue can take place for transplantation, therapeutic, medical or scientific purposes.

Absence of consent

In circumstances where it is not known whether a deceased person has consented to tissue removal from his or her body after death, tissue removal may take place for transplantation, therapeutic, medical or scientific purposes if:

a) the senior available next of kin consents to tissue removal ; or
b) if, after making a reasonable enquiry to locate the next of kin, no next of kin can be located, a designated officer has no reason to believe that the deceased person expressed an objection to tissue removal.

Please note, currently there is no definition of what constitutes a reasonable enquiry in the legislation.

Consent to non-regenerative tissue removal from adults

Adults may give written consent to the removal of specified non-regenerative tissue from their bodies for therapeutic, medical or scientific purposes. The removal of non-regenerative tissue from a minor for transplantation purposes is prohibited according to Victorian legislation.

In order to obtain a valid legal consent to non-regenerative tissue removal for transplantation the following criteria must be met:

a) the person consenting to the tissue removal must be at least 18 years of age;
b) consent must be in writing and clearly state the time that it was given;
c) a period of 24 hours must pass from the time in which consent was given before the specified tissue can be removed;
d) a consent certificate must be completed in the presence of a registered medical practitioner who must certify that the consent was voluntarily obtained from a competent adult, after the nature and effect of tissue removal had been explained to the donor prior to obtaining consent.

Consent to regenerative tissue removal from adults

Adults may give written consent to the removal of specified regenerative tissue from their bodies for therapeutic, medical or scientific purposes.

In order to obtain a valid legal consent to regenerative tissue removal for transplantation the following criteria must be met:

a) the person consenting to the tissue removal must be at least 18 years of age;
consent must be in writing and clearly state the time that it was given;
b) a period of 24 hours must pass from the time in which consent was given before the specified tissue can be removed;
c) a consent certificate must be completed in the presence of a registered medical practitioner who must certify that the consent was voluntarily obtained from a competent adult, after the nature and effect of tissue removal had been explained to the donor prior to obtaining consent.

In relation to minors, a parent may consent in writing to specified regenerative tissue removal from a child for the purpose of transplantation to a sibling or a parent of the donor child. For this to occur a doctor may certify in writing that:

a) the parent's consent was obtained in her or her presence;
b) prior to obtaining consent, the nature and effect of removal and transplantation of specified tissue was explained to both the parents and the child; and
c) the doctor is satisfied that at the time consent was obtained, the child understood and agreed to the proposed removal and transplantation of tissue.

In the event that a doctor believes a child is incapable of understanding the nature and effect of a transplant procedure, removal of regenerative tissue from a child for transplantation to a sibling is permitted in circumstances where the sibling would be likely to die without a transplant.

Consent to removal of blood

Oral consent from an adult donor it sufficient for the removal of blood for transfusion, therapeutic, medical or scientific purposes.

In relation to minors, a parent may consent in writing to removal of blood from his or her child for the purpose of transfusion o therapeutic, medical or scientific purposes if:

a) a medical practitioner advises that blood removal is not likely to be prejudicial to the child's health; and
b) the child agrees to the removal of his or her blood.

Notifying the next of kin

Where tissue removal takes place based on the consent of a deceased person, that person's next of kin must be informed of the tissue removal.

Revocation of donor consent

As outlined above, the legislation requires that a period of 24 hours must pass between obtaining consent and tissue removal. Hospitalised donors may revoke consent by informing a medical practitioner or nurse either orally or in writing of their decision to revoke their consent.

This revocation must be conveyed to any doctor intending to remove tissue. Once consent has been revoked, any record of the consent must be returned to the donor and revocation must be recorded and kept for a period of three years.

ACCESS TO HEALTH/MEDICAL RECORDS AND CONFIDENTIALITY

Confidentiality in the doctor-patient relationship

Confidentiality is a cornerstone of the doctor-patient relationship. As a general principle, patients have the right to expect that medical practitioners will not disclose information provided by patients in the course of the doctor-patient relationship without their permission. Medical practitioners have a duty to ensure that the confidentiality of such information is protected, even after the death of a patient.

Health Records Act 2001

In addition, medical practitioners have obligations to protect the confidentiality of their patients' medical records under a number of statutory provisions, - in particular, the requirements of the ***Health Records Act 2001.***

Privacy Act 1988

In particular, ***Health Privacy Principles*** *in that Act* and the ***Privacy Act 1988*** *(Australian Government Legislation).* Practitioners should refer to the published guidelines of the Health Complaints Commissioner and if in doubt about their obligations, seek advice from the **Health Complaints Commissioner** or their medical defence organisation.

Health Complaints Commissioner

Health Services Act 1988

Section 141 of the ***Health Services Act* 1988** requires that identifying information about a patient's care or treatment is not be given out without consent of the patient or if the patient has died, the senior available next of kin of the patient.

There are however, various exceptions to this obligation imposed on hospitals and health professionals and one is that you may communicate information in "general terms" to the next of kin or near relative of the patient "in accordance with the recognised customs of medical practice".

Sometimes an HMO is approached directly by an "outside body" requesting information or a statement/report about a patient, for a multitude of reasons. Patient information cannot be divulged in normal circumstances without a signed authority from the patient, senior next of kin or guardian.

Freedom of Information Act 1982/Health Records Act 2001

Freedom of Information Act 1982

Health Records Act 2001

Patients are entitled to seek access to their health information under both the ***Freedom of Information Act 1982*** (applying to public hospitals) and the ***Health Records Act 2001***. Patients who wish to gain access to their health information (which includes x-rays) should be asked to make a written request to the medical records office of a hospital. Doctors do not handle this.

Paperwork in Hospitals - Key Forms and Advice

This section will include some tips about your role in the hospital and the main forms in the medical record. You will need to familiarise yourself with these forms if you work in a public hospital, so if they are not shown to you during your Orientation, make sure you find out where they are kept, what they look like and who usually completes them in your hospital.

Points to note:

1. Admission – examination of the patient should be thorough and confidential.
2. Patient progress – as a hospital medical officer you should ensure that regular progress notes are made in the patient's medical record. Any tests should be monitored from day to day.
3. Issues to consider – consent; guardianship issues; communication with the patient/family; organ donation.

4. Discharge of patient/ Death of patient – ensure discharge summaries and drug scripts are completed in a timely manner; Remember there are casemix and coding implications for what is included in a discharge summary. In the case of a patient death, ensure all required documentation is completed.

Patient Medical Record

- Drug Administration
    - Drug prescribing/Administration Chart(completed by a hospital medical officer; administered by nursing staff)
    - Nursing Pain Assessment and Intervention Chart
    - Heparin Infusion Administration Form
    - Intravenous Analgesia Form
    - Acute/Adult Prescribing Chart
- Drug Administration
    - Inpatient Total Care Progress Notes Form
    - Intravenous Infusion Chart
    - Referral to rehabilitation and Aged Services program
    - Consultation Form
    - Consent for Medical Treatment/Procedure/Examination
    - Notification of Infectious Diseases (call or send to Department of Human Services)
- Death Certification
    - Notification of Death Form
    - Application for Cremation
    - Medical Certificate or cause of death of a person aged 28 days or over
    - Death Report to Coroner
    - Hospital Statement of Identification in a Coroner's Investigation
    - Jewellery Notification for Mortuary
- Request Forms
    - Antibiotic Monitoring Request Form
    - Blood Bank Request
    - Blood product Request Form
    - Cardiology Unit test requests (e.g. for ECG, exercise tests)
    - Diagnostic Imaging Request
    - MRI (Magnetic Resonance Imaging) Form
    - Pathology Request Form
    - Request for Body Composition/DEXA Bone Density Investigation

There are also a range of forms which nurses may complete. These are listed below for your information:

- Diabetes Treatment Chart
- Fluid Balance Chart and summary forms
- Neurological Observation Form

- Sedation and Pain Score
- Temperature and Pulse Monitoring
- Vascular monitoring chart

Medico-Legal Reports

All requests for reports, summaries etc. from Solicitors, Life Insurance Companies and Government Departments must be referred to the Patient Record Administration/Medical Administration area in your hospital. You should not give opinions or information in such cases.

