From:	Stokes, John
To:	Community Affairs, Committee (SEN)
Subject:	Re: Questions on notice - Senate Community Affairs References Committee - Medical complaints inquiry
Date:	Tuesday, 8 November 2016 5:55:09 PM
Attachments:	Eradicating_Medical_Student_Mistreatment___A.17.pdf Mobbing.pdf Peer review.pdf Mandatory reporting.pdf AHPRA---Guidelines-for-mandatory-notifications.PDF.pdf Medical-Board---Code-of-conduct.PDF.pdf Unaccountable.pdf

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Josh,

I have attached the relevant academic published articles that I promised and that supported my submission to the Senate Enquiry and directly relate to the Question on Notice regarding bullying and AHPRA processes.

In addition I mentioned in my verbal submission that I had identified major areas that needed reform. I have outlined those in item 7.

These attachments all relate to improving the processes related to Bullying in Question on notice.

1. The article which I mentioned that longitudinally followed bullying of medical students in the United States from 1995-2008 (Eradicating Medical Student Mistreatment: A Longitudinal Study of One Institution's Efforts).

2. The article which described the phenomenon of "mobbing" which is found more frequently in health organisations. (A Story to Tell: Bullying and Mobbing in the Workplace).

3. The article which describes the phenomenon of "Sham Peer Review. (Clinical peer review in the United States: History, legal development and subsequent abuse).

4. The article that was published in the Medical Journal of Australia, (Mandatory reports of concerns about the health, performance and conduct of health practitioners) researched the process and had this summary statement:

"This study is best understood as a first step in establishing an evidence base for understanding the operations and merits of Australia's mandatory reporting regime. The scheme is in its infancy and reporting behaviour may change as health practitioners gain greater awareness and understanding of their obligations. Several potential pitfalls and promises of the scheme remain to be investigated for example, the extent to which mandatory reporting stimulated a willingness to deal with legitimate concerns, as opposed to inducing an unproductive culture of fear, blame and vexatious reporting. Qualitative research, including detailed file reviews and interviews with health practitioners and doctors' health advisory services, would help address these questions. Further research should also seek to under-stand the relationship between mandatory reports and other mechanisms for identifying practitioners, such as patient complaints, incident reports, clinical audit, and other quality assurance mechanisms."

5. The guidelines for Mandatory reporting which are very loose and promote the abuse of "in good faith reporting". (National Board guidelines for registered health practitioners - GUIDELINES FOR MANDATORY NOTIFICATIONS)

6. The Medical Board Code of Conduct (GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA) which does not mention “making false complaints, vexatious complaints or bullying” as professional misconduct and in my opinion should be stated in that document so that both students and practitioners realise it is unacceptable behaviour.

7. The Strategies I suggest will reduce the problems we discussed and will reduce bullying;

1. Urgently revise the legislation with particular emphasis on ensuring natural justice, due process and absence of bias

2. Define the principles of Peer Review and produce a National Standard for Peer Review such that

Honest peer review is practiced
Sham Peer review is eradicated
Mobbing is identified and reduced

3. Make the AHPRA system transparent and accountable, more efficient and less remote.

4. Accept vexatious reporting is professional misbehaviour and requires serious sanction and consequences. Place such a statement in the Code of Conduct for Practitioners.

5. Define the current problems and recognise the suicides, illness and financial suffering associated with the current AHPRA notification process.

6. Place patient care at the centre of the process for improvement.

7. Restore the principles of natural justice, due process is available to Health Professionals.

8. Make use of efficient triage, use mediation and require a declaration of good faith, absence of a vested interest, and review the mandatory rules for reporting by practitioners.

9. Educate professionals about correct process.

10. Recognise the hidden curriculum in Medical Student and Postgraduate Education that allows the continuation of bullying.

8. Lastly I have provided a cover shot of “Unaccountable" from Amazon.com of the book I mentioned in my submission.

Many thanks,

John

John Stokes

Associate Professor John Stokes
College of Medicine and Dentistry
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Eradicating Medical Student Mistreatment: A Longitudinal Study of One Institution's Efforts

Joyce M. Fried, Michelle Vermillion, Neil H. Parker, MD, and Sebastian Uijtdehaage, PhD

Abstract

Purpose
Since 1995, the David Geffen School of Medicine at UCLA (DGSOM) has created policies to prevent medical student mistreatment, instituted safe mechanisms for reporting mistreatment, provided resources for discussion and resolution, and educated faculty and residents. In this study, the authors examined the incidence, severity, and sources of perceived mistreatment over the 13-year period during which these measures were implemented.

Method
From 1996 to 2008, medical students at DGSOM completed an anonymous survey after their third-year clerkships and reported how often they experienced physical, verbal, sexual harassment, ethnic, and power mistreatment, and who committed it. The authors analyzed these data using descriptive statistics and the students' descriptions of these incidents qualitatively, categorizing them as "mild," "moderate," or "severe." They compared the data across four periods, delineated by milestone institutional measures to eradicate mistreatment.

Results
Of 2,151 eligible students, 1,946 (90%) completed the survey. More than half (1,166/1,946) experienced some form of mistreatment. Verbal and power mistreatment were most common, but 5% of students (104/1,930) reported physical mistreatment. The pattern of incidents categorized as "mild," "moderate," or "severe" remained across the four study periods. Students most frequently identified residents and clinical faculty as the sources of mistreatment.

Conclusions
Despite a multipronged approach at DGSOM across a 13-year period to eradicate medical student mistreatment, it persists. Aspects of the hidden curriculum may be undermining these efforts. Thus, eliminating mistreatment requires an aggressive approach both locally at the institution level and nationally across institutions.

Mistreatment can have deleterious effects on medical students' emotional well-being and attitudes, potentially eroding the values and competencies, such as professionalism, that the medical school curriculum intends to convey. Specifically, mistreatment both affects mental health, with students exhibiting the symptoms of posttraumatic stress,[1,2] and results in low career satisfaction.[3] Furthermore, verbal mistreatment affects students' confidence in their clinical abilities and their ability to succeed in residency.[4,5]

Unfortunately, more than two decades of studies have shown that the behaviors of faculty, residents, and nurses toward medical students are frequently unprofessional and abusive, particularly during clinical clerkship rotations.[1–13] Furthermore, data from the 2009–2011 Association of American Medical Colleges' (AAMC's) Medical School Graduation Questionnaires showed that, at the end of their fourth year, approximately one in six U.S. medical students reported that they had personally experienced mistreatment.[14] This problem is not limited to the United States, however; studies on medical student mistreatment in Japan,[6] the Netherlands,[7] and the United Kingdom[8] reported an equally high incidence of mistreatment.

The studies published in the last 20 years represent a snapshot of the prevalence of medical student mistreatment at a single institution or at multiple institutions. None of these studies, however, monitored the incidence and severity of abuse longitudinally to evaluate the concerted efforts of one institution to eradicate abusive behavior over time.

Addressing Medical Student Mistreatment at the David Geffen School of Medicine at UCLA

During the last 17 years, leaders at the David Geffen School of Medicine at UCLA (DGSOM) have taken a proactive approach to eradicating medical student mistreatment. In 1995, they created the Gender and Power Abuse Committee, consisting of faculty, administrators, and mental health professionals, to initiate interventions and to provide support to victims of mistreatment. The committee members meet regularly to receive updates on the prevalence of reported mistreatment at DGSOM and to learn how to assist members of the medical school community in resolving incidents of mistreatment. The committee's initial charge included creating policies to prevent mistreatment, instituting mechanisms for reporting it, providing resources for safe and informal discussion and resolution, and educating faculty, residents, students,

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and nurses. In this study, we examined whether this concerted, multipronged approach spanning more than a decade accompanied a decrease in the incidence of medical student mistreatment.

Since the Gender and Power Abuse Committee was created in 1995, our institution has initiated a number of other interventions. For the purpose of our analysis, we divided the subsequent years (1996–2008) into four periods. For each period, we examined the prevalence and severity of medical student mistreatment at DGSOM. Period 1 (1996–1998) included the years preceding the implementation of any interventions.

In 1998, the Gender and Power Abuse Committee wrote the medical school's Statement on Supporting an Abuse-Free Academic Community, which was adopted by the leadership and widely disseminated both on bookmarks and on the Internet.[15] In addition, the school opened an Ombuds Office for Medical Sciences, which was staffed by a designated ombudsperson trained to understand the issues specific to a medical environment. Here, medical students, residents, faculty, and staff could confidentially report and mitigate mistreatment. Period 2 (1999–2000) included the two years immediately following these initiatives.

In 2001, marking the beginning of Period 3 (2001–2005), the Gender and Power Abuse Committee established a mechanism for the formal reporting and investigation of mistreatment. They drafted the Policy for Prevention of Student Mistreatment with input from students and residents. After the Faculty Executive Committee adopted this policy, the Gender and Power Abuse Committee disseminated it to all students and posted it on the student affairs Web site.[16] Also during this period, they implemented a comprehensive education program targeting students, residents, and faculty.

Since 2001, third-year medical students who are about to begin their required clinical clerkships have participated in a one-hour mandatory workshop on student mistreatment. The purpose of this workshop is to educate the students about mistreatment and to give them the skills to deal with mistreatment. Faculty define the types of mistreatment, share data to show prevalence, and discuss scenarios in small groups to prepare the students to respond to situations that they might encounter during their clerkships. For example, students are asked to strategize on how to respond in a collegial yet assertive manner when they are asked to pick up dinner for their team.

In addition, during Period 3, the Gender and Power Abuse Committee created a mandatory half-hour training session on professionalism in the work place to be held during resident orientation. The session cautions incoming residents against committing acts of mistreatment toward medical students and also provides them with resources should they be the object of mistreatment themselves. Finally, members of the committee provide sessions on student mistreatment to faculty at faculty meetings and grand rounds, as well as at grand rounds at the DGSOM-affiliated hospitals that host third-year students during their clerkships.

In 2005, the California state legislature mandated that all state-employed supervisors, including faculty and clinical staff, complete a two-hour online sexual harassment training course every two years. Period 4 (2006–2008) included the three years following this mandate. Also during this period, the faculty from the Doctoring course for third-year medical students introduced a small-group module on mistreatment, providing students the opportunity to discuss and to mitigate any mistreatment experiences that they may have encountered during their clerkships.

In our study, we reviewed medical students' mistreatment reporting patterns across these four periods, which included our multipronged effort to eradicate student mistreatment. The specific objectives of our study were to (1) assess the prevalence of mistreatment reported anonymously by medical students immediately following their third-year clerkships, (2) compare reporting patterns of male and female students, (3) determine whether institutional interventions accompanied changes in prevalence and severity of reported mistreatment, and (4) identify the purported sources of reported mistreatment.

Method

Beginning in 1996, we surveyed all medical students at the end of their third-year clerkships. From 1996 to 2005, students voluntarily completed a paper-based, anonymous survey on the day of their clinical performance examination. In 2006, we moved the survey to CoursEval3™ (Academic Management Systems, Amherst, New York), a secure, anonymous course evaluation system already used by DGSOM. From that time on, students completed the survey online within a three-week period; participation was mandatory.

In the questionnaire, we asked students to indicate whether or not and, if so, how often, they experienced mistreatment during their clerkships in the following categories: (1) physical mistreatment (defined as "slapped, struck, pushed"), (2) verbal mistreatment (defined as "yelled or shouted at, called a derogatory name, cursed, ridiculed"), (3) sexual harassment (defined as "inappropriate physical or verbal advances, intentional neglect, sexual jokes," and, starting in 2005, "mistreatment based on sexual orientation"), (4) ethnic mistreatment (defined as "intentional neglect, ethnic jokes, comments and expectations regarding stereotypical behavior"), and (5) power mistreatment (defined as "made to feel intimidated, dehumanized, or had a threat made about a recommendation, your grade, or your career").

We asked students to indicate the frequency with which they experienced each category ("once," "twice," "on numerous occasions") as well as to identify the sources of that mistreatment using the following choices: preclinical faculty, clinical faculty, residents, students, patients, nurses, or other (added in 2003). From 1997 through 2005, students were able to select multiple sources of mistreatment for each incident; however, starting in 2006, they were able to select only one. Finally, we asked them to describe any incidents of mistreatment, but we did not require them to do so.

Although we do not report the results here, we also asked students (1) to identify the department and institution where the mistreatment occurred, (2) to or from whom they reported the incident

or sought help, and (3) for those who indicated that they did not seek help, why they did not seek help or attempt to report the incident.

The questions regarding students' experiences with mistreatment remained the same over the course of our study period with a notable exception. In 2003 and 2004, we added a separate question asking students if, as a medical student, they had been mistreated because of their sexual orientation. Because affirmative responses were rare, starting in 2005, we included this type of mistreatment in the definition of sexual harassment. For the purposes of our analysis, we included affirmative responses from 2003 and 2004 in the sexual harassment category.

In this analysis of anonymous, archived data, we compared mistreatment patterns across our four study periods using descriptive statistics (χ^2 analysis and Fisher exact test). We used SPSS version 17.0 (IBM Corp, Armonk, New York) for these quantitative analyses.

We then qualitatively analyzed the students' descriptions of their experienced incidents of mistreatment to determine the severity of each. We combined these qualitative data from all years for each mistreatment category. We considered comments in the context of the mistreatment category under which they were originally reported; however, in three instances, we felt that comments reported under verbal mistreatment indicated a clear instance of sexual harassment, so we moved them to that category. Two of us (J.F. and M.V.) independently analyzed the comments to identify a preliminary set of subcategories. At this stage, we eliminated comments related to mistreatment by a patient or comments without sufficient information to determine source or severity. The same two of us compared our individual subcategories, agreed on a final categorization scheme, and then independently classified all comments according to the agreed-on scheme. The two of us and a third investigator (S.U.) reconvened to compare all classifications (line by line). We resolved all disagreements through consensus. Finally, we assigned a severity rating of "mild," "moderate," or "severe" to each comment, which we then agreed on. If a comment described more than one incident, we determined its severity rating according to the most severe of the incidents described.

Through consultation with the UCLA Office of Human Research Protection Program, the study was determined to not meet the definition of human subject research per federal regulations and, therefore, not require institutional review board review.

Results

A total of 1,946 of 2,151 eligible medical students participated in our study from 1996 to 2008. Our overall response rate was 90%, although response rates for individual years ranged from 63% in 2001 (when, due to a clerical error, only a portion of the class was invited to participate) to 100% in 2006, 2007, and 2008 when participation was mandatory. In all years, students were not required to answer every question; therefore, denominators may vary. We found a shift in demographics over the course of the study period ($\chi^2 = 36.6$, $df = 12$, $P < .001$). Before 2000, the majority of the students in each class were male; starting in 2001, classes were on average equally divided by gender.

Overall incidence of mistreatment

Incidence of mistreatment was highest in Period 1 before DGSOM adopted the Statement on Supporting an Abuse-Free Academic Community. During this period, 317 of 422 (75%) students reported having experienced some form of mistreatment during their clerkships; this dropped significantly to an average of 57% (849 of 1,497 students) across the subsequent three periods ($\chi^2 = 47.2$, $df = 3$, $P < .001$), between which we found no significant differences. None of the measures instituted after 1998, such as the antimistreatment education program or the mandatory sexual harassment prevention training, were accompanied by a decrease in overall incidence of mistreatment ($\chi^2 = 0.5$, $df = 2$, $P = .794$).

Incidence of specific categories of mistreatment

Figure 1 illustrates that the drop in overall incidence of mistreatment after the adoption of the Statement on Supporting an Abuse-Free Academic Community was largely attributable to a decline in incidence of verbal mistreatment ($\chi^2 = 41.7$, $df = 1$, $P < .001$) and power mistreatment ($\chi^2 = 22.4$, $df = 1$, $P < .001$). Before 1998, a majority of students (243 of 438, 55%) reported having been verbally mistreated, and 43% (190 of 443) reported power mistreatment. From 1999 to 2008, an average of 38% (572 of 1,499) of students reported they were verbally mistreated and 31% (463 of 1,503) reported power mistreatment. Although the incidence of these two forms of mistreatment decreased significantly from Period 1 to Period 4, they remained quite prevalent.

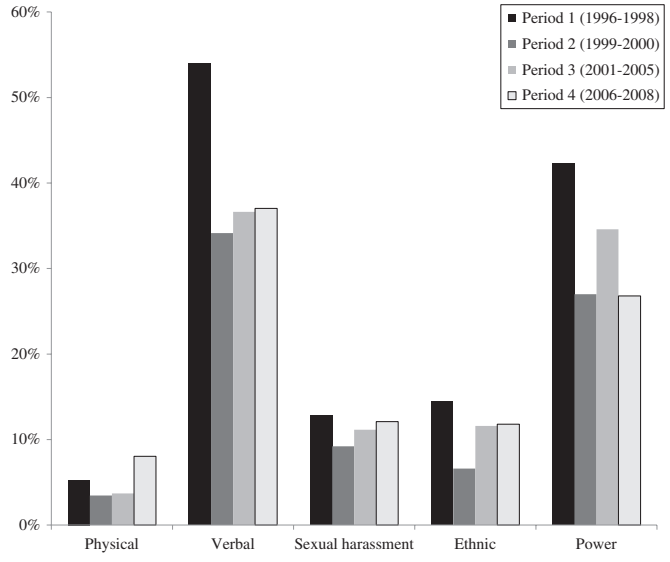

Figure 1 Incidence of medical student mistreatment by category of mistreatment, David Geffen School of Medicine at UCLA, 1996–2008. Incidents of mistreatment by patients have been excluded.

The incidence of reported sexual harassment remained stable from 1996 to 2008. Averaged across all four study periods, 13% (260 of 1,940) of students reported being a victim of sexual harassment. The mandatory sexual harassment prevention training introduced in 2005 then had no discernible influence on the incidence of sexual harassment.

After 1998, incidence of ethnic mistreatment dropped significantly from 17% (76 of 443) in Period 1 to an average of 12% (178 of 1,503) in subsequent periods ($\chi^2 = 8.5$, $df = 1$, $P = .004$).

Incidents of physical mistreatment appeared to be relatively rare; across the four study periods, only 5% (104 of 1,930) of students reported that they were victims of physical mistreatment. Incidence of reported physical mistreatment did not decline over time, despite the various institutional interventions. In fact, incidence of physical mistreatment increased significantly to 8% (38 of 472) in Period 4 compared with previous periods ($\chi^2 = 9.551$, $df = 3$, $P < .001$).

Gender differences

Table 1 compares the percentages of male and female students who reported various categories of mistreatment across the four study periods. We found no difference in the incidence of reported physical mistreatment between male and female students until 2006. In Period 4, female students reported incidents of physical mistreatment more frequently than male students (27 of 259, 10% versus 11 of 213, 5%; $P < .05$). Similarly, female students reported incidents of verbal mistreatment more frequently than male students in Period 4 (108 of 259, 42% versus 69 of 213, 32%; $P < .05$). Again, female students reported incidents of sexual harassment more frequently than male students across all survey periods ($P < .001$). In Period 1, 31% of female students reported being sexually harassed (dropping to approximately 20% in subsequent years) compared with 5% of male students. We found no gender differences in reports of ethnic mistreatment or power mistreatment during any of the study periods.

Mistreatment severity

A total of 1,166 students reported some form of mistreatment in our survey; of those, only 945 (81%) chose to provide details on the circumstances and nature of the mistreatment (see Table 2). After excluding comments describing incidents involving patients or comments that lacked sufficient detail, we were left with 783 comments, which included 58 descriptions of physical mistreatment, 323 of verbal mistreatment, 114 of sexual harassment, 82 of ethnic mistreatment, and 206 of power mistreatment. Figure 2 shows the percentages of comments describing each severity (mild, moderate, and severe) of all categories of mistreatment. Across the four study periods, we categorized 505 (64%) of the comments as severe, 228 (29%) as moderate, and 48 (6%) as mild. We found no statistically significant differences in this distribution across the four study

Table 1

Comparison of Male Versus Female Third-Year Medical Students Reporting Mistreatment, by Study Period, David Geffen School of Medicine at UCLA, 1996–2008

Category of mistreatment	Study period, no. (%)			
	Period 1 1996–1998	Period 2 1999–2000	Period 3 2001–2005	Period 4 2006–2008
Physical				
Male	13/235 (5.5)	6/176 (3.4)	12/350 (3.4)	11/213 (5.2)
Female	10/188 (5.3)	5/119 (4.2)	17/365 (4.7)	27/259 (10.4)*
Verbal				
Male	140/239 (58.6)	63/176 (35.8)	126/349 (36.1)	69/213 (32.4)
Female	100/194 (51.5)	48/119 (40.3)	149/364 (40.9)	108/259 (41.7)*
Sexual harassment				
Male	7/241 (2.9)	7/176 (4.0)	14/350 (4.0)	17/213 (8.0)
Female†	60/193 (31.1)	22/119 (18.5)	80/364 (22.0)	51/259 (19.7)
Ethnic				
Male	43/242 (17.8)	13/176 (7.4)	42/351 (12.0)	29/213 (13.6)
Female	32/196 (16.3)	13/119 (10.9)	50/365 (13.7)	29/259 (11.2)
Power				
Male	101/242 (41.7)	53/176 (31.1)	111/351 (31.6)	53/213 (24.9)
Female	86/196 (43.9)	27/119 (22.7)	138/365 (37.8)	72/259 (27.8)

*$P < .05$, male versus female in Period 4.
†$P < .001$, male versus female across all periods.

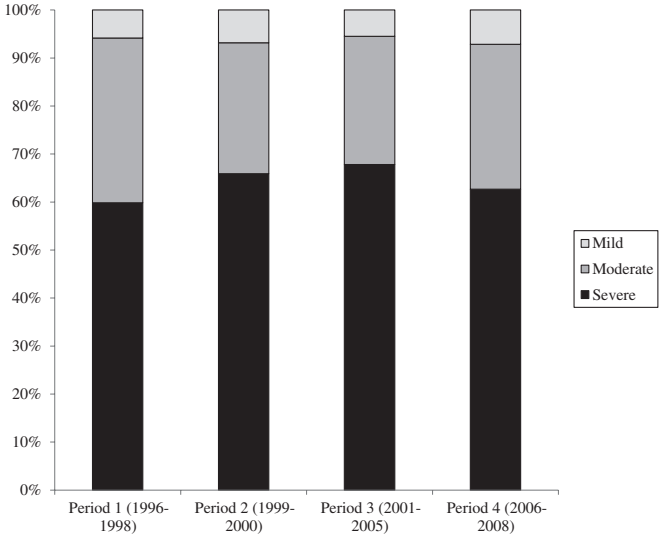

Figure 2 Comparison of mild, moderate, and severe incidents of medical student mistreatment by study period, David Geffen School of Medicine at UCLA, 1996–2008.

