Medical Council
OF NEW SOUTH WALES

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Spotlight on prescribing

When it comes to prescribing, doctors often find themselves treading a complex path through what can be a clinical, ethical and legal minefield.

Prescribing irresponsibly can cause harm. Prescribing responsibly, including choosing not to prescribe, can be a source of patient dissatisfaction and complaint. In fact, prescribing generates about 12% of all complaints to the Council, according to our in-house statistics.

Dr Greg Kesby, outgoing President, Medical Council of NSW

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Changes at the Medical Council

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New Council members announced

The Council's President Dr Greg Kesby, Professor Anthony Eyers, and community member Mr Kenneth Hong completed their terms on 30 June 2018.

Associate Professor Richard Walsh was appointed the new Council President on 1 July with Dr John Sammut appointed as the new Deputy President.

Two new members, Dr Geoffrey Brieger, nominee of the Royal Australian and New Zealand College of Obstetrics, and Dr Elizabeth Tompsett (pictured), nominee of the Royal Australian College of Surgeons, were also appointed.

Prescribing drugs - the issues facing doctors

Prescribing drugs of addiction

Did you know that when you prescribe drugs of addiction (Schedule 8 drugs) to someone you think may be an addict you must first be issued with an authority by the NSW Ministry of Health? A lot of doctors don't.

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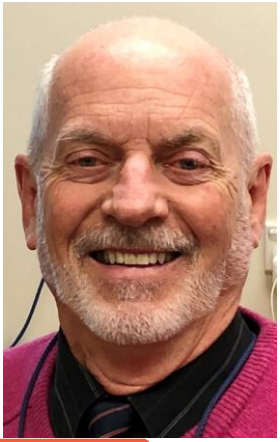
Perils of prescribing

We interview Bruce Battye, the Director of the NSW Pharmaceutical Regulatory Unit about key prescribing issues facing doctors.



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Doctor Shopping - Frequently Asked Questions

How to identify doctor shoppers

Here are some frequently asked questions to help doctors identify a drug dependent patient who may be doctor shopping and some useful techniques to help you cut off trouble before it starts.

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"Australians are two-and-a-half times more likely to die from an opioid overdose prescribed by a doctor or stolen from a hospital, than from street drugs."

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When you're the doctor in the family - just say No

Do you sometimes dread the family barbecue? When Uncle Bill asks about his bad hip or your sister-in-law asks if you could ‘just write a quick script’ for her son’s asthma?

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Good Practice: Seven ages of a doctor

A doctor’s career will go through many transitions: from earnest medical student to sleep deprived hospital doctor, from a busy life in general practice to an active retirement.
With each transition comes fresh challenges – some will be exciting and invigorating, and some will be difficult and stressful. Whatever the transition, doctors need to think ahead and plan for significant career changes.

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New medical certificate guidelines

Medical certificates are a common source of complaint to the Medical Council.

Find out more about the new Medical Certificate Guidelines.

Read more

Honours for NSW doctors

This year's Queen's Birthday Honours list has recognized the work of many NSW doctors and medical researchers, including the late professor David Cooper, who received a Companion of the Order of Australia.

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President's message - Prescribing

When it comes to prescribing, doctors often find themselves treading a complex path through what can be a clinical, ethical and legal minefield.

Prescribing irresponsibly can cause harm. Prescribing responsibly, including choosing not to prescribe, can be a source of patient dissatisfaction and complaint. In fact, prescribing generates about 12% of all complaints to the Council, according to our in-house statistics. It is a greater generator of complaints than disrespectful communication, inadequate medical record keeping, the crossing of physical or sexual boundaries or concerns about a doctor's own health.

Complaints about prescribing are also increasing; on average by 20% annually for the past four years. The main complaints relate to the prescribing of drugs of addiction, inappropriate or non-evidence-based prescribing, and refusal to prescribe.