Access to Medical Records

Changes to both Commonwealth and Victorian legislation have given patients the right to access their personal health information in both the public and private sector.

Giving patients access to their records is a relatively new phenomenon in Victoria and can still be a sensitive exercise. Practitioners who are uncertain about their obligations can contact the **Health Complaints Commissioner**

 Health Complaints Commissioner

The Health Privacy Principles

Health Records Act 2001

The ***Health Records Act 2001*** has created new privacy rights that enable individual's to exercise greater control over how an organisation collects, uses and discloses health information that relates to them. The new Act has implemented eleven Health Privacy Principles (HPP's) to describe how health information is to be handled.

Summary of the eleven Health Privacy Principles.

Progress Notes for inpatients

It is important for all doctors to document their patients' progress during hospitalisation. Any omissions from a patient's medical record creates a significant medico-legal problem for all medical staff involved with the patient and the vicarious liability that the hospital carries in being responsible for the quality and standards of the medical care provided by its staff.

Section 5 – Living in Victoria – Useful Information for You and Your Family

BASIC FACTS

Sources of information about Australia, its way of life, its attractions and key sporting and cultural events are plentiful. Guide books (such as those produced by Lonely Planet) and tourist publications (available at Tourism Victoria and local tourist information centres) provide information on climate, attractions, local events, accommodation and restaurants.

ABOUT AUSTRALIA

Department of Home Affairs

- Visit Australia
- Study in Australia
- Work in Australia
- Live in Australia
- Australian Citizenship

Australia.gov.au

- Australia the country
- Australia's political system
- Levels of Government
- States or Territories
- Law and democracy in Australia
- Australian values and principles
- Australian customs
- Life in Australia

Tourism Australia

General information on arts and culture, climate, attractions, and links to each of the States and Territories.

ABOUT VICTORIA

City of Melbourne

Provides links to a variety of information, including maps and guides, tourism services, parks and recreation, events and festivals, local laws, rates, and parking and transport.

Tourism Victoria

MIGRATION AGENTS

Office of the Migration Agents Registration Authority

Adult Multicultural Education Services (AMES)

AMES is Victoria's largest provider of English language services. It offers courses for all levels of English, from beginner to advanced.

HOUSING

Renting a Home: A guide for Tenants and Landlords

Consumer Affairs Victoria

- getting prepared to look for a private rental property in Victoria
- applying for a property in the private rental market
- your rights and responsibilities as a tenant
- being treated fairly by a landlord or estate agent.

EDUCATIONAL SERVICES AND FACILITIES

In Australia there are three levels of education:
Primary schooling
Secondary schooling
Tertiary or higher education – University or Technical and Further Education (TAFE)

Primary School is seven years from prep to grade 6, and secondary school is six years, from year 7 to year 12.

Department of Education and Training

Private/Non-Government Independent Schools

There is a large non-government school sector in Victoria (subsidised by the government and collection of student fees). There is a system of Catholic Education managed by the Catholic Education Office, and a number of non-Catholic Independent schools.

Independent Schools Victoria

Catholic Schools Victoria

Tertiary Education

Technical and Further Education (TAFE)

Skills Victoria

- find a course or training provider
- get links and tips about how to get started as an apprentice or trainee
- learn how to get recognised as an apprentice, trainee, student, teacher or employer through the Victorian Training Awards
- get links and tips on how to get started with staff training, including employing an apprentice or trainee
- get up-to-date labour market information.

University

Victoria offers first degree education through to post-graduate levels of study through nine universities. The majority of universities are in or around Melbourne. You will need to have gained the Victorian Certificate of Education (VCE) or equivalent to gain entry.

Australian Universities Directory

Adult and Community Education

The Centre for Adult Education (CAE) is the largest provider of adult and community education in Victoria. The CAE offers educational opportunities to people of all ages, backgrounds and abilities.

Childcare Facilities

There are a range of child care options available across Victoria, offered in a variety of settings. Child care is managed by local councils, school councils, non-government agencies, parent committees, private businesses, TAFE colleges and universities.

The State Government, through the Department of Education and Early Childhood Development (Department), licences and monitors centre based children's services and family day care.

Under the provisions of the *Children's Services Act 1996* and the Children's Services Regulations 2009 , the Department maintains a register of licensed children's services that may assist you in locating a service that best meets your children's needs.

Register of Licensed Children's Services in Victoria

HEALTH INSURANCE

Australia's health system offers a range of publicly and privately funded health services. You can choose to simply have Medicare cover only, or a combination of Medicare and Private health insurance.

Medicare

As the basis of Australia's health care system, Medicare covers many health care costs. See Section 2 for information on Medicare, the Medicare levy, which you may have to pay, and the Medicare surcharge.

Private Health Insurance

Private health insurance provides additional cover for services not covered by Medicare. There are a number of organisations offering private health insurance, and a variety of reasons why it may be an attractive option for you to consider. If you have private health insurance, you are covered against some or all of the costs of being a private patient in either a public or private hospital. Alternatively, you can still choose to be treated as a public patient in a public hospital at no charge.

 **Private Health Insurance Administration Council**

SOCIAL SECURITY AND ASSISTANCE

 **Centrelink**

OPENING A BANK OR CREDIT UNION ACCOUNT IN VICTORIA

You will need to open a bank or credit union account when you start work as most employers in Australia prefer to pay salaries directly into employees' accounts.

To open a bank or credit union account in Australia you will need to visit the bank or credit union and present several different documents that show your identity. These could be your passport, your birth certificate, or other documents which show your name and address such as your driver's licence, your rental lease or bills from gas or electricity companies. Staff at the bank or credit union will explain what other documents may be suitable.

The Australian Credit Unions and Building Societies

DRIVING A CAR IN VICTORIA

Obtaining a Licence to Drive

The requirement to change your overseas driver licence to a Victorian driver licence depends on whether your stay in Victoria is temporary or permanent.

If you are in Victoria on a temporary visa, you can drive on your overseas driver licence for as long as it is current providing it is in English or accompanied by an English translation or International Driving Permit. There is no requirement to get a Victorian driver licence.

If you have entered Victoria on a permanent visa issued under the Migration Act 1958, you may drive on your overseas driver licence for:

- six months from the date you first entered Australia if the permanent visa was issued **before you entered Australia**; or,
- six months from the date when the permanent visa was issued to you if the permanent visa was issued to you **whilst in Australia**.

If you want to continue driving in Victoria after this time you must change your overseas licence to a Victorian driver licence.

New Zealand residents who hold a current licence are treated as interstate drivers.

Driving in Victoria – the road rules

Driving in Victoria – obtaining a road map

The Royal Automobile Club of Victoria (RACV) produces a range of maps and Directories, which are available free, if you become a member, or for purchase.

PUBLIC TRANSPORT

Victoria has a comprehensive public transport system which includes trains, trams and buses.