Table 2

Categories of Mistreatment, Severity of Mistreatment, and Illustrative Quotations From Third-Year Medical Students, David Geffen School of Medicine at UCLA, 1996–2008

Category of mistreatment	Severity	Quotation
Physical		
Physically mistreated causing pain or potential injury	Severe	A cardiology fellow slapped my hand when I was unable to answer an EKG question and said: "If teaching doesn't help you learn, then pain will."
Pushed/slapped hand ("get-out-of-the way" communication)	Moderate	Pushed out of way for multiple deliveries during ob–gyn
Exposed to other forms of physical mistreatment used to express frustration, make a point, or get attention	Moderate	I was walking (slowly apparently) in front of my intern. She was frustrated and pushed me forward with both of her hands on my shoulders, saying: "walk faster!"
Verbal		
Accused	Severe	Chief resident accused me and another student of not coming to the rotation on the prior day since she had not seen us…. She flat out accused us of lying even after we told her exactly which faculty and residents we had been with the prior day … leaving me in tears.
Threatened/intimidated	Severe	A surgical resident threatened to kill me during a chest tube placement. However, he was quite friendly afterwards.
Yelled at/snapped at	Moderate	Yelled at for paging fellow about time of rounds and about speaking up at journal club
Degraded/ridiculed/humiliated/insulted/sworn at/scolded/berated	Moderate	Many incidents of faculty and residents making derogatory comments regarding students in general, sometimes directed at me. Comments related to performance, knowledge, dress (i.e., how I look), etc. Unfortunately this is all too common.
Exposed to inappropriate conversation/comments (of nonsexual and nonracial nature)	Mild	[The resident] then started screaming about "I … hate surgery. I should have gone into anesthesiology. Do you want to be a surgeon?" I said" "not anymore" and he said: "good, don't even think about it! I hate surgery" (insert many curse words in between). He wasn't necessarily verbally abusive but created a pretty hostile environment.
Sexual harassment		
Exposed to hostile environment, including inappropriate physical contact, gender discrimination, sexual jokes, inappropriate comments, innuendo, and inappropriate requests	Severe	Attending grabbed and attempted to kiss [me]. This was the reported incident. The other incidences consisted of being asked out and comments on how pretty and "distracting" to the other surgeons I was.
Asked out (quid pro quo)	Moderate	There was one attending (~50 years old) that asked me to play tennis with him. When I made excuses, he pushed me harder. When I reminded him that I was married and that I could not leave early to play tennis because I had work to do on the ward, he told my resident to give me the afternoon off. This attending never tried to kiss me, etc., but he did make me feel very uncomfortable.
Ignored because of gender	Mild	Most cases were just intentional neglect. On several rotations, I was paired with male medical students. Invariably, if there was a male attending over a certain age, I got ignored in favor of the male med student. I learned to live with it.
Ethnic		
Exposed to racial or religious slurs/jokes	Severe	Upon hearing my last name, attending surgeon made "Chinese" noises.
Stereotyped	Moderate	Resident said that I'm just like all the other Asian families whose parents never love their kids and give unbelievable amounts of pressure to do well.
Neglected/ignored (because of student's ethnicity)	Mild	I noticed the white males were addressed more and the other student I was paired with (white male) received many more opportunities to do ultrasounds; when I requested to do them, I was told that they were too busy…. I felt like they were trying to get rid of me … when I tried to do extra things or help, I was constantly overlooked or unwanted.
Power		
Dehumanized/demeaned/humiliated (nonverbally)/pimped out	Severe	Made to feel stupid for my mistakes. Made to feel ill at ease during rotations. Sometimes made to feel like a slave. Mostly made to doubt my abilities.
Intimidated/threatened with evaluation or grade consequences	Severe	Two different residents made comments about if I left the OR to go to lecture or Doctoring, it would be reflected on my evaluation.
Asked to do inappropriate tasks/scut work	Moderate	Other team's residents made me get them dinner. They paid for the meal but made me lose out on 3 hrs of patient care as I went thru menus with them. Then I delivered them all food individually because they wouldn't come to me.
Forced to adhere to inappropriate scheduling	Moderate	Resident wanted us to take excessive calls, more than was expected, and in a very short time period…. Always wanted us to take calls before doctoring or lectures, even when that was not part of the expectations of the clerkship.
Neglect/ignored	Mild	On medicine I had to consult surgery but the surgeon refused to speak to me because I was a medical student despite having the most complete knowledge about the patient as the new interns had just started that day.

periods. The percentage of comments for which we categorized the mistreatment as "mild," "moderate," or "severe" remained similar across the four study periods.

Reporting of mistreatment

We found that few students who reported an incident of mistreatment on our survey indicated that they sought help or chose to formally report it to someone at DGSOM. The vast majority of the incidents captured in our survey then remained otherwise unreported. Students were least likely to report incidents of ethnic mistreatment (17 of 250 [7%] incidents were reported), followed by incidents of verbal mistreatment (102 of 780, 13%), power mistreatment (93 of 640, 15%), sexual harassment (37 of 253, 15%), and physical mistreatment (13 of 81, 16%). In general, the percentage of incidents of mistreatment that students formally reported did not increase across the four study periods. Students were only more likely in Period 4 to report incidents of verbal mistreatment (41 of 174 [24%] in Period 4 versus an average of 61 of 607 [10%] in Periods 1 to 3; $\chi^2 = 25.266$, $df = 3$, $P < .001$).

Sources of mistreatment

Across all categories of mistreatment, students most frequently reported being mistreated by residents (947 of 2,396; 40%) and clinical faculty (862 of 2,396; 36%). See Table 3 for a complete comparison of the reported sources of mistreatment.

Discussion

Our longitudinal study examined the incidence and severity of specific categories of mistreatment in third-year medical students over a period of 13 years. Despite the proactive approach taken by our institution to eradicate student mistreatment over this period, we found that the majority of our students continued to report some form of mistreatment at least once during their third-year clerkships. Students most commonly reported incidents of verbal and power mistreatment, followed by sexual harassment and ethnic mistreatment. Even incidents of physical mistreatment persisted throughout the study, albeit less frequently. Although we surveyed students at the end of their third year, AAMC Graduation Questionnaire data, collected from the same students at the end of their fourth year, indicated that the incidence of mistreatment at our institution is near the national average, 17% in 2009, suggesting that the environment at our institution is comparable to that at many other medical schools in the nation.

We are unsure why students immediately after their clerkships reported mistreatment at higher rates compared with graduating seniors. We hypothesize that students' experiences during the first two years of medical school, when they are the center of attention, are very different from their experiences during clerkships, when suddenly the patients, their families, and their care take priority. By the end of their fourth year, students may better be adjusted and understand their role in a complex health care system. However, this hypothesis deserves further study.

To our knowledge, our study is the first to consider the severity of mistreatment in an analysis of mistreatment patterns. We had hoped that, because the incidence of mistreatment had remained steady across the study periods, at least the severity of the mistreatment would have shown a pattern of decline. In other words, such a scenario would have been a promising sign that the institutional initiatives were effective because minor incidents were being reported more often than more serious ones. Unfortunately, our qualitative analysis of students' descriptions of their mistreatment suggested that this was not the case; we found no evidence that the percentage of serious forms of mistreatment decreased across our study period.

Our finding that female students more often reported mistreatment than their male counterparts is consistent with a number of studies[6,7,9,12]; in particular, female students more frequently reported incidents of verbal mistreatment and sexual harassment. In addition, we found an increase in the number of incidents of physical mistreatment reported by females on our survey during Period 4.

Also consistent with previous studies,[3,4,6,9,11–13] we found that students most frequently reported being mistreated by residents and clinical faculty. Nurses were also frequent offenders, particularly of verbal and physical mistreatment. Although we continue to believe in the importance of training clinical staff and residents in what constitutes inappropriate behavior toward students and holding those who mistreat students accountable, our findings suggest that such interventions, no matter how well intended, may fail to address the full complexity of the culture

Table 3

Comparison of Sources of Medical Student Mistreatment, by Category of Mistreatment, David Geffen School of Medicine at UCLA, 1996–2008

	Category of mistreatment, no. (% of category total)					
Source of mistreatment	Physical	Verbal	Sexual harassment	Ethnic	Power	All categories
Preclinical faculty	4 (4.4)	54 (5.5)	11 (4.0)	24 (8.2)	59 (7.9)	152 (6.3)
Clinical faculty	33 (36.3)	364 (36.9)	83 (30.1)	105 (36.0)	277 (36.9)	862 (36.0)
Resident	24 (26.4)	369 (37.4)	99 (35.9)	82 (28.1)	373 (49.7)	947 (39.5)
Student	2 (2.2)	28 (2.8)	22 (8.0)	29 (9.9)	5 (0.7)	86 (3.6)
Patient	4 (4.4)	57 (5.8)	43 (15.6)	34 (11.6)	7 (0.9)	145 (6.1)
Nurse	23 (25.3)	112 (11.3)	16 (5.8)	12 (4.1)	24 (3.2)	187 (7.8)
Other	1 (1.1)	3 (0.3)	2 (0.7)	6 (2.1)	5 (0.7)	17 (0.7)
Total	91 (100.0)	987 (100.0)	276 (100.0)	292 (100.0)	750 (100.0)	2,396 (100.0)

of mistreatment at our, and likely other, institutions.

Drawing on models from organizational psychology, Rees and Monrouxe[8] highlighted the complex interaction between person and environment by proposing four factors that contribute to a culture of mistreatment—the perpetrators, the organization (i.e., climate and hierarchy), the nature of the work, and, importantly, the victim. Illustrating how these factors interact with each other and operate in a complex academic health center, a recent survey conducted in part at UCLA found that two-thirds of residents have felt humiliated by nurses or witnessed other forms of inappropriate behavior, which then was associated with higher levels of resident cynicism and burnout.[11] In this context, the model "see one, do one, teach one" could result in residents emulating inappropriate behaviors in their own teaching, perpetuating the widespread view that student mistreatment is a "rite of passage." In light of this finding, we consider it naïve to expect that our 30-minute workshop regarding student mistreatment given to residents at the beginning of their training would mitigate the effects of this hidden curriculum. Obviously, we need to do much more.

To make the situation more complex, academic health centers are not isolated entities; they exist within, and are influenced by, a national medical culture. Residents join training programs and are recruited from medical schools across the country (and beyond), where various levels of belittlement and harassment continue[4] and where the fraternity mentality of medicine persists (represented by a disparity in the composition of faculty who are promoted and hold leadership positions).[17]

How, then, can we eradicate the mistreatment of medical students? We find indispensible a concerted single institution-based effort, consisting of a coherent set of measures including, but not limited to, clearly articulated and well-disseminated zero-tolerance policies in regard to student and resident mistreatment, safe reporting mechanisms, and the investigation and mitigation of each individual incident of student mistreatment, using an approach such as that suggested by Best and colleagues.[10] Building on this effort, we at DGSOM are now making a particular effort to identify individuals who demonstrate disrespectful behavior so that we can counsel these individuals.

Specifically, we will include targeted questions in the evaluations that students complete for all residents and faculty with whom they interacted during their clerkships. The students will rate the extent to which "I was treated with respect by this individual" and "I observed others (students, residents, staff, patients) being treated with respect by this individual." Faculty at the University of California, San Francisco, successfully have used both questions to identify faculty and residents who have behaved inappropriately. Students' negative responses to these questions will trigger both investigations into the residents' and faculty's behavior and consequences where warranted. We will disseminate widely this change in the wording of the evaluations because we believe that faculty and residents may be deterred from mistreating students once they understand that their inappropriate behavior will be specifically tracked. Conversely, we also will document the respect and duty that faculty, residents, and students show each other and consider such behavior in faculty promotion decisions.[4]

Going forward, we must address the impact that institutional stressors can have on faculty and staff. Although no excuse for mistreating students is acceptable, we may be able to mitigate such behavior with efforts designed to ensure that faculty and staff also feel valued and respected. Thus, we will reward departments whose faculty and residents score high on the student evaluation respect questions. In addition, we need mandatory training programs that involve trainees (i.e., medical students, residents, and fellows) and all those who interact with them (i.e., attendings, nurses, and staff). We will partner with the UCLA Health System to create a training module for the latter group. Also, we need both to continue to remind students that, when they report mistreatment, they are part of the solution, and to give them the tools to diffuse the situation themselves, which might serve them better in the long term. By more effectively mitigating individual incidents without retaliation, we hope to encourage students to appropriately stand up for themselves when possible and/or to report the incident to someone who will intervene on their behalf when necessary.

To supplement such local measures, we also must encourage a national approach to eradicating medical student mistreatment. We suggest that national organizations such as the American Medical Association and the AAMC continue both to lead a dialogue about the deleterious consequences of student and resident mistreatment and to promote a research program that elucidates the complex interactions of factors contributing to a culture of mistreatment. Finally, we need to identify the training methods that are effective in preventing mistreatment and to disseminate widely best practices and resources, through venues such as MedEdPortal[18] and iCollaborative.[19]

Limitations

Our study has several limitations. First, it reflects the experiences of students at one medical school and may not represent the experiences of those at other U.S. institutions. Second, our study is based on retrospective anonymous surveys of third-year students; we did not corroborate their responses with a third party. Third, although one of the strengths of our study is that we asked the same questions of students over an extended period of time, different cohorts of students may have interpreted the questions differently. With what we know about generational differences in medical students, it is possible that the students we surveyed in 1996 (born around 1972) may, as a cohort, have slightly different values and social norms than those students surveyed in 2008 (born around 1984), as suggested by one study.[20] Therefore, the changes in incidence of mistreatment that we observed (or the lack thereof) may not have been the result of policy changes but, instead, of a shift in attitudes among students regarding mistreatment. Fourth, our finding of differences in incidence of mistreatment by gender over time could be attributed to the gradual increase in the number of female students in medical school. Despite

these limitations, however, we find it disconcerting that students continued to report incidents of all categories of mistreatment at these rates.

Conclusions

Whereas the formal curriculum at DGSOM attempts to instill humanism in our students, the hidden curriculum can undermine these efforts when faculty and residents do not model the behavior taught to students in the classroom. We suspect that our institution is not alone in this challenge. Although we find it difficult to share data revealing such thwarted efforts, exposing a hidden curriculum that perpetuates a culture of mistreatment is crucial to finding a solution. Furthermore, we must focus future research efforts on improving our understanding of how the interaction of factors related to a complex academic health center may hamper a change in the culture of mistreatment.

The steps that we have taken, including creating informal and formal mechanisms of reporting and resolving incidents of mistreatment, providing education for students, residents, and faculty, and promoting the open discussion of this topic at all levels, did not result in a change in culture. Eradicating medical student mistreatment then requires an aggressive, multipronged approach locally at the institution level as well as nationally across institutions.

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A Story to Tell: Bullying and Mobbing in the Workplace

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Abstract

Bullying and mobbing are secretive, targeted, and widespread forms of abuse in the workplace (European Foundation, 2002). This behavior is designed to ostracize, isolate, undermine, and eliminate the person(s) being targeted. For reasons as yet unknown, this behavior appears to occur more frequently in the social service, health care, and educational sectors. Targets, often the most creative members of organizations, experience emotional and financial costs. Due to the loss of talented employees, a decrease in productivity, and staff demoralization, the costs to the organization are high. Multiple factors that create vulnerability are explored, as are potential points of intervention. Leaders, feeling helpless to intervene, may reinforce the culture of abuse. This phenomenon is a complex one that can only be addressed through systemic response and change in organizational culture. A framework for multi-level analysis and remediation is presented.

Keywords: administrative leadership, organizational change, workplace relationships, organizational bullying, mobbing behavior

Introduction

Bullying and mobbing (a covert form of group bullying) are violent, deliberate acts meant to harm another (Belak, 2002; Davenport, Schwartz, & Elliott, 2002; Denenberg & Bravernman, 2001; European Foundation, 2002). While this phenomenon is increasingly a focus of research and intervention in our elementary and secondary schools, until recently this form of violent intimidation and mistreatment of one person by another has not been recognized as common in the workplace (Lee & Brotheridge, 2006).

Given that social service, health, and educational occupations have higher rates of bullying than other organizations (European Foundation, 2002), workplace bullying and mobbing are of particular concern to social service organizations. Yet, little attention has been focused on the existence, causes, and consequences, of mobbing and bullying in the workplace, particularly in the United States (U.S.).

The phenomenon of bullying and mobbing has yet to be fully confronted, researched, and studied. The dynamics are complex and the incidence, prevalence, and high costs to victims and organizations are confirmed. Studies from Europe and Canada examine the phenomenon of bullying and mobbing exploring the prevalence, behavior, and impact (European Union, 2002). In the U.S. much of the research has been carried out by the Workplace Bullying Institute (WBI) and has focused solely on examining prevalence (Namie & Namie, 2009). While the scope has been limited, the findings strengthen our understanding of the links to targeting members of traditionally marginalized communities. Among the many consequences of bullying behavior are anxiety, withdrawal, low self-esteem, and other physical and mental health difficulties. Rather than recognizing these behaviors as a consequence of the abuse, too often they are turned into causes implying that the target is to blame, at least in part. Too often, the target of bullying (individual or group) is blamed for the violence committed by the bully, implying that the target must have done something to warrant the ire of others.

While the reason for the difference has yet to be studied, it has been established that the problem is almost three times as likely to occur in the social service, health, and educational professions than in other occupations (European Foundation, 2002). Further, research on, or even a discussion of, this phenomenon is noticeably missing from the social sciences literature, creating a gap in the professional knowledge base. As professionals we need to learn to care for and support each other, yet, little has been done by and for social scientists concerning bullying and mobbing in the workplace. In order to meet the needs of the people we work with, we need to create empathetic organizations in which we care for and about our professional communities and ourselves.

Naming and Describing the Behavior

Bullying and mobbing are "vindictive, cruel, malicious or humiliating attempts to undermine an individual or groups of employees" with mobbing additionally defined as a "concerted effort by a group of employees to isolate a co-worker through ostracism and denigration" (Denenberg & Braverman, 2001, p. 7). Perpetrators actively, though often covertly, seek to harm others--physically, emotionally, and spiritually, using tactics designed to injure individuals and create physical and psychological power imbalances (Burgess, Garbarino, & Carlson, 2006).

Mobbing is an extreme form of group bullying in which one or more employees covertly attacks another. The goal is to ostracize, isolate, and eliminate the target (Westhues, 2003). Offenders participate in character assassination, humiliation, and disruption as they place blame, criticize, and question ability. A group of factors is employed in combination to achieve a specific end result (Davenport, et al, 2002), including the use of scapegoating and innuendo along with spreading deprecating rumors, all while pretending to be nice in public encounters. The target is badgered, intimidated, and humiliated through persistent, targeted, hostile behavior (verbal and nonverbal) designed to undermine the integrity of the target. Through this process, the mobber, who is deliberate and intentional in their behavior and mindful of the consequences, enlists the cooperation of witnesses who participate, often accidentally, in the bully behavior. Those conscripted as "participants" may not understand the impact of his/her behavior as they are drawn into isolating and denigrating the target.

Mobbing and bullying form a phenomenon that engages a process designed to dehumanize the *other*, which is anchored in hate and the denial of individual human needs. These are never benign activities, but rather, involve the deliberate destruction of another and in doing so are always violent acts. The perpetrators engage in a process of psychological (Belak, 2002) and emotional terrorism (Davenport et al., 2002) wherein the target or victim is driven into a helpless position (see description of behaviors in Table 1). Hate speech (see Cortese, 2006 and Ma, 1995 for further discussion on hate speech) is one mechanism that can be used to create and maintain the unequal power relationships of bullying and mobbing, particularly when the target is a member of a traditionally marginalized group. Hate speech is designed to harm and silence while creating a context for expanding micro-aggressions that support the waging of violence that appears *normal.*

Table 1. Bullying/Mobbing Behavior

Interrupts the target in meetings
Sighs, rolls eyes, glares at target
Discounts/discredits target's ideas and accomplishments
Ignores target (silent treatment)
Intimidates through gestures
Questions target's competence
Insults the target
Yells and screams
Makes unreasonable demands
Steals credit for work done by target
Cuts target out of information loop
Blames target for fabricated errors
Nice to target in public; makes rude comments to or about target in private
Constant criticism of target
Poisons workplace with angry outbursts

This purposeful and willful destruction of another human being; consciously or unconsciously, deliberately or accidentally, is "now considered a major public health issue" (Burgess et al., 2006, p. 1). The International Labour Organization (ILO) recognizes emotional abuse as *psychological violence,* identifying bullying and mobbing as the two main forms of this violence (Denenberg & Braverman, 2001). Further, the ILO "gives equal emphasis to physical and psychological behaviour, and …full recognition to the significance of minor acts of violence" (p. 7). The process may continue even after the target leaves the organization. For example, the offenders may continue negative rumors about the target amongst other organizations with which the target may seek employment. This assists the offender(s) in maintaining their position of "rightness" (Davenport et al., 2002) and power over the target.

Bullying and mobbing silence and marginalize targets as perpetrators seek to prevent targets and witnesses from engaging fully in their work, thereby denying them both supportive relationships and their individual identities. The bully decides to target an individual he or she finds threatening. This often involves targeting the "best employees-- those who are highly-skilled, intelligent, creative, ethical, able to work well with others, and independent (who refuse to be subservient or controlled by others)" (McCord & Richardson, 2001, p. 2). The targeted individual is ignored, isolated, excluded, and cut out of the communication loop (McCord & Richardson), with their livelihood and health--physical and mental--threatened (Namie & Namie, 2003). If the bully is in a position of formal power, they may also threaten the target with job loss and exhibit inconsistency with rule compliance (Namie & Namie).

