Living and Working in Western Australia:
An Orientation Manual for International Medical Graduates

Medical Workforce Branch
Office of the Chief Medical Officer

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Acknowledgements

This document, Living and Working in Western Australia – an Orientation Manual for International Medical Graduates has been developed by the Medical Workforce Branch of the Western Australian Department of Health, with funding provided by Health Workforce Australia. The Medical Workforce Branch acknowledges that some of the material used in this manual builds on Working in Victoria’s Public Hospitals – an orientation guide for International Medical Graduates (14th edition) published by the Postgraduate Medical Council of Victoria with funding provided by the Victorian Department of Health. The Medical Workforce Branch would also like to acknowledge reference to the document International Medical Graduate Orientation Handbook (2nd edition) developed by the Central Coast Local Health Network and the Northern Sydney Local Health Network, part of New South Wales Health.

We gratefully acknowledge the work of these organisations and the additional advice and feedback received during consultation with a number of groups and individuals representing International Medical Graduates, employers, supervisors and professional bodies.

Disclaimer

This Orientation Manual is provided as an information source only and readers are encouraged to make their own assessment of the material provided and to seek the most current information directly from the organisations referenced in this manual and other relevant organisations.

The information provided does not constitute professional advice and should not be relied upon as such. Formal advice from appropriate sources and organisations should be sought before making any decisions.

The Department of Health does not accept liability to any person for the information or advice contained in this manual.

While every effort is made to ensure accuracy, the information contained in this manual is subject to regular change. Accordingly it is the responsibility of the reader to make their own decision about the relevance and accuracy of the material contained in this document.

Further information: Department of Health website for International Medical Graduates

Terminology

Use of the term “International Medical Graduate” within this document refers to doctors who obtained their primary medical qualification outside Australia. An alternate term which may be used elsewhere is overseas trained doctor.

The use of the term “Aboriginal” within this document refers to Australians who identify as Aboriginal and/or Torres Strait Islander people.

This project was possible due to funding made available by Health Workforce Australia
## Contents

- **Foreword** .......................... 8
- **Helpful information** ............... 9

### Section 1  Australian healthcare system  11

#### 1.1 Medicare – access to health care as a public patient  12
- The Medicare levy ........................ 12
- Australian Government rebate on private health insurance  12
- Accessing Medicare ....................... 13
- Reciprocal Health Care Agreements ...... 13
- Centrelink Health Care Card ............... 13
- Medicare provider number for medical practitioners ......... 13
- Billing arrangements by doctors ............ 14

#### 1.2 Pharmaceutical Benefits Scheme  14
- Patient charges .......................... 14
- Safety net schemes ......................... 15
- Prescriber numbers for medical practitioners .......... 15
- Pharmaceutical Benefit Scheme prescribing ........... 15

#### 1.3 Private health care  16
- Private health insurance rebate .......... 16

#### 1.4 Department of Veterans’ Affairs  16

### Section 2  Western Australian healthcare system  17

#### 2.1 WA public health service  17

#### 2.2 Metropolitan health service providers  18
- Child and Adolescent Health Service  18
- North Metropolitan Health Service  18
- South Metropolitan Health Service  19
- East Metropolitan Health Service  19

#### 2.3 Country health services  19
- Kimberley health ........................ 20
- Pilbara health ............................ 20
- Midwest health ........................... 20
- Goldfields health ......................... 21
- Wheatbelt health .......................... 21
- South west health ......................... 21
- Great southern health ...................... 21

#### 2.4 Community health services  23
2.5 Dental health services 23
2.6 Public health services and health protection 23
2.7 Mental health services 23
2.8 Private health services in WA 24
2.9 Other health service organisations 25
  Community-based services 25
  Emergency services 26
  Other organisations 26

Section 3 Communication and cultural awareness 28
3.1 Australian society 28
  Meeting people and communicating with them 29
  Polite behaviour 29
  Clothing 29
3.2 Aboriginal Australians 30
  Western Australian Aboriginal population 31
  Aboriginal patients 32
3.3 The Australian patient 32
3.4 Cultural awareness 33
3.5 Training in cultural awareness 34
3.6 Communication 34
3.7 Professional conduct of doctors 35
  Working with Children 36
  Mandatory reporting of child sexual abuse 36
  Child neglect 36

Section 4 Australian Law 38
4.1 Criminal offences 38
4.2 Violence 38
  Domestic or family violence 38
  Sexual assault 39
  Legal age of consent 39
  Rights of children 39
  Child protection 39
  Forced early marriage 39
4.3 Female reproductive health and rights 40
4.4 Drugs, smoking and drinking 40
  Tobacco 40
  Alcohol 40
Section 5  Registration of doctors in Australia

5.1  Medical Board of Australia
- Registration with the Medical Board of Australia
- Health assessments and monitoring
- Revised Guidelines
- Revised registration standards

5.2  Australian Medical Council
- Primary source verification
- Examinations

5.3  Competent Authority Pathway

5.4  Specialist Pathway

5.5  Standard Pathway
- Workplace-based assessment in WA

5.6  Professional development and education
- Specialist Colleges
- Professional Organisations
- Support Organisations and Services

Section 6  Working in Western Australia

6.1  Working in hospitals
- Hospital structure
- Role of hospital doctors
- Orientation to the hospital
- Performance reviews
- Communication and handover
- Interactions with nursing staff
- Discharge planning and communication with General Practitioners
- Hospital emergency departments
- Support and assistance
- Rosters
- Pay rates

6.2  Occupational safety and health

6.3  Imaging and pathology: ordering and reporting

6.4  Prescribing medications

6.5  Schedule 8 medicines

6.6  Medical credentialing and defining scope of practice

6.7  Infection control
Hand washing 59
Wearing gloves 59
Handling sharp instruments 60
Exposure to blood or body fluids in the workplace 60
Immunisations 60
Infectious diseases 60
Responsibilities of treating medical practitioners 61

6.8 Taxation and insurance 61
Taxation 61
Salary packaging 61
Superannuation 61
General insurance and income protection 62
Professional indemnity insurance 62
WorkCover Western Australia Authority 63
Insurance Commission of Western Australia 63

6.9 Medico-Legal 63
Medical records 64
Medico-legal reports 64
Medical litigation 64
Patient confidentiality 64
Notifiable conditions 65
Patient rights 66
Patient complaints 66
Patient consent to treatment 2
Advanced Care Planning 4
Guardianship 5
Medical procedures involving children and mature minors 5
Freedom of information 6
Sexual harassment and unlawful discrimination 6
Violence, aggression and bullying in the workplace 7

6.10 Deaths in hospital 7
Deaths reportable to the coroner 7
Certification of death 8
Organ transplantation 8

6.11 Working in general practice 10
Restrictions to medical practice – the 10 year moratorium 10
Working in rural general practice 10
Visiting Medical Practitioners 11
Support for country doctors 11
Telehealth 12
General practice organisations 12
Section 7  Living in Western Australia 14
7.1  About Western Australia 14
   Local councils 14
   General information 14
7.2  Visa requirements 15
7.3  What to do soon after arrival 15
   Apply for a tax file number 15
   Register with Medicare 15
   Opening a bank account 15
   Register with Centrelink 15
   Contact the Health Undertaking Service 16
   Register for English classes 16
   Enrol your children in a school 16
   Apply for a driver’s licence 17
7.4  Housing and essential services 17
7.5  Private health insurance 18
7.6  Non-government and higher education 19
   Private/independent schools 19
   Tertiary education 19
   Vocational education 19
7.7  Employment for partners 19
7.8  Childcare 20
7.9  Emergency services 20
   Ambulance service 20
   Fire service 20
   Police service 20
   State Emergency Service 20
7.10 Transport 20
   Public transport 20
   Taxi services 21
   Uber 21
   Private vehicles 21
7.11 Information for seniors 21
<table>
<thead>
<tr>
<th>Appendix 1</th>
<th>Medication terminology</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose frequency or timing</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Route of administration</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>Unit of measure</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Dose forms</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Latin terms for other dose forms</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Dangerous abbreviations</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Health industry acronyms</td>
<td>25</td>
</tr>
</tbody>
</table>
International medical graduates (IMGs) play a vital role in helping the Western Australian public health system, WA Health, meet its service delivery responsibilities. A significant percentage of doctors in WA trained overseas, particularly those doctors working in country WA. Rural Health West reports that in November 2011, IMGs made up 52.5% of the rural and remote medical workforce.

This Orientation Manual has been developed for IMGs, and other medical practitioners not familiar with the WA health system, to provide an introduction to the WA and Australian health systems. It aims to cover the information required by doctors commencing work in WA and includes key areas of operation and management that will assist IMGs new to the WA health system.

This second edition of the Orientation Manual addresses the key areas identified by the Australian Medical Council in their Orientation Guidelines. It also provides practical advice on settling in WA and identifies professional support organisations and resources.

The manual also introduces workplace-based assessment, currently being piloted at two hospitals in country WA. This important program is allowing IMGs to gain general registration with the Medical Board of Australia through a practical and supportive assessment process.

The WA health system is a complex web of public and private organisations working together to provide health services across the hospital and community settings. As the amount of detail that can be provided in any manual is limited, wherever possible, advice has been included on where to access more detailed information through websites or other contacts.

We hope this manual provides you with the information you need to make a smooth transition to your new workplace and wish you success in establishing a fulfilling medical career in WA.

Kim Snowball
DIRECTOR GENERAL
DEPARTMENT OF HEALTH WA

12 March 2013
Helpful information

This orientation manual is maintained by the Medical Workforce Branch in the Office of the Chief Medical Officer within the Clinical Services and Research Division of the Western Australian Department of Health.

This orientation manual has been updated to ensure compliance with the Medical Board of Australia’s (MBA) revised [IMG Supervision Guidelines](#) introduced on 04 January 2016. These guidelines apply to all IMGs granted limited or provisional registration.

Included with this revision is the requirement for an orientation report. The following table lists the requirements of the MBA orientation report, indicating the corresponding section that addresses the requirements within this orientation manual. See section 5 of this manual for further information on the changes to the guidelines.

<table>
<thead>
<tr>
<th><strong>Orientation to the Australian healthcare system</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure and funding of the Australian healthcare system, interface between private and public health services</td>
<td>Sections 1.1 and 1.3</td>
</tr>
<tr>
<td>State Department of Health, Department of Veterans Affairs, Medicare Australia, WorkCover authority</td>
<td>Sections 2.1, 1.4, 1.1 and 6.8</td>
</tr>
<tr>
<td>Medical Board of Australia – registration, code of conduct, professional performance, conduct and health assessment and monitoring relevant under the Health Practitioner Regulation National Law as in force in each state and territory</td>
<td>Sections 5.1 and 3.7</td>
</tr>
<tr>
<td>Australian Medical Association (AMA), specialist colleges, postgraduate medical councils</td>
<td>Section 5.6</td>
</tr>
<tr>
<td>Provider and Prescriber numbers</td>
<td>Section 1.2</td>
</tr>
<tr>
<td>Prescribing – Pharmaceutical Benefits Scheme, authority prescriptions, therapeutic guidelines</td>
<td>Sections 1.2, 6.4 and 6.5</td>
</tr>
<tr>
<td>Doctor’s bag – legal requirements relating to S8 prescribing, drugs of dependence</td>
<td>Section 6.5</td>
</tr>
<tr>
<td>Referral system – pathology, radiology, other specialists, allied health services, hospital emergency departments, Ambulance</td>
<td>Sections 6.1, 6.3 and 2.9</td>
</tr>
<tr>
<td>Service, community services, sexual assault support services, local support groups. <em>NB: The employer should provide a list of service providers and their contact details</em></td>
<td>Sections 2.4, 2.5, 2.6, 2.7, 2.9, 4.2 and 5.6</td>
</tr>
<tr>
<td>Other contact phone numbers – supervisors, interpreter service, drugs and poisons information</td>
<td>Sections 2.9, 3.3, and 6.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Orientation to the hospital/practice</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and procedures manual — including infection control, patient confidentiality, clinical records, complaint processes</td>
<td><em>To be addressed by hospital during orientation</em></td>
</tr>
<tr>
<td>IT systems for example prescribing, pathology and radiology ordering and reporting</td>
<td><em>To be addressed by hospital during orientation</em></td>
</tr>
<tr>
<td>Infection control</td>
<td>Section 6.7</td>
</tr>
<tr>
<td>Occupational health and safety</td>
<td>Section 6.2</td>
</tr>
</tbody>
</table>
### Orientation to legislation and professional practice

<table>
<thead>
<tr>
<th>Topic</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislative framework governing practice in state or territory, including the Coroner’s Act</td>
<td>6.9 and 6.10</td>
</tr>
<tr>
<td>Mental health legislation</td>
<td>2.7</td>
</tr>
<tr>
<td>Mandatory reporting – suspected child abuse</td>
<td>3.7</td>
</tr>
<tr>
<td>Patient rights and responsibilities, patient complaints</td>
<td>6.9</td>
</tr>
<tr>
<td>Patient consent and adolescent autonomy</td>
<td>6.9</td>
</tr>
<tr>
<td>Access to health/medical records</td>
<td>6.9</td>
</tr>
<tr>
<td>Litigation and indemnity</td>
<td>6.8 and 6.9</td>
</tr>
<tr>
<td>Organ transplantation</td>
<td>6.10</td>
</tr>
</tbody>
</table>

### Professional development

<table>
<thead>
<tr>
<th>Topic</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical education and training</td>
<td>5.6</td>
</tr>
<tr>
<td>Access to clinical publications</td>
<td>5.6</td>
</tr>
<tr>
<td>Australian Medicines Handbook, therapeutic guidelines, relevant college guidelines, Cochrane library</td>
<td>5.6 and 6.4</td>
</tr>
</tbody>
</table>

### Cultural diversity and social context of care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural awareness and respect</td>
<td>3.1, 3.4, 3.6 and 7.1</td>
</tr>
<tr>
<td>Australian society, including multiculturalism, the status of women, children and the elderly</td>
<td>3.1, 4.2, 4.3, 7.1, 7.11</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander culture</td>
<td>3.2</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>4.2</td>
</tr>
<tr>
<td>Drug seeking patient</td>
<td>6.5</td>
</tr>
<tr>
<td>Doctor/patient relationship</td>
<td>3.7</td>
</tr>
</tbody>
</table>

### Other topics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical abbreviations</td>
<td>1</td>
</tr>
<tr>
<td>Health industry acronyms</td>
<td>2</td>
</tr>
</tbody>
</table>

Please send any requests for changes or additions to the Medical Workforce branch workplace based assessment email at: wbawa@health.wa.gov.au
Section 1 Australian healthcare system

- Australian government and funding
- Medicare: funding, who can access, provider numbers, billing arrangements
- Pharmaceutical Benefits Scheme: patient charges, prescriber numbers, prescribing
- Private health care
- Department of Veterans’ Affairs

Australia is a federation of six states and two territories governed by three tiers of government:

1. Australian government (also referred to as Federal or Commonwealth)
2. State / Territory government
3. Local government.