Not infrequently, some of these complaints actually reflect well on a doctor. Being complained about by a 'doctor shopper' to whom you have refused to prescribe an opioid is obviously a good thing. The Council easily recognizes this, as the assessments of all complaints about doctors brought to our attention are assessed by clinically active medical practitioners.
"a lack of professional rigour around prescribing standards may result in increasing pressures to engage in inappropriate prescribing practices."

But some prescribing habits do not reflect well on either the individual practitioner or the profession as a whole. In some instances, a lack of professional rigour around prescribing standards may result in increasing pressures to engage in inappropriate prescribing practices. Sadly, time and time again we have seen this slippage come to eventually result in professional crisis.

The stories, ideas and tips on this newsletter are drawn from our experience with complaints about prescribing. I hope that they may be of assistance to you.

After more than 10 years involvement with the former NSW Medical Board and the Medical Council of NSW, I reached the statutory limit on my term of service on 30 June.

I would like to thank all those who have assisted me over my time as President, in particular my Council, the Executive Officer Ms Caroline Lamb, and all of the Council staff at Gladesville.

I would also like to extend a sincere thank you to the more than 30,000 medical practitioners in NSW who continue to provide high quality care and breathe life into our Code of Conduct in the hundreds of thousands of teaching, research and clinical-care episodes we collectively engage in every day.

His Excellency General The Honourable David Hurley AC DSC (Ret'd), Governor of New South Wales, has appointed Associate Professor Richard Walsh as the next President. His Excellency's much quoted maxim of *'the standard you walk past is the standard you*

accept' is a value that I found myself often referring to when calibrating Council discussions and 'right-touch' regulatory oversight of the profession.

I extend to Richard and the new Council my very best wishes as they continue effecting their protective responsibility of ensuring appropriate professional standards in the delivery of care by medical practitioners and safeguarding the continued confidence of the public in our honourable profession.

Greg Kesby, outgoing President, Medical Council of NSW

Changes at the Council

A number of new Medical Council members have been appointed. From 1 July 2018, the new Council members are:

President

Associate Professor Richard Walsh.

Associate Professor Walsh has been a member of the Council since 2012. He is a Visiting Medical Officer (Anaesthetics & Medical Pedusion) at the Royal Prince Alfred Hospital, Strathfield Private Hospital, the Mater Hospital Sydney and the Macquarie University Hospital.

He holds the positions of Clinical Associate Professor at Macquarie University and Adjunct Associate Professor at the University of Sydney.

He is the former head of Cardiothoracic Anaesthesia and Medical Perfusion at Royal Prince Alfred Hospital, and is a Fellow of the Australian Society of Anaesthetists.

Professor Walsh was the Deputy President of the Council.

Deputy President

Dr John Sammut has been appointed Deputy President of the Council.

Dr Sammut has been a member of the Council since 2014. He is currently the Director of the lntensive Care Unit at Canterbury Hospital.

He has been a representative of the Primary Examination Committee for the Australasian College for Emergency Medicine since 1998.

New Appointments

The two new Council members are:.

Dr Geoffrey Brieger

Dr Geoffrey Brieger, nominee of the Royal Australian and New Zealand College of Obstetrics and Gynaecology

Dr Brieger holds an appointment at the Mater Hospital and is in private obsteric practice.

He has been practising medicine for over 30 years and has been a specialist for 22 years.

He has been a Fellow of the Royal Australian and New Zealand College of Obstetrics and Gynaecology since 1995, and has worked as a senior consultant in obstetrics and gynaecology at Royal Prince Alfred and Royal North Shore.

Dr Elizabeth Tompsett

Dr Elizabeth Tompsett, nominee of the Royal Australasian College of Surgeons

Dr Tompsett has been a Visiting Medical Officer in General Surgery at the Hawkesbury District Health Service since 2000, and is a Fellow of the Royal Australasian College of Surgeons.

Dr Tompsett is the Chair of the Medical Staff Council, Medical Advisory Committee, and Medical Appointments Committee of the Clinical Advisory at Hawkesbury Hospital.