Because people are social beings who "evolved with a desire to *belong*, not to *compete*" (Clark, 1990, p. 39), they need to form relationships with others. Given that these social bonds "are a biologically, physiologically, and psychologically based human needs" (p. 46), the worksite is more than a job. As individuals seek relationships it becomes a social environment that is central to the quality of everyday life. Not only do people seek to form relationships through work environment, but also to meet their identity needs (See Galtung, 1990, for a discussion of human needs theory). Identity, social interaction, and basic human needs are intertwined (Staub, 2003). Organizational violence, manifested as bullying and mobbing, inhibits the ability of individuals to meet their basic human needs. When individuals are unable to attain their goals and meet their needs intrapersonal and interpersonal conflict creates stress for targets, witnesses, and the organizational structure (see further discussion in Fisher, 1990 and Galtung, 1996).

Target Characteristics

Mobbing and bullying cut across the organization with targets and offenders who can be peers, subordinates, and/or superiors. These behaviors can begin with the administration; they can also begin among the staff who target superiors and/or colleagues (Namie & Namie, 2009). Bullying and mobbing are individual and group behaviors employed to resist change in work and social norms. Those targeted are often people who threaten the organizational stasis; and, the most common characteristics identified as reasons for being targeted are refusing to be subservient (58%), superior competence and skill (56%), positive attitude and being liked (49%), and honesty (46%) (Namie & Namie).

Occupation, gender, race, and age are all related to the risk of being mobbed, though as yet the dynamics underlying these differences have not been studied. Workers in social occupations (e.g., social/health services and education) are at a 2.8 times greater than average risk of being bullied or mobbed (European Foundation, 2002). Younger workers (under age 25) and older workers (over age 55) are at greater risk of being targets (European Foundation).The European Foundation identified women as at 75% greater risk of being targets and the WBI identified women, African Americans, and Latino/as as facing higher risks of being mobbed (Namie & Namie, 2009). Women are more likely to be targeted, while men are more likely to be bullies. On the other hand, female mobbers and bullies are more likely to target women than men while men bully both women and men (Namie & Namie, 2009). Research, to date, has examined the prevalence, but not identified the reasons for the gender differences. Historically marginalized groups are at greater risk. This is not surprising given that mobbing behavior builds from and reinforces prejudice (Davenport et al., 2002).

Organizational Context

Organizations tolerate bullies in positions of power, in part, because a narrative is created in which the good leader possesses the characteristics of a bully. Many offenders are in leadership roles and in privileged positions where they can inflict pain on their targets. Namie and Namie (2009) stated that “most bullies are bosses” (p. 26). Others, however, are peers who leave their targets and others in turmoil and confusion. Even people in supervisory and management roles can be mobbed (Namie & Namie).

While those who are cooperative and collaborative are too often framed as weak (Namie & Namie, 2009), the person who leads through temper tantrums, critical aggressive demands, greed, insulting behavior, and dominance is framed as a skilled leader. One of the consequences is that both the individuals and the organizational structures conspire to protect the bully/mobber. Organizational architectures that facilitate bullying and mobbing perpetuate structural violence. The complexity deepens when the two phenomena are intertwined. Through the process of mobbing, the target becomes vulnerable in the organization. Individual bullies in positions of power then attack, isolate, and eliminate their targets.

One of the difficulties in identifying mobbing is the secretive nature of the behavior (McCord & Richardson, 2001). The offender is difficult to recognize and name because publicly they frequently appear to be helpful and cooperative employees (Lee & Brotheridge, 2006; McCord & Richardson). Working from their own insecurities and fear of inadequacy, these offenders engage in covert attacks against the best workers (McCord & Richardson). On an organizational level, there is speculation that the process of group scapegoating provides a tension release for the organization or organizational unit (Polya as cited in Westhues, 2003). Paradoxically, although the process can create tension within the organization, at the same time it relieves the pressure by focusing the stress and blame for the stress on the target. Those participating in the mobbing ingratiate themselves to those with perceived power by exhibiting a readiness to attack the target (Polya as cited in Westhues).

Organizational cultures that support a veneer of civility can inadvertently reinforce bullying and mobbing behavior. A lack of overt, appropriate conflict can point to an organization that deals with conflict in backhanded ways (Coser, 1967). Team relationships are destroyed as the offending behavior operates “surreptitiously under the guise of being civil and cooperative” (McCord & Richardson, 2001, p. 1). Avoidance of conflict and unpleasantness can suppress discussion of crucial issues. This avoidance interferes with processes that are necessary for the pursuit of a common purpose and community (Massy, Wilger, & Colbeck, 1994).

Organizational environments that support the development of healthy relationships are rooted in communication patterns that are fact based, open, and supportive of dialogue. On the other hand, mobbing and bullying breed within a culture based on inaccurate or inadequate memory; dishonesty; quick judgments and a judgmental attitude; crisis response without thought and process; and the need for staff to take sides (Namie & Namie, 2003). Sameha's[i] experience exhibits some of these factors.

> *Sameha worked at the Social Work Department at Hayden Hospital for fifteen years. Her annual evaluations were consistently positive. Recently, a supervisor and several new staff were hired amidst other changes at the hospital. Most of the new staff formed strong connections with the new supervisor, Connie. Although transitions such as this can be disruptive, Connie did not address the ensuing conflict amongst the staff. Some of the new social workers started ridiculing Sameha's ideas and suggestions. Sameha approached Connie, to discuss the difficulties. She did not feel like Connie listened and the meeting ended abruptly with Connie accusing Sameha of being inflexible with change. Connie told her to go back and make an effort to "get along."*
>
> *Sameha tried to change her behavior and spent several months reaching out to new staff. Peers who previously were supportive, tried to avoid Sameha. Over the next six months, Sameha became increasingly depressed and was frequently ill. Her absences and lack of enthusiasm were noted on her annual evaluation and she was put on probation. Sameha reached out to an upper administrator, Carlos, but was told that it was inappropriate for her to go around Connie. Sameha left the institution not long after that.*
>
> *Because she blamed herself, she did not return to work in the social work field. During the next year she heard from several of her peers who had been supportive before the transition but avoided her once she was targeted by the new staff. One by one, each became the target. They all eventually left the hospital.*

As exemplified, employers seldom examine and redress the wrongs perpetrated against the target of workplace mobbing (Leymann, 1987, as cited in Leymann, 1990; Namie & Namie, 2009; Westhues, 2003) and other forms of bullying (McCord & Richardson, 2001). Some of the organizational structures which support bullying and mobbing are poor management, denial of conflict, intensely stressful environment, unethical activities (Davenport et al., 2002), closed systems, and constricted, ineffective, secretive, incompetent, and indirect communication (Namie & Namie, 2003). Because the offenders are maintained and the system left in tact, in the vast majority of cases studied, the scapegoating and ostracizing continues as administrators and new employees are drawn into this workplace virus (Namie & Namie, 2009).

Consequences

The Target

The negative consequences of bullying and mobbing are greater and more common for the target than for the offender (European Foundation, 2002). While "bullies need targets to live; targets find it hard to live when bullies intrude in their lives" (p. 4). Targets experience isolation and shame; may lose their employment or have their employability negatively impacted; experience mental health and/or physical crises; and are at risk of suicide (European Foundation; McCord & Richardson, 2001) (see Table 2).

A large study of mobbing behavior in Germany (European Foundation) found that almost all (98.7%) of those targeted experienced employment and/or health consequences. Close to half (43.9%) became ill and 68.1% left their employment (includes 14.8% who were dismissed). The WBI found that 77% of targets changed employment (Namie & Namie, 2009). Dr. Heinz Leymann, who first identified this syndrome, estimated that workplace mobbing was responsible for 15% of suicides in Sweden (Leymann, 1990).

Table 2. Changes Experienced by Targets

- Poor concentration
- Insomnia
- Substance abuse
- Headaches
- Gastrointestinal disorders
- Depression
- Anxiety
- Exhaustion
- Suspicion
- Fear
- Forgetfulness
- Fatigue
- Failure to pay bills
- Crying
- Irritability
- Change in appearance

(Davenport, et al, 2002; European Foundation, 2002; McCord & Richardson, 2001)

The Offender

Offenders often face no consequences. The European Foundation (2002) found that only 19.3% (including the 8.2% dismissed) were required to change employment while the WBI found that only 23% of bullies were punished (Namie & Namie, 2009). Target isolation and sense of shame, along with the silencing of witnesses, help assure the permanence of the offender in the organization (Namie & Namie, 2009). Because the offenders are maintained and the system left intact, in the vast majority of cases studied, the scapegoating and ostracizing continues as administrators and new employees are infected by this workplace virus (Namie & Namie, 2009).

The Organization

The WBI found that only 1.7% of employers "conducted [a] fair investigation and protected [the] target from further bullying with negative consequences for the bully" (Namie & Namie, 2009, p. 315). The costs of this failure to respond with organizational change are significant (Davenport et al., 2002; Dunn, 2003). Mobbing and bullying are disruptive to ongoing operations and staff relations (see Table 3) while organizations suffer through the loss of their best employees. Among the consequences of not addressing these behaviors are increased staff demoralization and decreased productivity and creativity (McCord & Richardson, 2001).

Mobbing "destroys morale, erodes trust, cripples initiative, and results in dysfunction, absenteeism, resignations, guilt, anxiety, paranoia, negativity, and marginal production. Key players leave and the effects are long-lasting" (McCord & Richardson, p. 2). Leaders at all organizational levels need to ask: If targets did not start out as difficult employees, what happened? The answer is usually the presence of a toxic work environment that supports a culture of secrecy, rumor, and innuendo and the presence of a veneer that brushes over organizational violence.

Table 3. Organizational Costs

- Loss of best employees
- Demoralization of staff
- Resignations
- Unable to hire diverse staff
- Disruption of operations and staff relations
- Company reputation suffers
- Anxiety
- Decrease in productivity and creativity
- Increased absenteeism
- Loss of trust
- System stays in place when players change

Implications for Leadership and Intervention

Administrative response to mobbing and bullying incidents that resulted in an end to the destructive behavior involved quick action by various stakeholders (Westhues, 1998). Bullying, individual and group, can be controlled or eradicated by shifting the environment away from factors that support the offending behavior, and toward the creation of a culture of respect (McCord & Richardson, 2001) and empathy. An environment is created where negative social behaviors are no longer valued; and, the resources needed to remediate the health and employment consequences of bullying and mobbing are provided. Response starts with higher administration sensitizing and training individuals in leadership roles. The skillful employer purges bullies while poor one's promote them (Namie & Namie, 2003).

When a tear in the social fabric of an organization occurs, it is incumbent upon the leaders to take decisive action. Organizations, as places of contention and hostility, are destructive and unhealthy. The problem is not too much conflict; rather, it is the failure to manage conflict productively. Fruitful conflict is essential to organizational growth. Organizations that do not manage conflict effectively develop unhealthy structures that produce and support "evil" actors (Galtung, 1990, 1996). Bullies and mobbers exploit bad structures to their advantage, using them to support forms of othering and dehumanization. Power is gained through the intentional destruction of others with the means of destruction reified as *normal*.

There is no neutrality within the violent context that feeds bullying and mobbing. "Morally courageous people, as active bystanders, can make a crucial difference at important moments in many settings" (Staub, 2003, p. 5). Frank de Mink (2010) uses moral development framework to describe a *suspension of conscience* that allows management and other bystanders to support the process of violence. Bystander inaction signals to both the target and the bully/mobber that the behavior is acceptable (van Heugten, 2010).

Leadership Style

While laissez-faire leadership creates an environment that breeds mobbing, authoritarian leadership breeds bullying behavior. Just knowing the leadership style, however, is inadequate for understanding the dynamics that maintain mobbing and bullying cultures (Einarsen, 2010). In fact, leadership style cannot, by itself, explain the development and response of these behaviors (Einarsen). As Einarsen reports, current models do not supply the theoretical dimensions needed to support the assessment of leaders as both *good* and *bad*. Leadership models with the depth required for exploring this phenomenon include dimensions that evaluate leadership support for both organizational goals and the goals and interests of the individual.

In a workplace environment that is built on a narrative that values staff needs for identity, belonging, and social interaction, workers are humanized. Cooperation, compassion, empathy, and mutual aid are engendered and employees work together to meet mutual goals, becoming allies rather than threats. Instead of viewing each other as competitors for scarce resources, organizational members are seen as collaborators; and differences in work styles and skills are valued, not feared. Workplaces become sites of individual and organizational growth. Organizational members assist each other in achieving their individual and collective needs.

The Physical Space

Creating shared and sacred space where organizational members engage in humane discourse is an important requirement. The physical limitations of buildings can make the creation of sacred space challenging, but it must be done. Individuals need opportunities to bond with others and to create people-centered communities defined by trust and dignity. Establishing spaces where dialogue is encouraged underscores the importance of relationship and runs counter to the dehumanization of isolation. The development of a culture of respect is facilitated by frequent interactions, places for staff to gather, incorporation of difference as creative capital, energized debates, and effective leadership (Massy et al., 1994). Open communication, which breaks the culture of silence in which bullying behavior thrives, is imperative.

Communication, Change, and Decision Making

The culture of silence is disrupted through a process similar to that used to disrupt groupthink. A skilled facilitator, outside the system of abuse and also outside the management chain that supports bullying and mobbing dynamics, is necessary. The process of remediation requires open, free, blunt, honest, well-informed discussion by multiple constituencies (Westhues, 2003). The creation of "community is crucial in fulfilling needs for connection and identity" (p. 10), which shift the dynamics of interaction and bravery in facing dehumanizing behavior. The respect for energized debate and differing opinions are a sign of a healthy institution. Divergent thinking is encouraged in a safe, inviolable environment.

The development of processes for making decisions about when to invest and when to terminate, along with a plan that protects targets and organizational integrity, is essential to assuring the safety of other staff when employees with a history of offending behavior are retained. Confronting and disempowering offenders is necessary. The response of offenders to confrontation determines the next steps. Staff accidentally drawn into the process of bullying without understanding their role can be educated and supported in change. Those who deliberately employ psychological violence for power, due to personality problems, and/or poor sense of self require intensive intervention and monitoring. Negotiating with bullies is useless and inappropriate as it validates their unacceptable behavior.

Working with Individuals

On the individual level, intervention focuses on anyone who has been a target or witness of workplace bullying or mobbing; and, on the administrators and staff who have responsibility for intervening. Public support of the target through multi-level recognition of her/his accomplishments, competence, innocence, and value to the organization, starts the creation of a healing environment. It is essential to help those who have lived through bullying and mobbing to reframe their experience. Individuals can come to view themselves as survivors of a violent assault. As a survivor, one gains and maintains power and bullies and mobbers are denied power-over. In surviving, both targets and witnesses build resilience. Carmen's experience exemplified some of the key factors.

> *Carmen joined the Department of Human Services six months ago with an MSW and several years experience in child welfare. She is creative in contributing to conversations during staff meetings. Each time she speaks, however, several of the staff look at each other and roll their eyes. Frequently, she is cut-off in mid-sentence. Last week, she heard rumors about herself that have no basis in truth. Because her immediate supervisor, David, supports the staff who started the rumor and is part of the group which interrupts her, she decided to talk with his supervisor, Sandra.*
>
> *Sandra listened intently, indicating a sense of understanding, and a willingness to "believe" Carmen's perceptions and observations. Sandra said she would follow up and return to discuss her observations with Carmen. After spending time in the department--watching, listening, and asking questions, Sandra decided that there was a problem. Because she previously suspected that some of the better staff were being isolated and "pushed out," Sandra decided to address the issues both individually and systemically.*
>
> *Sandra worked with Carmen to build a system of support. Sandra also spoke to David. He steadfastly blamed all of the problems on Carmen saying "she is the kind of person who draws this on herself."*

Because of his response, Sandra moved David out of the department and back into a line staff position with a strong supervisor. She decided to provide him with an opportunity to recognize and change his behavior so that he could stay with the agency. She did not, however, want him in a role with supervisory responsibility over Carmen.

Sandra informed the staff that she would be bringing in one of the agency's strongest supervisors. She also informed them that she and the new supervisor would be meeting with each of them individually for their annual reviews. A review in six months showed significant change in individual interactions and employee satisfaction with their jobs.

After listening and observing, the supervisor took decisive action. It is a leader's responsibility to assist organizational members in reweaving the social tapestry. Deliberate, positive communication that engages reasoned and coordinated cooperation supports group processes that set aside the strict and sole focus on the individual and refocuses to also center collective interests (Habermas, 1984), strategies that decrease the dehumanizing effects of bullying and mobbing. Genuine dialogue *re*-humanizes targets and witnesses, and structural and direct violence are reduced. The process of re-humanizing targets contributes to the peaceful transformation of conflict and reconciliation of the disputants' relationship.

While 96% of bullying incidents are witnessed, for many reasons the witnesses (bystanders) do not come to the aid of the target (Namie & Namie, 2003). Van Heugten (2010) found that the relationships between targets, witnesses, and bystanders are complex with the vast majority of bystanders remaining passive. Activating bystanders shifts the message and has the potential to create change agents (van Heugten). There are many ways co-workers, friends, and family can assist a target. First, targets need someone to listen, uncritically and empathically to their stories of the bullying and the impact it has on them. Co-workers can be helped to interrupt and neutralize the bullying/mobbing by refusing to allow the target to be isolated or defamed and by confronting the bully regarding their behavior. Witnesses to the bullying or mobbing can offer to document the incident in writing, providing a copy to the target.

By becoming an ally the potential for isolation is immediately decreased. Persons become open witnesses to the experience and set a model for other faculty/staff as they talk with peers, those who are not participating in the bullying or mobbing intentionally, about joining as allies with the target(s). They can also confront or dislodge bully behavior when it occurs. One way to begin this process is to refuse to hold secrets or carry rumors. Finally, witnesses can impact the system by talking collectively with an administrator or supervisor.

To help relieve tension, organizations can develop cultures in which individuals can safely address work issues with others. By changing behavior and patterns of interaction, witnesses can be empowered to shift the organization's communication style. Communication policies need to be two-fold. On the one hand, policies that support leaders and managers in refusing to speak about another member of the organization in that member's absence break links of secrecy. Individuals are then provided an opportunity to engage in discussions that have them as the subject. Sharing information prevents rumors from developing and communication from taking on a hostile form. On the other hand, structures that support the reporting of targeting behavior cannot be blocked by rigid rules of hierarchy that interfere with open communication about abusive conduct.

Summary

Bullying and mobbing behaviors are widespread in organizations, particularly social service, health, and educational organizations. The negative consequences are apparent in our communities and organizations. Because bullying and mobbing dynamics both thrive in a dehumanizing, competitive environment, remediation of either or both and the establishment of an environment intolerant to these behaviors involves the same basic components. Organizational environments that work counter to these behaviors are respectful, empathetic, productive in managing conflict, provide spaces for interaction and dialogue, encourage open communication, celebrate and welcome difference, are intolerant of targeting, and create spaces for informal interaction.

The consequences for targets of organizational violence often result in physical, psychological, and emotional injury. Common mental health consequences include post-traumatic stress, low self-esteem, damage to self-confidence, anxiety and depression, poor concentration, exhaustion, and insomnia. Physical consequences include gastrointestinal disorders, headaches, and substance abuse. Witnesses of workplace violence suffer as well and organizations experience a lowering of staff moral, increased absenteeism, and decreased creativity. Effective response supports the target as she/he comes to understand the phenomena to which she/he has been subjected. It is important for the target to recognize that they are not at fault and to reconnect with her/his sense of self—not the distorted perspective the bully has been trying to get others to adopt. Educating the target about the options available (including the legal ones) and identifying the necessity and availability of support can be empowering. It is rare that a target confronts a bully, but it can be effective to simply tell the offender that the behavior will not be tolerated.

In a mobbing situation, only response from higher administrators is likely to resolve the structural and therefore ongoing problems; rarely, however, do administrators take steps on behalf of the target and the witnesses who are also traumatized.Supervisors and administrators educated about mobbing and bullying, and the importance of focusing on both organizational and individual needs, have a broader lens through which they can monitor the work-life climate of the organization. The heightened awareness gained by leaders and administrators can then be integrated into the implementation of traditional management strategies, such as walking around, observing, listening, talking, and asking questions.

While administrative leadership is needed to remediate the impact of bullying and mobbing on the organization and the individuals, our knowledge of the significant leadership dimensions is limited. New research (Einarsen, 2010) identifies additional dimensions that add depth to the assessment of leadership effectiveness beyond examining leadership style. These include a dual commitment to the health and development of both the individual and the organization. Evaluating the phenomenon of bullying and mobbing at the intersection of leadership style and the dual commitment to the individual and the organization offers promise for increasing the effectiveness of prevention, intervention, and remediation.

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[1] Sameha and Carmen are pseudonyms based on composites of female social workers who have been targets of bullying/mobbing. These women shared their stories with the authors following presentations on the topic of workplace mobbing and bullying.. . . . . .

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EDITORIAL

Clinical peer review in the United States: History, legal development and subsequent abuse

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Abstract

The Joint Commission on Accreditation requires hospitals to conduct peer review to retain accreditation. Despite the intended purpose of improving quality medical care, the peer review process has suffered several setbacks throughout its tenure. In the 1980s, abuse of peer review for personal economic interest led to a highly publicized multimillion-dollar verdict by the United States Supreme Court against the perpetrating physicians and hospital. The verdict led to decreased physician participation for fear of possible litigation. Believing that peer review was critical to quality medical care, Congress subsequently enacted the Health Care Quality Improvement Act (HCQIA) granting comprehensive legal immunity for peer reviewers to increase participation. While serving its intended goal, HCQIA has also granted peer reviewers significant immunity likely emboldening abuses resulting in Sham Peer Reviews. While legal reform of HCQIA is necessary to reduce sham peer reviews, further measures including the need for standardization of the peer review process alongside external organizational monitoring are critical to improving peer review and reducing the prevalence of sham peer reviews.

Key words: Peer review; Medical malpractice; Healthcare

Core tip: This article will highlight progress and drawbacks of the current clinician's peer review system prevailing in the United States.

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INTRODUCTION

In 1952 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began requiring physician peer review at all United States hospitals[1]. However, economic abuse of the review process and a subsequent court ruling in 1986 lead many physicians to fear the possible consequences in participating in peer reviews[2]. In order to legislatively solidify the role of peer review as a means of physician quality improvement across the United States, Congress enacted the Health Care Quality Improvement Act (HCQIA) in 1986[2,3]. Despite its intended role of physician quality improvement, HCQIA has unintentionally led to significant abuse of the peer review system across the United States[4] This review focuses on the history and legal development of physician peer review in the United States, and addresses subsequent abuses resulting in what is known today as "Sham Peer Review".