The Australian health system comprises a mixture of public and private service providers, supported by legislative, regulatory and funding arrangements, with responsibility distributed across the three levels of government, non-government organisations and individuals.

Funding is provided by all levels of government, health insurers, non-government organisations and individuals. Other funding sources which contribute to the use of health services by Australians include private insurance, accident compensation schemes and individual out-of-pocket contribution to the cost of services.

The Australian Government mainly contributes through three national health subsidy schemes, the Medicare Benefits Scheme (known as Medicare), the Pharmaceutical Benefits Scheme (PBS) and the 30 percent Private Health Insurance (PHI) Rebate.

- Medicare subsidises payments for services provided by doctors, optometrists, and some allied health professionals.
- The PBS subsidises payments for a large proportion of prescription medicines bought from community pharmacies.
- The 30 percent PHI Rebate supports people’s choice to take-up and retain private health insurance.

State, territory and local governments are responsible for delivery and management of public health services including public hospitals, mental health and dental health services, population health, community health centres and health promotion.

Supplementary support is provided by the Australian Government through social welfare arrangements, regional and remote programs, funding programs for chronic and complex conditions and healthcare arrangements for those associated with the Australian Defence Force through the Department of Veterans’ Affairs.

In addition there are private organisations which operate hospitals and accept fee-paying patients and patients for whom additional service-fees are covered by medical insurance companies. Some private hospitals may also provide services to public patients under contract to State governments.

This system aims to ensure that all Australians are well covered for their health care needs.

Australia’s Health 2016 provides additional information on Australia’s complex healthcare system.
1.1 Medicare – access to health care as a public patient

Medicare is Australia’s universal health insurance scheme which was introduced by the Australian Government in 1984 to ensure all Australians (and visitors from countries with whom Australia has signed a Reciprocal Health Care Agreement) have access to medical and hospital care when they need it.

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

Medicare is available to people in Australia who:

- hold Australian citizenship
- have been granted permanent resident status
- have applied for a permanent resident visa and meet certain other criteria
- are covered by a Reciprocal Health Care Agreement.

When admitted to a public hospital people eligible for Medicare can access free treatment as a public (Medicare) patient. The hospital will choose the doctors and specialists who treat them and the patient is not charged for care, treatment or after-care by the treating doctor or hospital. Medicare does not pay towards ambulance costs, most dental services, physiotherapy, spectacles, podiatry, chiropractic services, or private hospital accommodation.

People who choose to be admitted as a private patient in either a public or private hospital, are able to choose the doctor to treat them. Medicare will pay 75% of the Medicare schedule fee for the services and procedures provided by the treating doctor. If the patient has private health insurance, this may cover some or all of the outstanding balance. Private patients are charged for hospital accommodation and items such as theatre fees and medicines. These costs may be covered by private health insurance.

Further information: [Private health insurance](#)

Further information: [Range of services covered by Medicare](#)

The Medicare levy

Australian residents contribute to the funding of the Medicare scheme by paying a Medicare levy through the income tax system. The Medicare levy payable is based on your taxable income and is in addition to any other income tax payable. Normally, the Medicare levy is calculated at 2% of taxable income but this rate may vary depending on individual circumstances.

People whose taxable income is above a certain level and who don’t have private health insurance may have to pay the Medicare levy surcharge in addition to the Medicare levy.

Further information: [Medicare levy](#)

Australian Government rebate on private health insurance

Families and individuals who qualify for Medicare and who pay private health insurance premiums may be eligible for Australian Government rebates on private health insurance. If you are paying a registered hospital and/or general private health fund insurance, your costs may be reduced.
Further information: [Rebate on private health insurance](#)

**Accessing Medicare**

Any person eligible for Medicare will be issued with a Medicare card. This is a green plastic card issued by Medicare, printed with the holder’s name (and that of any other eligible family members) and Medicare number.

A Medicare card is required:

- when a person visits a doctor
- when a person wishes to make a claim for a benefit at a Medicare office
- to make enquiries with Medicare
- to show at a public hospital when a person seeks treatment as a public patient
- to show a pharmacist when a person takes a prescription to a pharmacy to be filled.

**Reciprocal Health Care Agreements**

Although overseas visitors holidaying in Australia are generally not entitled to receive services under Medicare, there are exceptions in the case of visitors from those countries that have a Reciprocal Health Care Agreement with Australia. These countries currently are United Kingdom, the Republic of Ireland, New Zealand, Sweden, the Netherlands, Finland, Belgium, Norway, Slovenia, Malta and Italy. Students from Norway, Finland, Malta and the Republic of Ireland aren't covered by agreements with those countries.

Further information: [Reciprocal Health care Agreements](#) and [Languages other than English](#)

**Centrelink Health Care Card**

Patients receiving Centrelink payments or earning a low income may be eligible for an Australian Government Health Care Card. The card entitles patients to a range of concessions, including the cost of medicines and the health services: doctor, dentist and ambulance. They will still need to present their Medicare card with their Health Care Card for all basic hospital and medical treatment.

Further information: [Health Care Card](#)

**Medicare provider number for medical practitioners**

In order for a doctor to provide services under Medicare, they must apply for and be granted a Medicare provider and prescriber number which enables Medicare to identify the health professional and the location at which the service was delivered. All doctors working in private and public hospitals require these numbers. Doctors working at a number of different locations need a provider number for each location.

Provider numbers are also used to identify practitioners for referral and diagnostic test request purposes. A prescriber number should be included on prescriptions when prescribing PBS medicines for patients who are being discharged.

Further information: [how to apply for provider and prescriber numbers](#)

Alternatively you can contact Medical Administration at your employing hospital for details on how to obtain a prescriber number and a provider number.
Billing arrangements by doctors
In Australia there are two methods of billing depending on the doctor and the patient.

Direct billing (also known as bulk billing), is where a doctor chooses to charge Medicare directly rather than seeking payment from the patient. The doctor accepts the Medicare benefit as full payment for this service. Patients must sign a completed form (after the consultation with the doctor, not before) and be given a copy of the form. There is no charge to the patient.

Alternatively, doctors may issue the patient with an account. Patients are usually expected to pay the account at the time of the consultation and the payment may be more than the Medicare scheduled fee (the gap) (doctors can charge higher fees if they choose).

Patients can submit a Medicare claim at the doctors. If your doctor doesn’t offer electronic claiming, you can submit a claim for some services using your Medicare online account or Express Plus Medicare app. To submit a Medicare claim online, you must be registered for a Medicare online account and have your Medicare card and the doctor’s account for the items you want to claim. There are item numbers that cannot be claimed online.

If the patient does not pay the account at the time of the consultation, Medicare will send the patient a cheque payable to the doctor, which the patient then sends to the doctor together with any outstanding amount (the gap).

1.2 Pharmaceutical Benefits Scheme
The PBS is a system of subsidising the cost of selected prescription medicines. These subsidies are available to Australian residents and eligible foreign visitors, that is, people from countries that have Reciprocal Health Care Agreements with Australia.

The aim of the PBS, which has been in operation since 1948, is to provide reliable access to a wide range of necessary prescription medicines at a reduced cost for patients. Public hospitals also provide free medications to inpatients.

The Department of Health oversees the management of the PBS including administration of the Pharmaceutical Benefits Schedule (‘the Schedule’), which lists all the medicines under the PBS and explains how they can be subsidised. The Schedule is updated every month.

Before a medicine can be subsidised under the PBS, the Pharmaceutical Benefits Advisory Committee (PBAC) must recommend it for listing on the PBS. When recommending a medicine to be listed on the PBS, the PBAC takes into account the medical conditions for which the medicine has been approved for use in Australia, its clinical effectiveness, safety and cost-effectiveness (value for money) compared with other treatments.

Patient charges
Under the PBS, eligible persons fall into one of two categories which determines the amount the patient contributes and the amount of subsidy paid.

- General category: General patients pay the cost of dispensed medicines up to a maximum amount per item. Where the dispensed price of a drug is above that maximum, the general patient pays that amount and the PBS pays the balance up to the listed price. If the prescription involves a more costly but equivalent brand, the subsidy may be limited to the lower cost brand (the minimum pricing policy).
Concessional category: People who have a Medicare card and also have a Centrelink issues card including a Pensioner Concession Card, Australian Seniors Health Card, Health Care Card or Department of Veterans' Affairs (DVA) Gold, Orange, or White Card. To claim these concessions, the patient’s Medicare number (including the individual reference number) or Veterans’ Repatriation Health Care entitlement number must be included in the appropriate spaces on the prescription form.

Further information: Frequently asked questions.

The Pharmacy Department in your hospital should also be able to answer any questions.

Safety net schemes
For individuals and families who visit a doctor often or use a large number of PBS prescriptions each year, the Australian Government has set in place safety net schemes which reduce the cost of accessing services once a set number of visits or scripts has been reached.

The Medicare Safety Net covers a range of out-of-hospital doctor visits and tests listed on the MBS. For individuals, Medicare keeps a record of the medical expenses while families and couples need to register for the safety net scheme so that Medicare can link the individuals to track combined medical expenses. Once the Medicare Safety Net threshold is reached, visits to the doctor or having tests may cost less for the rest of the calendar year. Patients may be eligible for additional Medicare benefits once the Medicare Safety Net threshold is reached.

The PBS safety net scheme is designed to protect patients and their families who require a large number of PBS medications each year. When patients reach a certain level of spending within a calendar year, they are entitled to receive further PBS items at a cheaper price or free of charge for the remainder of that year.

Further information: explanatory notes

Prescriber numbers for medical practitioners
A doctor is automatically given a PBS prescriber number when applying for their initial Medicare provider number. Unlike the Medicare provider number which is linked to a specific location, the PBS prescriber number stays with the doctor for life.

Pharmaceutical Benefit Scheme prescribing
Medicines prescribed for patients by their medical practitioner under the PBS in the course of their treatment are listed in the Schedule of Pharmaceutical Benefits. The Schedule also details the clinical conditions and other criteria that must be satisfied for a patient to qualify for a PBS medicine.

Prescribers have a responsibility to make sure that all PBS medicine is prescribed in accordance with the PBS requirements. Medicines listed in the Schedule fall into one of three broad categories of pharmaceutical benefits:

- **Unrestricted**: Medicine that can be prescribed through the PBS without PBS restrictions on therapeutic use. The uses for the medicine under the PBS are in accordance with the uses registered in Australia with the Therapeutic Goods Administration (TGA)
- **Restricted**: Medicine that can be prescribed through the PBS if the prescriber is satisfied that the patient's clinical condition matches the therapeutic uses listed in the Schedule.
- **Authority Required** (two categories):
Authority Required - restricted medicine that requires prior approval from the Department of Human Services (Human Services) or the Department of Veterans' Affairs (DVA).

Authority Required (Streamlined) - restricted medicine that does not require prior approval from Human Services or DVA but can be done electronically using an Authority code.

Further information:

Prescribing process and how to use the PBS correctly
Health professional information and education on therapeutic goods administration

1.3 Private health care

Private health insurers and Medicare work in tandem in the Australian health care system. The private health system is a major provider of hospital services, and assists to lessen the demand on public hospital services.

Private health services also give the public the option of choosing their own doctor, shorten the waiting time for elective surgery, and provide access to services not covered by Medicare.

The Australian Prudential Regulation Authority oversees banks, credit unions, building societies, general insurance and reinsurance companies, life insurance, private health insurance, friendly societies and most members of the superannuation industry.

Private health insurance rebate

The Australian Government rebate on PHI reduces costs for people eligible for Medicare, within income thresholds and with certain health funds. Families and individuals who pay PHI premiums may be eligible for Australian Government rebates on PHI. The rebate amount is based on the age of the oldest person covered by the policy and by annual earnings.

1.4 Department of Veterans’ Affairs

The DVA aims to support those who serve or have served in defence of our nation and commemorate their service and sacrifice. The DVA provides a broad range of health care and support services to eligible veterans and dependants through DVA and various health service providers.