She is currently an instructor in Early Management of Severe Trauma for the Royal Australasian College of Surgeons and has also worked as a Clinical Examiner for Basic Surgical Training.

View a full list of all 19 Council members.

Schedule 8 - Prescribing Knowledge Gap

Did you know that when you prescribe drugs of addiction (Schedule 8 drugs) to someone you may need an authority by the NSW Ministry of Health?
Many doctors don't.

An authority from the Ministry of Health is required to prescribe or supply a drug of addiction to:

- a drug dependent person; or to
- any person who is prescribed or supplied with drugs of addiction continuously for more than two months.

It is important to remember that an authority from the NSW Ministry of Health is not the same as an authority from Medicare Australia, which is for the purposes of a subsidy under the Pharmaceutical Benefits Scheme (PBS).

The NSW Ministry of Health form 'Application for Authority to Prescribe a Drug of Addiction' is available here:
http://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/default.aspx

To find out more details about s.8 drugs, visit the NSW Ministry of Health website: http://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/prescribe-S8-opioid.aspx

Interview with Bruce Battye Pharmaceutical Regulatory Unit

The Director the NSW Pharmaceutical Regulatory Unit, Bruce Battye discusses what his unit does and key prescribing issues doctors need to be aware of.

What is the Pharmaceutical Regulatory Unit (PRU) and what does it do?

The PRU is part of the Legal and Regulatory Services Branch of the NSW Ministry of Health. The Unit is responsible for the administration and enforcement of the Poisons and Therapeutic Goods Act 1966 and the Poisons and Therapeutic Goods Regulation 2008.

The Unit aims to minimise risk:

- arising in the course of the prescription, manufacture, sale, supply, storage, handling, use and disposal of medicines and poisons, and
- of medicines and poisons being diverted for unlawful purposes.

The PRU issues authorities to prescribe Schedule 8 drugs and a wide range of other authorities, including for the possession and supply of prohibited drugs for research purposes. The Unit licenses wholesale distributors of medicines, and undertakes inspections and investigations to ascertain compliance with the Poisons and Therapeutic Goods legislation.

What type of prescribing creates the most trouble for doctors?

At the PRU inappropriate prescribing of Schedule 8 drugs is given priority. In NSW the abuse of prescription opioids - together with the associated risks of dependency and overdoses - is now a greater problem than illicit heroin.

The prescribing of high dose oxycodone, high dose fentanyl transdermal patches and injectable opioids are of particular concern. This concern is escalated with the concomitant prescribing of benzodiazepines, including alprazolam.

Prescribing of opioids to drug dependent patients without authority is a serious concern because of another prescriber who is already authorised to prescribe Schedule 8 opioids, the patient is at risk of an overdose.

It is very important to remember that an authority to prescribe Schedule 8 drugs issued by NSW Health is independent of an authority to prescribe under the Pharmaceutical Benefits Scheme (PBS) which is for the purpose of subsidising the costs of medicines to patients.

Fentanyl has been in the media quite a lot lately. What should doctors be aware of when it comes to this drug?

The Unit is concerned that some doctors are prescribing fentanyl 100 mcg per hour transdermal patches to drug dependent patients without apparently recognising that the

application of one 100mcg patch each 72 hours is the equivalent of an oral morphine daily dose equivalent of 300mg (oMEDD = 300mg).

For more information: http://fpm.anzca.edu.au/documents/opioid-dose-equivalence.pdf

The injection of fentanyl extracted illegally from these patches is therefore of high risk, and may lead to overdose and death.

Fentanyl transdermal patches have high trafficking value.

Doctors should be aware of the potential for trafficking of fentanyl transdermal patches when requested to prescribe these without adequate justification. This is especially the case with requests for private (non-PBS) prescriptions.

All drugs should be prescribed within "recognised therapeutic standards" – what does this mean?

Whether we are considering Schedule 4 or Schedule 8 drugs, there will generally be no issue with recognised therapeutic standards when prescribing within the Therapeutic Goods Administration's published approved indications and at recommended doses (according to the approved Product Information).