What is peer review?

Peer review is the process whereby doctors evaluate the

quality of their colleagues' work in order to ensure that prevailing standards of care are being met[5]. The process has its roots dating back to the early 20th century when the American College of Surgeons began using peer review as a means of defining minimum standard of care requirements for hospitals and their medical staff[6,7]. Today, the majority of peer review conducted in the United States occurs exclusively through retrospective chart review *via* peer review committees. The ultimate decision making authority however often lies with the hospital board of directors, often which follows the recommendations of the review committees[8]. The process has continued to grow in the 20th century and is now required by the JCAHO for hospital accreditation[9].

Currently, there are three main reasons peer reviews are conducted throughout the United States. First, in order to maintain accreditation, hospitals are required to initiate peer reviews for all privileges requested for new physicians and any new requests by existing physicians for new privileges[9,10]. Second, while initiation of peer reviews can often be triggered by substandard physician performance as required by JCAHO, physician colleague and hospital administrators can often request peer reviews of specific physicians that can be granted or denied by the hospital's peer review committee[4,10-12]. Finally, some hospitals have used peer review to improve quality by randomly selecting cases or designing schemes looking at poor outcome cases in order to determine root causes[8]. Nonetheless, despite being mandated by JCAHO, the manner in which peer reviews are conducted, analyzed, and utilized varies widely across institutions[8].

History of peer review

Physician regulation was strongly opposed by both the public and physicians in the early 19th century[10]. Despite the opposition, governmental and medical societies saw a critical need for the standardization of care in order to protect both the public and the medical profession. In turn, State Medical Licensure Boards were created in the late 19th century with an emphasis on creating peer review systems to monitor physician behavior[10]. However, both the American Medical Association and the United States Department of Health and Human Services saw that efforts by these organizations did not meet standardized criteria for improving care and enforcing disciplinary action[11,12]. This deficiency was attributed mainly to physician unwillingness to conduct peer reviews[13].

To further exacerbate these concerns, disciplinary action handed down by either hospitals or State Medical Licensure committees was often circumvented by "State Hoppers", or, physicians who avoided disciplining actions by moving to another state or hospital which were not aware of their previous disciplinary action[3,13]. In response, States developed a national data bank of disciplinary action to stop such actions. Unfortunately, the data bank was often found to be ineffective[13].

Patrick vs Burget

The peer review process further suffered a major blow in 1986 when Dr. Timothy Patrick, a general and vascular surgeon, sued Columbia Memorial Hospital (CMH) after being unfairly subjected to a bad faith peer review for economic reasons[14]. Upon starting practice in the small town of Astoria, Oregon, Dr. Patrick joined a group of established surgeons at the Astoria Clinic. After several years of employment Patrick was offered partnership at the clinic which he later refused in order to open his own, competing surgical practice in the same geographic area. In retaliation, Patrick's former colleagues at the Astoria Clinic reported Patrick to the hospital executive committee at CMH for peer review. The charges levied claimed that Patrick exhibited irresponsible behavior towards patient care. An executive peer review committee was formed and was chaired by Dr. Gary Boeling, a partner of the Astoria Clinic. After an investigation was conducted and subsequent false evidence concerning Patrick's care was presented, the committee voted to terminate Patrick's privileges at CMH. Fearing termination, Patrick instead chose to resign[14].

A subsequent federal antitrust lawsuit filed by Patrick against partners of the Astoria Clinic, including Dr. William Burget, claimed that the defendants participated in a bad faith peer review in order to stifle competition. The United States Supreme court which later ruled in Patrick's favor awarded the plaintiff $2.2 million and further disbanded the Astoria Clinic based on the clinic's violation of the Sherman Antitrust Act[14,15].

Following the Patrick verdict many physicians became hesitant to participate in peer review activities as they feared possible involvement in future litigation. More concerning at the time was that malpractice lawsuits were at an all-time high during the same period. Viewing peer review as a critical means of decreasing the number of malpractice claims, then Rep. Ron Wyden (now Senator), brought forth legislation known as the HCQIA to expand reviewer immunity in order to encourage physician participation in the process[16].

HCQIA and the national data bank

Five reasons were explicitly stated by congress for the enactment of HCQIA (Table 1). HCQIA consists of two parts. Part A of the law grants hospitals and reviewers immunity from litigation resulting from physicians aggrieved by the process. In order to qualify for this immunity however, congress set four minimum requirements that must be met when conducting peer reviews (Table 2)[17]. Part B of the law tackled the issue of "state hoppers" by creating the National Practitioner Data Bank (NPDB). The NPDB was created to serve as a centralized repository given the authority to collect and release information relating to the competence and professionalism of physicians. Currently, in order to gain clinical privileges at hospitals, all practitioners are required by law to be screened through the NPDB[18]. The NPDB receives three types of reports: adverse actions, malpractice payments, and Medicare/Medicaid exclusion reports. Table 3 further quantifies the types of reports in the NPDB. The NPDB can only be ac-

Table 1 Congressional reasons for law enactment

The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state
There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance
This nationwide problem can be remedied through effective professional peer review
The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review
There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review

Table 2 Part A Health Care Quality Improvement Act peer review immunity requirements

Peer review action is taken:
In the reasonable belief that the action was in furtherance of quality of care
After a reasonable effort to obtain the facts of the matter
After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances
In the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts

Table 3 Causes of reports to the National Practitioner Data Bank (Satiani 2004)

Adverse actions (17%)
Peer review findings adversely affect the clinical privileges of physicians or dentist for more than 30 d
Privileges are restricted or surrendered while under peer review investigation for possible incompetence or improper professional conduct
Privileges are restricted or surrendered in exchanged for peer reviewers not conducting an investigation
Physician's or Dentists' license are revoked, suspended, or surrendered
Physicians or Dentists are censured, reprimanded, or put on probation
Malpractice payments (82%)
Insurers settling claims or judgments relating medical malpractice on behalf of physicians
Medicare/medicaid exclusion reports (1%)

Percentage refers to proportion of reports attributable to 132896 physicians in the National Practitioner Data Bank in 2002.

cessed by third parties directly involved in physician regulation including hospitals, state medical boards, and professional societies[19]. Despite repeated efforts by public consumer groups to access the NPDB however, congress has kept the database confidential and closed to consumer review[18,20].

SHAM PEER REVIEW

Sham peer review is characterized as a review called for by either a single, or group of physicians, conducted in order to lead to adverse action taken by the review committee[21]. Prior to HCQIA, such bad faith cases could often be fought in court as in the Patrick case. However, the extraordinary levels of immunity granted to hospitals and peer reviewers under HCQIA have inhibited such successful endeavors. Currently the prevalence of such cases in the medical community is undefined due the dearth of published literature on the subject[21,22]. As an estimate however, thirty three lawsuits were brought to United States courts claiming sham peer review between 2003-2007[23]. Further estimates put the number of sham peer reviews occurring at upwards of 10% of cases reviewed[24].

Legislative history of HCQIA

In the process of drafting HCQIA, the Patrick *vs* Burget ruling was delivered by the Supreme Court and many members of congress saw further need to protect peer reviewers. However, congress was simultaneously well aware of the real potential for abuse the law had. In turn, original immunity provisions granted by the HCQIA were specifically scaled back in order to avoid misinterpretation of the law[25]. In fact, Rep. Henry Waxman, floor manager of the bill at the time, stated that "Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540"[26]. Nevertheless, since its initiation in 1986, the congressionally written HCQIA has been transformed from a law granting hospitals and peer reviewers limited immunity provisions into a law that today grants nearly absolute immunity by the courts[26].

HCQIA immunity and the courts

In one example of claimed peer review abuse, Dr. Susan Meyer, an emergency room physician at Sunrise Hospital, was required to undergo review after her treatment of Adolph Anguiano, a homeless patient who two hours after being seen by her in the ER, died in the parking lot of Sunrise Hospital[27]. Upon entering the ER, Meyer performed a full physical exam, took vital signs, measured oxygenation levels of Mr. Anguiano and subsequently determined the patient did not require any acute medical care and later discharged the patient from the

ER. Upon discovering that Mr. Anguiano had died, Dr. Graham Wilson, Chair of the Department of Emergency Services advised Dr. Meyer to finish her shift in the ER and subsequently informed her that she was being suspended due to her substandard care. She was advised to obtain legal counsel in order to undergo a fair hearing process.

Meyer, who later lost an appeal of her case in the Nevada Supreme Court, was later informed by Dr. Rick Kilburn, the Chief Operating Officer of Sunrise Hospital, that she would be suspended regardless of the result of her peer review hearing. Despite knowing the final result beforehand, Meyer requested a formal peer review by the hospital in order to have her clinical judgment assessed by her colleagues. Despite several Emergency room physicians testifying that Meyer's treatment was "well within the standard of care", the review committee found otherwise and recommended her suspension. The recommendation was reaffirmed by the Appellate Review Committee of the hospital.

Meyer in turn filed a civil action lawsuit against Columbia Sunrise hospital alleging a breach of contract and breach of the covenant of good faith and fair dealing. The hospital, claiming immunity under HCQIA in turn succeeded in dismissing the case in district court. The case was met with the same decision at the Nevada Supreme Court. However, the Justices gave a rare glimpse into the reason for Meyer's loss and the extent of the powerful immunity granted to hospitals and peer reviewers in their concluding summary statement.

I must concur in the result reached in the majority opinion because HCQIA sets such a low threshold for granting immunity to a hospital's so-called peer review. Basically, as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, whether legitimate or not, they are immune from liability. Unfortunately, this may leave the hospitals and review board members free to abuse the process for their own purposes without regard to quality medical care.... Unfortunately, the immunity provisions of HCQIA sometimes can be used, not to improve the quality of medical care, but to leave a doctor who is unfairly treated without any viable remedy [emphasis added][27].

In a second, similar sham review case, Dr. Carol Bender, an internist, brought a lawsuit against the Maryland Suburban Hospital to the Maryland Special Court of Appeals for a breach of contract and early termination alongside defamation *via* the peer review process[28]. The court ruled against Bender despite having "legitimate gripe (with the hospital)" stating that the hospital was granted immunity under HCQIA despite how "reprehensible some of [the peer reviewers] actions may have been" [28]. In another example of Jenkins v. Methodist Hospital of Dallas, United States District Court of the Northern District of Texas, held that the court was troubled that a statue exist under HCQIA granting immunity to individuals that are knowingly providing false information to the courts[29].

Characteristics of sham peer review

Two types of physicians are targeted in sham peer review. The first are often competitors to an often larger, more powerful physician group[21,22]. The second are often outspoken critics of patient quality of care or safety issues seen as whistleblowers by hospital leadership[21,22]. William Parmley, currently the immediate past Editor-in-Chief of the Journal of the American College of Cardiology, has recently characterized three sham peer review cases he has recently been presented with[21]. The cases describe either solo practitioners or practitioners working in small groups at private hospitals. Their accusers are often large groups that appear to be moving against them using peer review in order to stifle competition. The accusers often have positions on the executive hospital board or, are deeply connected to the board. In one case, Parmley describes a situation where an external peer review committee was hired by the hospital to give a bad faith review. The result was the loss of hospital privileges for two of three physicians and in turn their forced relocation. The third physician was cleared of any wrongdoing at the expense of severe financial loss. Parmley further describes these scenarios as being "far more common than is appreciated" [21].

NPDB reporting

Hospitals are mandated by law to query practitioner's request of clinical privileges, or admission to the medical staff and re-queries are required every 2 years for any clinician on staff[30,31]. Moreover, hospitals are required to report any adverse actions to the NPDB (Table 3)[31]. Sham peer reviews rely heavily on the fear of physicians being reported to the NPDB[4]. Physicians reported to the NPDB face significant hurdles when seeking employment, licensure, and credentialing[4]. Physicians are often questioned about all previous reports to the NPBD prior to receiving any hospital credentialing activities[4,31]. Furthermore, HMOs and insurance carriers are increasingly using the NPDB when choosing physicians to be covered under provider panels[4]. Single transgressions in the NPDB or loss of medical privileges can often result in further negative consequences as physicians become progressively dropped from these provider panels[4,32].

Consequences of sham peer review

In light of the immunity granted to peer reviewers and hospitals, many physicians find themselves victims of sham peer review without any timely legal recourse. Consequently, upon seeing the signs of an impending sham peer review, wrongly accused physicians will choose one of two dire possibilities. On one hand, practically all peer reviews meet the "reasonable belief" provision of HCQIA and in turn qualify for near absolute immunity. Moreover, proving malicious intent to the courts is almost practically impossible[23]. Despite the odds, some physicians will choose to fight sham peer reviews in court often at substantial financial and reputational cost, mental stress, and time[27-29,33,34]. On the other hand, as previously

stated, physicians acknowledge that being reported to the NPDB can negatively affect future employment and reputation. In this situation, many physicians will often instead decide to resign from their hospitals or retract statements seen as unfavorable by hospital executives in exchange for early termination of the investigation and subsequent failure to report to the NPDB.

Hospitals are required by law to report situation in where physicians resign in the midst of a peer review investigation[31,35]. Nevertheless, several studies have shown that there is significant evidence of hospital underreporting to the NPDB every year[9,36-38]. Furthermore, a five year study looking at hospital reporting to the NPDB showed that 67% of hospitals did not report a single adverse event to the NPDB[39]. Another study showed that 75% of potentially reportable actions and 60% of unquestionable reportable actions were not reported to the NPDB by their respective hospitals. While ambiguous, such significant underreporting can likely account for such an arrangement.

FUTURE DIRECTION

Evidently legal immunity is necessary to protect hospitals and physicians conducting good faith peer review as not every review of a physician is unwarranted, abusive or malicious. These peer reviews serve to protect the public and the medical profession from poorly behaved, unethical, or incompetent physicians. However, such absolute immunity undear HCQIA has evidently weakened the process and lead to significant abuse. In the case of Dr. Timothy Patrick, a direct competitor was able to chair the peer review committee and was able to maliciously affect the peer review outcome in order to gain economic advantage. In order to change this paradigm, a multifaceted approach must be employed focusing on standardization, external peer reviews and finally legislative reform.

Standardization of peer review

Lack of standardization of the peer review process at the majority of hospitals leaves the door open for abuse. Today, only 62% of hospitals consider their review process to be either highly, or greatly, standardized[9]. The variation in structure in turn leaves two variants of peer review systems in place at most hospitals. The first is a highly standardized process involving several committees, revolving peer reviewers, and finally objective measures of quality assessment. The second is an unstandardized review process that can be significantly prone to exploitation due to the complete subjective nature of such committees.

Moreover, studies have shown that peer reviews are often unreliable measures of quality and have not served their intended role in quality improvement[6,40]. Standardization of the review process stands to benefit from both significant quality improvement and likely decreased abuse of the process to allow for sham peer reviews[41]. However, national standardization efforts of peer review remains difficult as the process is both costly and requires significant resources. Nevertheless, several models implemented at both large and small United States hospitals have shown that standardization and structuring of the review process can significantly improve medical care[42-48].

External peer reviews

Recognizing the concerns peer review has placed on hospitals and physicians, recent JCAHO reforms of the Medical Staff Standards for hospitals were released in 2007. These changes require mechanisms allowing for fair hearings and appeal process in decisions adversely affecting medical staff members[49]. However, it is unclear how much these reforms have contributed to mitigating sham peer review. Furthermore, while hospitals are required to implement such reforms, these standards still do not provide for independent peer review or oversight of the review process to ensure proper implementation. One approach to solving this issue is the creation of a second layer of protection involving external peer reviewers to verify that actions are taken in compliance with HCQIA and JCAHO requirements. Another suggested approach requires the use of Quality Improvement Organizations (QIOs) to independently review and supervise peer reviews conducted across United States hospitals. QIOs are physician operated organizations contracted by the Centers for Medicare and Medicaid Services in order to conduct reviews and further improve quality of services provided to Medicare beneficiaries in all 50 states[50]. These QIOs are currently accustomed to dealing with quality across United States hospitals and could be primed to serve as important, external supervisors of the peer review process.

Legislative reform of HCQIA

Despite countless physician lawsuits against sham peer reviews reaching high level United States federal courts, the United States Supreme Court has continually denied to preside over such appeals in order to rule certiorari over the legality of HCQIA immunity[51-54]. Considering the extent of immunity granted, several legal commentators have argued that these antitrust immunities should be repealed[40,41,55,56]. Nonetheless, considering the firm position for immunity in the medical community and congress, this is unlikely. In turn, several measures can be taken to ensure peer review fairness *via* HCQIA reform rather than repeal[23]. While these recommended reforms have been described in extensive detail elsewhere, we will provide a short overview here[23].

First, due process requirements under HCQIA are inadequate and must be reformed in order to inhibit partial or biased reviewers from passing judgments on physicians. Second, the "reasonable belief" standard under HCQIA is virtually impossible to challenge in court and often place a significant burden on the targeted physicians to overcome. In turn, Congress or the Department of Health and Human Services needs to narrowly clarify what is meant by "reasonable belief" in order to qualify for HCQIA immunity. Third, legislation reform should

effectively mandate umbrella oversight by outside institutions in order to ensure fair, evidence-based, and appropriately motivated peer reviews are conducted[23]. Lastly, if congressional reform unlikely, advocacy at the state level, which cannot be preempted by HCQIA, should be sought to further protection against Sham peer reviews[26].

CONCLUSION

Peer review serves to discipline incompetent or unethical physicians in order to protect the public. Immunity granted under HCQIA serves to protect hospitals and peer reviewers from litigations from appropriately sanctioned physicians. Unfortunately, HCQIA extends these immunities to sham peer reviews. In the hypercompetitive and highly political United States medical system, this immunity has been abused and has led to the devastating destruction of many physicians careers. Considering Congressional and Judicial forbearance on this crisis, significant leadership by physicians, professional societies, and hospital administrators is needed in order to remedy the faults of peer review. Furthermore, there is considerably need to study the precise prevalence of sham peer review across the United States Moreover, further research is needed to show if the recent JCAHO reforms have decreased the prevalence of such cases. Lastly, further research is needed in order to determine the cause of NPDB underreporting of adverse events.

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Mandatory reports of concerns about the health, performance and conduct of health practitioners

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Abstract

Objective: To describe the frequency and characteristics of mandatory reports about the health, competence and conduct of registered health practitioners in Australia.

Design and setting: Retrospective review and multivariate analysis of allegations of "notifiable conduct" involving health practitioners received by the Australian Health Practitioner Regulation Agency (AHPRA) between 1 November 2011 and 31 December 2012.

Main outcome measures: Statutory grounds for reports, types of behaviour reported, and incidence of notifications by profession, sex, age, jurisdiction and geographic area.

Results: Of 819 mandatory notifications made during the study period, 501 (62%) related to perceived departures from accepted professional standards, mostly standards of clinical care. Nurses and doctors dominated notifications: 89% (727/819) involved a doctor or nurse in the role of notifier and/or respondent. Health professionals other than the respondents' treating practitioners made 46% of notifications (335/731), and the profession of the notifier and respondent was the same in 80% of cases (557/697). Employers made 46% of notifications (333/731). Psychologists had the highest rate of notifications, followed by medical practitioners, and then nurses and midwives (47, 41 and 40 reports per 10 000 practitioners per year, respectively). Incidence of notifications against men was more than two-and-a-half times that for women (46 v 17 reports per 10 000 practitioners per year; $P < 0.001$) and there was fivefold variation in incidence across states and territories.

Conclusions: Although Australia's mandatory reporting regime is in its infancy, our data suggest that some of the adverse effects and manifest benefits forecast by critics and supporters, respectively, have not materialised. Further research should explore the variation in notification rates observed, evaluate the outcomes of reports, and test the effects of the mandatory reporting law on whistleblowing and help-seeking behaviour.

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Health practitioners are often well placed to identify colleagues who pose risks to patients, but they have traditionally been reluctant to do so.[1-4] Since 2010, laws in all Australian states and territories require health practitioners to report all "notifiable conduct" that comes to their attention to the Australian Health Practitioner Regulation Agency (AHPRA).

Legal regimes in other countries, including New Zealand,[5] the United States[3,6] and Canada,[7] mandate reports about impaired peers in certain circumstances. However, Australia's mandatory reporting law is unusually far-reaching. It applies to peers and treating practitioners, as well as employers and education providers, across 14 health professions. Notifiable conduct is defined broadly to cover practising while intoxicated, sexual misconduct, or placing the public at risk through impairment or a departure from accepted standards. Key elements of the law are shown in Box 1.

Mandatory reporting has sparked controversy and debate among clinicians, professional bodies and patient safety advocates. Supporters believe that it facilitates the identification of dangerous practitioners, communicates a clear message that patient safety comes first,[8] encourages employers and clinicians to address poor performance, and improves surveillance of threats to patient safety. Critics charge that mandatory reporting fosters a culture of fear,[9] deters help-seeking,[10] and fuels professional rivalries and vexatious reporting.[11,12] Concerns have also been raised about the subjectivity of reporting criteria.[13] The Australian Medical Association opposed the introduction of the mandatory reporting regime for medical practitioners, citing several of these objections.[14]

Little evidence is available to evaluate the veracity of these different views. We sought to provide baseline information on how the regime is working by analysing an early sample of mandatory notifications. Specifically, we aimed to determine how frequently notifications are made, by and against which types of practitioners, and about what types of behaviour.

Methods

We conducted a retrospective review and multivariate analysis of all allegations of notifiable conduct involving health practitioners received by AHPRA between 1 November 2011 and 31 December 2012. The Human Research Ethics Committee at the University of Melbourne approved the study.

Data sources

We obtained data from two AHPRA sources: mandatory notification forms and the national register of health practitioners.

AHPRA receives notifications on a prescribed form. Notifiers may access the form on AHPRA's website or by calling a notifications officer on a toll-free number. Two of us (MMB, DMS) helped AHPRA develop the form in 2011. It includes over 40 data fields; most fields have closed-ended categorical responses, but there is also space for free-text descriptions of concerns. Notifiers may append supporting documentation such as medical records and witness statements.