Sources:


Central Coast Local Health Network and the Northern Sydney Local Health Network. International Medical Graduate Orientation Handbook (2nd edition)
Section 2 Western Australian healthcare system

- Western Australian government and structure of the public health system
- Metropolitan health services
- Country health services
- Other WA health service providers

2.1 WA public health service

In March 2016, the estimated population for Western Australia (WA) was 2.6 million (Australian Bureau of Statistics). In general, the WA community enjoys enviable health outcomes, with life expectancy among the best in the world and infant mortality rates among the lowest in Australia. Western Australian hospitals perform well in the key areas of safety and quality and patients benefit from excellent care. The WA population is predominantly based in the metropolitan area of Perth (around 2 million). The remaining population lives in rural and regional areas of the State.

The Government of WA is responsible for ensuring that the people of WA receive the best possible health care. The coordination of health services is managed through the Department of Health which reports to the Minister for Health and the Minister for Mental Health.

The Western Australian public health system is known as “WA Health” and consists of:

- The Department of Health
- Five Health Service Providers
- Health Support Services

The Department of Health is led by the Director General and provides leadership and management of the whole health system.

Further information: Department of Health and current ministers

The Health Service Providers are governed by Health Support Boards with each Health Service Provider is responsible for their local areas and communities.

The Health Service Providers include:

- Child and Adolescent Health Service
- North Metropolitan Health Service
- South Metropolitan Health Service
- East Metropolitan Health Service (from 1 July 2016)
- WA Country Health Service (WACHS)

The WACHS consists of seven administrative regions supported by the Perth central office:

- Kimberley
- Pilbara
- Midwest
- The Wheatbelt
- The Goldfields
- The South West
- The Great Southern
2.2 Metropolitan health service providers

As part of the broader WA health system, the metropolitan health service providers deliver the majority of public health care services in WA through a range of primary, secondary and tertiary care services. They provide health care services to over 2 million people through the Child and Adolescent Health Service, North Metropolitan Health Service, South Metropolitan Health Service and East Metropolitan Health Service.

Child and Adolescent Health Service

The Child and Adolescent Health Service comprise Princess Margaret Hospital (PMH), Child and Adolescent Community Health (CACH), Child and Adolescent Mental Health Service (CAMHS), and the Perth Children’s Hospital Project.

PMH is internationally recognised as a tertiary paediatric facility treating children and adolescents from around the State, providing over 250,000 patient visits each year.

CACH provides a comprehensive range of child health prevention and promotion services including early identification, intervention and treatment of child health issues in the community. Populations recognised to be “at-risk”, such as WA’s Aboriginal community are of particular focus, as are newly arrived refugees. Core services include child and school health, immunisation and child development.

CAMHS provides mental health services to infants, children and young people across the Perth metropolitan area. Acute, community and specialised services are available. The Bentley Adolescent Unit provides a statewide specialised service for young people under 16 years of age with severe mental health conditions. Support is available statewide.

Perth Children’s Hospital will replace PMH as WA’s dedicated children’s hospital providing specialty medical treatment as well as secondary services including inpatient and outpatient care and day stay care.

North Metropolitan Health Service

The North Metropolitan Health Service (NMHS) is the largest health service in the metropolitan area providing public hospital, community, mental and public health services to almost one million people living in Perth’s north and north-eastern suburbs. NMHS comprises five hospitals, BreastScreen WA, PathWest and the Queen Elizabeth II (QEII) Medical Centre Trust. It also oversees the provision of contracted public health care from the privately operated Joondalup Health Campus. The public hospitals include:

- Sir Charles Gairdner Hospital
- King Edward Memorial Hospital
- Graylands Hospital
- Joondalup Public Hospital
- Osborne Park Hospital

The NMHS provides the following services:

- Emergency services
- Intensive and high dependency care
- Coronary care
- Medical services
- Maternity and newborn services
- Surgical services
- Cancer services
- Rehabilitation and aged care
- Mental health services
- Ambulatory care
- Primary health care
- Clinical support services
A range of statewide, highly specialised multi-disciplinary services are also offered from several hospital and clinic sites.

The QE II Medical Centre Redevelopment will include an expanded Comprehensive Cancer Centre, new PathWest facility, new Mental Health Unit and a new Harry Perkins Institute of Medical Research.

**South Metropolitan Health Service**
The South Metropolitan Health Service (SMHS) provides a range of services to people living in Perth’s southern suburbs. SMHS consists of one tertiary hospital, two general hospitals and two specialist hospitals providing specific health care services, such as mental health, aged care, rehabilitation and elective surgery. Public hospitals include:

- Fiona Stanley Hospital
- Peel Health Campus
- Rockingham General Hospital
- Fremantle Hospital
- Murray Districts Hospital

The SMHS provides the following services:

- Aged care
- Cancer, haematology and palliative care
- Complex heart and lung services
- Elective and emergency surgery
- Emergency services and critical care
- General medicine
- Mental health
- Rehabilitation
- Women, children and neonatal
- Pathology, radiology and pharmacy

**East Metropolitan Health Service**
The East Metropolitan Health Service (EMHS) was established from 1 July 2016 with a catchment area of more than 670,000 people. Tertiary, secondary and specialist health care services are provided. Public hospitals include:

- Royal Perth Bentley Group
- Armadale Health Service
- St John of God Midland Public Hospital

The EMHS provides the following services:

- Aged care
- Palliative care
- State trauma
- Elective and emergency surgery
- Emergency services and critical care
- General medicine
- Mental health
- Rehabilitation
- Women, children and neonatal
- Inpatient and outpatient services

### 2.3 Country health services
The WA Country Health Service (WACHS) is the largest country health service in Australia covering 2.5 million square kilometres. WACHS provides services across 70 hospitals and a number of smaller health centres and nursing posts as well as Indigenous health, population health, mental health and aged care services.
WACHS comprises seven administrative regions supported by a central office in Perth. WACHS extends from the Kimberley region in the north to the Great Southern region in the south with the Indian Ocean to the west and the Northern Territory and South Australian borders in the east.

The WACHS service delivery model includes regional resource centres, integrated district health services and flexible services with a primary health care focus for small towns and isolated communities. Services are managed and adapted to address local need and circumstance with input from a wide range of community representatives and key stakeholders.

The WACHS offers a range of health services on including:

- Emergency and hospital services
- Public and primary health care
- Drug and alcohol services
- Child and community health
- Population
- Mental health
- Aboriginal health
- Residential and community aged care services

**Kimberley health**

The Kimberley health region covers the Kimberley region of WA and is the most northern region bordered by the Pilbara region to the south and the Northern Territory to the east. The Kimberley encompasses an area of 424,517 square kilometres and is almost 3 times that of the United Kingdom. The major population centres in the Kimberley region are the towns of Broome, Kununurra, Derby, Halls Creek, Wyndham and Fitzroy Crossing.

There are also over 100 Aboriginal communities of various population sizes, scattered throughout the region and nearly 100 properties servicing the pastoral industry. The region has a large indigenous population, with nearly a third of the region Aboriginal or Torres Strait Islander people.

**Pilbara health**

The Pilbara health region covers the Pilbara region of WA and is the second most northern region defined by the Indian Ocean to the west and the Northern Territory border to the east. The Kimberley region lies to the north and the southern borders reach the Midwest and Goldfields health regions. The region covers a total area of 507,896 square kilometres (including offshore islands). Most of the inhabitants are located in the western third, whereas the eastern third is largely desert with few inhabitants.

**Midwest health**

The Midwest health region is located in the northern middle section of WA and covers more than 470,000 square kilometres equivalent to nearly one fifth of the State, with its population concentrated along the coast. The region incorporates four health districts - Gascoyne, Geraldton, Midwest and Murchison. Geraldton is the only non-metropolitan town (other than Bunbury) that has both a public and private hospital, and provides access to a broad range of secondary and specialist health services in addition to region-based community health, mental health and public health service facilities and programs.

The area has a high Aboriginal population and an increasing proportion of aged people.
Goldfields health
The Goldfields health region incorporates nine local government areas and is located in the south eastern corner covering almost a third of the State. It is the largest region in WA and is bounded by the Pilbara region to the north, the Midwest and Wheatbelt regions the west, and the Great Southern region to the south-west.

It is estimated that 8% of the region's population is of Aboriginal descent, compared to 3% for WA as a whole. There are 17 Aboriginal communities within the Goldfields.

Wheatbelt health
The Wheatbelt health region extends east from the coast north of Perth to the western boundary of the Goldfields, and south from the Darling Scarp to the northern boundary of the Great Southern Region. The Wheatbelt has 45 local government areas and covers 154,051 square kilometres. The population is estimated to be more than 70,000, however, the dispersion is scattered with a progressing median age and shift in density towards the north-western perimeters. The four sub-regional centres are Merredin, Moora, Narrogin and Northam.

The Wheatbelt contains the majority of WA’s grain growing areas.

South west health
The southwest health region encompasses an area of 24,000 square kilometres, with a population of around 141,000 or approximately 7% of the State’s population. The south west region extends from Yarloop in the north, Augusta in the south and Walpole in the east and is a popular tourist destination.

Great southern health
The great southern health region is bounded by Woodanilling in the north, Bremer Bay in the east, Denmark in the west and Albany in the south. It has a population of around 55,000 over approximately 40,500 square kilometres. A high proportion of older people live in the major centres.
Map 1: Map of WACHS regions
2.4 Community health services
WA Health’s community-based services (Healthy@Home) helps patients manage their health, maintain their independence, and stay out of hospital. The services provided aim to prevent people from unnecessarily entering hospital and assist people to leave hospital sooner. It involves doctors, specialists and allied health professionals and usually, this care takes place at the patient’s home, in the community or in another setting such as a doctor’s clinic. The services provided include:

- community physiotherapy
- falls prevention programs (Falls Linkage Independence Program)
- Hospital in the Home (see section 2.9)
- WoundsWest.

2.5 Dental health services
The Dental Health Service is a service unit of the WA Department of Health whose mission is to promote and improve the oral health across WA. The service provides emergency dental care for eligible persons; facilitates general dental care for financially or geographically disadvantaged persons and other special groups of people; provides general dental care for all school children enrolled in the School Dental Service; supports the training and education of oral health professionals and contributes to oral health research.

2.6 Public health services and health protection
The Public Health and Clinical Services Division is responsible for the development, coordination and delivery of a wide range of statewide public health policy and programs with a particular focus on healthy public policy (including legislation), community awareness and professional education.

Through this work the division aims to promote health in the community; prevent disease before it occurs; and manage risk, whether natural or man-made. The division works across a diverse group of stakeholders including:

- Area Health Services
- WA Country Health Service
- Child and Adolescent Health Services
- Office of Aboriginal Health
- local, state and federal government
- non-government organisations (NGOs)
- consumer, advocacy and media groups
- Healthway
- General practice and primary care organisations
- Universities, research and professional groups.

2.7 Mental health services
There has been significant reform of the mental health system over the past five years, including the appointment of the State’s first Minister for Mental Health, the establishment of Australia’s first Mental Health Commission and creation of the Department of Health’s Office of Mental Health (Mental Health Unit).
The Mental Health Unit (MHU) was formed on 1 July 2016 under the new governance arrangements of the Health Services Act 2016. The MHU guides and promoted best practice in mental health services and delivery through leadership, innovation, direction and support for statewide mental health clinical policy and planning.

The MHU works closely with the Mental Health Commission to support implementation of The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 and the Office of the Chief Psychiatrist to ensure compliance with the Chief Psychiatrist’s regulations.

The Chief Psychiatrist is an independent statutory officer holding powers and duties as prescribed by the Mental Health Act 2014. The Chief Psychiatrist reports to and provides advice to the Minister for Health. The Chief Psychiatrist has governance over any Mental Health Service and other specified agencies that seek to influence the delivery of mental health treatment and care to the WA community.

The Mental Health Commission amalgamated with the Drug and Alcohol Office on 1 July 2015 with responsibility for planning and purchasing mental health, alcohol and other drug services in WA through the network of drug and alcohol treatment services and programs formerly provided by the Drug and Alcohol Office and contracted non-government organisations.

The MHC provides links to emergency services and help lines.

If you feel someone is at risk of harm call 000

For mental health emergency assessment, support and referral contact:

- Metropolitan: 1300 555 788 Mental Health Emergency Response Line (MHERL)
- Peel: 1800 676 822 Mental Health Emergency Response Line (MHERL)
- Country: 1800 552 002 Rural Link
- National: 1800 022 222 After hours GP Helpline

If you need someone to talk to:

- Beyondblue and Youth beyondblue: 1300 224 636
- Crisis Care Helpline metro: 9223 1111
- Crisis Care Helpline country toll free: 1800 199 008
- Headspace: 1800 650 800
- Kids Helpline: 1800 551 800
- Lifeline: 13 11 14
- Men’s Line Australia: 1300 789 978
- Suicide Call Back Service: 1300659 467
- The Samaritans Crisis Line metro: 9381 555
- The Samaritans Crisis Line country: 1800 198 313
- The Samaritans Crisis Line Youth Link: 9388 2500

2.8 Private health services in WA

As in other Australian states, the people of WA are well served by a network of private hospitals and general practice clinics throughout the metropolitan area and major regional towns. Additionally, some country and metropolitan private hospitals are contracted to provide public health services further easing the pressure on public hospital services.
MyHospitals lists all hospitals in WA.