Some examples of prescribing outside of recognised therapeutic standards of concern to the PRU include prescribing phentermine as a stimulant to truck drivers, prescribing benzodiazepines long term for the purpose of maintaining a dependency, prescribing somatropin and anabolic androgenic steroids for body building, and prescribing of fentanyl 100microgram/hour transdermal patches at an application rate of more than one every 72 hours, or as private prescriptions for supply of two, three or more packs at a time.

What should doctors take into account if they wish to prescribe off label medicines?

The evidence base should be considered for any prescribing off label medications that are not in accordance with the approved indications of evidence accepted by relevant specialists or their specialist professional colleges. Evidence could include: evidence recognised in clinical practice guidelines (such as Therapeutic Guidelines; evidence published in recognised peer reviewed journals.

Doctors should also consider whether off label prescribing is acceptable to their indeminity insurers.

And what about prescribing non-evidence based drugs?

Outside a clinical trial framework, prescribing non-evidence based drugs may precipitate a complaint of professional misconduct. Prescribing drugs without an acceptabale evidence base should be regarded as experimental, where patient health and welfare may well be put at unacceptable risk.

An example is the prescribing of melanotan II, prescribed as a pharmacy compounded medicine for the lifestyle purposes of sunless tanning, appetite suppression and sexual stimulation.

The Therapeutic Goods Administration has stated that in the absence of any detailed risk analysis, there is no clinical and efficacy data related to melanotan II, and the side effects and toxicity profile greatly outweigh any benefits of use.

For more information about the PRU go to:

http://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/default.aspx

How do you identify a doctor shopper?

There are the obvious signs that you may have a doctor shopper in your consulting room. They:

- have lost or misplaced their medications
- are a long way from home
- request a drug by its specific name or a specific dosage – and refuse all other therapeutic options
- seek opioids, benzodiazepines or stimulants
- display signs of anxiety or agitation when discussing their prescriptions
- may exhibit the classic physical signs of drug abuse: dilated or constricted pupils, extreme excitability or fatigue, and poor personal hygiene.

But are doctor shoppers becoming harder to spot?

Doctor shoppers have certainly become more sophisticated.

Recently a doctor shopper gave a GP the mobile phone number of his “regular doctor”. This doctor was, in fact, an accomplice playing the role of friendly medical colleague over the phone.

In another recent case, a doctor shopper impersonated a policeman and convinced a GP that he needed drugs for an “undercover case” he was working on.

Others employ an older patient on pain medication to supplement their income by being a proxy doctor shopper for a third party. Among doctor shoppers this practice is known as ‘fossil farming’.

How do you handle a drug dependent patient?

Anytime a patient **requests** a medicine that is subject to abuse a doctor should be very circumspect.

Before prescribing for the patient the doctor must be satisfied – based on clear and reasonable medical judgement – that the medication requested is the most appropriate for the situation.

If you suspect a patient is drug-dependent it is illegal to prescribe them **Schedule 8**medications – such as OxyContin, Fentanyl, MS Contin, and Xanax - without prior written approval from the NSW Ministry of Health (For more information see the Hot Button Issue in this newsletter).

If someone you suspect is drug dependent requests an S8 medication you should politely but firmly decline such a request.

You could refer the person to a community Drug and Alcohol Unit, or for general advice on handling drug-seeking patients you could call the Duty Pharmaceutical Officer at Pharmaceutical Services (NSW Ministry of Health) during business hours on **(02) 9391 9944**.

What are some techniques for managing a doctor shopper?

Managing an encounter with a doctor shopper can be frustrating, and sometimes a bit frightening.

The first question you should ask yourself is simple: what kind of doctor shopper are you dealing with?

Are they already heavily dependent on the drug they are seeking? Maybe they seeking prescription drugs to deal with withdrawal symptoms from illicit drugs? Depending on the patient's state, it might be possible intervene clinically to help them.