We obtained PDF copies of all notification forms received in five states and two territories between 1 November 2011 and 31 December 2012. Reports from New South Wales were not included. Although health practitioners in NSW are subject to the same reporting requirements as those in other states, AHPRA has a

1 Elements of mandatory reporting law for health practitioners in Australia

Who can be subject to a report?
All registered health practitioners in Australia (doctors, nurses, dentists and practitioners from 11 allied health professions)*

Who has an obligation to report?
Employers, education providers and health practitioners†

What types of conduct trigger the duty to report?
The practitioner: (a) practised the profession while intoxicated by alcohol or drugs, (b) engaged in sexual misconduct in connection with the practice of the profession, (c) placed the public at risk of substantial harm in the practice of the profession because of an impairment, or (d) placed the public at risk of harm by practising in a way that constitutes a significant departure from accepted professional standards

What is the threshold for reporting?
Reasonable belief that notifiable conduct has occurred

What protections are available to the notifier?
A reporter who makes a notification in good faith is not liable civilly, criminally, in defamation or under an administrative process for giving the information

What are the penalties for failing to report?
Individuals may be subject to health, conduct or performance action; employers may be subject to a report to the Minister for Health, a health complaints entity, licensing authority and/or other appropriate entity; education providers may be publicly named by the Australian Health Practitioner Regulation Agency (AHPRA)

* Registered students are subject to mandatory reporting if they place the public at risk of substantial harm because of an impairment, or are subject to certain criminal charges or convictions. † Health practitioners are exempt from the obligation to report if they reasonably believe that AHPRA has already been notified of the conduct, or if they become aware of the conduct in the course of legal proceedings, professional indemnity insurance advice or approved quality assurance activities. Treating practitioners are exempt from the obligation to report in Western Australia only. ◆

2 Statutory grounds for notification and types of concerns at issue (*n* = 811)*

Statutory ground and type of concern	No. (%)	Example of alleged behaviour
Departure from standards	501 (62%)	
Clinical care	336 (41%)	An optometrist failed to refer a child with constant esotropia to an ophthalmologist for 2 years, resulting in permanent visual impairment
Professional conduct	107 (13%)	A director of nursing engaged in bullying and intimidation, including rude and abusive outbursts towards nurses
Breach of scope or conditions	50 (6%)	An occupational therapist with conditional registration did not comply with a requirement that she work under supervision
Impairment	140 (17%)	
Mental health	75 (9%)	A nurse with a history of bipolar disorder began to behave erratically and engaged in loud confrontations with patients
Cognitive or physical health	31 (4%)	A midwife suffered a head injury in a car accident and subsequently experienced cognitive deficits, including difficulty with maths calculations
Substance misuse	25 (3%)	An anaesthetist self-prescribed medication for anxiety and insomnia and developed a benzodiazepine dependency
Intoxication	103 (13%)	
Drugs	61 (8%)	A nurse working in a hospital had an altered level of consciousness; empty morphine ampoules and syringes were found in her pocket
Alcohol	42 (5%)	A surgeon was noted to smell of alcohol and to have slow reactions during surgery; a breath alcohol test was used to confirm that he was intoxicated
Sexual misconduct	67 (8%)	
Sexual relationship between practitioner and patient	31 (4%)	A psychologist began a personal relationship with her patient after the breakdown of his marriage and asked him to move in with her
Sexual contact or offence	28 (3%)	A male nurse in an aged care facility sexually assaulted an elderly female patient who was immobile after a stroke
Sexual comments or gestures	8 (1%)	A pharmacist asked a patient to lunch and when she refused he posted sexual comments and pornographic images on her Facebook page

* Statutory grounds were unknown for eight cases. Type of concern was missing for a further eight reports relating to departure from standards and nine relating to impairment. ◆

more limited role in relation to notifications made in NSW: when AHPRA receives such notifications, they are referred to the NSW Health Care Complaints Commission to be handled as complaints. AHPRA cannot log and track these notifications in the same way as it can notifications arising in other jurisdictions.

Data collection

We collected data onsite at AHPRA's headquarters in Melbourne from April 2013 to June 2013. Three reviewers were trained in the layout and content of the notification forms, the variables of interest, methods for searching the health practitioner register, and confidentiality procedures. For each form lodged during the study period, the reviewers extracted variables describing the statutory grounds for notification, type of concern at issue, and characteristics of the practitioner who made the notification ("notifier") and the reported practitioner ("respondent"). We also coded a variable classifying the relationship of the notifier to the respondent (treating practitioner, fellow practitioner, employer, education provider). Practitioner-level variables extracted from the notification forms were cross-checked with information recorded on the register.

One of AHPRA's core functions is to maintain a national register of licensed health practitioners. To enable calculations of notification rates, AHPRA provided a de-identified practitioner-level extract of the register as at 1 June 2013. The extract consisted of variables indicating practitioners' sex, age and profession, and the postcode and state or territory of their registered practice address. Practitioners from NSW and those with student registration were excluded to ensure that the register data matched the sample of notifications. Postcodes were converted to a practice location variable with three categories (major cities, inner and outer regional areas, and remote and very remote areas), based on the Australian Statistical Geography Standard.[15]

Analyses

We calculated counts and proportions for characteristics of notifications, notifiers and respondents. We also calculated frequency of notification according to the professions of the notifiers and respondents, respectively.

We used multivariable negative binomial regression to calculate

incidence of notifications by five respondent characteristics: profession, sex, age, state or territory, and practice location. Incidence measures reported for each characteristic were adjusted for the size of the underlying population and all other observed characteristics. Details of the calculation method and regression results are provided in Appendix (online at mja.com.au).

All analyses were done using Stata 13.1 (StataCorp).

Results

AHPRA received 850 mandatory notifications during the study period. After excluding notifications relating to nine practitioners from NSW and 22 students, our sample consisted of 819 notifications. The median time between the alleged behaviour and its notification to AHPRA was 18 days (interquartile range, 5 to 58 days).

Grounds and conduct

The distribution of notifications by statutory ground and type of concern, with examples, is shown in Box 2. This information was available for 811 of the 819 notifications. Sixty-two per cent were made on the grounds that the practitioner had placed the public at risk of harm through a significant departure from accepted professional standards; 17% alleged that the practitioner had an impairment that placed the public at risk of substantial harm (more than half of these related to mental health); 13% alleged that the respondent had practised while intoxicated; and 8% related to sexual misconduct (most commonly a sexual relationship between the practitioner and a patient).

Characteristics of notifiers and respondents

The characteristics of notifiers and respondents are shown in Box 3. Nurses and doctors dominated notifications, with 89% of all notifications (727/819) involving a doctor or nurse in the role of notifier and/or respondent. Nurses and midwives accounted for 51% of notifiers and 59% of respondents. Doctors accounted for 29% of notifiers and 26% of respondents.

Men constituted 37% of notifiers and 44% of respondents. Eighty per cent of notifications were about practitioners in three jurisdictions: Queensland (39% [321/819]), South Australia (22% [184/819]), and Victoria (18% [150/819]).

Nexus between notifiers, respondents and conduct

Among the 731 notifications for which it was possible to identify the professional relationship between the notifier and the respondent, 46% were made by fellow health practitioners (ie, health professionals other than the respondents' treating practitioners) (Box 3). Forty-six per cent of notifications were made by the respondents' employers; this included cases in which the notifier was also a registered health practitioner (eg, medical director of a hospital) but the notification was made in an employer rather than individual capacity.

Among 736 notifications for which it was possible to tell how the respondent's behaviour came to the attention of the notifier, the conduct was directly observed by the notifier in about a quarter of cases (201/736). In more than half of notifications (376/736), the conduct at issue came to the notifier's attention through a third party — the patient, a colleague or some other person. For the remainder, the conduct was either identified through an investigatory process such as a record review, clinical audit, or police or coronial investigation (81/736) or self-disclosed by the respondent (78/736).

Intraprofessional and interprofessional notifications

Among 697 notifications for which it was possible to determine the profession of the notifier and the respondent, the profession of the notifier and respondent was the same in 80% of cases (557/697). This concentration of intraprofessional notifications is depicted in Box 4 by the diagonal line of relatively large bubbles running from the bottom left to the top right of the figure. Nurse-on-nurse notifications (those involving nurses and/or midwives) and doctor-on-doctor notifications accounted for 73% (507/697) of notifications.

3 Characteristics of notifiers and respondents*

	Number (%)	
Characteristic	**Notifiers**	**Respondents**
Profession	*n* = 754	*n* = 816
Nurse and/or midwife	387 (51%)	482 (59%)
Medical practitioner	220 (29%)	216 (26%)
Psychologist	38 (5%)	48 (6%)
Pharmacist	29 (4%)	33 (4%)
Dentist	7 (1%)	15 (2%)
Other health practitioner	16 (2%)	22 (3%)
Non-health practitioner	57 (8%)	—
Age	*n* = 750	*n* = 750
< 25 years	4 (1%)	16 (2%)
25 to 34 years	69 (9%)	111 (15%)
35 to 44 years	159 (21%)	204 (27%)
45 to 54 years	281 (37%)	227 (30%)
55 to 64 years	219 (29%)	145 (19%)
⩾ 65 years	18 (2%)	47 (6%)
Sex	*n* = 791	*n* = 816
Female	498 (63%)	460 (56%)
Male	293 (37%)	356 (44%)
Relationship to respondent	*n* = 731	—
Fellow health practitioner	335 (46%)	—
Employer	333 (46%)	—
Treating practitioner	58 (8%)	—
Education provider	5 (1%)	—
Practice location	—	*n* = 809
Major cities	—	535 (66%)
Inner or outer regional	—	229 (28%)
Remote or very remote	—	45 (6%)
Jurisdiction of practice		*n* = 819
Queensland	—	321 (39%)
South Australia	—	184 (22%)
Victoria	—	150 (18%)
Tasmania	—	25 (3%)
Western Australia	—	97 (12%)
Northern Territory	—	11 (1%)
Australian Capital Territory	—	31 (4%)

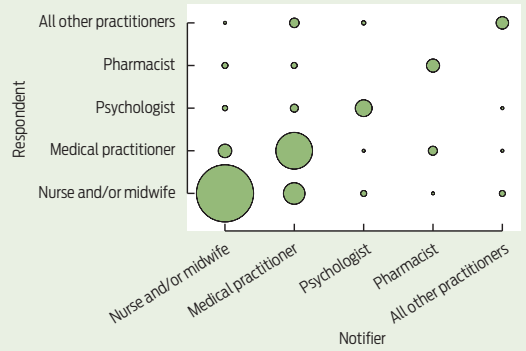
* Differences in *n* values are because of missing data. ◆

Interprofessional notifications mostly involved doctors notifying about nurses (7% [51/697]) and nurses notifying about doctors (3% [20/697]). The remainder were widely distributed across other interprofessional dyads.

Incidence of notifications

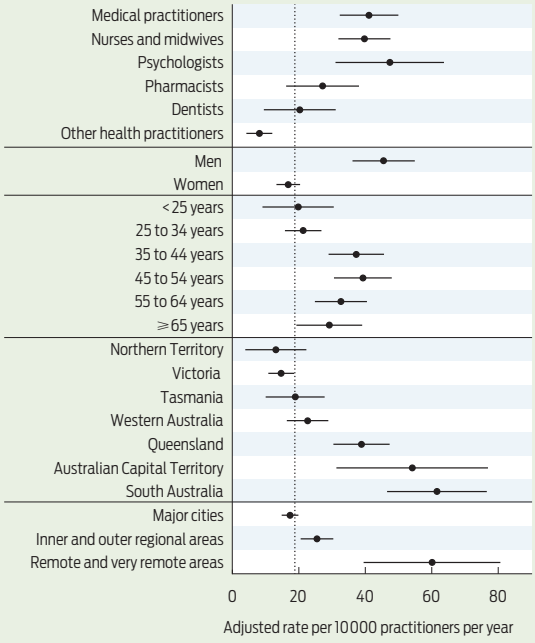
The unadjusted incidence of mandatory reporting was 18.3 reports per 10 000 practitioners per year (95% CI, 17.0 to 19.6 reports per 10 000

4 Frequency of notifications, by profession of notifiers and respondents ($n = 697$)*



*Bubble sizes correspond to numbers of notifications in each of the 25 dyads shown.

5 Incidence of notifications per 10 000 registered practitioners per year, by characteristics of respondents*



*Rates are adjusted for all variables reported in the figure; dashed line indicates overall unadjusted incidence.

practitioners per year). Adjusted rates of notification for the five respondent characteristics analysed are shown in Box 5. Psychologists had the highest rate of notifications, followed by medical practitioners, and then nurses and midwives (47.4, 41.1 and 39.7 reports per 10 000 practitioners per year, respectively).

The incidence of notifications against men was more than two-and-a-half times that for notifications against women (45.5 v 16.8 reports per 10 000 practitioners per year; $P < 0.001$). Health practitioners working in remote and very remote areas had a much higher incidence of notification than those in major cities and regional areas (60.1 v 17.4 and 25.5 reports per 10 000 practitioners per year). There were also large differences in incidence of notifications across jurisdictions, ranging from 61.6 per 10 000 practitioners per year in South Australia to 13.1 per 10 000 practitioners per year in the Northern Territory.

Discussion

We found that perceived departures from accepted professional standards, especially in relation to clinical care, accounted for nearly two-thirds of reports of notifiable conduct received by AHPRA during the study period. Nurses and doctors were involved in 89% of notifications, as notifiers, respondents or both. Interprofessional reports were uncommon. We observed wide variation in reporting rates by jurisdiction, sex and profession — for example, a nearly fivefold difference across states and territories, and a two-and-a-half times higher rate for men than for women.

Our results suggest that some of the harms predicted by critics of mandatory reporting and some of the benefits touted by supporters are, so far, wide of the mark. Concerns that mandatory reporting would be used as a weapon in interprofessional conflict should be eased by the finding that the notifier and respondent were in the same profession in four out of five cases. Indeed, the low rate of notifications by nurses about doctors (3%) gives rise to the opposite concern. Although nurses are often well placed to observe poorly performing doctors, our data suggest that the new law has not overcome previously identified factors that may make it difficult for nurses to report concerns about doctors.[2]

On the other hand, supporters of mandatory reporting who heralded it as a valuable new surveillance system may be concerned by the low rates of reporting in some jurisdictions. Part of the variation in incidence of notifications across jurisdictions that we observed might reflect true differences in incidence of notifiable events, but it is also likely that differences in awareness of reporting requirements and differences in notification behaviour contribute to the variation. US research suggests that underreporting of concerns about colleagues is widespread, even when mandatory reporting laws are in place.[3] The identified barriers to reporting fall primarily into four categories: uncertainty or unfamiliarity regarding the legal requirement to report; fear of retaliation; lack of confidence that appropriate action would be taken; and loyalty to colleagues that supports a culture of "gaze aversion".[2,3,16-18] Action to better understand and overcome these barriers could be aimed at jurisdictions with the lowest reporting rates.

The higher rate of notification for men that we observed is consistent with previous research showing that male doctors are at higher risk of patient complaints,[19,20] disciplinary proceedings[21] and malpractice litigation.[22] While systematic differences in specialty and the number of patient encounters may explain some of the heightened risk observed for men, other factors, such as sex differences in communication style and risk-taking behaviour,[23,24] are probably also in play.

The main strength of our study is that we included data from every registered health profession and all but one jurisdiction. The ability to access multistate data for research and evaluation purposes is an important benefit of Australia's new national regulation scheme, and would not have been possible 5 years ago. Other federalised countries with siloed regulatory regimes continue to struggle with fragmented workforce data.

Our study has three main limitations. First, because mandatory reporting was implemented in concert with other far-reaching changes to the regulation of health practitioners, it was not possible to compare the incidence of notifications before and after the introduction of the new law. Second, it was not feasible to include information on the outcomes of notifications: too small a proportion of notifications had reached a final determination at the time of our study

to provide unbiased data. As the scheme matures, it would be useful to explore what proportion of reports were substantiated and resulted in action to prevent patient harm, at an individual or system level. Third, our analysis did not include notifications against practitioners based in NSW.

This study is best understood as a first step in establishing an evidence base for understanding the operations and merits of Australia's mandatory reporting regime. The scheme is in its infancy and reporting behaviour may change as health practitioners gain greater awareness and understanding of their obligations. Several potential pitfalls and promises of the scheme remain to be investigated — for example, the extent to which mandatory reporting stimulated a willingness to deal with legitimate concerns, as opposed to inducing an unproductive culture of fear, blame and vexatious reporting. Qualitative research, including detailed file reviews and interviews with health practitioners and doctors' health advisory services, would help address these questions. Further research should also seek to understand the relationship between mandatory reports and other mechanisms for identifying practitioners, such as patient complaints, incident reports, clinical audit, and other quality assurance mechanisms.

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Australian Health Practitioner Regulation Agency

National Board guidelines for registered health practitioners

GUIDELINES FOR **MANDATORY NOTIFICATIONS**

March 2014

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MANDATORY NOTIFICATIONS GUIDELINES

About the National Boards and AHPRA

The 14 National Boards regulating registered health practitioners in Australia are responsible for registering practitioners and students (except for in psychology, which has provisional psychologists), setting the standards that practitioners must meet, and managing notifications (complaints) about the health, conduct or performance of practitioners.

The Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with the National Boards to implement the National Registration and Accreditation Scheme, under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The core role of the National Boards and AHPRA is to protect the public.

About these guidelines

These guidelines have been developed jointly by the National Boards under section 39 of the National Law. The guidelines are developed to provide direction to registered health practitioners, employers of practitioners and education providers about the requirements for mandatory notifications under the National Law.

The inclusion of mandatory notification requirements in the National Law is an important policy initiative for public protection.

The relevant sections of the National Law are attached.

Who needs to use these guidelines?

These guidelines are relevant to:

- health practitioners registered under the National Law
- employers of practitioners, and
- education providers.

Students who are registered in a health profession under the National Law should be familiar with these guidelines. Although the National Law does not require a student to make a mandatory notification, a notification can be made about an impaired student.

MANDATORY NOTIFICATIONS GUIDELINES

Contents

SUMMARY

These guidelines explain the requirements for registered health practitioners, employers of practitioners and education providers to make mandatory notifications under the National Law to prevent the public being placed at risk of harm.

The threshold to be met to trigger a mandatory notification in relation to a practitioner is high. The practitioner or employer must have first formed a reasonable belief that the behaviour constitutes notifiable conduct or a notifiable impairment or, in the case of an education provider, a notifiable impairment (see Section 3 for the definition of 'notifiable conduct' and Appendix A for the definition of 'impairment').

Making a mandatory notification is a serious step to prevent the public from being placed at risk of harm and should only be taken on sufficient grounds. The guidelines explain when these grounds are likely to arise.

Importantly, the obligation to make a mandatory notification applies to the conduct or impairment of all practitioners, not just those within the practitioner's own health profession.

These guidelines also address the role of the Australian Health Practitioner Regulation Agency (AHPRA) as the body for receiving notifications and referring them to the relevant National Board.

1 Introduction

The National Law requires practitioners, employers and education providers to report 'notifiable conduct', as defined in section 140 of the National Law, to AHPRA in order to prevent the public being placed at risk of harm.

These guidelines explain how the Boards will interpret these mandatory notification requirements. They will help practitioners, employers and education providers understand how to work with these requirements – that is, whether they must make a notification about a practitioner's conduct and when.

The threshold to be met to trigger the requirement to report notifiable conduct in relation to a practitioner is high and the practitioner or employer must have first formed a reasonable belief that the behaviour constitutes notifiable conduct.

The aim of the mandatory notification requirements is to prevent the public from being placed at risk of harm. The intention is that practitioners notify AHPRA if they believe that another practitioner has behaved in a way which presents a serious risk to the public. The requirements focus on serious instances of substandard practice or conduct by practitioners, or serious cases of impairment, that could place

members of the public at risk. For students, the requirements focus on serious cases of impairment of students.

That is, the requirements focus on behaviour that puts the public at risk of harm, rather than not liking the way someone else does something or feeling that they could do their job better.

Similarly, if the only risk is to the practitioner alone, and there is no risk to the public, the threshold for making a mandatory notification would not be reached. For example, in a case where the risk is clearly addressed by being appropriately managed through treatment and the practitioner is known to be fully compliant with that, mandatory notification would not be required. Conversely, a mandatory notification is required if the risk to the public is not mitigated by treatment of the practitioner or in some other way.

1.1 Voluntary notifications

The National Law also provides for voluntary notifications for behaviour that presents a risk but does not meet the threshold for notifiable conduct, or for notifications made by individuals who are not subject to the mandatory notification obligations such as patients or clients (see ss. 144 and 145 of the National Law).

1.2 Protection for people making a notification

The National Law protects practitioners, employers and education providers who make notifications in good faith under the National Law. 'Good faith' is not defined in the National Law so has its ordinary meaning of being well-intentioned or without malice. Section 237 provides protection from civil, criminal and administrative liability, including defamation, for people making notifications in good faith. The National Law clarifies that making a notification is not a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct.

These provisions protect practitioners making mandatory notifications from legal liability and reinforce that making mandatory notifications under the National Law is consistent with professional conduct and a practitioner's ethical responsibilities. Legally mandated notification requirements override privacy laws. Practitioners should be aware that if they make notifications that are frivolous, vexatious or not in good faith, they may be subject to conduct action.

2 General obligations

The obligation is on any practitioner or employer who forms a reasonable belief that another practitioner has engaged in notifiable conduct to make a report to AHPRA as soon as practicable. The definition of 'notifiable conduct' is set out in section 140 of the National Law (also refer to Section 3 of these guidelines for more information on notifiable conduct). In this context, the word 'practicable' has its ordinary meaning of 'feasible' or 'possible'.

The mandatory notification obligation applies to all practitioners and employers of practitioners in relation to the notifiable conduct of practitioners. The obligation applies to practitioners in all registered health professions, not just those in the same health profession as the practitioner. It also applies where the notifying practitioner is also the treating practitioner for a practitioner, except in Western Australia and Queensland in certain circumstances (see Section 4 *Exceptions to the requirement of practitioners to make a mandatory notification* of these guidelines for details).

There is also a mandatory obligation for education providers and practitioners to report a student with an impairment that may place the public at substantial risk of harm.

While the mandatory reporting provisions in the National Law are an important policy change, the duties covered in them are consistent with general ethical practice and professional obligations. In addition to their legal obligations with respect to mandatory reporting, practitioners are also under an ethical obligation to notify concerns about a practitioner, in accordance with the broad ethical framework set out in the health profession's code of conduct (see the *Code of conduct* and the voluntary reporting provisions of the National Law). More information about making

a voluntary notification is published on the National Boards' and AHPRA's websites.