Public Transport Victoria

V/Line – Public Transport for Regional Victoria

Appendix A - Clinical Acronyms and Abbreviations

Abbreviations		
- ; -ve	-	Negative
+	-	Increased, Plus, Positive, Slight Trace
++	-	Moderate, Trace
+++	-	Increased, Moderately Severe
++++	-	Large Amount, Severe
+ve	-	Positive
1/24	-	One Hour
12/12	-	Twelve Months
2 / 4WF	-	Two Or Four Wheel Frame
3/7	-	Three Days
4PS	-	Four Point Stick
6/52	-	Six Weeks

A		
Ⓐ	-	Assessment Or Assistance
A&E	-	Accident And Emergency
A&W	-	Alive And Well
a.c.	-	Before Meals (Pharmacy)
a/a	-	As Above
a/c	-	Associated With
A1	-	Aortic Valve, First Sound
A2	-	Aortic Valve, Second Sound
A2<P2	-	Aortic Second Sound Less Than Pulmonary Second Sound
A2>P2	-	Aortic Second Sound Greater Than Pulmonary Second Sound
aa	-	Arterio-Alveolar (Gradient)
AA	-	Alcoholics Anonymous
AAA	-	Abdominal Aortic Aneurysm
AAL	-	Anterior Axillary Line
AB	-	Apex Beat
Ab / Abn	-	Abnormal
ABC	-	Airway, Breathing, Circulation (ABC Of Resuscitation)
ABCDE	-	Airway, Breathing, Circulation, Deficit, Exposure

ABG	-	Arterial Blood Gases
ABI	-	Acquired Brain Injury
ABND / F	-	Apex Beat Not Detected / Felt
ABS	-	Acute Brain Syndrome
ac	-	Acromio Clavicular
AC	-	Air Conduction (Ear)
ACAS	-	Aged Care Assessment Service
ACAT	-	Aged Care Assessment Team
ACL	-	Anterior Cruciate Ligament
ACLS	-	Advanced Cardiac Life Support
ACS	-	Acute Coronary Syndrome
ACTH	-	Adrenocorticotrophic Hormone
ADD	-	Attention Deficit Disorder
ADH	-	Antidiuretic Hormone
ADHD	-	Attention Deficit Hyperactivity Disorder
ADL	-	Activities Of Daily Living
p-ADL	-	Personal Activities
d-ADL	-	Domestic Activities
c-ADL	-	Community Activities
Adm	-	Admitted, Admission
ADT	-	Adult Diphtheria Tetanus
Ae	-	Air Entry
AE	-	Above Elbow
AED	-	Automatic External Defibrillator
AF	-	Atrial Fibrillation / Flutter
Af	-	Anteflexed (Uterus)
AFA	-	Advanced First Aid
AHP	-	Allied Health Professional
AI	-	Aortic Incompetence / Insufficiency
AI	-	Artificial Insemination
AICD	-	Automatic Implantable Cardioverter/Defibrillator
AIDS	-	Acquired Immune Deficiency Syndrome
AIIS	-	Anterior Inferior Iliac Spine
AJ	-	Ankle Jerk
AK	-	Above Knee
ALL	-	Acute Lymphoblastic Anaemia
ALS	-	Advanced Life Support

am	-	Morning, Before Noon (Ante Meridiem)
Ambo	-	Ambulance Officer
AMI	-	Acute Myocardial Infarction
AML	-	Acute Myelocytic Leukaemia
AN	-	Antenatal
AO	-	Alert And Oriented
AOM	-	Acute otitis media
AOR	-	At own risk
AP	-	Abdominal pain
AP	-	Anterior-posterior
APACHE	-	Acute physiology and chronic health evaluation (in ICU)
APATT	-	Aged Psychiatry Assessment Treatment Team
APH	-	Ante partum haemorrhage
APLS	-	Advanced Paediatric Life Support
APTT	-	Activated partial thromboplastin time
ARC	-	Australian Resuscitation Council
ARDS	-	Adult respiratory distress syndrome
ARF	-	Acute renal failure
ARM	-	Artificial rupture of membranes
AROM	-	Active range of movement
ASAP	-	As soon as possible
ASD	-	Atrial septal defect
ASIS	-	Anterior superior iliac spine
ASO	-	Antistreptolysin O
ATLS	-	Advanced Trauma Life Support
ATN	-	Acute tubular necrosis
ATSP	-	Asked to see patient
Av	-	Anteverted (uterus)
Av	-	Arterio venous (gradient)
AV	-	Atrio ventricular (node)
Ax	-	Assessment
AZT	-	Zidovudine

B

B cult	-	Blood culture
b.d. / b.i.d.	-	Twice daily (medication dosing)
b/o	-	Because of

b/w	-	Between
BA / BAC	-	Blood alcohol / concentration
BBB	-	Bundle branch block
BC	-	Bone conduction (ear)
BD	-	Twice daily
BE	-	Below elbow
BHCG	-	Beta human chorionic gonadotropin
BIBA	-	Brought in by ambulance
BiPAP	-	Bi-level positive airway pressure
BK	-	Below knee
BKA	-	Below knee amputation
BKPOP	-	Below knee plaster of Paris
BLS	-	Basic Life Support
BM	-	Bowel motion
BMI	-	Body mass index (weight in Kg/ height in meters squared)
BMR	-	Basal metabolic rate
bno	-	bowels not opened
bo	-	Bowels opened
BOS	-	Base of skull
BP	-	Blood Pressure
BPH	-	Benign prostatic hypertrophy
bpm	-	Beats per minute
BPV	-	Benign positional vertigo
BS	-	Bowel sounds / breath sounds
BSA	-	Body surface area
BSE	-	Breast self examination
BSL	-	Blood sugar level
Bx	-	Biopsy

C

c.c.	-	With food (medication dosing)
C/I	-	Contra-indicated
C/O	-	Complains of
c/w	-	Consistent with
CA	-	Cancer
CAB / G	-	Coronary artery bypass grafting
CaCx	-	Cancer of cervix

CAD	-	Coronary Artery Disease
c-ADL	-	Community Activities
CAG / S	-	Coronary artery graft / surgery
CAT	-	Coaxial or computerized axial tomography
CATT	-	Community crisis and treatment team
CBD	-	Common bile duct
CBR	-	Chemical, biological, radiological
CBS	-	Chronic brain syndrome
CBT	-	Cognitive behaviour therapy
CC	-	Chief complaint
CCF	-	Congestive cardiac failure
CCU	-	Cardiac / Coronary Care Unit
CDM	-	Chronic Disease Management
CEA	-	Carcino-embryonic antigen
CEs	-	Cardiac enzymes
CHB	-	Complete heart block
CHI	-	Closed head injury
CIN	-	Cervical intraepithelial neoplasia
CIS	-	Carcinoma in situ
CJD	-	Creutzfeldt-Jacob disease
CK	-	Creatine kinase
CKMB	-	Creatine kinase myocardial band
CLL	-	Chronic lymphocytic leukaemia
CMV	-	Cytomegalovirus
CNS	-	Central nervous system
CO	-	Carbon monoxide
CO	-	Cardiac output
CO2	-	Carbon Dioxide
COAD	-	Chronic obstructive airways disease
COP	-	Change of plaster
COPD	-	Chronic Obstructive Pulmonary Disease
CPAP	-	Continuous Positive Airway Pressure
CPFI	-	Chest pain for investigation
CPP	-	Cerebral perfusion pressure
CPR	-	Cardio-Pulmonary Resuscitation
CPR	-	Cardiopulmonary resuscitation
Creps	-	Crepitations / rales

CREST	-	Calcinosis, Raynaud's, esophageal dysfunction, sclerodactyly, telangiectasia
CRF	-	Chronic renal failure
CRP	-	C-reactive protein
C-section	-	Caesarean section
CSF	-	Cerebral Spinal Fluid
CSSD	-	Central sterile supply department
CSU	-	Catheter specimen of urine
CT	-	Computerised tomogram/tomography
CTG	-	Cardiotocograph
CTO	-	Community treatment order
CTPA	-	CT pulmonary angiography
CTR	-	cardiothoracic ratio
CTSP	-	Called / came to see patient
CVA	-	Cerebro-vascular Accident
CVC	-	Central venous catheter
CVD	-	Cardiovascular Disease
CVP	-	Central venous pressure
CVS	-	Cardiovascular system
Cx	-	Complications
Cx	-	Cervix
CXR	-	Chest X-ray

D		
D&C	-	Dilatation and curettage
D&V	-	Diarrhoea and vomiting
D/C	-	Discharge
d/w	-	Discussed With
d-ADL	-	Domestic Activities of Daily Living
DC	-	Direct current
DD	-	Dangerous drugs
DD	-	Differential diagnosis
DDAVP	-	Angiovasopressin
DDx	-	Differential diagnosis
Decub.	-	Lying down
DIC	-	Disseminated intravascular coagulation
DIP	-	Distal interphalangeal
DIS	-	Disseminated intravascular coagulation
DISPLAN	-	Disaster plan
DKA	-	Diabetic ketoacidosis
DM	-	Diabetes mellitus
DNA	-	Desoxyribonucleic acid
DNA	-	Did not attend
DNR	-	Do Not Resuscitate
DNW	-	Did not wait
DOA	-	Date of admission/ Dead on arrival
DOB	-	Date of Birth
DoHA	-	Department of Health and Ageing
DPL	-	Diagnostic peritoneal lavage
DSA	-	Digital substraction angiography
DT / DTs	-	Delirium Tremens
DTP	-	Diphtheria/Tetanus/Pertussis
DU	-	Duodenal Ulcer
DUI	-	Driving Under The Influence
DVT	-	Deep Vein / Venous Thrombosis
Dx	-	Diagnosis
E		
E&D	-	Eat(ing) and Drink(ing)
E&R	-	Equal and Reacting