2.9 Other health service organisations

Community-based services

Aged Care Assessment Team (ACAT): are teams of health professionals who help frail older people and their carers determine the level of care needed for the patient to remain at home or identify other available pathways if the older person is unable to remain at home. The assessment team may recommend people for government funded services such as:

- home care packages to assist people to remain at home (both low and high levels of care)
- residential aged care services
- residential respite services (both low and high levels of care)
- transition care, which provides care for those older people transitioning from the hospital to their home, or to permanent residential care (Transition Care Program)

Disability Services Commission (DSC): is a government department responsible for advancing opportunities, community participation and quality of life for people with disability. DSC works in partnership with service providers and other government departments to provide information, support and services to people with disability, their families and carers. DSC provides direct services and progressive improvements to social and community inclusion and policy.

Home and Community Care (HACC): Provides basic support services to some older frail people and younger people with a disability to assist them to continue living independently at home. The services provided include:

- Participation in social activity in a group or one-on-one
- Assistance with everyday household tasks
- Assistance with the preparation or delivery of meals
- Minor work in your home or yard to maintain your safety, independence and access
- Minor structural changes to your home to help maintain your independence and safety, such as hand rails
- Nursing care such as wound care, insulin injections, and assistance with management of diabetes, continence and pressure care - provided by a registered or enrolled nurse
- Assistance to support your independence in your personal care activities such as showering, dressing and basic foot care
- Assistance to keep up with essential activities such as shopping, banking and maintaining social contacts
- Allied health assistance such as physiotherapy or nutrition advice to help you maintain healthy diet, physical fitness, independence and safety
- Assistance to help you attend appointments and travel around the community

Hospital in the Home (HITH): provides short-term care in the patient’s home for health conditions that were traditionally treated in hospital. HITH includes daily home visits by nurses and allied health staff with medical management by either hospital-based specialists or occasionally a General Practitioner. This service includes Community Physiotherapy Services, Falls Linkage Independence Program, phone coaching and WoundsWest.
**Silver Chain**: provides a range of clinical and health care services to assist people of all ages and their carers, including the elderly and people with disabilities, illness and injury, to maintain their health at home in metropolitan as well as country and remote WA.

**Emergency services**
The following section provides information on some emergency services that you may use while working as a doctor in WA. An extensive list of emergency and crisis services is available at Healthy WA.

**Poisons Information Centre** *(WAPIC)*: a specialised unit that provides expert advice on the management of poisonings or suspected poisonings. Advice is also provided on poisoning prevention, drug information and the identification of toxic agents. **Contact**: 13 11 26

**Newborn Emergency Transport Service** *(NETS)*: coordinates emergency transfer of newly born babies from their hospital of birth to either Princess Margaret Hospital or King Edward Memorial Hospital for intensive care. **Contact**: 1300 638 792

**Royal Flying Doctor Service** *(RFDS)*: is a not-for-profit service providing aero medical retrievals and transfers, as well as 24 hour emergency services, telehealth, mental health and primary health care services. **Contact**: 1800 625 800.

The RFDS provides emergency evacuations throughout rural and remote Australia for people who are seriously ill or injured and require urgent medical attention. The RFDS in WA has 6 facilities located in Jandakot, Kalgoorlie, Meekatharra, Port Hedland, Derby and Broome and 15 aircraft assisting almost 70,000 people annually.

**St John Ambulance Australia** *(SJA)*: is the primary provider of pre-hospital care services in WA. While SJA is a charitable non-profit, humanitarian organisation, patients are charged for services provided, for both emergency and non-urgent ambulance transfers and treatment. **Contact**: 000 for emergency services

**Sexual Assault Resource Centre** *(SARC)*: provides a 24 hour emergency service in metropolitan Perth involving medical care, forensic examination and counselling support to people who have been sexually abused in the previous 14 days. SARC offers a free confidential service. **Contact**: 1800 199 888 or 6458 1828

SARC also provides counselling in centres across the Perth metropolitan area to people who have experienced sexual assault and sexual abuse in the past. The SARC team has female medical doctors and female and male psychologists, social workers and clinical psychologists.

In WA sexual assault and sexual abuse are ‘crimes against the state’.

**Other organisations**
**The Aboriginal Health Council of WA** *(AHCWA)*: the peak body for the 21 Aboriginal Community Controlled Health Services *(ACCHSs)* in WA. AHCWA acts as a forum to lead the development of Aboriginal Health policy, to influence and monitor performance across the health sector, to advocate for and support community development and capacity building in Aboriginal Communities, and to advocate for the rights and entitlements of all Aboriginal people throughout WA, at a local, regional, State and National level.
The ACCHSs are individual Aboriginal Health Services that are run by local Aboriginal people and their communities to manage their own health and well-being in accordance with protocols and procedures determined by their community members. The Services are founded on the principles of self-determination, empowerment and freedom of choice where Aboriginal people come together as one to; respect, welcome and understand the social and cultural needs; to network; provide support; advocate; to influence policy; monitor performance; build work capacity; improve and strengthen the social and emotional wellbeing of Aboriginal people.

**Sexual Health Quarters (SHQ):** an independent, non-profit organisation and the leading provider of sexual and reproductive health services in WA offering a range of services including STI testing and treatment; contraception information and supply; unplanned pregnancy support; information and referral; pap smears; specialist counselling; a confidential sexual health helpline for members of the public and professionals and education and training for community workers and health professionals including accredited training for doctors and nurses.

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**Sources:**

Section 3 Communication and cultural awareness

- **Australian society: customs, behaviours**
- **Aboriginal people and culture: overview and specific to WA**
- **The Australian patient**
- **Cultural awareness**
- **Communication**
- **Cultural awareness training**
- **Professional conduct**

### 3.1 Australian society

Australia is a democratic society with a government elected by the people every three or four years. Cultural diversity is one of the defining features of Australian society today. Australians come from all over the world. Around 46 per cent of Australians were either born overseas or have a parent who was born overseas.

Another feature is the egalitarian nature of this society, meaning that with hard work and commitment, all people have potentially, equal opportunity to succeed.

Australia has a tradition of free speech. However, it is unlawful to insult, humiliate, offend or intimidate another person or group on the basis of their age, race, country of origin, gender, marital status, pregnancy, political or religious beliefs, disability or sexual preference.

It is generally believed in Australia that no-one should be disadvantaged on the basis of their country of birth, cultural heritage, language, gender or religious belief. To maintain a stable, peaceful and prosperous community, Australians of all backgrounds are expected to uphold the shared principles and values of Australian society.

Our citizenship values provide the basis for Australia’s free and democratic society. They include support for:

- Parliamentary democracy
- The rule of law
- Living peacefully
- Respect for all individuals regardless of background
- Compassion for those in need
- Freedom of speech and freedom of expression
- Freedom of association
- Freedom of religion and secular government
- Equality of the individual, regardless of characteristics such as disability and age
- Equality of men and women
- Equality of opportunity.

The responsibilities of Australian citizens include:

- Obeying the law;
- Defending Australia should the need arise;
- Voting in federal and state or territory elections, and in referenda; and
- Serving on a jury if called to do so.
Under Australian law all people are free and equal and are expected to treat each other with dignity and respect. Australians reject the use of violence, intimidation or humiliation as ways of settling conflict in our society. No person or group is above the law. There are a number of laws in Australia that make sure a person is not treated differently to others because of their gender, race, disability or age. Men and women have equal rights and society is fair. Hard work and talent are valued. All people in Australia must obey the nation’s law or face the possibility of criminal and civil prosecution. People are also expected to generally observe Australian social customs, habits and practices.

The Australian Government encourages new residents to learn as much as they can about their new country, including Australia’s heritage, language, customs, values and way of life.

The Australian Government has produced some books to help you:
- Life in Australia
- Beginning a Life in Australia
- Australian Citizenship: Our Common Bond

Meeting people and communicating with them
When meeting someone for the first time, it is common in Australia to shake the person’s right hand with your right hand. People who do not know each other generally do not kiss or hug when they first meet. When meeting a new person, many Australians are not comfortable being asked questions about their age, marriage, children or money. In the workplace and with friends, Australians usually call each other by their first names. Many Australians look at the eyes of the people they are talking with, as a sign of respect and to show that they are listening.

Polite behaviour
Australians usually say “please” when asking for something and usually say “thank you” when someone helps or gives them something. Not saying please and thank you will be seen as impolite. Australians usually say “excuse me” to get someone’s attention and “sorry” when they accidentally bump into someone.

You should always try to be on time for meetings and other appointments. If you are going to be late, contact the person to let them know. This is very important for professional appointments (for example, an appointment with a doctor) as you could be charged money for being late or if you miss the appointment without letting the person know in advance. A person who is always late may be considered to be unreliable.

If you receive a written invitation it may include the letters ‘RSVP’ with a date provided. This means that the person inviting you would like to know whether or not you will be attending. It is polite to confirm whether you will be attending by that date.

It is important to know that some behaviour is not only impolite but is also against the law. Examples of offensive behaviour include swearing and spitting in public, and urinating or defecating anywhere except in a public or private toilet.

Clothing
Australia is a diverse society. The variety of clothing that people wear reflects this diversity. Many people tend to dress casually or informally for comfort or according to the social situation or climate. Many people also choose to wear traditional clothes, which may be religious or customary, particularly on special occasions.
There are few laws or rules on clothing, although there are requirements to wear certain clothing for work situations and in certain places. For example, safety boots and hard hats must be worn for safety reasons on construction sites, and police, military and staff of some businesses wear uniforms. Clubs, movie theatres and other places may require patrons to be in neat, clean clothing and appropriate shoes.

Women and men may wear clothing that does not cover their entire bodies. This is normal in western countries and does not mean they wish to attract attention.

3.2 Aboriginal Australians

Aboriginal and Torres Strait Islander people are the original (indigenous) inhabitants of Australia. Their culture is dynamic, adapting and changing over time, mainly due to their affinity with their surroundings. The Australian Government recognises that dispossession, interruption of culture and intergenerational trauma have significantly impacted on the health and wellbeing of Aboriginal and Torres Strait Islander people, and that they share a continuing legacy of resilience, strength and determination.

Aboriginal people tend to be more visual and verbal in communication, and there is much emphasis on imparting knowledge and culture through art, rituals and story-telling. The “Land” is at the core of belief and well-being and it remains of central importance to Aboriginal Australians today. Aboriginal and Torres Strait Islander people view health in a holistic context.

In the 2011 Census (Australian Bureau of Statistics, 2076.0), 548,400 people identified and were counted as being of Aboriginal and Torres Strait Islander origin, representing 2.5% of the Australian Census count. Western Australia’s count of Aboriginal people was 13%, the third highest in the nation. The Aboriginal and Torres Strait Islander population has a younger age distribution than the non-Aboriginal population with a median age of 21 years, compared with 38 years for non-Aboriginal people. Children under the age of 15 years made up 36% of the Aboriginal and Torres Strait Islander population, compared with 19% of the non-Aboriginal population. The proportion of Aboriginal and Torres Strait Islander people aged 65 years and over was considerably smaller than for non-Aboriginal people (4% compared with 14%). This is due to both higher fertility rates and earlier mortality among Aboriginal people.

Aboriginal people, as a whole, experience disproportionate levels of disadvantage and poorer health compared with other Australians. The Australian Health Minister’s Advisory Council report, 2015, Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report, identifies that in 2012–13, nearly half (47%) of Aboriginal Australians aged 18 years and over had a disability or restrictive long term health condition. In 2011, 12.6% of babies born to Aboriginal mothers were low birthweight, twice the non-Aboriginal rate. In 2011, 50% of Aboriginal women smoked during pregnancy, 4 times the non-Aboriginal rate. The Australian Bureau of Statistics National Aboriginal and Torres Strait Islander Health Measures Survey 2012/13 indicate that the likelihood of chronic illness increases with remoteness.

The Australian Bureau of Statistics Life tables for Aboriginal and Torres Strait Islander Australians 2010-12 estimate expectation of life, at birth, for Aboriginal people. Revised estimates show that Aboriginal males born in Australia in 2010-2012 could expect to live to 69.1 years, 10.6 years less than the 79.7 years expected for non-Aboriginal males. The expectation of life at birth of 73.7 years for Aboriginal females born in Australia in 2010-2012 was 9.5 years less than the expectation of 83.1 years for non-Aboriginal females.
The health and education inequality for Aboriginal Australians compared with non-Aboriginal Australians is a key focus for all Australian governments. The “Closing the Gap” reform agenda aims to close the life expectancy gap between Aboriginal and non-Aboriginal Australians within one generation and provide a better future for Aboriginal children. The campaign is built on evidence that significant improvements in the health status of Aboriginal peoples can be achieved within short time frames.

**Indigenous affairs** are the responsibility of the Department of the Prime Minister and Cabinet.

The Remote Area Health Corps provides online training modules for health professionals interested in remote health services in Aboriginal communities.

As Aboriginal culture is diverse and complex, there can be practical impacts on communication and health care delivery. The following are examples of situations that may arise.

- Literacy levels may be low due to the preference for visual and verbal communication. Therefore, assistance may be required if forms and questionnaires are to be completed.
- Use of technical terms or jargon may cause confusion. For example, it may be preferable to point to certain parts of the body where a pain might be.
- It is also important to recognise that Aboriginal people have “men’s business” and “women’s business”, and it is inappropriate to have men and women sharing a room in the hospital.
- Where possible, it is preferable to have the doctor of the same gender as the patient.
- When a death occurs, there are specific beliefs about the deceased’s spirit and about allowing visitors with the deceased.