There are some exceptions to the requirement for practitioners to notify AHPRA of notifiable conduct, which are discussed at Section 4 *Exceptions to the requirement of practitioners to make a mandatory notification.*

These guidelines do not affect other mandatory reporting requirements that may be established in separate legislation, for example requirements to report child abuse.

2.1 What is a reasonable belief?

For practitioners reporting notifiable conduct, a 'reasonable belief' must be formed in the course of practising the profession. The following principles are drawn from legal cases which have considered the meaning of reasonable belief.

1. A belief is a state of mind.
2. A reasonable belief is a belief based on reasonable grounds.
3. A belief is based on reasonable grounds when:
    i. all known considerations relevant to the formation of a belief are taken into account including matters of opinion, and
    ii. those known considerations are objectively assessed.
4. A just and fair judgement that reasonable grounds exist in support of a belief can be made when all known considerations are taken into account and objectively assessed.

A reasonable belief requires a stronger level of knowledge than a mere suspicion. Generally it would involve direct knowledge or observation of the behaviour which gives rise to the notification, or, in the case of an employer, it could also involve a report from a reliable source or sources. Mere speculation, rumours, gossip or innuendo are not enough to form a reasonable belief.

A reasonable belief has an objective element – that there are facts which could cause the belief in a reasonable person; and a subjective element – that the person making the notification actually has that belief.

A notification should be based on personal knowledge of facts or circumstances that are reasonably trustworthy and that would justify a person of average caution, acting in good faith, to believe that notifiable conduct has occurred or that a notifiable impairment exists. Conclusive proof is not needed. The professional background, experience and expertise of a practitioner, employer or education provider will also be relevant in forming a reasonable belief.

The most likely example of where a practitioner or employer would form a reasonable belief is where the person directly observes notifiable conduct, or, in relation to an education provider, observes the behaviour of an impaired student. When a practitioner is told about notifiable conduct that another practitioner or patient has directly experienced or observed, the person with most direct knowledge about the notifiable conduct should generally be encouraged to make a notification themselves.

2.2 What is 'the public'?

Several of the mandatory notification provisions refer to 'the public being placed at risk of harm'. In the context of notifications, 'the public' can be interpreted as persons that access the practitioner's regulated health services or the wider community which could potentially have been placed at risk of harm by the practitioner's services.

3 Notifiable conduct

Section 140 of the National Law defines 'notifiable conduct' as when a practitioner has:

a) practised the practitioner's profession while intoxicated by alcohol or drugs; or

b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or

c) *placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or*

d) *placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.*

The following sections of the guidelines discuss these types of notifiable conduct, followed by the exceptions. The guidelines are only examples of decision-making processes, so practitioners, employers and education providers should check the exceptions to make sure they do not apply.

If a practitioner engages in more than one type of notifiable conduct, each type is required to be notified.

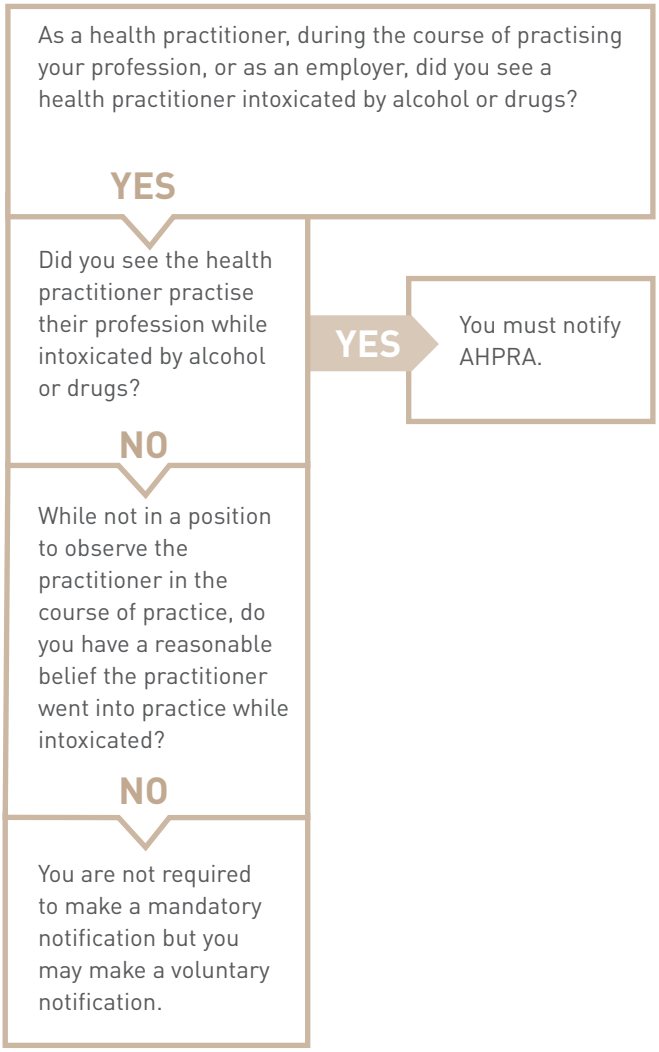
3.1 Practise while intoxicated by alcohol or drugs (section 140(a))

The requirement to make a mandatory notification is triggered by a practitioner practising their profession while intoxicated by alcohol or drugs. The word 'intoxicated' is not defined in the National Law, so the word has its ordinary meaning of 'under the influence of alcohol or drugs'.

The Boards will consider a practitioner to be intoxicated where their capacity to exercise reasonable care and skill in the practice of the health profession is impaired or adversely affected as a result of being under the influence of drugs or alcohol. The key issue is that the practitioner has practised while intoxicated, regardless of the time that the drugs or alcohol were consumed.

The National Law does not require mandatory notification of a practitioner who is intoxicated when they are not practising their health profession (that is, in their private life), unless the intoxication triggers another ground for mandatory notification.

3.2 Decision guide – notifying intoxication



3.3

3.4 Sexual misconduct in connection with the practice of the practitioner's profession (section 140(b))

Section 140(b) relates to sexual misconduct in connection with the practice of the practitioner's health profession; that is, in relation to persons under the practitioner's care or linked to the practitioner's practice of their health profession.

Engaging in sexual activity with a current patient or client will constitute sexual misconduct in connection with the practice of the practitioner's health profession, regardless of whether the patient or client consented to the activity or not. This is because of the power imbalance between practitioners and their patients or clients.

Sexual misconduct also includes making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient or client. Engaging in sexual activity with a person who is closely related to a patient or client under the practitioner's care may also constitute misconduct. In some cases, someone who is closely related to a patient or client may also be considered a patient or client, for example the parent of a child patient or client.

Engaging in sexual activity with a person formerly under a practitioner's care (i.e. after the termination of the practitioner–patient/client relationship) may also constitute sexual misconduct. Relevant factors will include the cultural context, the vulnerability of the patient or client due to issues such as age, capacity and/or health conditions; the extent of the professional relationship; for example, a one-off treatment in an emergency department compared to a long-term program of treatment; and the length of time since the practitioner–patient/client relationship ceased.

3.5 Decision guide – notifying sexual misconduct

As a practitioner, during the course of practising your health profession, or as an employer, do you reasonably believe that another practitioner has engaged in sexual misconduct, e.g. (a) sexual activity with a person under the practitioner's care or (b) sexual activity with a person previously under the practitioner's care where circumstances such as the vulnerability of the patient or client results in misconduct?

NO	YES
You are not required to make a mandatory notification but you may make a voluntary notification.	You must notify AHPRA.

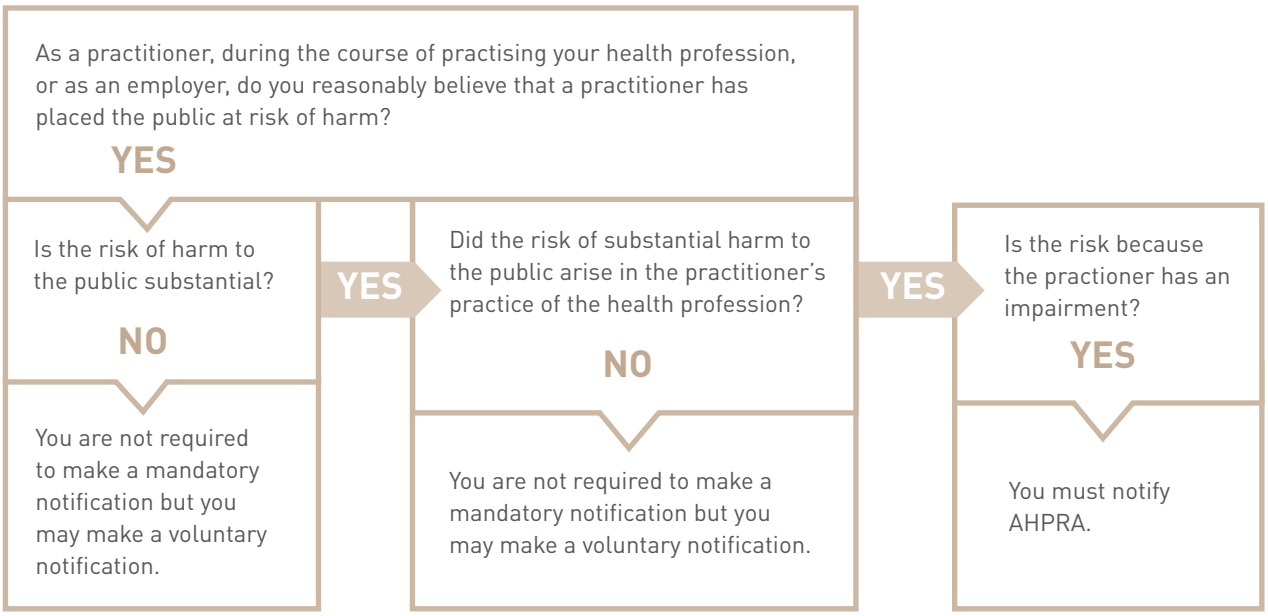
3.6 Placing the public at risk of substantial harm because of an impairment (section 140(c))

Section 5 of the National Law defines 'impairment' for a practitioner or an applicant for registration in a health profession as meaning a person has 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession.'

To trigger this notification, a practitioner must have placed the public at risk of substantial harm. 'Substantial harm' has its ordinary meaning; that is, considerable harm such as a failure to correctly or appropriately diagnose or treat because of the impairment. For example, a practitioner who has an illness which causes cognitive impairment so they cannot practise effectively would require a mandatory notification. However, a practitioner who has a blood-borne virus who practises appropriately and safely in light of their condition and complies with any registration standards or guidelines and professional standards and protocols would not trigger a notification.

The context of the practitioner's work is also relevant. If registered health practitioners, employers and education providers are aware that the employer knows of the practitioner's impairment, and has put safeguards in place such as monitoring and supervision, this may reduce or prevent the risk of substantial harm.

3.7 Decision guide – notifying impairment in relation to a practitioner



* for notification of student impairment, please see Section 5 of these guidelines

3.8 Placing the public at risk of harm because of practice that constitutes a significant departure from accepted professional standards (section 140(d))

The term 'accepted professional standards' requires knowledge of the professional standards that are accepted within the health profession and a judgement about whether there has been a significant departure from them. This judgement may be easier for other members of the practitioner's health profession.

Mandatory notifications about a practitioner from another health profession are most likely to arise in a team environment where different health professions are working closely together and have a good understanding of the contribution of each practitioner; for example, a surgical or mental health team.

The difference from accepted professional standards must be significant. The term 'significant' means important, or of consequence *(Macquarie concise dictionary)*. Professional standards cover not only clinical skills but also other standards of professional behaviour. A significant departure is one which is serious and would be obvious to any reasonable practitioner.

The notifiable conduct of the practitioner must place the public at risk of harm as well as being a significant departure from accepted professional standards before a notification is required. However, the risk of harm just needs to be present – it does not need to be a substantial risk, as long as the practitioner's practice involves a significant departure from accepted professional standards. For example, a clear breach of the health profession's code of conduct which places the public at risk of harm would be enough.

This provision is not meant to trigger notifications based on different professional standards within a health profession, provided the standards are accepted within the health profession; that is, by a reasonable proportion of practitioners. For example, if one practitioner uses a different standard to another practitioner, but both are accepted standards within the particular health profession, this would not qualify as a case of notifiable conduct.

Similarly, if a practitioner is engaged in innovative practice but within accepted professional standards, it would not trigger the requirement to report.

3.9 Decision guide – significant departure from accepted professional standards

4 Exceptions to the requirement for practitioners to make a mandatory notification

There are particular exceptions to the requirement to make a mandatory notification for practitioners. The exceptions relate to the circumstances in which the practitioner forms the reasonable belief in misconduct or impairment. They arise where the practitioner who would be required to make the notification:

a. is employed or engaged by a professional indemnity insurer, and forms the belief because of a disclosure in the course of a legal proceeding or the provision of legal advice arising from the insurance policy

b. forms the belief while providing advice about legal proceedings or the preparation of legal advice

c. is exercising functions as a member of a quality assurance committee, council or other similar body approved or authorised under legislation which prohibits the disclosure of the information

d. reasonably believes that someone else has already made a notification

e. is a treating practitioner, practising in Western Australia, or

f. is a treating practitioner, practising in Queensland in certain circumstances.

Practitioners in Western Australia are not required to make a mandatory notification when their reasonable belief about misconduct or impairment is formed in the course of providing health services to a health practitioner or student. However, practitioners in Western Australia continue to have a professional and ethical obligation to protect and promote public health and safety. They may therefore make a voluntary notification or may encourage the practitioner or student they are treating to self-report.

Under the *Health Ombudsman Act 2013* (Qld), practitioners in Queensland are not required to make a mandatory notification when their reasonable belief is formed as a result of providing a health service to a health practitioner, where the practitioner providing the service reasonably believes that the notifiable conduct relates to an impairment which will not place the public at substantial risk of harm and is not professional misconduct. From 1 July 2014, mandatory notifications originating in Queensland must be made to the Health Ombudsman rather than AHPRA. The Ombudsman must advise AHPRA about the notification in certain circumstances.

Practitioners should refer to Appendix A of these guidelines for an extract of the relevant legislation; see section 141 if it is possible one of these exceptions might apply.

5 Mandatory notifications about impaired students

Education providers are also required, under section 143 of the National Law, to make mandatory notifications in relation to students, if the provider reasonably believes:

a) 'a student enrolled with the provider has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm, or

b) a student for whom the provider has arranged clinical training has an impairment that, in the course of the student undertaking the clinical training, may place the public at substantial risk of harm.'

Practitioners are required to make a mandatory notification in relation to a student if the practitioner reasonably believes that a student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm (section141(1)(b)).

In all cases, the student's impairment must place the public at substantial, or considerable, risk of harm in the course of clinical training.

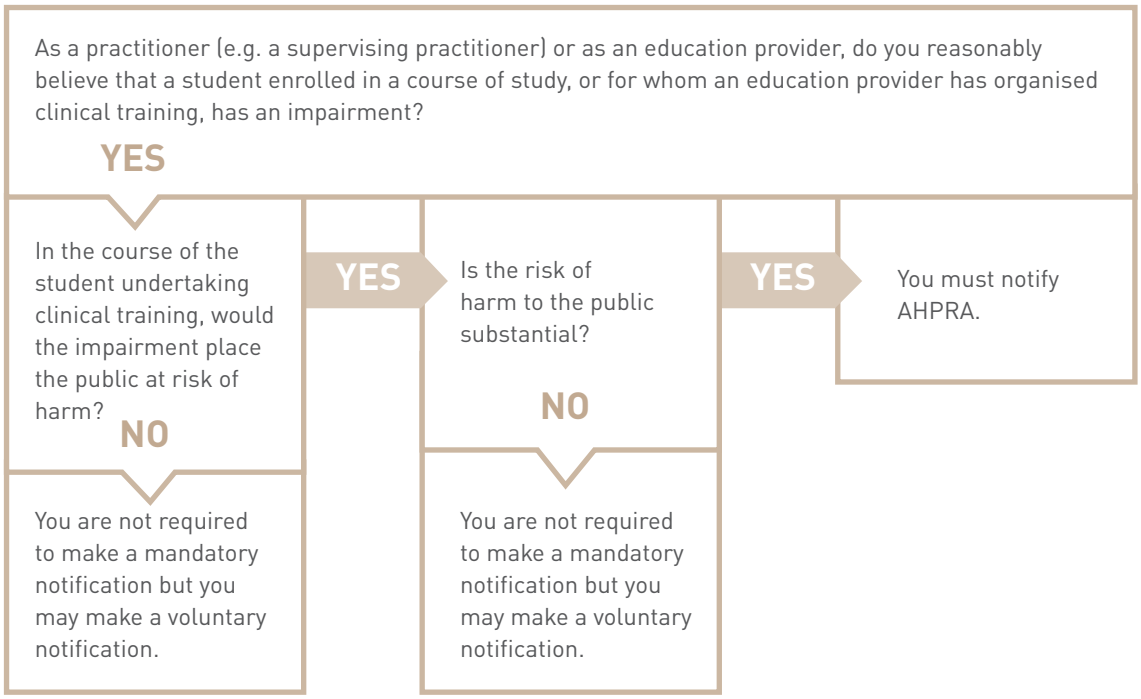
In relation to a student, 'impairment' is defined under section 5 of the National Law to mean the student 'has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the student's capacity to undertake clinical training –

(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.'

An education provider who does not notify AHPRA as required by section 143 does not commit an offence. However, the National Board that registered the student must publish details of the failure to notify on the Board's website and AHPRA may, on the recommendation of the National Board, include a statement about the failure in AHPRA's annual report.

5.1 Decision guide – student impairment



6 Consequences of failure to notify

6.1 Registered health practitioners

Although there are no penalties prescribed under the National Law for a practitioner who fails to make a mandatory notification, any practitioner who fails to make a mandatory notification when required may be subject to health, conduct or performance action.

6.2 Employers of practitioners

There are also consequences for an employer who fails to notify AHPRA of notifiable conduct as required by section 142 of the National Law.

If AHPRA becomes aware of such a failure, it must give a written report about the failure to the responsible Minister for the jurisdiction in which the notifiable conduct occurred. As soon as practicable after receiving such a report, the responsible Minister must report the employer's failure to notify to a health complaints entity, the employer's licensing authority or another appropriate entity in that participating jurisdiction.

Importantly, the requirement to make a mandatory notification does not reduce an employer's responsibility to manage the practitioner employee's performance and protect the public from being placed at risk of harm. However, if an employer has a reasonable belief that a practitioner has behaved in a way that constitutes notifiable conduct, then the employer must notify, regardless of whether steps are put in place to prevent recurrence of the conduct or impairment, or whether the practitioner subsequently leaves the employment.

7 How a notification is made (section 146)

Under the National Law, notifications are be made to AHPRA, which receives notifications and refers them to the relevant National Board.

The notification must include the basis for making the notification; that is, practitioners, employers and education providers must say what the notification is about. It may assist practitioners, employers and education providers in making a notification if they have documented the reasons for the notification, including the date and time that they noticed the conduct or impairment.

To make a notification verbally, practitioners, employers and education providers may ring 1300 419 495 or go to any of the state and territory AHPRA offices.

To make a notification in writing, go to the *Notifications and outcomes* section of the AHPRA website at www.ahpra.gov.au, download a notification form and post your completed form to AHPRA, GPO Box 9958 in your capital city.

If you are unsure about whether to make a mandatory notification, you may wish to seek advice from your insurer and/or professional association.

Review

Date of issue: 17 March 2014

Date of review: These guidelines will be reviewed from time to time as required. This will generally be at least every three years.

Last reviewed: September 2013

Appendix A
Extract of relevant provisions from the National Law

s. 5 ***impairment****, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect—*

(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or

(b) for a student, the student's capacity to undertake clinical training—

(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.

Education provider means—

(a) a university; or

(b) a tertiary education institution, or another institution or organisation, that provides vocational training; or

(c) a specialist medical college or other health profession college.

Part 5, Division 3 Registration standards and codes and guidelines

39 Codes and guidelines

A National Board may develop and approve codes and guidelines—

(a) to provide guidance to the health practitioners it registers; and

(b) about other matters relevant to the exercise of its functions.

Example. A National Board may develop guidelines about the advertising of regulated health services by health practitioners registered by the Board or other persons for the purposes of section 133.

40 Consultation about registration standards, codes and guidelines

(1) If a National Board develops a registration standard or a code or guideline, it must ensure there is wide-ranging consultation about its content.

(2) A contravention of subsection (1) does not invalidate a registration standard, code or guideline.

(3) The following must be published on a National Board's website—

(a) a registration standard developed by the Board and approved by the Ministerial Council;

(b) a code or guideline approved by the National Board.

(4) An approved registration standard or a code or guideline takes effect—

(a) on the day it is published on the National Board's website; or

(b) if a later day is stated in the registration standard, code or guideline, on that day.

41 Use of registration standards, codes or guidelines in disciplinary proceedings

An approved registration standard for a health profession, or a code or guideline approved by a National Board, is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the health profession.

Part 8, Division 2 Mandatory notifications

140 Definition of notifiable conduct

In this Division—
notifiable conduct*, in relation to a registered health practitioner, means the practitioner has—*

(a) practised the practitioner's profession while intoxicated by alcohol or drugs; or

(b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or

(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or

(d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

141 Mandatory notifications by health practitioners

*(1) This section applies to a registered health practitioner (the **first health practitioner**) who, in the course of practising the first health practitioner's profession, forms a reasonable belief that—*

*(a) another registered health practitioner (the **second health practitioner**) has behaved in a way that constitutes notifiable conduct; or*

(b) a student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm.

(2) The first health practitioner must, as soon as practicable after forming the reasonable belief, notify the National Agency of the second health practitioner's notifiable conduct or the student's impairment.

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law. Section 237(3) provides that the making of a notification does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct and nor is any liability for defamation incurred.

(3) A contravention of subsection (2) by a registered health practitioner does not constitute an offence but may constitute behaviour for which action may be taken under this Part.