But it's also possible that the doctor shopper in your consult room is simply a criminal, drug dealer hoping to sell prescription drugs to support their illicit habit or just to make money?

Be firm and polite and refuse their request.

How can I cut off trouble before it starts?

If a doctor suspects that a patient is a doctor shopper, they can call Medicare Australia's Prescription Shopping Information Service on **1800 631 181** to obtain a summary of what PBS medicines have been supplied to the patient from community pharmacies. But remember: doctors must first register with the service.

As it's easy for a doctor shopper to add an extra zero to a digit, remember you are required to record the amount to be dispensed in both words and numbers on the prescription.

Also, always put several lines through unused space on the prescription and keep your prescription pad or spare script paper for eprescribing in a secure location.

To register with the Prescription Shopping Information Service, go to: https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/prescription-shopping-programme

For more on handling drug dependent patients, see this resource from the NSW Ministry of Health: http://www.health.nsw.gov.au/pharmaceutical/doctors/Pages/faq-medical-practitioners.aspx

For more on making general practice a safe place, see this resource from the RACGP: https://www.racgp.org.au/download/Documents/PracticeSupport/17185-general-practice-a-safe-place.pdf

Doctors over prescribing opioids

When it comes to prescription drug addiction, doctor shoppers are not the whole story.

Australians are two-and-a-half times more likely to die from an overdose of an opioid prescribed by a doctor, or stolen from a hospital, than from a hit of illegally imported heroin bought on the street.

Opioids are now more widely available in little bottles with child proof caps, or in mass produced lozenges and patches, than in unmarked zip-lock plastic bags.

But this is not due solely to doctor shoppers gulling naive doctors. As Central Coast GP Dr Paul Muthiah wrote recently in **Australian Doctor**, "blaming the conniving doctor shopper doesn't wholly address the issue".

Firstly, Australian doctors are prescribing opioids like never before. Since 2009, Australia has seen a massive general increase in opioid prescriptions – rising from 10 million to 14 million annually.

Secondly, the majority of people overdosing on prescription drugs are not the stereotypical doctor shopper. In seven out of 10 prescription drug overdose cases examined by the Victorian Coroners Court, for example, the deceased had only seen just one GP.

Given this context, Dr Muthiah has a fairly blunt message for his colleagues in the medical profession: "What I am talking about is our failure as GPs to address our role in the crisis and alter our prescribing choices".

Speaking late last year, the Executive Officer of the Victorian Alcohol and Drug Association Sam Biondo told the ABC that opioid addiction can be difficult to identify and treat, especially in patients who don't fit the doctor shopper stereotype. He also argued that "sloppy prescribing practices" have contributed to Australia's increasing rates of prescription drug addiction.

Some observers have put this down to "indication creep": the increasing use of opioids in the management of chronic non-cancer pain.

Despite the fact that, according to the **Medical Journal of Australia**, "there is limited evidence of the long term efficacy of opioids for chronic non-cancer pain", some doctors continue to prescribe them in just such cases.

An added layer of complexity arises from the expectations of patients. Nowadays many patients assume they will walk away from a doctor's appointment with a script for a pharmaceutical fix to their problem.

Earlier this year the Therapeutic Goods Administration (TGA) issued a discussion paper on the use and misuse of strong prescription opioids. Among other things, the discussion paper aimed to "increase health care professional awareness of alternatives to opioids in the management of chronic pain".

In its submission to the TGA, the Australian Rheumatology Association (ARA) proposed general practitioners should have restrictions placed on their ability to prescribe higher dose Schedule 8 opioids.

The ARA argued that this would help to break a growing trend among those GPs who are inappropriately prescribing these medicines to patients with treatable diseases.