EBM	-	Evidence Based Medicine
EBV	-	Epstein-Barr Virus
ECC	-	External Cardiac Compression
ECF	-	Extracellular Fluid
ECG	-	Electro Cardiogram
ECG	-	Electrocardiogram
ECMO	-	Extracorporal Membrane Oxygenation
ECT	-	Electroconvulsive Therapy
ED	-	Emergency Department
EDC	-	Expected Date Of Confinement
EDD	-	Expected Date Of Delivery
EDH	-	Extradural Haematoma
EDM	-	Early Diastolic Murmur
EEG	-	Electroencephalogram
EEG	-	Electroencephalogram
EENT	-	Ears, Eyes, Nose And Throat
ENT	-	Ears, Nose And Throat
EF	-	Ejection Fraction
EFT	-	Electronic Funds Transfer
EIA	-	Enzyme Immunoassay
ELISA	-	Enzyme-Linked Immunosorbent Assay
ELS	-	Emergency Life Support
EM	-	Ejection Murmur
EMD	-	Electromechanical Dissociation
EMG	-	Electromyogram
EMLA	-	Trade Name For Topical Anaesthetic
EMST	-	Emergency Management Of Severe Trauma
ENG	-	Electronystagmography
ENT	-	Ear, Nose, Throat
EOM	-	External Otitis Media
EPC	-	Enhanced Primary Care
ERCP	-	Endoscopic Retrograde Cholangio Pancreatography
ESM	-	Ejection Systolic Murmur
ESR	-	Erythrocyte Sedimentation Rate
ESWL	-	Extracorporal Shock-Wave Lithotripsy
ET or ETT	-	Endotracheal (Tube)
ETA	-	Estimated (Expected) Time Of Arrival

ETOH	-	Alcohol
ETT	-	Exercise Tolerance Test
EUA	-	Examination Under Anaesthesia
Ex	-	Examination

F

#	-	Fracture
F	-	Female
F/T	-	Full Time
F/U	-	Follow Up
FAST	-	Focused Assessment With Sonography In Trauma
FB	-	Foreign Body
FBC	-	Full Blood Count
FBE	-	Full Blood Examination
FD	-	Foetal Distress / Forceps Delivery
FDP	-	Fibrin Degradation Products
FDP	-	Flexor Digitorum Profundus
FDS	-	Flexor Digitorum Superficialis
FEV	-	Forced Expiratory Volume
FEV1	-	Forced Expiratory Volume In 1 Second
FFP	-	Fresh Frozen Plasma
FH	-	Foetal Heart
FHH	-	Foetal Heart Heard
FHNH	-	Foetal Heart Not Heard
FHR	-	Foetal Heart Rate
FHx	-	Family History
FI	-	For Investigation
FiO2	-	Fractional Inspired Oxygen Concentration
FMFF	-	Foetal Movement First Felt
FOB	-	Faecal Occult Blood
FOBT	-	Faecal Occult Blood Testing
FOI	-	Freedom Of Information
FROM	-	Full Range Of Movement / Motion
FS	-	Frozen Section
FT	-	Full Term / Full Thickness
FTND	-	Full Term Normal Delivery
FUO	-	Fever Of Unknown Origin

FVC	-	Forced Vital Capacity
FWB	-	Full Weight Bearing
FWD	-	Full Ward Diet
FWT	-	Full Ward Test (Urine)
Fx	-	Fracture

G

G	-	Gravida
G&H	-	Group And Hold
GA	-	General Anaesthetic
GAMP	-	General Anaesthesia, Manipulation And Plaster
GBS	-	Guillain-Barré syndrome
GCS	-	Glasgow Coma Score
GDM	-	Gestational Diabetes Mellitus
GE	-	Gastroenteritis / Gastroenterology
GHB	-	Gamma Hydroxybutyrate
GI	-	Gastrointestinal
GIT	-	Gastrointestinal Tract
GnPn	-	Gravida (Number 1..2..3) Parity (Number 1..2..3..)
GOR / D	-	Gastro-Oesophageal Reflux / Disease
GOT	-	Glutamic Oxaloacetic Transaminase
GP	-	General Practitioner
GPMP	-	GP Management Plan
Grav. 2	-	Second Pregnancy (See Para 1)
GTN	-	Glyceryl Trinitrate
GTT	-	Glucose Tolerance Test
GU	-	Gastric Ulcer
GUS	-	Genito-Urinary System
Gyn	-	Gynaecology

H

H&M	-	Haematemesis And Melaena
h.d.	-	At Bedtime (Hora Decubitus) (medication dosing)
h/o	-	History Of
H2O	-	Water
HAV	-	Hepatitis A Virus
Hb	-	Haemoglobin

HBC	-	Hepatitis B Core Antibody
HBS	-	Hepatitis B Surface Antibody
HBV	-	Hepatitis B Virus
HCG	-	Human Chorionic Gonadotropin
Hct.	-	Haematocrit
HCV	-	Hepatitis C Virus
HDL	-	High Density Lipoprotein
HDU	-	High Dependency Unit
Hep	-	Hepatitis
Hib	-	Haemophilus Influenzae Type B
HITH	-	Hospital In The Home
HIV	-	Human Immunodeficiency Virus
HMO	-	Hospital Medical Officer
HOPC	-	History Of Presenting Complaint
HOV	-	Head On View
HPT	-	Hypertension
HR	-	Heart Rate
HSV	-	Herpes Simplex Virus
Hx	-	History

I

I&D	-	Incision And Drainage
IABC / P	-	Intraaortic Balloon Counterpulsator / Pump
IAP	-	Intra Abdominal Pressure
IBDIBS	-	Inflammatory Bowel Disease
ICC	-	Intercostal Catheter
ICF	-	Intracellular Fluid
ICH	-	Intracranial Haemorrhage
ICP	-	Intracranial Pressure
ICS	-	Intercellular Space
ICS	-	Intercostal Space
ICU	-	Intensive Care Unit
ID	-	Identify/ Identification
ID	-	Infectious Disease
IDC	-	Indwelling Urinary Catheter
IDDM	-	Insulin Dependent Diabetes Mellitus
IDU	-	Injecting Drug User

IF	-	Iliac Fossa
Ig	-	Immunoglobulin
IHD	-	Ischaemic Heart Disease
II	-	Image Intensifier
im	-	Intramuscular (medication dosing)
imi	-	Intramuscular Injection (medication dosing)
IMV	-	Intermittent Mandatory Ventilation
in	-	Intranasal (medication dosing)
INH	-	Isoniazid
INR	-	International Normalized Ratio (For Prothrombin Time)
IOFB	-	Intra-Ocular Foreign Body
IP	-	Interphalangeal
IP	-	Intraperitoneal
IPAP	-	Inspiratory Positive Airway Pressure
IPPV	-	Intermittent Positive Pressure Ventilation
IQ	-	Intelligence Quotient
ISQ	-	The Same As Previously (In Status Quo)
ISS	-	Injury Severity Score
ISS	-	Interstitial Space
ITP	-	Idiopathic Thrombocytopenic Purpura
IU	-	International Unit / Intrauterine
IUCD	-	Intrauterine Contraceptive Device
IV	-	Intravenous (medication dosing)
iv	-	Intravenous (medication dosing)
IVAB	-	Intravenous Antibiotics
IVC	-	Inferior Vena Cava / Intravascular Coagulopathy / I.V. Cannula
IVDU	-	Intravenous Drug Use
IVF	-	Invitro Fertilisation
ivi	-	Intravenous Injection (medication dosing)
IVP	-	Intravenous Pyelogram
IVS	-	Intravascular Space
Ix	-	Investigation