(4) For the purposes of subsection (1), the first health practitioner does not form the reasonable belief in the course of practising the profession if—

(a) the first health practitioner—

(i) is employed or otherwise engaged by an insurer that provides professional indemnity insurance that relates to the second health practitioner or student; and

(ii) forms the reasonable belief the second health practitioner has behaved in a way that constitutes notifiable conduct, or the student has an impairment, as a result of a disclosure made by a person to the first health practitioner in the course of a legal proceeding or the provision of legal advice arising from the insurance policy; or

(b) the first health practitioner forms the reasonable belief in the course of providing advice in relation to the notifiable conduct or impairment for the purposes of a legal proceeding or the preparation of legal advice; or

(c) the first health practitioner is a legal practitioner and forms the reasonable belief in the course of providing legal services to the second health practitioner or student in relation to a legal proceeding or the preparation of legal advice in which the notifiable conduct or impairment is an issue; or

APPLICATION OF THE NATIONAL LAW IN WESTERN AUSTRALIA

Part 2, Section 4(7) *Health Practitioner Regulation National Law (WA) Act 2010*

In this Schedule after section 141(4)(c) *insert*—

141(4)(d) the first health practitioner forms the reasonable belief in the course of providing health services to the second health practitioner or student; or

APPLICATION OF THE NATIONAL LAW IN QUEENSLAND

section 25 *Health Ombudsman Act 2013* (3) National Law provisions, section 141— *insert*—

(5) Subsection (2) does not apply in relation to the second health practitioner's notifiable conduct if the first health practitioner—

(a) forms the reasonable belief as a result of providing a health service to the second health practitioner; and

(b) reasonably believes that the notifiable conduct—

(i) relates to an impairment which will not place the public at substantial risk of harm; and

(ii) is not professional misconduct

(d) the first health practitioner—

(i) forms the reasonable belief in the course of exercising functions as a member of a quality assurance committee, council or other body approved or authorised under an Act of a participating jurisdiction; and

(ii) is unable to disclose the information that forms the basis of the reasonable belief because a provision of that Act prohibits the disclosure of the information; or

(e) the first health practitioner knows, or reasonably believes, the National Agency has been notified of the notifiable conduct or impairment that forms the basis of the reasonable belief.

142 Mandatory notifications by employers

(1) If an employer of a registered health practitioner reasonably believes the health practitioner has behaved in a way that constitutes notifiable conduct, the employer must notify the National Agency of the notifiable conduct.

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law. Section 237(3) provides that the making of a notification does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct and nor is any liability for defamation incurred.

(2) If the National Agency becomes aware that an employer of a registered health practitioner has failed to notify the Agency of notifiable conduct as required by subsection (1), the Agency must give a written report about the failure to the responsible Minister for the participating jurisdiction in which the notifiable conduct occurred.

(3) As soon as practicable after receiving a report under subsection (2), the responsible Minister must report the employer's failure to notify the Agency of the notifiable conduct to a health complaints entity, the employer's licensing authority or another appropriate entity in that participating jurisdiction.

(4) In this section—
employer, of a registered health practitioner, means an entity that employs the health practitioner under a contract of employment or a contract for services.

licensing authority, of an employer, means an entity that under a law of a participating jurisdiction is responsible for licensing, registering or authorising the employer to conduct the employer's business.

143 Mandatory notifications by education providers

(1) An education provider must notify the National Agency if the provider reasonably believes—

(a) a student enrolled in a program of study provided by the provider has an impairment that, in the course of the student undertaking clinical training as part of the program of study, may place the public at substantial risk of harm; or

(b) a student for whom the education provider has arranged clinical training has an impairment that, in the course of the student undertaking the clinical training, may place the public at substantial risk of harm;

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who make a notification under this Law. Section 237(3) provides that the making of a notification does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct and nor is any liability for defamation incurred.

(2) A contravention of subsection (1) does not constitute an offence.

(3) However, if an education provider does not comply with subsection (1)-

(a) the National Board that registered the student must publish details of the failure on the board's website; and

(b) the National Agency may, on the recommendation of the National Board, include a statement about the failure in the Agency's annual report.

144 Grounds for voluntary notification

(1) A voluntary notification about a registered health practitioner may be made to the National Agency on any of the following grounds—

(a) that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;

(b) *that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the practitioner's health profession is, or may be, below the standard reasonably expected;*

(c) *that the practitioner is not, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession;*

(d) *that the practitioner has, or may have, an impairment;*

(e) *that the practitioner has, or may have, contravened this Law;*

(f) *that the practitioner has, or may have, contravened a condition of the practitioner's registration or an undertaking given by the practitioner to a National Board;*

(g) *that the practitioner's registration was, or may have been, improperly obtained because the practitioner or someone else gave the National Board information or a document that was false or misleading in a material particular.*

(2) *A voluntary notification about a student may be made to the National Agency on the grounds that—*

(a) *the student has been charged with an offence, or has been convicted or found guilty of an offence, that is punishable by 12 months imprisonment or more; or*

(b) *the student has, or may have, an impairment; or*

(c) *that the student has, or may have, contravened a condition of the student's registration or an undertaking given by the student to a National Board.*

145 Who may make voluntary notification

Any entity that believes that a ground on which a voluntary notification may be made exists in relation to a registered health practitioner or a student may notify the National Agency.

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law.

Part 8, Division 4 Making a notification

146 How notification is made

(1) *A notification may be made to the National Agency—*

(a) *verbally, including by telephone; or*

(b) *in writing, including by email or other electronic means.*

(2) *A notification must include particulars of the basis on which it is made.*

(3) *If a notification is made verbally, the National Agency must make a record of the notification.*

Part 11, Division 1, section 237 Protection from liability for persons making notification or otherwise providing information

(1) *This section applies to a person who, in good faith—*

(a) *makes a notification under this Law; or*

(b) *gives information in the course of an investigation or for another purpose under this Law to a person exercising functions under this Law.*

(2) *The person is not liable, civilly, criminally or under an administrative process, for giving the information.*

(3) *Without limiting subsection (2)—*

(a) *the making of the notification or giving of the information does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct; and*

(b) *no liability for defamation is incurred by the person because of the making of the notification or giving of the information.*

(4) *The protection given to the person by this section extends to—*

(a) *a person who, in good faith, provided the person with any information on the basis of which the notification was made or the information was given; and*

(b) *a person who, in good faith, was otherwise concerned in the making of the notification or giving of the information.*

APPLICATION OF THE NATIONAL LAW IN QUEENSLAND

section 25 *Health Ombudsman Act 2013*

(1) National Law provisions, section 141(2) and (4(e), 'National Agency'—

omit, insert—

health ombudsman

(2) National Law provisions, section 141(3), after 'this Part'—

insert—

or the *Health Ombudsman Act 2013*

(3) National Law provisions, section 141—insert—

(5) Subsection (2) does not apply in relation to the second health practitioner's notifiable conduct if the first health practitioner—

(a) forms the reasonable belief as a result of providing a health service to the second health practitioner; and

(b) reasonably believes that the notifiable conduct—

(i) relates to an impairment which will not place the public at substantial risk of harm; and

(ii) is not professional misconduct

26 Amendment of s 142 (Mandatory notifications by employers)

(1) National Law provisions, section 142(1), 'National Agency'—

omit, insert—

health ombudsman

(2) National Law provisions, section 142(2) and (3)—

omit, insert—

(2) If the health ombudsman becomes aware that an employer of registered health practitioner has failed to notify the health ombudsman of notifiable conduct as required by subsection (1), the health ombudsman—

(a) must notify the National Agency; and

(b) may—

(i) refer the matter to the employer's licensing authority; or

(ii) refer the matter to another appropriate entity in this jurisdiction or another jurisdiction; or

(iii) advise the responsible Minister of the matter.

(3) National Law provisions, section 142(4)—

renumber as section 142(3).

27 Amendment of s 143 (Mandatory notifications by education providers)

(1) National Law provisions, section 143(1),

'National Agency'—

omit, insert—

health ombudsman

(2) National Law provisions, section 143(2) and (3)—

renumber as section 143(3) and (4).

(3) National Law provisions, section 143—

insert—

(2) The health ombudsman must give to the National Agency a copy of each notification received under subsection (1).

Medical Board of Australia

GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA

March 2014

MBA1401 01

GOOD MEDICAL PRACTICE

Contents

GOOD MEDICAL PRACTICE

GOOD MEDICAL PRACTICE

1 About this code

1.1 Purpose of the code

Good medical practice (the code) describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community. The code was developed following wide consultation with the medical profession and the community. The code is addressed to doctors and is also intended to let the community know what they can expect from doctors. The application of the code will vary according to individual circumstances, but the principles should not be compromised.

This code complements the Australian Medical Association *Code of ethics*[1] and is aligned with its values, and is also consistent with the *Declaration of Geneva and the international code of medical ethics*[2], issued by the World Medical Association.

This code does not set new standards. It brings together, into a single Australian code, standards that have long been at the core of medical practice.

The practice of medicine is challenging and rewarding. No code or guidelines can ever encompass every situation or replace the insight and professional judgment of good doctors. Good medical practice means using this judgement to try to practise in a way that would meet the standards expected of you by your peers and the community.

1.2 Use of the code

Doctors have a professional responsibility to be familiar with *Good medical practice* and to apply the guidance it contains.

This code will be used:

- to support individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgement
- to assist the Medical Board of Australia in its role of protecting the public, by setting and maintaining standards of medical practice against which a doctor's professional conduct can be evaluated. If your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration
- as an additional resource for a range of uses that contribute to enhancing the culture of medical professionalism in the Australian health system; for example, in medical education; orientation, induction and supervision of junior doctors and international medical graduates; and by administrators and policy makers in hospitals, health services and other institutions.

The code applies in all settings. It is valid for technology-based patient consultations as well as for traditional face-to-face consultations and also applies to how doctors use social media. To guide doctors further, the Medical Board of Australia has issued *Guidelines for technology-based patient consultations*.[3]

1.3 What the code does not do

This code is not a substitute for the provisions of legislation and case law. If there is any conflict between this code and the law, the law takes precedence.

This code is not an exhaustive study of medical ethics or an ethics textbook. It does not address in detail the standards of practice within particular medical disciplines; these are found in the policies and guidelines issued by medical colleges and other professional bodies.

While good medical practice respects patients' rights, this code is not a charter of rights.[4]

1 https://ama.com.au/codeofethics

2 www.wma.net/en/30publications/10policies/c8/

3 Section 39 of the National Law and *Guidelines for technology-based patient consultations* issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

4 The Australian Commission on Safety and Quality in Health Care's *Australian charter of healthcare rights*: www.safetyandquality.gov.au/our-work/national-perspectives/charter-of-healthcare-rights/.

1.4 Professional values and qualities of doctors

While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice.

Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.

Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.

Doctors have a responsibility to protect and promote the health of individuals and the community.

Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.

Good communication underpins every aspect of good medical practice.

Professionalism embodies all the qualities described here, and includes self-awareness and self-reflection. Doctors are expected to reflect regularly on whether they are practising effectively, on what is happening in their relationships with patients and colleagues, and on their own health and wellbeing. They have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgement as they gain experience, and contribute to their profession.

1.5 Australia and Australian medicine

Australia is culturally and linguistically diverse. We inhabit a land that, for many ages, was held and cared for by Aboriginal and Torres Strait Islander Australians, whose history and culture have uniquely shaped our nation. Our society is further enriched by the contribution of people from many nations who have made Australia their home.

Doctors in Australia reflect the cultural diversity of our society, and this diversity strengthens our profession.

There are many ways to practise medicine in Australia. The core tasks of medicine are caring for people who are unwell and seeking to keep people well. This code focuses primarily on these core tasks. For the doctors who undertake roles that have little or no patient contact, not all of this code may be relevant, but the principles underpinning it will still apply.

1.6 Substitute decision-makers

In this code, reference to the term 'patient' also includes substitute decision-makers for patients who do not have the capacity to make their own decisions. This can be the parents, or a legally appointed decision-maker. If in doubt, seek advice from the relevant guardianship authority.

2 Providing good care

2.1 Introduction

In clinical practice, the care of your patient is your primary concern. Providing good patient care includes:

2.1.1 Assessing the patient, taking into account the history, the patient's views, and an appropriate physical examination. The history includes relevant psychological, social and cultural aspects.

2.1.2 Formulating and implementing a suitable management plan (including arranging investigations and providing information, treatment and advice).

2.1.3 Facilitating coordination and continuity of care.

2.1.4 Referring a patient to another practitioner when this is in the patient's best interests.

2.1.5 Recognising and respecting patients' rights to make their own decisions.

2.2 Good patient care

Maintaining a high level of medical competence and professional conduct is essential for good patient care. Good medical practice involves:

2.2.1 Recognising and working within the limits of your competence and scope of practice.

2.2.2 Ensuring that you have adequate knowledge and skills to provide safe clinical care.

2.2.3 Maintaining adequate records (see Section 8.4).

2.2.4 Considering the balance of benefit and harm in all clinical-management decisions.

2.2.5 Communicating effectively with patients (see Section 3.3).

2.2.6 Providing treatment options based on the best available information.

2.2.7 Taking steps to alleviate patient symptoms and distress, whether or not a cure is possible.

2.2.8 Supporting the patient's right to seek a second opinion.

2.2.9 Consulting and taking advice from colleagues, when appropriate.

2.2.10 Making responsible and effective use of the resources available to you (see Section 5.2).

2.2.11 Encouraging patients to take interest in, and responsibility for, the management of their health, and supporting them in this.

2.2.12 Ensuring that your personal views do not adversely affect the care of your patient.

2.3 Shared decision-making

Making decisions about healthcare is the shared responsibility of the doctor and the patient. Patients may wish to involve their family, carer or others. See Section 1.6 on substitute decision-makers.

2.4 Decisions about access to medical care

Your decisions about patients' access to medical care need to be free from bias and discrimination. Good medical practice involves:

2.4.1 Treating your patients with respect at all times.

2.4.2 Not prejudicing your patient's care because you believe that a patient's behaviour has contributed to their condition.

2.4.3 Upholding your duty to your patient and not discriminating on medically irrelevant grounds, including race, religion, sex, disability or other grounds, as described in anti-discrimination legislation.[5]

2.4.4 Giving priority to investigating and treating patients on the basis of clinical need and effectiveness of the proposed investigations or treatment.

5 Australian Human Rights Commission, *A guide to Australia's anti-discrimination laws*: http://humanrights.gov.au/info_for_employers/law/index.html.

2.4.5 Keeping yourself and your staff safe when caring for patients. If a patient poses a risk to your health and safety or that of your staff, take action to protect against that risk. Such a patient should not be denied care, if reasonable steps can be taken to keep you and your staff safe.

2.4.6 Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.

2.4.7 Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

2.5 Treatment in emergencies

Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.

3 Working with patients

3.1 Introduction

Relationships based on respect, openness, trust and good communication will enable you to work in partnership with your patients.

3.2 Doctor–patient partnership

A good doctor–patient partnership requires high standards of professional conduct. This involves:

3.2.1 Being courteous, respectful, compassionate and honest.

3.2.2 Treating each patient as an individual.

3.2.3 Protecting patients' privacy and right to confidentiality, unless release of information is required by law or by public-interest considerations.

3.2.4 Encouraging and supporting patients and, when relevant, their carer or family, in caring for themselves and managing their health.

3.2.5 Encouraging and supporting patients to be well informed about their health and to use this information wisely when they are making decisions.

3.2.6 Recognising that there is a power imbalance in the doctor–patient relationship, and not exploiting patients physically, emotionally, sexually or financially.

3.3 Effective communication

An important part of the doctor–patient relationship is effective communication. This involves:

3.3.1 Listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences.

3.3.2 Encouraging patients to tell you about their condition and how they are currently managing it, including any other health advice they have received, any prescriptions or other medication they have been prescribed and any other conventional, alternative or complementary therapies they are using.

3.3.3 Informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment.

3.3.4 Discussing with patients their condition and the available management options, including their potential benefit and harm.

3.3.5 Endeavouring to confirm that your patient understands what you have said.

3.3.6 Ensuring that patients are informed of the material risks associated with any part of the proposed management plan.

3.3.7 Responding to patients' questions and keeping them informed about their clinical progress.

3.3.8 Making sure, wherever practical, that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect understanding.

3.3.9 Familiarising yourself with, and using whenever necessary, qualified language interpreters or cultural interpreters to help you to meet patients' communication needs. Information about government-funded interpreter services is available on the Australian Government Department of Immigration and Citizenship website.[6]

3.4 Confidentiality and privacy

Patients have a right to expect that doctors and their staff will hold information about them in confidence,

6 The Australian Government Department of Immigration and Citizenship's Translating and Interpreting Service (TIS) National can be contacted on 131 450, or via the website: www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/index.htm.

unless release of information is required by law or public interest considerations. Good medical practice involves:

3.4.1 Treating information about patients as confidential.

3.4.2 Appropriately sharing information about patients for their health care, consistent with privacy law and professional guidelines about confidentiality.

3.4.3 Using consent processes, including forms if required, for the release and exchange of health information.

3.4.4 Being aware that there are complex issues related to genetic information and seeking appropriate advice about disclosure of such information.

3.4.5 Ensuring that your use of social media is consistent with your ethical and legal obligations to protect patient confidentiality and privacy.[7]

3.5 Informed consent

Informed consent is a person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved. The information that doctors need to give to patients is detailed in guidelines issued by the National Health and Medical Research Council (NHMRC).[8] Good medical practice involves:

3.5.1 Providing information to patients in a way that they can understand before asking for their consent.

3.5.2 Obtaining informed consent or other valid authority before you undertake any examination, investigation or provide treatment (except in an emergency), or before involving patients in teaching or research.

3.5.3 Ensuring that your patients are informed about your fees and charges.

3.5.4 When referring a patient for investigation or treatment, advising the patient that there may be additional costs, which patients may wish to clarify before proceeding.

3.6 Children and young people

Caring for children and young people brings additional responsibilities for doctors. Good medical practice involves:

3.6.1 Placing the interests and wellbeing of the child or young person first.

3.6.2 Ensuring that you consider young people's capacity for decision-making and consent.

3.6.3 Ensuring that, when communicating with a child or young person, you:

- treat them with respect and listen to their views
- encourage questions and answer their questions to the best of your ability
- provide information in a way that they can understand
- recognise the role of parents or guardians and when appropriate, encourage the young person to involve their parents or guardians in decisions about their care.

3.6.4 Being alert to children and young people who may be at risk, and notifying appropriate authorities, as required by law.

3.7 Culturally safe and sensitive practice

Good medical practice involves genuine efforts to understand the cultural needs and contexts of different patients to obtain good health outcomes. This includes:

7 *Social media policy* issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

8 National Health and Medical Research Council's documents, *General guidelines for medical practitioners on providing information to patients* 2004: www.nhmrc.gov.au/guidelines/publications/e57 and *Communicating with patients: advice for medical practitioners* 2004: www.nhmrc.gov.au/guidelines/publications/e58.

3.7.1 Having knowledge of, respect for, and sensitivity towards, the cultural needs of the community you serve, including Aboriginal and Torres Strait Islander Australians and those from culturally and linguistically diverse backgrounds.

3.7.2 Acknowledging the social, economic, cultural and behavioural factors influencing health, both at individual and population levels.

3.7.3 Understanding that your own culture and beliefs influence your interactions with patients and ensuring that this does not unduly influence your decision-making.

3.7.4 Adapting your practice to improve patient engagement and healthcare outcomes.

3.8 Patients who may have additional needs

Some patients (including those with impaired decision-making capacity) have additional needs. Good medical practice in managing the care of these patients involves:

3.8.1 Paying particular attention to communication.

3.8.2 Being aware that increased advocacy may be necessary to ensure just access to healthcare.

3.8.3 Recognising that there may be a range of people involved in their care, such as carers, family members or a guardian, and involving them when appropriate, being mindful of privacy considerations.

3.8.4 Being aware that these patients may be at greater risk.

3.9 Relatives, carers and partners

Good medical practice involves:

3.9.1 Being considerate to relatives, carers, partners and others close to the patient, and respectful of their role in the care of the patient.

3.9.2 With appropriate consent, being responsive in providing information.

3.10 Adverse events

When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, to review what has occurred and to report appropriately.[9] When something goes wrong you should seek advice from your colleagues and from your medical indemnity insurer. Good medical practice involves:

3.10.1 Recognising what has happened.

3.10.2 Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.

3.10.3 Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.

3.10.4 Acknowledging any patient distress and providing appropriate support.

3.10.5 Complying with any relevant policies, procedures and reporting requirements.

3.10.6 Reviewing adverse events and implementing changes to reduce the risk of recurrence (see Section 6).

3.10.7 Reporting adverse events to the relevant authority, as necessary (see Section 6).

3.10.8 Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant healthcare complaints commission or medical board).

3.11 When a complaint is made

Patients who are dissatisfied have a right to complain about their care. When a complaint is made, good medical practice involves:

3.11.1 Acknowledging the patient's right to complain.

3.11.2 Providing information about the complaints system.

9 Australian Commission on Safety and Quality in Health Care, The Australian Open Disclosure Framework: www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework/.

3.11.3 Working with the patient to resolve the issue, locally where possible.

3.11.4 Providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology.

3.11.5 Ensuring the complaint does not adversely affect the patient's care. In some cases, it may be advisable to refer the patient to another doctor.

3.11.6 Complying with relevant complaints law, policies and procedures.

3.12 End-of-life care

Doctors have a vital role in assisting the community to deal with the reality of death and its consequences. In caring for patients towards the end of their life, good medical practice involves:

3.12.1 Taking steps to manage a patient's symptoms and concerns in a manner consistent with their values and wishes.

3.12.2 Providing or arranging appropriate palliative care.

3.12.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.

3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.

3.12.5 Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.

3.12.6 Respecting different cultural practices related to death and dying.

3.12.7 Striving to communicate effectively with patients and their families so they are able to understand the outcomes that can and cannot be achieved.

3.12.8 Facilitating advance care planning.

3.12.9 Taking reasonable steps to ensure that support is provided to patients and their families, even when it is not possible to deliver the outcome they desire.

3.12.10 Communicating bad news to patients and their families in the most appropriate way and providing support for them while they deal with this information.

3.12.11 When your patient dies, being willing to explain, to the best of your knowledge, the circumstances of the death to appropriate members of the patient's family and carers, unless you know the patient would have objected.

3.13 Ending a professional relationship

In some circumstances, the relationship between a doctor and patient may become ineffective or compromised, and you may need to end it. Good medical practice involves ensuring that the patient is adequately informed of your decision and facilitating arrangements for the continuing care of the patient, including passing on relevant clinical information.