HealthInfoNet is a useful resource for information about Aboriginal health care issues and includes cultural, historical, social, economic and physical environment issues. The website is designed to share knowledge and information among people working in health and related services and includes online medical and technical dictionaries as well as links to formal training courses and other websites.

The Little Red Yellow Black website provides an introduction to the history and culture of Indigenous Australia.

**Western Australian Aboriginal population**

Aboriginal people make up 3.4 per cent of the total Western Australian population with a young age profile due to higher birth rates and lower life expectancy. Of the 3.4 percent, 62 percent live in rural or remote areas.

Aboriginal people overall experience a greater burden of disadvantage and have a higher risk of developing chronic disease and suffering injury. In WA, Aboriginal people experience higher levels of psychological distress than non-Aboriginal people and have higher exposure to a range of risk factors compared to non-Aboriginal people that contributes to poor health outcomes.

Aboriginal Health is a statewide office within WA Health responsible for facilitating a collaborative and coordinated approach within WA Health’s public health system to improve health outcomes for all Aboriginal people living in WA. Aboriginal Health provides high level strategic leadership including advice for matters which directly and indirectly impact health outcomes.
WA Health is committed to closing the health gap between Aboriginal and non-Aboriginal people in Western Australia and continuing to develop the capacity of WA Health to more adequately respond to the health needs of Aboriginal communities.

**Aboriginal patients**

Aboriginal people are very diverse and there is no such thing as a standard approach to dealing with Aboriginal patients. That said, patients with a strong traditional culture may have very different non-verbal communication and eye contact than non-Aboriginal people and direct eye contact may be seen as aggressive or rude. During conversation long pauses and silences are common. Medical staff may feel that they are being ignored which is generally not the case. Byalawa contains research-based multimedia learning and teaching resources to facilitate appropriate, culturally-safe interviewing and case history taking skills.

Newly arrived medical practitioners are encouraged to develop links with a local community representative and an Aboriginal health worker to assist in their care of Aboriginal patients.

Culture can influence Aboriginal people’s decisions about when and why they should seek health services, their acceptance of treatment, the likelihood of adherence to treatment and follow up, and the likely success of prevention and health promotion strategies. Ensuring that health services and providers are culturally competent will lead to more effective health service delivery and better health outcomes. The restoration and continuation of cultures provide both the reason for change, and the pathway for securing it.

A comprehensive, technical resource on best-practice management of the major health problems facing Aboriginal peoples and Torres Strait Islanders, written to assist doctors working in Aboriginal health is “Aboriginal Primary Health Care”, 3rd edition, written by Dr Sophia Couzos and Dr Richard Murray for the Kimberley Aboriginal Medical Service Council (Oxford University Press ISBN 0 19 5516192). Proceeds from book sales support the continued operations of Aboriginal Community Controlled Health Services.

The Remote Primary Health Care Manuals website provides online access to five manuals used in Aboriginal and remote primary health care in Australia, including:

- Clinical Procedures Manual for remote and rural practice, 3rd edition;
- Medicines Book for Aboriginal Health Workers, 3rd edition
- Reference Book for the Remote Primary Health Care Manuals.

You will be required to register and login to access these manuals free of charge.

### 3.3 The Australian patient

Because Australia is a multi-cultural society there is no “typical” definition of an Australian patient. Patients will vary depending on the area in which they live and work and their economic and educational backgrounds. In recent times Australian patients have become better informed and may choose to take an active part in the decision making process. There are also a number of consumer organisations who challenge health care systems in Australia.

Most Australians prefer to be treated as individuals and expect to be treated with respect as an equal. The extended family unit is not as dominant in Australia and many elderly patients may
live alone. Australians tend to be direct when discussing issues, events and ideas and may use your first name or call you “Doc”.

Australians love to tell a joke or have a joke and may tease or ‘pull your leg’, as it is commonly known. This is a form of acceptance and by no means meant to be an insult or form of discrimination, however, if you are offended by this, let them know that you are, and why you feel that way. “Being open” or upfront or honest means that you will have better relationships with your patients and your colleagues. Often patients will joke about their condition or illness, even if the situation is serious. It is common for Australians to use metaphor. For example, if a patient is asked how they have been since you last saw them, and they respond “It’s been plain sailing,” they are likely to mean that no problems have occurred, rather than that they have been in a boat. Australians also have a healthy scepticism about governments, institutions, politicians and often doctors.

As a rule, Australian patients expect to be kept informed about their health care. This includes possible treatment options, the benefits and risks, any tests required and the nature of their illness. Should the patient be unable to participate or understand due to difficulty understanding English, you should engage an appropriate interpreter. Care must be taken to avoid using family members for formal interpreting due to privacy issues. Interpreters have professional training to provide appropriate and direct communication between the health care worker and the patient.

If you are concerned that the patient does not understand your recommendations or is refusing your treatment, which could lead to serious consequences for the patient, consider consulting your colleagues or supervisor; offering further information or a second medical opinion; meeting with family members or holding a case conference with other health professionals involved in the patient’s care.

The Health Translations Directory is particularly useful for health practitioners working with culturally and linguistically diverse communities to find reliable translated health information.

3.4 Cultural awareness

Australia is made up of people from a variety of cultures, many of whom hold different values and beliefs about health and medical treatment. These different beliefs and values will impact on your patients’ perceptions of appropriate treatment and behaviour. Determining what is appropriate, given the various cultures, beliefs and expectations, within which you must work, may not be easy.

It is important to be aware of your own cultural background, beliefs and values and be aware that this may influence your expectations and communication with your patients. At times these may clash with the wishes or beliefs of your patients. Doctors in Australia are expected to keep the patient’s needs uppermost in delivering health care.

The Australian Medical Council (AMC), Australian Medical Association (AMA) and Medical Board of Australia (MBA) all have Codes of Conduct for medical practitioners that highlight the importance recognising when your personal beliefs and/or opinions may impact on the care given to your patients and recognising that you are free to decline to personally provide or participate in that care. Further information on these codes is provided in section 3.7.

In areas in which you have strong personal beliefs, ensure you research alternative approaches more rigorously than usual and ask advice from others. The patient needs to be supported by you to find alternative help. Areas of health care that are potentially sensitive include:
• termination of a pregnancy
• the process of dying
• treatment of pain
• prescription of contraceptives
• AIDS related care
• sexual orientation
• cultural requirements (e.g. circumcision)
• organ donation
• substance abuse.

These are areas where your personal views and your role as a doctor may conflict strongly. Be aware of these areas of conflict to ensure your judgment does not impact on your ability to provide appropriate care for the patient.

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

3.5 Training in cultural awareness

Cultural awareness education helps participants to extend their knowledge about Aboriginal history and culture, explore attitudes and values that can influence perceptions and behaviours, improve their understanding of the key issues facing Aboriginal people and examine how they may become more culturally aware.

Through cultural safety training, participants come to understand what is needed to develop a culturally safe environment where individuals can be who they are without assault, challenge or denial of identity. This training involves participants identifying and planning improvements to their cultural safety practices, assisted by a local Aboriginal community representative.

All WA Health employees are required to undertake the on-line cultural awareness training module within the first three months of their employment. Staff should also attend any locally provided Cultural Awareness programs.

Cultural awareness training programs are also provided by external agencies, including:

**Combined Universities Centre for Rural Health (CUCRH):** a generic program developed by WACHS and CUCRH which provides information to assist health professionals develop a deeper understanding of Aboriginal culture, values and practices.

**Share Our Pride:** website developed by Reconciliation Australia to provide an introduction to Aboriginal and Torres Strait Islander people and their culture and assist in building respectful relationships.

**Diverse WA:** Cultural competency program developed by the Office of Multicultural Interests to educate WA public sector staff how to assist people from culturally and linguistically diverse backgrounds.

**Royal Australian College of General Practitioners (RACGP):** provides online and face-to-face learning programs which meet professional development requirements for general practice.

3.6 Communication

In a health care environment, cultural differences take on a greater significance. Proficiency in English may not always be enough to remove cultural barriers between doctor and patient. If in doubt, ask the patient whether they understand and accept your proposed actions and confirm that you have a shared understanding.
When consulting with the patient, it is best to introduce yourself, establish good eye contact and be polite, honest and direct about your diagnosis and their health care. Where possible, it is best not to rush the consultation with the patient. Gaining the trust of your patient, and being open and honest in your communication with them, will assist you to achieve an effective medical consultation. Good communication underpins every aspect of good medical practice.

If you need to conduct a physical examination that could be considered intimate, you should ensure the patient’s privacy but also consider having another person in the room – for your peace of mind and for the patient’s. If this is not possible, it would be sensible to check with the patient whether they are happy to proceed without a witness.

Some basic principles for communicating with a person from a different culture include:

- assume differences until similarity is proven
- check your assumptions in a culturally sensitive way
- emphasise description rather than interpretation or evaluation
- delay judgment until you have had sufficient time to observe and interpret the situation
- practice empathy – try and see the situation from the other person’s perspective
- treat your interpretation as a working hypothesis until you have sufficient data to support it.

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

The Australian College of Emergency Medicine offers an Indigenous Health and Cultural Competency program consisting of a series of culturally relevant education tools and resources designed for doctors and other healthcare workers to enhance culturally competent communication and overall care for Aboriginal, Torres Strait Islander and other culturally and linguistically diverse patients in the emergency department.

### 3.7 Professional conduct of doctors

In Australia, medical practice is patient-centred and acknowledges that each patient is unique. This requires doctors to understand that they work in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. Doctors have a responsibility to protect and promote the health of individuals and the community.

The MBA has adopted and revised the AMC’s Code of Conduct for Doctors and developed a set of guidelines for the medical profession. These help to clarify the MBA’s expectations on a range of issues and include:

- Good Medical Practice
- Medical - Guidelines for Mandatory Notifications
- Sexual Boundaries: Guidelines for doctors.

The AMA’s Code of Ethics promotes ethical principles to guide doctors’ conduct in their relationships with patients, colleagues and society. The doctor-patient relationship is based on mutual respect and collaboration and both the doctor and the patient have rights and responsibilities. The following topics are covered:
The Doctor and the Patient: patient care, clinical research, clinical teaching, the dying patient, transplantation.

The Doctor and the Profession: professional conduct, advertising, referral to colleagues.

Professional independence

The Doctor and Society

One of the greatest challenges in medical practice is having the insight to know when to seek assistance from your colleagues. Having access to a peer group, whether it is through one of the specialist colleges, a hospital or a practice makes it easier to seek such assistance. There are a number of resources and organisations available which can help you continue your professional development (see section 5.6).

Working with Children

WA Health has a duty of care to provide the highest level of safety for clients. Children are some of the most vulnerable members of our society and their wellbeing and protection from harm is the paramount consideration in all decisions made regarding the employment or exclusion of persons from working in a child-related area.

A Working with Children Check is compulsory for people whose usual duties involve, or are likely to involve, contact with a child in connection with specific work categories defined in Working with Children (Criminal Record Checking) Act 2004 including:

- a public or private hospital ward in which children are ordinarily patients
- a community child health service
- a counselling or other support service.

Mandatory reporting of child sexual abuse

As prescribed by the Children and Community Services Amendment (Reporting Sexual Abuse of Children) Act 2008 provisions to the Children and Community Services Act 2004 (the Act), mandatory reporters of child sexual abuse are doctors, midwives, nurses, teachers and police officers ("reporters") who are required to make a report when they have formed a reasonable belief that child sexual abuse occurred or has occurred on or since 1 January 2009.

The Department for Child Protection and Family Support (DCPFS) administers the Act which places the responsibility for making a report on the reporter. Reporters employed within WA Health should make an immediate written report to DCPFS when a ‘belief’ is formed.

There is a duty for all health professionals to report any child abuse or neglect. WA Health employees should follow the Guidelines for Protecting Children 2015.

Child neglect

Suspected cases of child neglect can be referred to the Child Protection Unit (CPU), a specialised unit within Princess Margaret Hospital. The CPU accepts cases not only where there are concerns of child abuse but also cases where long and short-term protection are issues of concern. Cases that would be appropriate for referral include:

- Children who have injuries or have had previous injuries that may be inflicted injury e.g. fractures, bruises, lacerations, burns
- Children with non-organic failure to thrive
- Children where there is a concern of sexual abuse, neglect and induced/fabricated illness
• Children where there has been a previous unexplained infant death in the family
• Children who are believed to be at risk due to the mental or physical ill health of the parents
• Children who are believed to be at risk due to domestic violence, alcohol abuse or drug use

The National Association for Prevention of Child Abuse and Neglect (NAPCAN) is a not-for-profit organisation whose mission is to prevent child abuse and neglect and to ensure the safety and wellbeing of every Australian child.

Sources:


Department of the Prime Minister and Cabinet: https://www.dpmc.gov.au/indigenous-affairs
Section 4 Australian Law

- Criminal offences
- Violence
- Female reproductive health and rights
- Drugs, smoking and drinking
- Legal Aid

Everyone in Australia is expected to obey all Australian laws. Some things that are accepted in other countries are illegal in Australia and may result in severe penalties. Being familiar with Australian laws will help you to adjust to life in the Australian community and help you to avoid having problems.

4.1 Criminal offences

Crime is defined as any behaviour that is against the law and may result in punishment. Serious crimes include murder, assault, sexual assault, violence against people or property, armed robbery or theft, having sexual relations with children or young people who are aged below the age of consent, driving dangerously, possession and use of illegal drugs and fraud.