J

JRMO	-	Junior resident medical officer
JVP	-	Jugular venous pressure

JVPNE	-	Jugular venous pressure not elevated

K

Kg	-	Kilo gram
KUB	-	Kidney-ureter-bladder (X-ray)
K-wire	-	Kirschner wire

L

Ⓛ	-	Left
L	-	Left
LA	-	Local Anaesthetic
LAD	-	Left Axis Deviation
LAMP	-	Local Anaesthetic, Manipulation And Plaster
LAP	-	Left Atrial Pressure
Lat.	-	Lateral
LBBB	-	Left Bundle Branch Block
LCA	-	Left Coronary Artery
LCL	-	Lateral Collateral Ligament
LDL	-	Low Density Lipoprotein
LFT	-	Liver Function Test
LIF	-	Left Iliac Fossa
LIH	-	Left Inguinal Hernia
LLL	-	Left Lower Lobe
LLQ	-	Left Lower Quadrant
LMN	-	Lower Motor Neurone
LMO	-	Local Medical Officer
LMP	-	Last Menstrual Period
LMW	-	Low Molecular Weight
LOC	-	Level Of Consciousness (In Glasgow Scale)
LOC	-	Loss Of Consciousness
LOS	-	Length Of Stay
LOW	-	Loss Of Weight
LP	-	Lumbar Puncture
LSCS	-	Lower Segment Caesarean Section
LUQ	-	Left Upper Quadrant
LV	-	Left Ventricular
LVF	-	Left Ventricular Failure

LVH	-	Left Ventricular Hypertrophy

M

M	-	Male
mane	-	In The Morning (medication dosing)
MAOI	-	Monamine Oxidase Inhibitor
MAP	-	Mean Arterial Pressure
MAST	-	Military Antishock Trousers
MBS	-	Medicare Benefits Schedule
MCHC	-	Mean Corpuscular Haemoglobin Concentration
MCL	-	Mid-Clavicular Line / Medial Collateral Ligament
MCP	-	Metacarpophalangeal
MCS	-	Microscopy, Culture and Sensitivity
MCV	-	Mean Corpuscular Volume
MET	-	Medical Emergency Team
Mets.	-	Metastases
mg	-	Milligram
MH	-	Mental Health
MHP	-	Mental Health Professionals
MICA	-	Mobile Intensive Care Ambulance
Midi	-	At Midday (medication dosing)
ml	-	Millilitre
Mmol	-	Millimole
MMR	-	Measles, Mumps, Rubella
MMSE	-	Mini-Mental State Examination
MND	-	Motor Neuron Disease
MODF	-	Multiorgan Dysfunction Syndrome
MRI	-	Magnetic Resonance Imaging
MRSA	-	Methicillin-Resistant Staphylococcus Aureus
MS	-	Multiple Sclerosis
MSU	-	Midstream Urine
MUA	-	Manipulation Under Anaesthesia
MVA	-	Motor Vehicle Accident
Mx	-	Management

N

Ⓝ	-	Normal

N	-	Normal
N&V	-	Nausea And Vomiting
N/A	-	Not Applicable
N/S	-	Normal Saline
NAD	-	No Abnormalities Detected
NBM or NPO	-	Nil By Mouth
ND	-	Normal Delivery / Nocturnal Dyspnoea
NESB	-	Non English Speaking Background
NETS	-	Neonatal Emergency Transfer Service
NFO	-	No Further Order
NFR	-	Not For Resuscitation
NG (T)	-	Nasogastric (Tube)
NH	-	Nursing Home
NHL	-	Non-Hodgkin's Lymphoma
NHMRC	-	National Health & Medical Research Council
NIBP	-	Non-Invasive Blood Pressure
NICU	-	Neonatal Intensive Care Unit
NIDDM	-	Non Insulin Dependent Diabetes Mellitus
NKA	-	No Known Allergies
NKDA	-	No Known Drug Allergies
NMP	-	Normal Menstrual Period
NMR	-	Nuclear Magnetic Resonance
NMS	-	Neuroleptic Malignant Syndrome
NOAD	-	No Other Abnormalities Detected
nocte	-	At Night (medication dosing)
NOF	-	Neck Of Femur
NOK	-	Next Of Kin
NonSTEMI	-	Non ST Elevation Myocardial Infarction
NOS	-	Not Otherwise Specified
NPO	-	Nil By Mouth
NPPV	-	Non-Invasive Positive Pressure Ventilation
NS	-	Normal Saline
NSAID	-	Non-Steroidal Anti-Inflammatory Drug
NSR	-	Normal Sinus Rhythm
NSVD	-	Normal Spontaneous Vaginal Delivery
NTT	-	Nasotracheal Tube
NUM	-	Nurse Unit Manager

NVD	-	Nausea, Vomiting And Diarrhoea / Normal Vaginal Delivery
NWB	-	Non Weight Bearing

O

O/A	-	On Arrival
O/E	-	On Examination
O/n	-	Overnight
O+G	-	Obstetrics And Gynaecology
O2	-	Oxygen
Obs	-	Observations
Obs	-	Obstetrics
OCD	-	Obsessive Compulsive Disorder
OCP	-	Oral Contraceptive Pill
OD	-	Overdose
od	-	Every Day (medication dosing)
OE	-	Otitis Externa
OG	-	Orogastric
OM	-	Occipitomental
OM	-	Otitis Media
Op	-	Operation
OPD	-	Outpatient Department
OPG	-	Orthopantomogram (X-Ray Of Mandibles and Teeth)
OR	-	Operating Room
ORIF	-	Open Reduction And Internal Fixation
OT	-	Occupational Therapy
OTC	-	Over The Counter

P

Ⓟ	-	Plan
P	-	Parity
p.a.	-	Per Axilla
p.c.	-	After Food (Post Cibum) (medication dosing)
p.m.	-	Afternoon (Post Meridiem) (medication dosing)
p.o.	-	Per Os (By Mouth) (medication dosing)
p.p.	-	After Meals (Post Prandial) (medication dosing)

p.r.	-	Per Rectum (Rectal) (medication dosing)
p.r.n.	-	As Required (Pro Re Nata) (medication dosing)
p.v.	-	Per Vaginam (Vaginally) (medication dosing)
P/T	-	Part Time
p/w	-	Presents With
Pa	-	Partial Pressure
PA	-	Posterioranterior
PaCO2	-	Partial Pressure Of CO2 In Arterial Blood
PADL	-	Personal Activities Of Daily Living
PaO2	-	Partial Pressure Of Oxygen In Arterial Blood
PAO2	-	Partial Pressure Of Oxygen In Alveoli
Para 0, 1	-	(Nulliparous, Uni Para) No Delivery, One Delivery / One Full Pregnancy
PAT	-	Paroxysmal Atrial Tachycardia
PAWP	-	Pulmonary Arterial Wedge Pressure
PBS	-	Pharmaceutical Benefits Scheme
PCA	-	Patient Controlled Analgesia
PCA	-	Percutaneous Coronary Angioplasty
PCL	-	Posterior Cruciate Ligament
PCP	-	Pneumocystis Carinii Pneumonia
PCR	-	Polymerase Chain Reaction
PCTA	-	Percutaneous Coronary Transluminal Angioplasty
PD	-	Peritoneal Dialysis
PDL	-	Peritoneal Diagnostic Lavage
PDx	-	Principal Diagnosis / Provisional Diagnosis
PE	-	Pulmonary Oedema/Embolism
PE	-	Physical Examination
PE	-	Pre-Eclampsia
PEA	-	Pulseless Electrical Activity
PEARL	-	Pupils Equal And Reacting To Light
PEEP	-	Positive End-Expiratory Pressure
PEF	-	Peak Expiratory Flow
PEFR	-	Peak Expiratory Flow Rate
PEG	-	Percutaneous Endoscopic Gastrostomy
PERLA	-	Pupils Equal And Reactive To Light And Accommodation
PET	-	Pre-Eclamptic Toxaemia
PET (scan)	-	Positron Emission Tomography