To view the MJA article go to:
https://www.mja.com.au/journal/2016/204/8/using-opioids-general-practice-chronic-non-cancer-pain-overview-current-evidence

For the ABC article see:
http://www.abc.net.au/news/2017-11-21/doctor-shoppers-not-at-heart-of-prescription-opioid-crisis/9167606

To view the submissions to the TGA see:
https://www.tga.gov.au/submissions-received-prescription-strong-schedule-8-opioid-use-and-misuse-australia-options-regulatory-response

Just say no

Do you sometimes dread the family barbecue? When Uncle Bill asks about his bad hip or your sister-in-law asks if you could 'just write a quick script' for her son's asthma?

According to **Good Medical Practice – A Code of Conduct**: “whenever possible avoid providing medical care to anyone with whom you have a close personal relationship”.

A doctor who provides care to people they know well – family, friends, work colleagues – may be acting unprofessionally because they will lack the objectivity required of a medical practitioner.

It is a risk to both the friend or relative and the doctor because continuity of care could be affected.

Of course, sometimes offering care to friends, family, or work colleagues is unavoidable. Accidents happen. Crises occur.

But as **The Code of Conduct** advises: “good medical practice requires recognition and careful management of these issues”.

It’s a judgment call. Doing CPR on a friend who collapses on a fun run is very different from getting into the habit of writing scripts for your asthma-suffering nephew.

So tell them you’d love to, but you can’t.

Tell them it’s not worth the risk to them or to you.

Tell them that without proper medical assessment their medical care is being compromised.

Tell them that the Medical Council of NSW – which regulates the behavior and practice of all the doctors in NSW – recommends against it.

Good Practice - ‘The Seven Ages of a Doctor’

A doctor’s career will go through many transitions: from earnest medical student to sleep deprived hospital doctor, from a busy life in general practice to an active retirement - all the while trying to manage family life, earn a living, and hopefully find some time for hobbies along the way.

With each transition comes fresh challenges – some will be exciting and invigorating, and some will be difficult and stressful. Whatever the transition, doctors need to think ahead and plan for significant career changes.

In this newsletter we look at an increasingly common transition, from the perspective of two Sydney doctors: moving from a privately owned practice to a corporate practice.

Dr Michael Chambers: “It’s a great way to bundy out of general practice”

Dr Michael Chambers is a seasoned GP who has worked on Sydney’s Northern Beaches since the mid 1970s. He’s from the old school of general practice - 24 hour on call, cradle to grave, home visits, and delivering babies - 2000 of them at the last count.

When he started his career, Dr Chambers worked solo or in small practices. By the late 1990s he was running what he describes as a “boutique practice” with two associates.

“I was as busy as a bee and as happy as a pig in mud”, he tells me.

But by the time he entered his fifties, Dr Chambers started to think about the future. He was still passionate about medicine, but he wasn’t so keen on spreadsheets and BAS forms.

He wanted to lay down a new path for the future that would allow him to slow down a bit, but also ensure his loyal patients were getting good care.

He amalgamated his practice with another local multi-doctor practice and they brought in a management company to handle the day-to-day running of the business.

It was a disaster.

The management company collapsed owing millions, including to them. An expensive, energy-sapping court case followed.

Despite this setback, the practice itself had been a big success.

“I think it was because we were practising good medicine, and we had good rooms and good staff”, he says.

Now older, wiser - and poorer - Dr Chambers was forced to look around again for management support. This time he and his partner chose the corporate route and joined a major operator of general practice medical centres.

Before signing up, Dr Chambers had some concerns.

“I didn’t want them to force me to see a lot of extra patients. I wanted to practise in a similar style, and with the same ethics, as I had done in the past. I didn’t want them to dictate how we practised medicine”.

Such concerns never arose, he says.

“It turned out to be one of the best things we’ve ever done professionally”.

He also enjoys the collegiality of the now large practice.

“We’re working with each other. We’re stimulating each other. And we have visits from other health professionals to stimulate us even further. I think my medicine has improved since I’ve become a corporate doctor”.

Dr Chambers turns 70 next year and is looking forward to handing in his stethoscope and leaving behind a happy, well run practice.

“It’s a great way to bundy out of general practice”, he says.

When I spoke to Dr Chambers it was late on a Wednesday morning and he had just finished one of his regular bike rides. He now works three days a week.