It is a serious offence to bribe (offer money to) or attempt to bribe an official, such as a police officer or a federal, state or local employee. Offering gifts or bribes to influence the decisions of public officials is illegal and will be reported.

It is also against the law to carry a weapon (such as a gun) without a licence. There may also be restrictions in most states and territories against carrying other potential weapons in public such as knives.

4.2 Violence

Violence towards another person is not tolerated in Australia and is illegal. There are various services to support victims of crime or violence, including domestic violence, violence in the home.

Domestic or family violence

This is violence within the home and within marriage and can include experience or fear of physical, sexual or psychological abuse and damage, forced sexual relations, forced isolation or economic deprivation. This behaviour is against the law.

There are helplines to provide counselling and assistance, and services to support adults and children affected by domestic violence, as well as those who want to change their violent behaviour.

- In an emergency - if someone is in immediate danger 000
- Women’s Domestic Violence Help Line 08 9223 1188
- Calls from outside of Perth 1800 007 339
- Men’s Domestic Violence Help Line 08 9223 1199
- Calls from outside of Perth 1800 000 599
- Police Operations (to report incident)………….131 444
- Referral to a women’s refuge 08 9223 1188

**Sexual assault**

Sexual assault or violence is illegal and carries serious penalties. It is any behaviour of a sexual nature that is unwanted or happens without agreement or consent. This includes behaviour in a marriage or recognised relationship.

Sexual assault includes harassment, assault, childhood abuse and rape. Sexual violence is an abuse of power that may involve force, threat or coercion.

- Domestic Violence 24 Hour Hotline (1800 RESPECT) 1800 737 732
- Sexual Assault 24 Hour Help Line (SARC) 1800 199 888 or (08) 9340 1828

**Legal age of consent**

The legal age of consent is the age the law recognises an individual as of age to agree to have sex with another person. In WA the legal age of consent is 16 years of age for males and females. In South Australia and Tasmania the legal age of consent is 17 years of age.

Having sex with a person below the age of consent (having sex with children) is illegal and carries serious penalties. This protects children from sexual exploitation.

In WA the following limitations apply:

- If you're under 16 years it's not OK to have sex. The law says you're too young to consent to sex.
- If you're 16 to 17 years old it's not OK to have sex if the older person is in a position of care or authority over you (such as a sports coach, teacher or foster carer).
- If you're 18 years old or older you can consent (agree) to have sex with anyone else over 18.

Further information:
- Legal Aid Western Australia infoline 1300 650 579

**Rights of children**

The human rights of children in Australia are protected by law, including from physical, sexual and emotional abuse, neglect and violence, both at home and at school. Children must be reasonably supervised and cared for, and physical discipline such as hitting is discouraged. If a child suffers significant harm this is illegal. Physical discipline is not allowed in schools.

See section 3.7 professional conduct for further information.

**Child protection**

Child protection services may become involved to ensure the safety and wellbeing of a child or young person where it is suspected or known that protection is needed from violence or abuse.

See section 3.7 professional conduct for further information.

**Forced early marriage**

Children under 16 years of age are not allowed to marry, and between 16 and 18 years of age there must be consent from parents and the Australian court.

It is illegal to organise forced early marriage, including sending a child to another country for this purpose.

Further information:
4.3 Female reproductive health and rights
In Australia it is illegal to practice female genital mutilation (cutting), or any other act that alters female genitals unless it is done for health reasons.

It is illegal to organise female genital mutilation by sending or taking a child to another country for this purpose.

Women and children arriving in Australia with related health problems have access to services that can provide help.

The Women's Information Service offers free, confidential information for women throughout WA. The free telephone service operates from 9.00am to 4.00pm on week days. It provides information and referrals about issues such as health, finances, legal matters, counselling and domestic violence.

Further information:
- Women’s Information Service (WIS) 1800 199 174
- Email wis@dlgc.wa.gov.au

4.4 Drugs, smoking and drinking
There are many laws about having possession of and using drugs. There are severe penalties for breaking the laws and different laws apply to those people using illegal drugs and those people who make, supply and/or sell illegal drugs.

Tobacco
There are many public places that smoking tobacco is prohibited including most government offices, health clinics, workplaces, restaurants and shopping centres. If you are not sure you can check for a 'no smoking' sign similar to these images below:

It is illegal to buy or be supplied tobacco or cigarettes unless you are over 18 years of age. If you are under 18 years of age you are considered a minor in the eyes of the law.

Alcohol
Drinking alcohol is legal in Australia in certain places at certain times. It may be prohibited in some public areas such as sporting ovals. It is against the law to sell or buy alcohol if you are a minor (under 18 years of age). A minor is also not allowed to drink alcohol except on private property such as a private home.

Further information:
- WA Health Drug and Alcohol Office
- Alcoholics Anonymous Australia 1300 22 22 22
- Narcotics Anonymous Australia 1300 652 820
4.5 Legal Aid

In WA, the organisation that informs people of their legal rights and obligations and to help with access the justice system is Legal Aid. Legal Aid can provide advice and helps to eligible people on criminal matters, family breakdown, family violence, migration, mental health, social security, debt and traffic offences.

Legal Aid WA has created a set of online, interactive community legal education resources:

- Community Online Resources Essentials (CORE)
- R U Legal?
- What’s the Law?

Further information: Legal Aid WA
Section 5 Registration of doctors in Australia

- Medical Board of Australia
- Australian Medical Council
- Medical registration pathways: Competent Authority, Specialist, Standard
- Professional development, education, colleges and organisations

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the registration and accreditation of 14 health professions across Australia. Each health profession that is part of the National Registration and Accreditation Scheme is represented by a National Board (the Boards). The primary role of the Boards is to protect the public by setting standards and policies that all registered health practitioners must meet. The MBA is one of the Boards supported by AHPRA.

AHPRA's operations are governed by the Health Practitioner Regulation National Law Act, (National Law) which came into effect on 1 July 2010. Under the National Law there are a number of MBA registration categories under which a doctor can practise medicine in Australia. Different categories apply to different types of registration: general, specialist, provisional, limited and non-practicing. Student registration can also be granted to medical students undertaking an approved program of study.

5.1 Medical Board of Australia

Every doctor practicing medicine in Australia must be registered with the MBA. The MBA keeps up-to-date public registers of all registered medical practitioners with general, provisional, limited and non-practicing registration, and those who are recognized as specialists. Medical practitioners with general registration can practice in any state or territory in Australia.

Registration with the Medical Board of Australia

IMGs who wish to apply for initial registration must provide evidence of eligibility under one of the following pathways: Competent Authority Pathway, Specialist Pathway or Standard Pathway.

The MBA requires all IMGs to provide proof of English language proficiency for all initial registration unless it has granted an exemption. All applicants are advised to make arrangements to obtain that proof before they apply under any of the assessment pathways. Acceptable evidence of English language proficiency may be a certified copy of the original or the original of any one of the following test results:

- Occupational English Test (OET) results (grades A or B)
- International English Language Testing System (IELTS) Academic Module results (scores 7 or higher in each of the 4 components)
- Pearson Test of English (PTE Academic) (minimum overall score of 65 and a minimum score of 65 in each of the four communicative skills)
- Test of English as a Foreign Language internet-based test (TOEFL iBT) measures your ability to use and understand English at the university level (minimum total score of 94)
- a pass in the Professional Linguistic Assessment Board (PLAB) in the United Kingdom (PLAB pass letter)
- a pass in the New Zealand Registration Examination (NZREX) in New Zealand.
The results of the English language examinations will be accepted if they were obtained within the two years before the date you lodge your initial registration.

Health assessments and monitoring
Under the National Law a registered health practitioner or student may be required to undergo a health assessment if the National Board reasonably believes that impairment has or may adversely affect capacity to practice. The National Law defines impairment as a ‘physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect’ their capacity to practise or undertake clinical training.

Restrictions can be imposed on the registration of a practitioner or student to limit practice (conditions) or require certain undertakings. These restrictions can be imposed by a National Board, panel or tribunal to keep the public safe while the practitioner continues to practice. When restrictions are in place on registration, AHPRA monitors compliance with the restrictions. This process is referred to as ‘monitoring and compliance’.

Revised Guidelines
On 4 January 2016 the MBA introduced revised guidelines on the supervision of IMGs. All IMGs who are granted limited registration or provisional registration must be supervised. Supervision remains a requirement of registration for the duration of the IMG’s limited or provisional registration.

The key changes to supervision arrangements for IMGs are:

- changes to the requirements for supervisors, including a new online education and assessment module for supervisors
- changes to the number of IMGs permitted per supervisor
- clearer descriptions of the four levels of supervision
- revised supervision arrangements for IMGs working after-hours, on-call or providing home visits and locum services
- a new process for appointing temporary supervisors
- a new audit provision - IMGs and their supervisors may be audited to check compliance with the Board’s supervision requirements

Templates included with this revision:

- supervised practice plan and principal supervisor’s agreement
- orientation report
- work performance report

Revised registration standards
From 1 October 2016 the mandatory registration standards for recency of practice, and continuing professional development came into effect. Applicable medical practitioners must meet these registration standards when applying for registration or renewing registration.

From 1 January 2016 the mandatory registration standard for professional indemnity insurance arrangements was updated. Medical indemnity insurers must meet the minimum product standards that apply to all medical indemnity insurers as defined in the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (Cth).
Revised registration standards for limited registration for IMGs came into effect from 1 July 2016. These include:

- Limited registration for area of need
- Limited registration for postgraduate training or supervised practice
- Limited registration for teaching or research
- Limited registration in public interest

From 1 July 2015 mandatory registration standards updates came into effect for criminal history registration and English language skills registration.

5.2 Australian Medical Council

The AMC is an independent national standards body for medical education and training. Its mission is to “promote and protect public health and safety by ensuring a safe and competent workforce distributed across Australia to meet community needs”.

The AMC conducts the assessment process for IMGs in the Standard Pathway only, to ensure they meet the same standard of medical knowledge, clinical skills and attitudes expected of new graduates from Australian medical schools. The examinations are comprised of a number of parts designed to test medical knowledge, clinical competencies and professional attitudes for the safe and effective clinical practice of medicine in Australia.

IMGs whose primary medical qualifications are not from accredited Competent Authorities can gain eligibility for general registration through the Standard Pathway AMC examinations or Standard Pathway workplace-based assessment and completion of a period of supervised clinical practice approved by the MBA.

Primary source verification

As of 1 October 2015 the AMC requires IMGs to apply online for primary source verification of their medical qualifications. IMGs seeking registration in any category in Australia must apply for primary source verification using the Education Commission for Foreign Medical Graduates’ (ECFMG) Electronic Portfolio of International Credentials (EPIC) system.

Examinations

The AMC examination consists of two sections.

The first section, the AMC Computer Adaptive Test Multiple Choice Questionnaire (CAT MCQ) Examination, is a computer-administered fully integrated multi-choice question examination of 150 A-type MCQs delivered in one 3.5 hour session in examination centres worldwide. The exam tests the principles and practice of medicine in the fields of internal medicine, paediatrics, psychiatry, surgery, general practice and obstetrics and gynaecology.

The second section, the Clinical Examination, is an integrated multidisciplinary structured clinical assessment consisting of a 16-component multi-station assessment undertaken in a single morning or afternoon session. Clinical assessment of clinical skills will cover medicine and surgery, obstetrics and gynaecology, paediatrics and psychiatry. It also assesses ability to communicate with patients, their families and other health workers.

You must pass the AMC CAT MCQ Examination to be eligible to apply to sit the AMC Clinical Examination provided that your eligibility status is not conditional (that is the AMC is not waiting on required documentation to assess your credentials).
Workplace based assessment, an alternative to the AMC Clinical Examination, is being implemented by the AMC in conjunction with some Australian states. See section 5.5 for information.

5.3 Competent Authority Pathway
The Competent Authority Pathway is intended for overseas-trained non-specialists, but is also available to specialists, including general practitioners (GPs).

From 1 July 2014, IMGs who have completed the requirements of the MBA-designated competent authority can apply directly to the MBA for provisional registration.

The MBA-designated competent authorities are:

- United Kingdom - General Medical Council (PLAB examination or graduates of GMC-accredited medical courses in the UK)
- Canada – licentiate examinations of the Medical Council of Canada (LMCC)
- United States - Educational Commission for Foreign Medical Graduates (USMLE)
- New Zealand - Medical Council of New Zealand registration examination (NZREX)
- Ireland - medical courses accredited by the Medical Council of Ireland

5.4 Specialist Pathway
The Specialist Pathway is open to:

- overseas trained specialists whose qualifications have been partially recognised by an Australian/Australasian specialist college
- overseas trained specialists seeking work as an Area of Need specialist
- overseas trained specialists and specialists-in-training who wish to undertake training in Australia for a limited period (for example, one year).

All applicants must have a primary qualification in medicine and surgery from a training institution listed in the current International Medical Education Directory of the Foundation for Advancement of International Medical Education and Research.

Specialists applying for an assessment of their comparability for specialist recognition or for an assessment of their suitability for an area of need position must also have satisfied all the training and examination requirements to practise in their field of specialty in their country of training. To be eligible for short-term training, the IMG must have completed their training or be no more than two years away from completing their specialist training overseas.

From 1 July 2014 IMGs applying for registration through the specialist pathway apply directly to the specialist medical college. The outcome of a specialist medical college’s assessment of the IMG’s application for the Specialist Pathway will determine the type of registration an IMG may apply for with the Board. The Board makes the final decision on whether to grant registration.