PF	-	Peak Flow
PHx	-	Past History
PIC	-	Chest Pain
PICC	-	Peripherally Inserted Central (Venous) Catheter
PID	-	Pelvic Inflammatory Disease
PIP	-	Proximal Interphalangeal / Peak Inspiratory Pressure
PM	-	Post Mortem
PMHx	-	Past Medical History
PMS	-	Premenstrual Syndrome
PMT	-	Premenstrual Tension
PN	-	Post Natal / Pneumonia
PND	-	Post Natal Depression
PND	-	Paroxysmal Nocturnal Dyspnoea
PNS	-	Peripheral Nervous System
Pnx	-	Pneumothorax
PO2	-	Pressure Of Oxygen
POC	-	Products Of Conception
POP	-	Plaster Of Paris
PP	-	Placenta Praevia / Post Partum / Presenting Part
PPE	-	Personal Protective Equipment
PPH	-	Postpartum Haemorrhage
PROM	-	Premature Rupture Of Membranes
PROM	-	Passive Range Of Movement
PRVC	-	Pressure-Regulated Volume Control
PSA	-	Prostate-Specific Antigen
PSVT	-	Paroxysmal Supraventricular Tachycardia
Pt	-	Patient
PT	-	Prothrombin Time
PTCA	-	Percutaneous Transluminal Coronary Angioplasty
PTP	-	Pre-Test Probability
PUD	-	Peptic Ulcer Disease
PUO	-	Pyrexia Of Unknown Origin
PUVA	-	Psoralen Ultraviolet A Therapy
PVD	-	Peripheral Vascular Disease
PWB	-	Partial Weight Bearing

Q		
q.d	-	Every Day (Quaque Diem) (medication dosing)
q.i.d / q.d.s.	-	Four Times A Day (Quarter In Die) (medication dosing)
QA	-	Quality Assurance
R		
®	-	Right
R	-	Right
R/O	-	Removal Of
R/V	-	Review
RA	-	Rheumatoid Arthritis
RA	-	Room Air
RAD	-	Right Axis Deviation
RAP	-	Right Atrial Pressure
RBBB	-	Right Bundle Branch Block
RBC	-	Red Blood Cells
RCA	-	Right Coronary Artery
ref.	-	Refer
REFT	-	Reverse Electronic Funds Transfer
reg.	-	Regular
RF	-	Radio Frequency / Renal Failure / Rheumatic Fever / Rheumatoid Factor
RIB	-	Rest In Bed
RICE	-	Rest, Ice, Compression, Elevation
RIF	-	Right Iliac Fossa
RIH	-	Right Inguinal Hernia
RIND	-	Reversible Ischaemic Neurological Deficit
RIP	-	Rest In Peace
RITH	-	Rehabilitation In The Home
RLL	-	Right Lower Lobe
RLQ	-	Right Lower Quadrant
RMO	-	Resident Medical Officer
RN	-	Registered Nurse
RNA	-	Ribonucleic Acid
ROM	-	Range Of Movement / Rupture Of Membranes
ROSC	-	Return Of Spontaneous Circulation
RR	-	Respiratory Rate

RSI	-	Repetitive Strain Injury
RSV	-	Respiratory Syncytial Virus
RTA	-	Road Traffic Accident
RTW	-	Returned To Ward / Return To Work
RTx	-	Radiotherapy
RUQ	-	Right Upper Quadrant
RVH	-	Right Ventricular Hypertrophy
Rx	-	Treatment

S

s.c.	-	Subcutaneous
s.l.	-	Under The Tongue, Sublingual (medication dosing)
S/B	-	Seen By
S/E	-	Side Effects
S1-5	-	Sacral Vertebrae 1-5
SA	-	Sinoatrial
SAH	-	Subarachnoid Haemorrhage
SaO2	-	Arterial Oxygen Saturation
SARS	-	Severe Acute Respiratory Syndrome
SBE	-	Shortness Of Breath On Exertion
SBE	-	Sub-Acute Bacterial Endocarditis
SBO	-	Small Bowel Obstruction
SBP	-	Systolic Blood Pressure
SBR	-	Serum Bilirubin
SBT	-	Skin Bleeding Time
SC	-	Sternoclavicular
SCIWORA	-	Spinal Cord Injury Without Radiological Abnormality
SD	-	Spontaneous Delivery
SDH	-	Subdural Haemorrhage
SDL	-	Standard Drug List
SGOT	-	Transaminase
SHx	-	Social History
SI	-	Sacro-Iliac
SIADH	-	Syndrome Of Inappropriate Antidiuretic Hormone Secretion
SIDS	-	Sudden Infant Death Syndrome
Sig.	-	Write / Label (In Prescriptions)
SIJ	-	Sacroiliac Joint

SIMV	-	Synchronized Intermittent Mandatory Ventilation
SK	-	Streptokinase
SLE	-	Systemic Lupus Erythematosus
SLR	-	Straight Leg Raise
SM	-	Systolic Murmur
SOA	-	Swelling Of Ankles
SOAP	-	Subjective, Objective, Action , Plan
SOB	-	Shortness Of Breath
SOB	-	Short Of Breath
SOBOE	-	Short Of Breath On Exertion
SOL	-	Space Occupying Lesion
SOOB	-	Sitting Out Of Bed
SPS	-	Single Point Stick
SR	-	Sinus Rhythm
SROM	-	Spontaneous Rupture Of Membranes
SSD	-	Silver Sulfadiazine
SSG	-	Split Skin Graft
SSRI	-	Selective Serotonin Reuptake Inhibitor
ST	-	Sinus Tachycardia / Soft Tissue
Stat.	-	Immediately (Statim) (medication dosing)
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
STEMI	-	ST Elevation Myocardial Infarction
SVC	-	Superior Vena Cava
SVD	-	Septal Ventricular Defect / Spontaneous Vaginal Delivery
SVT	-	Supraventricular Tachycardia
Sx	-	Symptoms/Signs

T		
T	-	Temperature / Thoracic
T&A	-	Tonsillectomy And Adenoidectomy
t.d.s / t.d.	-	Three Times A Day (Ter De Die) (medication dosing)
t.i.d.	-	Three Times A Day (Ter In Die) (medication dosing)
t/f	-	Transfer
T/P/S	-	Tone, Power And Sensation
Tabs	-	Tablets
TAC	-	Transport Accident Commission

TAC	-	Tetracaine, Adrenaline And Cocaine In A Gel Preparation
TB	-	Tuberculosis
TBA	-	To Be Advised
TBI	-	Traumatic Brain Injury
TBSA	-	Total Body Surface Area
TCA	-	Team Care Arrangements
TDS	-	Three Times A Day (medication dosing)
TEA	-	Thromboendarterectomy
TEDS	-	Thrombo-Embolic Disease Stockings
TENS	-	Transcutaneous Electrical Nerve Stimulation
THR	-	Total Hip Replacement
TPR	-	Temperature, Pulse, Respirations
TIA	-	Transient Ischaemic Attack
Tib.&fib.	-	Tibia And Fibula
TIG	-	Tetanus Immunoglobulin
TLC	-	Tender Loving Care
TM	-	Temporomandibular / Tympanic Membrane
TMJ	-	Temperomandibular Joint
TNF	-	Tumour Necrosis Factor
TNM	-	Tumour-Nodes-Metastasis (Cancer Staging)
TOE	-	Transoesophageal Echocardiogram
TOL	-	Trial Of Labour
TOP	-	Termination Of Pregnancy
TPA	-	Tissue Plasminogen Activator
TPN	-	Total Parenteral Nutrition
TPP	-	Time, Place, Person
TRISS	-	Revised Trauma Score And Injury Severity Score Combined
TSH	-	Thyroid Stimulating Hormone
TSST	-	Toxic Shock Syndrome Toxin
TT	-	Thrombin Time
TURP	-	Transurethral Prostate Resection
TVH	-	Total Vaginal Hysterectomy
Tx	-	Treatment / Therapy