3.14 Personal relationships

Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient. In some cases, providing care to those close to you is unavoidable. Whenever this is the case, good medical practice requires recognition and careful management of these issues.

3.15 Closing or relocating your practice

When closing or relocating your practice, good medical practice involves:

3.15.1 Giving advance notice where this is possible.

3.15.2 Facilitating arrangements for the continuing medical care of all your current patients, including the transfer or appropriate management of all patient records. You must follow the law governing health records in your jurisdiction.

4 Working with other healthcare professionals

4.1 Introduction

Good relationships with medical colleagues, nurses and other healthcare professionals strengthen the doctor–patient relationship and enhance patient care.

4.2 Respect for medical colleagues and other healthcare professionals

Good patient care is enhanced when there is mutual respect and clear communication between all healthcare professionals involved in the care of the patient. Good medical practice involves:

4.2.1 Communicating clearly, effectively, respectfully and promptly with other doctors and healthcare professionals caring for the patient.

4.2.2 Acknowledging and respecting the contribution of all healthcare professionals involved in the care of the patient.

4.2.3 Behaving professionally and courteously to colleagues and other practitioners including when using social media.

4.3 Delegation, referral and handover

Delegation involves you asking another health care professional to provide care on your behalf while you retain overall responsibility for the patient's care. *Referral* involves you sending a patient to obtain opinion or treatment from another doctor or healthcare professional. Referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose, such as care that is outside your area of expertise. *Handover* is the process of transferring all responsibility to another healthcare professional. Good medical practice involves:

4.3.1 Taking reasonable steps to ensure that the person to whom you delegate, refer or handover has the qualifications, experience, knowledge and skills to provide the care required.

4.3.2 Understanding that when you delegate, although you will not be accountable for the decisions and actions of those to whom you delegate, you remain responsible for the overall management of the patient, and for your decision to delegate.

4.3.3 Always communicating sufficient information about the patient and the treatment they need to enable the continuing care of the patient.

4.4 Teamwork

Most doctors work closely with a wide range of healthcare professionals. The care of patients is improved when there is mutual respect and clear communication, as well as an understanding of the responsibilities, capacities, constraints and ethical codes of each other's professions. Working in a team does not alter a doctor's personal accountability for professional conduct and the care provided. When working in a team, good medical practice involves:

4.4.1 Understanding your particular role as part of the team and attending to the responsibilities associated with that role.

4.4.2 Advocating for a clear delineation of roles and responsibilities, including that there is a recognised team leader or coordinator.

4.4.3 Communicating effectively with other team members.

4.4.4 Informing patients about the roles of team members.

4.4.5 Acting as a positive role model for team members.

4.4.6 Understanding the nature and consequences of bullying and harassment, and seeking to eliminate such behaviour in the workplace.

4.4.7 Supporting students and practitioners receiving supervision within the team.

4.5 Coordinating care with other doctors

Good patient care requires coordination between all treating doctors. Good medical practice involves:

4.5.1 Communicating all the relevant information in a timely way.

4.5.2 Facilitating the central coordinating role of the general practitioner.

4.5.3 Advocating the benefit of a general practitioner to a patient who does not already have one.

4.5.4 Ensuring that it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient.

5 Working within the healthcare system

5.1 Introduction

Doctors have a responsibility to contribute to the effectiveness and efficiency of the healthcare system.

5.2 Wise use of healthcare resources

It is important to use healthcare resources wisely.

Good medical practice involves:

5.2.1 Ensuring that the services you provide are necessary and likely to benefit the patient.

5.2.2 Upholding the patient's right to gain access to the necessary level of healthcare and, whenever possible, helping them to do so.

5.2.3 Supporting the transparent and equitable allocation of healthcare resources.

5.2.4 Understanding that your use of resources can affect the access other patients have to healthcare resources.

5.3 Health advocacy

There are significant disparities in the health status of different groups in the Australian community. These disparities result from social, cultural, geographic, health related and other factors. In particular, Aboriginal and Torres Strait Islander Australians bear the burden of gross social, cultural and health inequity. Good medical practice involves using your expertise and influence to protect and advance the health and wellbeing of individual patients, communities and populations.

5.4 Public health

Doctors have a responsibility to promote the health of the community through disease prevention and control, education and screening. Good medical practice involves:

5.4.1 Understanding the principles of public health, including health education, health promotion, disease prevention and control and screening.

5.4.2 Participating in efforts to promote the health of the community and being aware of your obligations in disease prevention, screening and reporting notifiable diseases.

6 Minimising risk

6.1 Introduction

Risk is inherent in healthcare. Minimising risk to patients is an important component of medical practice. Good medical practice involves understanding and applying the key principles of risk minimisation and management in your practice.

6.2 Risk management

Good medical practice in relation to risk management involves:

6.2.1 Being aware of the importance of the principles of open disclosure and a non-punitive approach to incident management.

6.2.2 Participating in systems of quality assurance and improvement.

6.2.3 Participating in systems for surveillance and monitoring of adverse events and 'near misses', including reporting such events.

6.2.4 If you have management responsibilities, making sure that systems are in place for raising concerns about risks to patients.

6.2.5 Working in your practice and within systems to reduce error and improve patient safety, and supporting colleagues who raise concerns about patient safety.

6.2.6 Taking all reasonable steps to address the issue if you have reason to think that patient safety may be compromised.

6.3 Doctors' performance — you and your colleagues

The welfare of patients may be put at risk if a doctor is performing poorly. If you consider there is a risk, good medical practice involves:

6.3.1 Complying with any statutory reporting requirements, including the mandatory reporting requirements under the National Law as it applies in your jurisdiction.[10]

6.3.2 Recognising and taking steps to minimise the risks of fatigue, including complying with relevant state and territory occupational health and safety legislation.

6.3.3 If you know or suspect that you have a health condition that could adversely affect your judgement or performance, following the guidance in Section 9.2.

6.3.4 Taking steps to protect patients from risk posed by a colleague's conduct, practice or ill health.

6.3.5 Taking appropriate steps to assist your colleague to receive help if you have concerns about a colleague's performance or fitness to practise.

6.3.6 If you are not sure what to do, seeking advice from an experienced colleague, your employer, doctors' health advisory services, professional indemnity insurers, the Medical Board of Australia or a professional organisation.

10 Sections 140–143 of the National Law, and *Guidelines for mandatory notifications* issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

7 Maintaining professional performance

7.1 Introduction

Maintaining and developing your knowledge, skills and professional behaviour are core aspects of good medical practice. This requires self-reflection and participation in relevant professional development, practice improvement and performance-appraisal processes, to continually develop your professional capabilities. These activities must continue throughout your working life, as science and technology develop and society changes.

7.2 Continuing professional development

The Medical Board of Australia has established registration standards that set out the requirements for continuing professional development and for recency of practice under the National Law.[11]

Development of your knowledge, skills and professional behaviour must continue throughout your working life. Good medical practice involves:

7.2.1 Keeping your knowledge and skills up to date.

7.2.2 Participating regularly in activities that maintain and further develop your knowledge, skills and performance.

7.2.3 Ensuring that your practice meets the standards that would be reasonably expected by the public and your peers.

7.2.4 Regularly reviewing your continuing medical education and continuing professional development activities to ensure that they meet the requirements of the Medical Board of Australia.

7.2.5 Ensuring that your personal continuing professional development program includes self-directed and practice-based learning.

11 Section 38(1)(c) and (e) of the National Law and registration standards issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

8 Professional behaviour

8.1 Introduction

In professional life, doctors must display a standard of behaviour that warrants the trust and respect of the community. This includes observing and practising the principles of ethical conduct.

The guidance contained in this section emphasises the core qualities and characteristics of good doctors outlined in Section 1.4.

8.2 Professional boundaries

Professional boundaries are integral to a good doctor–patient relationship. They promote good care for patients and protect both parties. Good medical practice involves:

8.2.1 Maintaining professional boundaries.

8.2.2 Never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient. Specific guidelines on sexual boundaries have been developed by the Medical Board of Australia under the National Law.[12]

8.2.3 Avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.

8.3 Reporting obligations

Doctors have statutory obligations under the National Law to report various proceedings or findings to the Medical Board of Australia.[13] They also have professional obligations to report to the Board and their employer if they have had any limitations placed on their practice. Good medical practice involves:

8.3.1 Being aware of these reporting obligations

8.3.2 Complying with any reporting obligations that apply to your practice.

8.3.3 Seeking advice from the Medical Board or your professional indemnity insurer if you are unsure about your obligations.

8.4 Medical records

Maintaining clear and accurate medical records is essential for the continuing good care of patients. Good medical practice involves:

8.4.1 Keeping accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be understood by other health practitioners.

8.4.2 Ensuring that your medical records are held securely and are not subject to unauthorised access.

8.4.3 Ensuring that your medical records show respect for your patients and do not include demeaning or derogatory remarks.

8.4.4 Ensuring that the records are sufficient to facilitate continuity of patient care.

8.4.5 Making records at the time of the events, or as soon as possible afterwards.

8.4.6 Recognising patients' right to access information contained in their medical records and facilitating that access.

8.4.7 Promptly facilitating the transfer of health information when requested by the patient.

8.5 Insurance

You have a professional obligation to ensure that your practice is appropriately covered by professional indemnity insurance. You must meet the requirements set out in the *Registration standard for professional indemnity insurance* established by the Medical Board of Australia under the National Law.[14]

12 Section 39 of the National Law and *Sexual boundaries: guidelines for doctors* issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

13 Sections 130, 140-143 of the National Law and *Guidelines for mandatory notifications* issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

14 Section 38(1)(a) of the National Law and registration standards issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

8.6 Advertising

Advertisements for medical services can be useful in providing information for patients. All advertisements must conform to relevant consumer protection legislation, the advertising provisions in the National Law and *Guidelines for advertising regulated health services* issued by the Medical Board of Australia.[15]

Good medical practice involves:

8.6.1 Making sure that any information you publish about your medical services is factual and verifiable.

8.6.2 Making only justifiable claims about the quality or outcomes of your services in any information you provide to patients.

8.6.3 Not guaranteeing cures, exploiting patients' vulnerability or fears about their future health, or raising unrealistic expectations.

8.6.4 Not offering inducements or using testimonials.

8.6.5 Not making unfair or inaccurate comparisons between your services and those of colleagues.

8.7 Medico-legal, insurance and other assessments

When you are contracted by a third party to provide a medico-legal, insurance or other assessment of a person who is not your patient, the usual therapeutic doctor–patient relationship does not exist. In this situation, good medical practice involves:

8.7.1 Applying the standards of professional behaviour described in this code to the assessment; in particular, being courteous, alert to the concerns of the person, and ensuring that you have the person's consent.

8.7.2 Explaining to the person your area of medical practice, your role, and the purpose, nature and extent of the assessment to be conducted.

8.7.3 Anticipating and seeking to correct any misunderstandings that the person may have about the nature and purpose of your assessment and report.

8.7.4 Providing an impartial report (see Section 8.8).

8.7.5 Recognising that, if you discover an unrecognised, serious medical problem during your assessment, you have a duty of care to inform the patient and/or their treating doctor.

8.8 Medical reports, certificates and giving evidence

The community places a great deal of trust in doctors. Consequently, doctors have been given the authority to sign a variety of documents, such as death certificates and sickness certificates, on the assumption that they will only sign statements that they know, or reasonably believe, to be true. Good medical practice involves:

8.8.1 Being honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate.

8.8.2 Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately.

8.8.3 Preparing or signing documents and reports if you have agreed to do so, within a reasonable and justifiable timeframe.

8.8.4 Making clear the limits of your knowledge and not giving opinion beyond those limits when providing evidence.

8.9 Curriculum vitae

When providing curriculum vitae, good medical practice involves:

8.9.1 Providing accurate, truthful and verifiable information about your experience and your medical qualifications.

8.9.2 Not misrepresenting, by misstatement or omission, your experience, qualifications or position.

15 Section 133 of the National Law and *Guidelines for advertising regulated health services* (available at: www.medicalboard.gov.au).

8.10 Investigations

Doctors have responsibilities and rights relating to any legitimate investigation of their practice or that of a colleague. In meeting these responsibilities, it is advisable to seek legal advice or advice from your professional indemnity insurer. Good medical practice involves:

8.10.1 Cooperating with any legitimate inquiry into the treatment of a patient and with any complaints procedure that applies to your work.

8.10.2 Disclosing, to anyone entitled to ask for it, information relevant to an investigation into your own or a colleague's conduct, performance or health.

8.10.3 Assisting the coroner when an inquest or inquiry is held into a patient's death by responding to their enquiries and by offering all relevant information.

8.11 Conflicts of interest

Patients rely on the independence and trustworthiness of doctors for any advice or treatment offered. A conflict of interest in medical practice arises when a doctor, entrusted with acting in the interests of a patient, also has financial, professional or personal interests, or relationships with third parties, which may affect their care of the patient. Multiple interests are common. They require identification, careful consideration, appropriate disclosure and accountability. When these interests compromise, or might reasonably be perceived by an independent observer to compromise, the doctor's primary duty to the patient, doctors must recognise and resolve this conflict in the best interests of the patient.

Good medical practice involves:

8.11.1 Recognising potential conflicts of interest that may arise in relation to initiating or continuing a professional relationship with a patient.

8.11.2 Acting in your patients' best interests when making referrals and when providing or arranging treatment or care.

8.11.3 Informing patients when you have an interest that could affect, or could be perceived to affect, patient care.

8.11.4 Recognising that pharmaceutical and other medical marketing influences doctors, and being aware of ways in which your practice may be being influenced.

8.11.5 Recognising potential conflicts of interest in relation to medical devices and appropriately managing any conflict that arises in your practice.

8.11.6 Not asking for or accepting any inducement, gift or hospitality of more than trivial value, from companies that sell or market drugs or appliances or provide services that may affect, or be seen to affect, the way you prescribe for, treat or refer patients.

8.11.7 Not asking for or accepting fees for meeting sales representatives.

8.11.8 Not offering inducements or entering into arrangements that could be perceived to provide inducements.

8.11.9 Not allowing any financial or commercial interest in a hospital, other healthcare organisation, or company providing healthcare services or products to adversely affect the way in which you treat patients. When you or your immediate family have such an interest and that interest could be perceived to influence the care you provide, you must inform your patient.

8.12 Financial and commercial dealings

Doctors must be honest and transparent in financial arrangements with patients. Good medical practice involves:

8.12.1 Not exploiting patients' vulnerability or lack of medical knowledge when providing or recommending treatment or services.

8.12.2 Not encouraging patients to give, lend or bequeath money or gifts that will benefit you directly or indirectly.

8.12.3 Avoiding financial involvement, such as loans and investment schemes, with patients.

8.12.4 Not pressuring patients or their families to make donations to other people or organisations.

8.12.5 Being transparent in financial and commercial matters relating to your work, including in your dealings with employers, insurers and other organisations or individuals. In particular:

- declaring any relevant and material financial or commercial interest that you or your family might have in any aspect of the patient's care
- declaring to your patients your professional and financial interest in any product you might endorse or sell from your practice, and not making an unjustifiable profit from the sale or endorsement.

9 Ensuring doctors' health

9.1 Introduction

As a doctor, it is important for you to maintain your own health and wellbeing. This includes seeking an appropriate work–life balance.

9.2 Your health

Good medical practice involves:

9.2.1 Having a general practitioner.

9.2.2 Seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment.

9.2.3 Making sure that you are immunised against relevant communicable diseases.

9.2.4 Conforming to the legislation in your state or territory in relation to self-prescribing.

9.2.5 Recognising the impact of fatigue on your health and your ability to care for patients, and endeavouring to work safe hours wherever possible.

9.2.6 Being aware of the doctors' health program in your state or territory if you need advice on where to seek help.

9.2.7 If you know or suspect that you have a health condition or impairment that could adversely affect your judgement, performance or your patient's health:

- not relying on your own assessment of the risk you pose to patients
- consulting your doctor about whether, and in what ways, you may need to modify your practice, and following the doctor's advice.

9.3 Other doctors' health

Doctors have a responsibility to assist medical colleagues to maintain good health. All health professionals have responsibilities in certain circumstances for mandatory notification under the National Law.[16] Good medical practice involves:

9.3.1 Providing doctors who are your patients with the same quality of care you would provide to other patients.

9.3.2 Notifying the Medical Board of Australia if you are treating a doctor whose ability to practise may be impaired and may thereby be placing patients at risk. This is always a professional, and in some jurisdictions, a statutory responsibility under the National Law.

9.3.3 Encouraging a colleague (whom you are not treating) to seek appropriate help if you believe they may be ill and impaired. If you believe this impairment is putting patients at risk, notify the Medical Board of Australia. It may also be wise to report your concerns to the doctor's employer and to a doctors' health program.

9.3.4 Recognising the impact of fatigue on the health of colleagues, including those under your supervision, and facilitating safe working hours wherever possible.

16 Sections 140-143 of the National Law and *Guidelines for mandatory notifications* issued by the Medical Board of Australia (available at: www.medicalboard.gov.au).

10 Teaching, supervising and assessing

10.1 Introduction

Teaching, supervising and mentoring doctors and medical students is important for their development and for the care of patients. It is part of good medical practice to contribute to these activities and provide support, assessment, feedback and supervision for colleagues, doctors in training and students.

10.2 Teaching and supervising[17]

Good medical practice involves:

10.2.1 Seeking to develop the skills, attitudes and practices of an effective teacher, whenever you are involved in teaching.

10.2.2 Making sure that any doctor or medical student for whose supervision you are responsible receives adequate oversight and feedback.

10.3 Assessing colleagues

Assessing colleagues is an important part of making sure that the highest standards of medical practice are achieved. Good medical practice involves:

10.3.1 Being honest, objective and constructive when assessing the performance of colleagues, including students. Patients will be put at risk if you describe as competent someone who is not.

10.3.2 Providing accurate and justifiable information when giving references or writing reports about colleagues. Do so promptly and include all relevant information.

10.4 Medical students

Medical students are learning how best to care for patients. Creating opportunities for learning improves their clinical practice and nurtures the future workforce.

Good medical practice involves:

10.4.1 Treating your students with respect and patience.

10.4.2 Making the scope of the student's role in patient care clear to the student, to patients and to other members of the healthcare team.

10.4.3 Informing your patients about the involvement of medical students and obtaining their consent for student participation, while respecting their right to choose not to consent.

17 The Medical Board of Australia has issued guidelines for supervised practice (available at: www.medicalboard.gov.au).

11 Undertaking research

11.1 Introduction

Research involving humans, their tissue samples or their health information, is vital in improving the quality of healthcare and reducing uncertainty for patients now and in the future, and in improving the health of the population as a whole. Research in Australia is governed by guidelines issued in accordance with the *National Health and Medical Research Council Act 1992*.[18] If you undertake research, you should familiarise yourself with, and follow, these guidelines.

Research involving animals is governed by legislation in states and territories and by guidelines issued by the National Health and Medical Research Council (NHMRC).[19]

11.2 Research ethics

Being involved in the design, organisation, conduct or reporting of health research involving humans brings particular responsibilities for doctors. These responsibilities, drawn from the NHMRC guidelines, include:

11.2.1 According to participants the respect and protection that is due to them.

11.2.2 Acting with honesty and integrity.

11.2.3 Ensuring that any protocol for human research has been approved by a human research ethics committee, in accordance with the *National statement on ethical conduct in human research.*

11.2.4 Disclosing the sources and amounts of funding for research to the human research ethics committee.

11.2.5 Disclosing any potential or actual conflicts of interest to the human research ethics committee.

11.2.6 Ensuring that human participation is voluntary and based on an adequate understanding of sufficient information about the purpose, methods, demands, risks and potential benefits of the research.

11.2.7 Ensuring that any dependent relationship between doctors and their patients is taken into account in the recruitment of patients as research participants.

11.2.8 Seeking advice when research involves children or adults who are not able to give informed consent, to ensure that there are appropriate safeguards in place. This includes ensuring that a person empowered to make decisions on the patient's behalf has given informed consent, or that there is other lawful authority to proceed.

11.2.9 Adhering to the approved research protocol.

11.2.10 Monitoring the progress of the research and promptly reporting adverse events or unexpected outcomes.

11.2.11 Respecting the entitlement of research participants to withdraw from any research at any time and without giving reasons.

11.2.12 Adhering to the guidelines regarding publication of findings, authorship and peer review.

11.2.13 Reporting possible fraud or misconduct in research as required under the *Australian code for the responsible conduct of research.*

11.3 Treating doctors and research

When you are involved in research that involves your patients, good medical practice includes:

11.3.1 Respecting the patient's right to withdraw from a study without prejudice to their treatment.

11.3.2 Ensuring that a patient's decision not to participate does not compromise the doctor–patient relationship or their care.

18 *National statement on ethical conduct in human research* NHMRC 2007: www.nhmrc.gov.au/guidelines/publications/e72 and the *Australian code for the responsible conduct of research* NHMRC 2007: www.nhmrc.gov.au/guidelines/publications/r39 .

19 *Australian code of practice for the care and use of animals for scientific purposes*, 7th edition NHMRC 2004: www.nhmrc.gov.au/guidelines/publications/ea16.

GOOD MEDICAL PRACTICE

Acknowledgements

The Medical Board of Australia acknowledges the work of the Australian Medical Council (AMC) in developing this code. In 2010 it was adopted by the Medical Board of Australia after minor revisions to ensure it is consistent with the Health Practitioner Regulation National Law, as in force in each state and territory.

In the first edition of the code, the AMC acknowledged the working group that guided the development of the code; the contribution of the organisations and individuals whose thoughtful feedback informed its development; the contribution of the Australian Government Department of Health and Ageing to the extensive consultation process that supported it; and the then state and territory medical boards that endorsed it.

In developing this code, the AMC considered and drew on both general and specific information about standards from codes of good medical practice issued by the then state and territory medical boards and the Australian Medical Association *Code of ethics*. The process was also informed by similar documents issued by the General Medical Council of the United Kingdom, the Medical Council of New Zealand, the National Alliance for Physician Competence in the United States and the Royal College of Physicians and Surgeons in Canada. In addition, sections of the code were informed by relevant guidelines issued by the National Health and Medical Research Council and by guidelines developed by specialist medical colleges in Australia and New Zealand.

Authority

This code is issued under section 39 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

Review

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Date of review: This code of conduct will be reviewed from time to time as required. This will generally be at least every three years.

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