5.5 Standard Pathway
The Standard Pathway is generally for non-specialist IMGs seeking general registration in Australia who do not qualify for the Competent Authority Pathway. Under this pathway, the AMC conducts two alternative processes leading to the AMC Certificate:
• **Standard Pathway (AMC examinations):** Assessment is by examination only – the AMC CAT MCQ Examination and the AMC Clinical Examination. Most non-specialist applicants will be assessed through this method.

• **Standard Pathway (workplace-based assessment):** Assessment is by examination and workplace-based assessment – the AMC CAT MCQ Examination and workplace-based assessment of clinical skills and knowledge by an AMC-accredited authority. The AMC has accredited a small number of workplace-based assessment programs and as a result, relatively few applicants are assessed through this pathway.

**Workplace-based assessment in WA**

Workplace-based assessment (WBA) in everyday clinical practice tracks your progress in integrating clinical knowledge and skills as a basis for safe and effective clinical judgments and decision making. It also assesses how well you deal with patients and whether you can work productively in a team of healthcare professionals.

The content and the assessment standard of accredited WBA programs are approved by the AMC and overseen by members of the AMC Board of Examiners, who ensure that the format and content of the assessments are consistent with the required standard.

The assessment methods for WBA programs are rigorous and structured. Disciplines covered include medicine, surgery, obstetrics and gynaecology, paediatrics, emergency medicine and psychiatry.

WA has three AMC-accredited sites undertaking WBA – Bunbury Hospital, Geraldton Hospital and Kalgoorlie Hospital. Candidates must apply for positions through standard recruitment processes to secure employment before being eligible to join the WBA program. Employment cannot be arranged on your behalf by either the AMC or WA Health.

### 5.6 Professional development and education

Because Australia is a large and diverse country, individual doctors cannot be expected to be expert in all the situations they meet. Some situations encountered by doctors will be uniquely Australian, for example spider bites or the impact of Aboriginal traditional beliefs on acceptance of medical treatment. It is not expected that you will be familiar with the diverse range of situations that you may need to deal with as a medical practitioner in Australia. Additionally, new information and regulations are frequently being published, from research and ethical analysis conducted in both Australia and overseas.

Under the National Law all registered health practitioners must undertake Continuing Professional Development (CPD). Practitioners registered with each Board must achieve a certain number of hours/points/credits each year on CPD activities. The MBA has developed a [CPD registration standard](#) that outlines these requirements.

Information on training workshops and education sessions will generally be posted on bulletin boards at your hospital and may be accessed on the intranet site of each health service, from the Director of Clinical Training and/or the Medical Education Office of your hospital. Most sites also have a medical library or access to online library resources where you can access clinical publications.

A list of libraries is available on the WA Health Library Network:
There are a number of organisations that provide professional and personal support to doctors in Australia and offer a valuable source of experience and knowledge. Do not be shy about using them. Asking for advice or help is part of the learning process and most of your colleagues will have faced similar situations during their working experience. Seeking advice can help you to build a rich network of collegiate support and friendship.

**Specialist Colleges**

Australian and New Zealand College of Anaesthetists - [ANZCA](http://www.anzca.edu.au)
Australasian College of Dermatologists - [ACD](http://www.acd.org.au)
Australasian College for Emergency Medicine - [ACEM](http://www.acem.org.au)
Australasian College of Legal Medicine - [ACLM](http://www.aclm.org.au)
Australasian College of Sports Physicians - [ACSP](http://www.acsp.org.au)
Australasian College of Rural and Remote Medicine - [ACRRM](http://www.acrrm.com.au)
College of Intensive Care Medicine of Australia and New Zealand - [CICM](http://www.cicm.org.au)
Royal Australian College of General Practitioners - [RACGP](http://www.racgp.org.au)
Royal Australasian College of Medical Administrators - [RACMA](http://www.racma.com.au)
Royal Australasian College of Physicians - [RACP](http://www.racp.org.au)
Royal Australasian College of Surgeons - [RACS](http://www.racs.org.au)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists - [RANZCOG](http://www.ranzcog.edu.au)
Royal Australian and New Zealand College of Ophthalmologists - [RANZCO](http://www.ranzco.org.au)
Royal Australian and New Zealand College of Psychiatrists - [RANZCP](http://www.ranzcp.org.au)
Royal Australian and New Zealand College of Radiologists - [RANZCR](http://www.ranzcr.org.au)
Royal College of Pathologists of Australasia - [RCPA](http://www.rcpa.org.au)
Further information: Council of Presidents of Medical Colleges

Professional Organisations

**Australian Doctors Trained Overseas Association (ADTOA):** represents Australian citizens and permanent residents who have trained overseas. ADTOA maintains contacts with government agencies, non-government organisations, medical boards, colleges & associations.

The website provides information on Australian medical registration, exams and study, courses, colleges and work, as well as political and legal issues. The ADTOA provides a forum for members and the public to discuss issues and share information.

**Australian Medical Association (AMA):** is an independent association which represents more than 27,000 doctors nationally whether salaried or in private practice, GPs and specialists, teachers and researchers or young doctors. It is a broad political body, which aims to protect the academic, professional, industrial needs and wellbeing of medical practitioners.

Members of the AMA are committed to ensuring professional values, excellence in teaching and research, and the delivery of high quality health care to all Australians, regardless of gender, political beliefs or geographic location.

**Australasian Medical Writers Association (AMWA):** the peak body for promoting excellence in health and medical communications in Australia and New Zealand through conferences, continuing education, networking and mentoring.

**Australian Society for Medical Research (ASMR):** is the peak professional society representing Australian health and medical research.

**Doctors Reform Society of Australia (DRS):** is an organisation of doctors and medical students promoting measures to improve health for all, in a socially just and equitable way.

**Rural Health West:** is a not-for-profit, membership-based organisation overseen by a Board of Directors. As a workforce agency for WA, Rural Health West aims to work collaboratively with organisations and individuals to ensure that the health needs of rural Western Australians are met by a high-quality, sustainable health workforce. Rural Health West is funded by the Australian Government Department of Health and the Western Australian Government of Health through the WA Country Health Services (WACHS).

Support Organisations and Services

**BeyondBlue:** provides information and support to help everyone in Australia achieve their best possible mental health, whatever their age and wherever they live. 1300 224 636

**Bush Support Services:** 24 hour telephone counselling service for ALL remote health workers/service providers and their families. 1800 805 391

**Doctors Health Advisory Service:** a confidential 24-hour service that offers professional peer support for medical students and doctors by an independent panel of experienced male and female GPs, in times of personal crisis. Contact can be made by the person themselves or a concerned family member, colleague or friend. All contact remains confidential. Telephone: (08) 9321 3098 24 hours/day, 7 days/week

**DoctorConnect:** an Australian Government website developed to assist doctors trained outside Australia to understand the Australian health system and provide information which can support them to work in regional, rural and remote Australia.
**Employee Assistance Program** (for State Government employees): Professional counselling service available 24 hours a day, 7 days a week. 1800 337 068 or 1300 361 008.

**Postgraduate Medical Council of WA (PMCWA):** provide leadership for early postgraduate medical education and training, including supporting clinicians and other professionals involved in the education and training of pre-vocational and other non-vocational doctors, and identifying and advising on matters that impact on the health and welfare of pre-vocational and other non-vocational doctors. PMCWA provides support for junior medical officer’s through the WA Junior Medical Officer (JMO) Forum, and have been supported by the JMO Forum to produce the JMO Survival Guide.

**Rural Doctors Association of Australia (RDAA):** is a national body representing the interests of rural medical practitioners around Australia and comprises the RDAs of each State and Territory.

**Rural Family Medical Network:** assists the spouses and families of doctors and medical students when moving to rural locations in NSW, Queensland, Victoria and WA. In WA this program is conducted through Rural Health Wests Family Support Program.
Section 6 Working in Western Australia

- Working in hospitals: structure, roles, orientation, support, communication, discharge planning, hospital emergency departments, rosters, pay rates
- Occupational safety and health
- Imaging and pathology
- Prescribing
- Schedule 8 medications and drugs of dependence
- Medical credentialing and scope of practice
- Infection control: hand-washing, immunisation, infectious diseases
- Taxation and insurance: superannuation, salary packaging, professional indemnity, WorkCover
- Medico-Legal: medical records, patient confidentiality, patient consent including children and minors, notifiable conditions, FOI, sexual harassment, violence and aggression
- Deaths in hospital: reportable deaths, certification of death, organ transplantation
- Working in general practice: 19 AB restrictions and area of need, visiting medical practitioners, support, telehealth

Like other Australian states and territories, WA has a mix of public and private health service providers that comprise the state’s health system. When first arriving in WA, IMGs are likely to work in metropolitan public hospitals or in country hospitals through WACHS. Restricted access to a Medicare provider number under the Health Insurance Act 1973, means IMGs wishing to work in general practice must generally seek employment in an Area of Need, generally located either in rural or outer metropolitan areas. See section 6.11 for further information.

6.1 Working in hospitals

Working in a hospital can provide you with a valuable experience that enables you to consolidate and extend your theoretical knowledge and technical skills. If you are employed as a resident medical officer (RMO) you will undertake placements which allow you to contribute positively to patient care as a member of the healthcare team while providing you with supervision to support your career development and satisfy any medical registration requirements.

Hospital structure

Hospitals have varied structures and you should receive a copy of your hospital’s governance and organisational structure during hospital orientation when you commence employment. Your main contacts will be the doctors in your clinical unit such as the Unit Head and nominated Supervisor, as well as other consultants, registrars, RMOs, interns, and relevant ward staff.

The education pathway in metropolitan teaching hospitals and the standard position titles associated with these training positions are described in Figure 1. A number of other titles are used for medical practitioners, particularly by WACHS, to indicate the level of training and responsibility of doctors working in these hospitals. Common position titles and the associated clinical occupation are set out in Figure 2.

As a doctor, there are a number of people that you will interact with directly including:

- patients and their relatives/friends
- medical practitioners including other junior doctors, registrars and consultants
- other health professionals including nursing and allied health
- GPs and health professionals involved in community services
- Medical administration and medical education staff.

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Position Title</th>
<th>Stage of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Junior Doctors</strong></td>
<td>Intern</td>
<td>Prevocational (postgraduate)</td>
</tr>
<tr>
<td>(Junior Medical Officers)</td>
<td>General Registration with MBA</td>
<td></td>
</tr>
<tr>
<td>(postgraduate years 1 to 5)</td>
<td>Resident</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Resident Medical Officer)</td>
<td></td>
</tr>
</tbody>
</table>

Clinical and written examinations in a Professional College (undertaken at any time from years 3 to 5)

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Position Title</th>
<th>Stage of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialists in Training</strong></td>
<td>Registrar</td>
<td>Basic Vocational (postgraduate)</td>
</tr>
<tr>
<td>(supervise Junior Doctors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completion of Professional College requirements.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior Registrar</td>
<td>Advanced Vocational (postgraduate)</td>
</tr>
</tbody>
</table>

Completion of Professional College requirements. Admission to Fellowship in Professional College.

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Position Title</th>
<th>Stage of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialists</strong></td>
<td>Consultant</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>(supervise Junior Doctors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Specialists in Training</td>
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</tbody>
</table>

Figure 1: Medical education pathway and position titles in Western Australian metropolitan teaching hospitals.

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Position Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior non-specialist doctors</strong></td>
<td>District Medical Officer (procedural and non-procedural)</td>
</tr>
<tr>
<td></td>
<td>Health Service Medical Practitioner</td>
</tr>
<tr>
<td></td>
<td>Senior Medical Officer</td>
</tr>
<tr>
<td></td>
<td>Senior Medical Practitioner</td>
</tr>
<tr>
<td></td>
<td>Visiting Medical Practitioner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Position Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical administration</strong></td>
<td>Area Director of Clinical Services (Clinical Leads)</td>
</tr>
<tr>
<td></td>
<td>Director Clinical Services</td>
</tr>
<tr>
<td></td>
<td>Director Medical Services</td>
</tr>
<tr>
<td></td>
<td>Medical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Position Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical education</strong></td>
<td>Director Clinical Training</td>
</tr>
<tr>
<td></td>
<td>Director Postgraduate Medical Education</td>
</tr>
</tbody>
</table>

Figure 2: Common medical position titles in Western Australia.

Role of hospital doctors
As a hospital doctor you will play a central role in the day-to-day management of patients, performing clinical duties including inpatient and outpatient services. You will be expected to
practice professionally and ethically, in accordance with the expectations of the community, the medical profession and the MBA.

You will liaise with medical, nursing, allied health and other relevant staff regarding patient management and should ensure that appropriate communication is maintained with external parties such as GPs. In addition you should ensure that adequate medical records and discharge planning systems are maintained, be punctual and courteous and be responsible for your personal health and safety.

**Orientation to the hospital**

The hospital will provide an orientation program for all new employees so that they can familiarise themselves with the workings of the hospital, the medical unit to which they have been assigned, and the overall operation of WA Health. Specific areas of the orientation may be provided by different staff. For example general administration may be covered by medical administration staff; information on specific hospital services may be covered by staff in those areas; and clinical information regarding your unit may be provided by your supervisor or another senior doctor in the unit.

WA Health has a program of mandatory training modules that all hospital medical staff must complete when they commence employment. Many of these modules can be completed online on the Department of Health intranet. These intranet sites are only accessible from computers within the hospital.