U

U&E	-	Urea And Electrolytes
U/K	-	Unknown

U/Q	-	Upper Quadrant
UA	-	Unstable Angina / Urinary Analysis
UEC	-	Urea, Electrolytes, Creatinine
UL	-	Upper Limb
ULQ	-	Upper Left Quadrant
UMN	-	Upper Motor Neuron
Ung.	-	Ointment (Unguentum)
UNH	-	Unfractionated Heparin
UO	-	Urinary Output
UR	-	Unit Record / Upper Respiratory
URTI	-	Upper Respiratory Tract Infection
USS	-	Ultrasound Scan
UTI	-	Urinary Tract Infection
UWSD	-	Under Water Seal Drainage

V

V&D	-	Vomiting And Diarrhoea
V/Q	-	Ventilation / Perfusion
VAVD	-	Visual Acuity
VDK	-	Venom Detection Kit
VDRL	-	Syphilis Test
VE	-	Vaginal Examination / Vacuum Extraction / Ventricular Ectopics
VEB	-	Ventricular Ectopic Beats
VF	-	Ventricular Fibrillation / Visual Field
VF or V-fib	-	Ventricular Fibrillation
VH	-	Vaginal Hysterectomy
VP	-	Venous Pressure
VP	-	Ventriculoperitoneal
VRE	-	Vancomycin Resistant Enterococci
VSD	-	Ventricular Septal Defect
VT	-	Ventricular Tachycardia
VV	-	Varicose Veins
vv.	-	Veins (Venae)
vWF	-	Von Willebrand's Factor
Vx	-	Vertex

W		
W/E	-	Weekend
w/h	-	Withhold
w/o	-	Without
w/r	-	Ward Round
WB	-	Weight Bearing
WBC	-	White Blood Cell(S)
WCC	-	White (Blood) Cell Count
WHO	-	World Health Organisation
WL	-	Waiting List
WNL	-	Within Normal Limits
WPW	-	Wolff-Parkinson-White
X		
X-match	-	Cross Match
XR	-	X-Ray
Y		
Y/O	-	Year-Old
Yr	-	Year

Appendix B - Health Organisation Acronyms

A		
AAGP	-	Australian Association of General Practitioners
AARN	-	Association of Australian Rural Nurses
ABS	-	Australian Bureau of Statistics
ACA	-	Australian Consumers Association
ACAT	-	Aged Care Assessment Teams
ACC	-	Aged and Community Care
ACEM	-	Australasian College for Emergency Medicine
ACFID	-	Australian Council for International Development
ACHSE	-	Australian College of Health Service Executives
ACLM	-	Australian College of Legal Medicine
ACLS	-	Advanced Cardiac Life Support
ACN	-	Australian Cancer Network
ACOSH	-	Australian Council on Smoking and Health
ACOSS	-	Australian Council of Social Services
ACRRM	-	Australian College of Rural and Remote Medicine
ACSQH	-	Australian Commission on Safety and Quality in Healthcare
ADEC	-	Australian Drug Evaluation Committee
ADGP	-	Australian Divisions of General Practice
AHA	-	Australian Healthcare Association
AHEC	-	Australian Health Ethics Committee
AHMAC	-	Australian Health Minister's Advisory Council
AHP	-	Allied Health Professionals
AHPRA	-	Australian Health Practitioner Regulation Agency
AIHW	-	Australian Institute of Health and Welfare
AMA	-	Australian Medical Association
AMC	-	Australian Medical Council
AMSA	-	Australian Medical Students Association
AN-DRG	-	Australian National Diagnosis Related Groups
ANF	-	Australian Nursing Federation
ANZAME	-	Australian & New Zealand Association for Medical Education
APA	-	Australian Physiotherapists Association
APAC	-	Australian Pharmaceutical Advisory Council
APHA	-	Australian Private Hospitals Association

APMA	-	Australian Pharmaceutical Manufacturers Association
ARC	-	Australian Resuscitation Council
ARHEN	-	Australian Rural Health Education Network
ASHM	-	Australian Society for HIV Medicine
ASMOF	-	Australian Salaried Medical Officers Federation
ASWPE	-	Adjusted Standard Whole Patient Equivalents
ATSI	-	Aboriginal and Torres Strait Islanders

B		
BLS	-	Basic Life Support
BMA	-	British Medical Association
BMJ	-	British Medical Journal
BNH	-	Bush Nursing Hospital

C		
CAL	-	Computer Assisted Learning
CASA	-	Centre Against Sexual Assault
CASF	-	Cardiac Arrest Support Foundation
CBT	-	Competency Based Training
CCCA	-	Clinical Casemix Committee of Australia
CHC	-	Community Health Centre
CHE	-	Centre for Health Economics
CHS	-	Community Health Service
CLD	-	Culturally and Linguistically Diverse
CME	-	Continuing Medical Education
COAG	-	Council of Australian Governments
CPAC	-	Clinical Practices Advisory Committee
CPE	-	Continuing Professional Education
CPMC	-	Committee of Presidents of Medical Colleges
CPMEC	-	Confederation of Postgraduate Medical Education Councils
CQI	-	Continuous Quality Improvement
CRC	-	Collaborative Research Centre
CVD	-	Cardiovascular Disease

D		
DCT	-	Director of Clinical Training
DDA	-	Disability Discrimination Act

DEST	-	Department of Education, Science and Training (National)
DET	-	Department of Education and Training (State)
DFaCSIA	-	Department of Family, Community Services and Indigenous Affairs
DFAT	-	Department of Foreign Affairs and Trade
DGPP	-	Divisions of General Practice Program
DH&AC	-	Department of Health & Ageing (National)
DH&AC	-	Department of Health and Family Services (now DH&AC)
DHS	-	Department of Human Services (State – Victoria)
DIAC	-	Department of Immigration and Citizenship
DMS	-	Director of Medical Services
DOHA	-	Department of Health and Ageing (Commonwealth – Canberra)
DRG	-	Diagnostic Related Groups
DRS	-	Doctors Reform Society

E

ECT	-	External Clinical Teacher
EFT	-	Effective Full Time
ELS	-	Emergency Life Support
EMST	-	Emergency Management of Severe Trauma
EPC	-	Enhanced Primary Care
EQuIP	-	Evaluation and Quality Improvement Program
ERT	-	Enhanced Rural Training

F

FLC	-	Flexible Learning Centre
FMCE&R Found.	-	Family Medical Care, Education & Research Foundation
FMP	-	Family Medicine Program
FOI	-	Freedom of Information
FRACGP	-	Fellow of the Royal Australian College of General Practitioners
FTE	-	Full Time Equivalent

G

GP	-	General Practitioner
GPDV	-	General Practice Divisions – Victoria
GPEA	-	General Practice Education Australia

H

HACC	-	Home and Community Care
HCN	-	Health Communication Network
HIC	-	Health Insurance Commission (now Medicare)
HIV	-	Human Immunodeficiency Virus
HMO	-	Hospital Medical Officer
HREOC	-	Human Rights and Equal Opportunities Commission
HSC	-	Health Services Commissioner
HSDP	-	Highly Specialised Drug Program

I		
IHF	-	International Hospitals Federation
IMG	-	International Medical Graduate (See OTD)
ISO	-	International Standards Organisation
IT	-	Information Technology

L		
LGA	-	Local Government Area

M		
MAV	-	Municipal Association of Victoria
MBA	-	Medical Board of Australia
MBCC	-	Medical Benefits Consultative Committee
MBS	-	Medical Benefits Schedule
MCE	-	Medical Clinical Educator
MEO	-	Medical Education Officer
Medical Deans		Medical Deans of Australia and New Zealand (Previously CDAMS)
MJA	-	Medical Journal of Australia
MLO	-	Medical Liaison Officer
MPBV	-	Medical Practitioners Board of Victoria

N		
NACCHO	-	National Aboriginal Community Controlled Health Organisation
NARHTU	-	National Association of Rural Health Training Units
NASOG	-	National Association of Specialist Obstetricians & Gynaecologists
NCEPH	-	National Centre for Epidemiology & Population Health
NESB	-	Non-English Speaking Background (See CLD)
NGO	-	Non-Government Organisation