There may have been some bumps along the way, but in Dr Chambers’ transition from private practitioner to corporate practice, the road to the finishing line of his career has been made a lot smoother.

Dr Margaret Gottlieb: “I was really run off my feet ...And I just thought: I want to stop doing this”

After graduation Dr Margaret Gottlieb spent five years working in hospitals as a paediatric registrar. In 1981 she started a general practice in Sydney’s Inner West.

“It was in a little house, basically. It was a sort of cottage industry general practice [with] a bunch of women all working part time”, she says

For the next two decades she happily plied her trade and then at the turn of the century she made a momentous decision.

It was the early days of corporate medicine in Australia and one of the big new medical practices was setting up in her area. Dr Gottlieb was cagey, but interested.

“I was really run off my feet. I had three small children. I was running a business. I was employing people. I had to work a lot of the school holidays. And I just thought: I want to stop doing this”, she explains.

So she jumped – on a handshake agreement. Almost from the beginning it was a bad fit.

Despite earlier assurances that she could continue to bill privately, they insisted she bulk bill. The company complained she didn’t see enough patients per day. Then they insisted she use their radiologist, which she declined to do. It wasn’t how she wanted to practise medicine.

Dr Gottlieb happily admits to a stubborn streak, and she worked hard to make the deal work the way she was comfortable with, but after eight years she’d had enough.

“I can’t say I was happy there, but I tried to make it work for me”, she says.

In 2008 she shifted to her husband's small private practice on the Lower North Shore, many of her patients followed her across the harbour - and she hasn't looked back since.

Today she is what you might call a 'portfolio medico': she works part-time in the practice with three other doctors; she lectures at a university; and she works in mental health.

Dr Gottlieb is also writer who maintains an active cultural life. When I spoke to her she was just back from spending a long weekend at the Bellingen Writers' Festival. She's also involved with Creative Doctors, which highlights the creative things doctors do when they're not being doctors. Each year they organize literary and visual arts events and performances.

"In fact, I should wind back something, but I don't know what to wind back because I really like it all!"

But with two elderly relatives to look after, and poetry to write, at least she now has the option of reducing her workload with relative ease if she feels the need.

New medical certificate guidelines

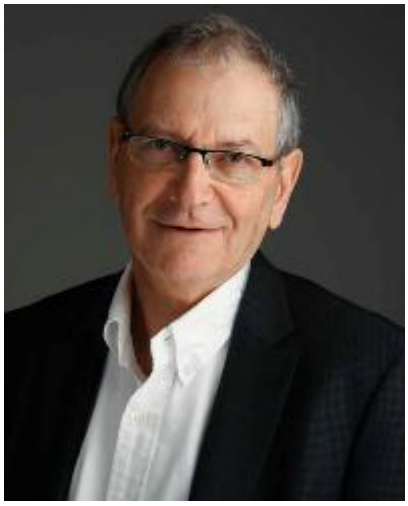
When it comes to medical certificates there are several points to remember:

- It is important when writing a certificate to have medical records which substantiate the certificate
- A doctor must always ensure that the patient's right to confidentiality is respected and that a diagnosis is not included in the certificate without the patient's consent, and
- If a certificate is written by a doctor after the patient has taken sick leave, the certificate must state the date it was written, it must not be backdated but it may cover the medically justifiable period that in the opinion of the doctor the patient would have been unfit for work.

The Council's new Medical Certificate Guidelines can be found at: https://www.mcnsw.org.au/sites/default/files/medical_certificate_guideline_-_medicalcouncilnsw-june_2018.pdf

Queen's birthday honours for NSW doctors

This year's Queen's Birthday Honours list has recognized the life's work of many doctors and medical researchers from NSW, including the late Professor David Cooper, who received a Companion of the Order of Australia.
Companion of the Order of Australia (AC)



Professor David Cooper

The late **Professor David Albert Cooper**, AO, was awarded a posthumous Order of Australia for his service to medicine.