NH&MRC	-	National Health & Medical Research Council
NOOSR	-	National Office of Overseas Skills Recognition
NPS	-	National Prescribing Service
NRHA	-	National Rural Health Alliance

O		
OATSIH	-	Office for Aboriginal and Torres Strait Islander Health
OECD	-	Organisation for Economic Cooperation and Development
OSCE	-	Objective Structured Clinical Examination
OTD	-	Overseas Trained Doctor (See IMG)

P		
PA	-	Privacy Act
PALS	-	Paediatric Advanced Life Support
PBAC	-	Pharmaceutical Benefits Advisory Council
PBS	-	Pharmaceutical Benefits Scheme
PCP	-	Primary Care Partnerships
PDA	-	Private Doctors of Australia
PHAV	-	Private Hospitals Association of Victoria
PGPPP	-	Prevocational General Practice Placements Program
PHCR&IS	-	Primary Health Care Research and Information Service
PMCV	-	Postgraduate Medical Council of Victoria
PSA	-	Pharmaceutical Society of Australia

Q		
QA	-	Quality Assurance
QA&CME	-	Quality Assurance & Continuing Medical Education
QAN	-	Quality Assurance Network

R		
RACGP	-	Royal Australian College of General Practitioners
RACMA	-	Royal Australasian College of Medical Administrators
RACN	-	Royal Australian College of Nursing
RANZCO	-	Royal Australian and New Zealand College of Ophthalmologists
RACP	-	Royal Australasian College of Physicians
RANZCOG	-	Royal Australian and New Zealand College of Obstetricians & Gynaecologists

RANZCR	-	Royal Australian and New Zealand College of Radiologists
RACS	-	Royal Australasian College of Surgeons
RRMA	-	Rural, Remote and Metropolitan Classification System
RAV	-	Rural Ambulance Victoria
RCNA	-	Royal College of Nursing Australia
RCPA	-	Royal College of Pathologists of Australasia
RCS	-	Rural Clinical School
RDAA	-	Rural Doctors Association of Australia
RDAV	-	Rural Doctors Association of Victoria
RDNS	-	Royal District Nursing Service
REN	-	Rural Education Network
RFDS	-	Royal Flying Doctor Service
RMO	-	Resident Medical Officer
RWAV	-	Rural Workforce Agency Victoria
S		
SH&FPA	-	Sexual Health and Family Planning Australia
SIT	-	Supervisor of Intern Training
SJAA	-	St. John Ambulance Australia
SPIRT	-	Strategic Partnerships with Industry - Research & Training
SWPE	-	Standardised Whole Patient Equivalent
T		
TGA	-	Therapeutic Goods Administration
TRD	-	Temporary Resident Doctor
TSP	-	Targeted Separation Package
U		
UDRH	-	University Department of Rural Health
V		
VAED	-	Victorian Admitted Episodes Dataset
VAGP	-	Victorian Academy of General Practice
VAHEC	-	Victorian Association of Health and Extended Care
VCHA	-	Victorian Community Health Association
VECCI	-	Victorian Employers Chamber of Commerce & Industry
VHA	-	Victorian Healthcare Association

VHIA	-	Victorian Hospitals Industrial Association
VMO	-	Visiting Medical Officer
VMPF	-	Victorian Medical Postgraduate Foundation
VPTAS	-	Victorian Patient Transport Assistance Scheme
VR	-	Vocational Registration

W

WHO	-	World Health Organisation
WIES	-	Weighted Inlier Equivalent Separation
WONCA	-	World Organisation of National Colleges, Academies & Academic Associations of General Practitioners/Family Physicians (Short name – World Organisation of Family Doctors)

Appendix C – Victorian public hospital websites

Metropolitan Melbourne Hospitals & Health Services	Rural Hospitals & Health Services
Austin Health The Austin Campus The Repatriation Campus The Royal Talbot Rehabilitation Centre Alfred Health The Alfred Caufield Hospital Sandringham Hospital Calvary Health Care Bethlehem Dental Health Services Victoria Royal Dental Hospital of Melbourne School Dental Service Eastern Health Angliss Hospital Box Hill Hospital Healesville & District Hospital Maroondah Hospital Peter James Centre Mercy Health & Aged Care Inc. Mercy Hospital for Women Mercy Hospice O'Connell Family Centre Werribee Mercy Hospital Northern Health Broadmeadows Health Service Bundoora Extended Care Centre Northern Hospital Peninsula Health Frankston Hospital Mt Eliza Aged Care & Rehabilitation Service Rosebud Hospital Peter MacCallum Cancer Institute Melbourne Health Royal Melbourne Hospital - City Campus Royal Melbourne Hospital - Royal Park Campus Victorian Infectious Diseases Reference Laboratory North West Dialysis Service	Albury Wodonga Health Alexandra District Hospital Alpine Health Bright District Hospital Mount Beauty General Hospital Myrtleford District War memorial Hospital Bairnsdale Regional Health Service Ballarat Health Services Barwon Health Network Geelong Campus Grace Mckellar Bass Coast Regional Health Beechworth Health Service Bendigo Health Anne Caudle Campus Bendigo Hospital Campus Casterton Memorial Hospital Colac Area Health Dunmunkle Health Services East Grampians Health Service East Wimmera Health Service Echuca Regional Health Edenhope & District Memorial Hospital Goulburn Valley Health Shepparton Campus Tatura Campus Waranga (Rushworth) Campus Hepburn Health Service Daylesford Campus Creswick Campus Trentham Campus Clunes Campus

North Western Mental Health Program
Royal Children's Hospital

Royal Victorian Eye & Ear Hospital

Royal Women's Hospital

Monash Health

Dandenong Hospital
Hampton Rehabilitation Hospital
Kingston Centre
Monash Medical Centre - Clayton
Monash Medical Centre - Moorabbin
Berwick wide Community Health Service
Cardinia Community Health Service
Cranbourne & District Community Health Service
Cranbourne Integrated Care Service
Dandenong Community Health Service
Springvale Community Health Service

St Vincent's Hospital Melbourne
St George's Health Services
Caritas Christi Hospice
Prague House

Western Health

Sunshine Hospital
Western Hospital
Williamstown Hospital

Kyabram & District Health Services

Kyneton District Health Service

Latrobe Regional Hospital

Lorne Community Hospital

Maryborough District Health Service

Maryborough Hospital
Dunolly Hospital

Mt Alexander Hospital

Mildura Base Hospital

Moyne Health Services

Port Fairy Hospital

Northeast Health Wangaratta

Otway Health & Community Services

Portland District Health

Rochester Elmore District Health Service

Seymour District Memorial Hospital

South West Healthcare

Warrnambool Campus
Camperdown Campus

Stawell Regional Health

Swan Hill District Hospital

Terang & Mortlake Health Service

Timboon & District Healthcare Service

Upper Murray Health & Community Services

Western District Health Service

Hamilton Campus
Penshurst Campus
Coleraine Campus

West Wimmera Health Service

Nhill Hospital
Kaniva Hospital
Jeparit Hospital
Rainbow Hospital
Natimuk Hospital

	West Gippsland Healthcare Group Wimmera Health Care Group Dimboola Campus Horsham Campus Yarram & District Health Service

Feedback

The Postgraduate Medical Council of Victoria (PMCV) is keen to obtain feedback on the Manual and any comments or suggestions you have regarding the content and format would be appreciated. We would also be grateful for feedback on any errors or inaccuracies you may find in the manual. Please complete this form and return via email to: pmcv@pmcv.com.au

Feedback form

1. What information were you looking for?

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2. Did you find the information you wanted?

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3. Did you identify any inaccuracies or errors in the manual? If so, please identify page and paragraph.

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4. Do you have any additional feedback? (e.g. suggested topics, new features, improvements)

……

5. How would you rate the following aspects of the manual?

	Excellent	Very good	Good	Fair	Poor
Appearance					
Layout					
Accuracy of information					
Relevance and scope					
Usefulness					

We appreciate your assistance. Thank you.