Professor Cooper dedicated his life to the prevention, treatment, and cure of HIV and other infectious diseases, and advocated for a person's health to be regarded as a fundamental human right. With Professor Ron Penny, he diagnosed the first case of HIV in Australia.

He was an internationally renowned leader in his field of immunology, and initiated ground-breaking, collaborative infectious disease research that saved countless lives in Australia, and around the world.

Professor Cooper was the Director of the UNSW's Kirby Institute since its establishment in 1986.

He passed away on 18 March 2018 after suffering for a short period from a rare auto inflammatory disease.

Officer in the General Division (AO)

Associate Professor Katherine Tucker from Sydney's Prince of Wales Hospital was awarded an AO for her distinguished service to medicine in the field of familial cancer genetics.

She was also recognized for her work as a clinician, researcher and author; and for her contribution to medical education and to professional bodies.

Dr Tucker established the first Hereditary Cancer Clinic Service in Australia in 1994 and is the Chair of the Family Cancer Clinics of New South Wales.

Member (AM) in the General Division

Professor Rodney John Baber was awarded an AM for significant service to medicine in the field of obstetrics and gynaecology, as both a clinician and researcher.

Professor Mark Ashley Brown was awarded an AM for significant service to medicine in the field of nephrology, and to medical research, particularly hypertension in pregnancy.

Associate Professor Geoffrey David Champion was awarded an AM for significant service to medicine in the field of paediatric rheumatology; and for his contributions to medical research in the treatment of musculoskeletal pain.

Dr Michael Gerard Cooper was awarded an AM for significant service to medicine in the field of anaesthesia; as a clinician, teacher, mentor and historian.

University of Sydney **Professor Anthony James Gill** was awarded an AM for significant service to medical research in the field of surgical pathology; as an academic, author, adviser and mentor.

Professor Andrew Stewart Kemp, Inaugural Chair in Paediatric Allergy and Clinical Immunology at Children's Hospital Westmead, was awarded an AM for significant service to medicine, and to medical education, as a clinician, academic and researcher.

Adjunct Professor of Surgery at the University of Notre Dame, Dr Terence William O'Connor was awarded an AM for significant service to medicine, particularly as a colorectal surgeon, and as an educator, clinician and administrator of medical organisations.

Former President of the Australian Medical Association, **Professor Brian Kenneth Owler** was awarded an AM for significant service to medicine through the leadership and administration of professional medical organisations, and to medical education.

Sydney University's Emeritus Professor David Harry Sonnabend was awarded an AM for significant service to medicine in the field of orthopaedics, both as a clinician and an administrator, and to medical education.

Dr Philip Geoffrey Thompson was awarded an AM for significant service to medicine as a plastic and reconstructive surgeon; to health initiatives in South East Asia; and to professional organisations.

Medal (OAM) in the General Division

Dr Peter Chester Arnold was awarded an OAM for service to medicine through a range of roles with professional organisations, and as a general practitioner.

The late **Dr Keith Francis Beck** was awarded an OAM for service to medicine through a range of roles.

University of New South Wales **Associate Professor Terry Dorcen Bolin** was awarded an OAM for service to medicine in the field of gastroenterology.

Dr Alan Edward Bray was awarded an OAM for service to medicine, particularly to vascular surgery.

Clinical Associate Professor Michael James Cooper from the University of Sydney was awarded an OAM for service to medicine in the field of gynaecology.

Dr Simon John Grant was awarded an OAM for service to medicine, particularly to endocrinology.

Associate Professor Paul Richard McKenzie was awarded an OAM for service to medicine, particularly to anatomical pathology.

Dr Kim Alexander Ostinga was awarded an OAM for service to medicine, particularly to orthopaedics.

Dr Sudarshan Kumar Sachdev was awarded an OAM for service to the community, and to medicine, particularly ophthalmology.

Emeritus Professor Bruce Albert Warren was awarded an OAM for service to medicine; and to medical education, particularly in pathology.