- CAHS intranet
- EMHS intranet
- NMHS intranet
- SMHS intranet
- WACHS intranet

**Performance reviews**

During each rotation, you will be assigned a supervisor employed by the hospital, who is responsible for helping you set goals, supervising your work and conducting mid-term (formative) and end of term (summative) assessment interviews, during which there is opportunity for all parties to provide feedback.

The **Australian Curriculum Framework (ACF)** is an excellent reference to guide you to set your learning goals and understand the level of clinical competence expected of junior doctors in Australia. Developed to support junior doctors in their prevocational training years, the ACF outlines the learning outcomes JMOs should achieve through their clinical rotations, education programs and individual learning.

**Communication and handover**

Communication with members of a multidisciplinary team is an essential part of fulfilling your role as a doctor in the provision of patient care. Whether you are informing nursing or allied health staff of your wishes or ensuring that other doctors covering your patients/ward know about your patients and are aware of any issues which must be monitored, effective communication is of the highest importance.
Incomplete transfer of clinical information between medical personnel, particularly during patient handover, has been identified as one of the most important contributing factors in serious adverse events. WA Health strives to avoid this through the use of the ISOBAR system (see below, the word that forms the pneumonic in each description is underlined).

I - introduce self (name, role, contact number) and the patient (name, date of birth, gender)

S - explain situation: presentation, diagnosis, principle problems, reason seeking transfer/advice

O - most recent primary survey including observations, drips and drains

B - background to the patient: medications, allergies, test results, social information

A - agree a plan: determine urgency and treatment priorities, who does what, when

R - read-back the situation: clarify for shared understanding, clear on treatment, doses, numbers, roles and tasks.

**Interactions with nursing staff**

As a hospital doctor you are encouraged to liaise with Nurse Managers and Clinical Nurse Specialists (CNS) of the wards in which they work. The CNS and Nurse Managers can provide invaluable assistance about ward practices and hospital procedures. They are senior members of the hospital staff whose primary role is to ensure that patients receive optimal care. Please talk to them about relevant issues, particularly where you have concerns.

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

**Discharge planning and communication with General Practitioners**

When a patient is discharged, it is of the greatest importance that communication is made with the doctor who is to provide follow-up treatment, provided the patient consents to this contact being made. This is a matter of courtesy and also ensures health practitioners in the community receive a written copy of the necessary information to support on-going management of the patient.

Discharge planning should commence as soon as possible after admission as early referrals will ensure the patient can leave hospital without unnecessary delays. This is particularly important for country patients in metropolitan hospitals. Planning should take into account:

- the patient’s medical, functional and psychological status, social circumstances and home environment
- availability of services to meet any necessary rehabilitation, social and long-term care needs
- patient and family involvement wherever possible.

In planning the discharge of patients, the following areas should be considered:
Communication with GPs
- follow-up appointments
- pharmacy requirements
- geriatric assessment (ACAT)
- Silver Chain assessment

Home services
- home help
- day hospital
- HACC assessment

Internal services
- palliative care
- stoma and prosthetic care
- anti-coagulant therapy
- diabetic clinic
- other hospital clinic outpatient services

Allied Health services
- physiotherapy
- occupational therapy
- speech and hearing
- social work requirements

A consideration for country patients is the cost of travel and accommodation to access certain services that may not be available where they live. These patients may be eligible for travel assistance funding through the Patient Assisted Travel Scheme administered by WACHS hospitals.

The introduction of the national activity based funding program requires a standardised approach to the rules regarding how activity is classified across Australia. A primary focus of the ABF/ABM implementation strategy has been to ensure health services count, classify and report activity correctly. The Admission, Readmission, Discharge and Transfer Policy for WA Health Services (the ARDT policy) is a key part of this process and its intent is to provide health services with a framework, containing detailed rules and criteria to enable accurate and timely information about the care we provide is used in many ways – including ensuring that our health services are adequately funded for the services they provide.

The WA Health Statewide Discharge Summary Policy was introduced on 1 July 2016 to help standardise policy and practice to ensure a consistent system across the whole of WA Health.

Hospital emergency departments
Emergency departments in public hospitals provide free 24 hour 7 day emergency care to anyone who needs immediate treatment for a serious injury or illness.

Triage categories are allocated to each patient based on an assessment of their presenting conditions, generally by the triage nurse, with triage 1 being the most urgent and triage 5 being the least urgent. Patients are always seen in order of clinical urgency.

The Australian Government Department of Health has developed an Emergency Triage Education Kit to provide a nationally consistent approach to the educational preparation of emergency clinicians for the triage role, and promotes the consistent application of the Australasian Triage Scale.

Emergency departments are located at the following metropolitan hospitals in WA:

- Armadale/Kelmscott District Memorial Hospital
- Fiona Stanley Hospital
- Joondalup Health Campus (formerly Wanneroo Hospital)
- King Edward Memorial Hospital for Women
- Peel Health Campus
- Princess Margaret Hospital for Children
- Rockingham General Hospital
- Royal Perth Hospital
- Sir Charles Gairdner Hospital
- St John of God Midland Public Hospital (replaced Swan District Hospital)
- St John of God Hospital Murdoch (private hospital – fees payable)

Map 2: WACHS Emergency Telehealth Service Sites
In the WACHS there are over 70 regional and remote hospital emergency departments and emergency care facilities. The Emergency Telehealth Service uses telehealth technology to provide specialist emergency medicine support to clinical staff treating acute patients in country hospital emergency departments, and outpatient consultations between metropolitan-based specialists and regionally-based public patients via videoconference.

Support and assistance
Should you find yourself in difficulty for personal or professional reasons or have issues to discuss such as career counselling, there are a number people available to support you in the hospital.

- Director of Medical Services
- medical administration
- Medical Officer representatives
- clinical supervisors
- Directors of Clinical Training/Medical Education Officers

Information on support organisations external to the hospital are provided in section 5.6 of this manual.

Rosters
Interns and RMOs at Royal Perth, Sir Charles Gairdner and Fiona Stanley Hospitals rotate through five terms of approximately 10 weeks each. Some of the rotations may be in one of the satellite hospitals attached to the tertiary hospital and opportunities exist to work at rural hospitals run by WACHS for some rotations. RMOs at King Edward Memorial Hospital undertake rotations of 8-9 weeks duration over 6 terms and RMOs at Princess Margaret Hospital undertake 12-14 week rotations across 4 terms. As either an Intern or an RMO you will be expected to work a mix of day, weekend and night rosters.

While the hospital will try to give consideration to personal preferences and individual requests, ensuring adequate staffing to support patient care remains the hospital's primary objective.

Further information: PMCWA RMO Application Guide

Pay rates
The conditions of employment for junior doctors working in Western Australian hospitals are subject to the terms and conditions of the doctor’s awards and agreements.

The current awards and agreements are the Department of Health Medical Practitioners (Metropolitan Health Services) AMA Industrial Agreement 2013 or Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2013.

6.2 Occupational safety and health
WA Health is committed to providing a safe work environment for all staff in keeping with the Occupational Safety & Health Act, 1984 (the OSH Act). To achieve this, WA Health has established comprehensive and effective Occupational Safety and Health (OSH) programs throughout all public health services in WA. The programs are implemented by the OSH Department for each Health Service to provide the organisational framework and achieve a safe work environment.
Success of the program relies on staff fulfilling their own responsibility for risk minimisation, identifying potential risk areas and reporting any potential or adverse incidents using the correct reporting mechanisms so that these can be remedied. New staff should ensure that they are familiar with reporting mechanisms and the designated OSH officer for their work area.

Ongoing development and maintenance of a safe working environment and management of risks to employees includes:

- injury prevention
- ergonomics
- hazardous substances management
- injury management and vocational rehabilitation
- workers’ compensation claims management.

WorkSafe is the Western Australian Government agency responsible for the administration of the OSH Act. It is a division of the Department of Commerce. The main objective of the OSH laws is to promote and secure the safety and health of people at the workplace. The scope of the OSH Act does not include every workplace. Workplaces and work activities in general industry will normally be included.

6.3 Imaging and pathology: ordering and reporting

Appropriate use of imaging and pathology related investigations contribute to patient care and should be considered in the context of ‘how will it affect decision making and management of the patient’.

The process for ordering imaging and pathology investigations will be different in each hospital. During the orientation to your hospital you will be informed how these investigations are ordered and reported.

It is important that you clearly complete the request form indicating the range of investigations to be performed on the sample. Most request forms will include a section for requesting additional reports (e.g. copy to the GP). As a general rule, ensure that all specimens are fully labelled, including: time and date of collection and type of specimen and site. Unlabelled specimens and/or specimens without completed request forms cannot be processed.

If specimens are urgent, mark these clearly and notify the laboratory in advance so that appropriate preparations can be made to facilitate faster results.

All results of investigations ordered must be reviewed as part of quality assurance. Where you are unable to review results for your patients, it is essential that you arrange for sound processes to be in place to ensure timely review by a clinician who can act in accordance with clinical need.

6.4 Prescribing medications

Medications in Australia are generally referred to by their brand name rather than the active ingredient, although either is acceptable. In both hospitals and general practice, drug names used may be different to those IMGs are used to from their work in other countries. Moreover, through the National Medicines Policy, the Australian Government encourages the use of generic drugs to reduce any financial pressure on the PBS.
When preparing a patient for discharge, ensure that they consult their GP for community-dispensed prescriptions (i.e. dispensed by the local chemist/pharmacy) for any ongoing medications.

IMGs new to the Australian health system should be aware that many medications may have several names. The following resources may assist you in becoming familiar with this terminology.

The National Medicines Policy website provides information on the Quality Use of Medicines program and links to a number of websites with information for those prescribing medications.

Australian Medicines Handbook is an essential reference tool for medical practitioners, pharmacists, nurses and nurse practitioners, dentists, students, hospitals, aged care facilities and any health practitioners with an interest in the quality use of medicines.

Therapeutic Goods Administration has developed and maintains lists of Australian approved terminology. For medicines, the lists cover substances (active ingredients and excipients), containers, dosage forms, routes of administration and units of expression and proportion.

The Medical Register of Australia runs a short medical terminology course held at various locations, one evening per week for about 2 months.

Medication Safety online training course: To explore the various causes of medication errors and equip you with the knowledge and skills to help prevent errors from occurring in the workplace and increase safety for your patients.

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

Commonly used and understood terminology and abbreviations relating to the prescription, dosage and administration of medications are provided in Appendix 1.

6.5 Schedule 8 medicines

The Medicines and Poisons Regulation Branch (formerly the Pharmaceutical Services Branch) of the Department of Health provides advice, develops policies and administers regulatory controls for medicines including Schedule 8 medicines (drugs of dependence), therapeutic goods and poisons in WA.

Medicines and poisons are classified into schedules based on their level of toxicity and their use. Schedule 8 or Controlled Drug prescription medicines require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

The Medicines and Poisons Regulation Branch has produced the Schedule 8 Medicines Prescribing Code and the legal requirements for the prescribing of schedule 8 medicines under the Medicines and Poisons Act 2014 and the Poisons Regulations 1965. In WA, S8 medicines include opioids, stimulants (methylphenidate and dexamphetamine) and benzodiazepines (flunitrazepam and alprazolam).
Please read the power point developed by the Medicines and Poisons Regulation Branch on the Schedule 8 Medicines Prescribing Code explanatory notes.

Practitioners are required to provide consultan support for any patient who meets one or more of the criteria in the list of high risk criteria.

Further information:

- Information for prescribers – consultant report requirements for Schedule 8 medicines
- Quick reference guide to low and high risk criteria
- Schedule 8 prescriber information service 9222 4424

6.6 Medical credentialing and defining scope of practice

All doctors who provide hospital services are subject to a credentialing process to confirm that medical practitioners are suitably qualified to undertake the work they are engaged to perform and that the standard of their clinical practice is maintained at an acceptable level.

The credentialing process includes:

- Verifying a medical practitioner’s credentials: qualifications, skills, experience and competencies.
- Defining the scope of clinical practice: determining the scope of clinical practice for a medical practitioner within a specific health care facility.

Credentialing is aligned with a medical practitioner’s employment/engagement and shall not exceed five years without re-credentialing. Re-credentialing may be planned or unplanned.

Further information: The Policy for Credentialling and Scope of Clinical Practice for Medical Practitioners (2nd Edition)

6.7 Infection control

Hand washing

Regular washing of hands is considered the most important measure in preventing the spread of infection. This should occur:

- before and after each patient contact
- if hands become contaminated
- before handling food
- after handling waste
- after removal of gloves
- after using the toilet
- after sneezing, coughing, using a tissue

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

You will be required to undertake mandatory training in Hand Hygiene during orientation to the hospital or health service.

Wearing gloves

Gloves should be worn when:

- handling blood or body fluids
- handling equipment or materials contaminated with blood or body fluids
• touching mucous membrane
• touching non-intact skin of any person
• performing venepuncture
• performing other invasive procedures.

Further information: Education on hand hygiene

Handling sharp instruments
Sharp instruments (such as needles and scalpel blades, known as “sharps”) should be handled in a safe manner and properly disposed of after use. Any incidents such as needle-stick injuries should be reported immediately to your Supervisor. To prevent needle-stick injury:

• needles should never be recapped, bent, broken, removed from disposable syringes or otherwise manipulated
• you should pick up a syringe by the barrel and when discarding place the syringe and needle in a puncture-proof container (known as a “sharps container”).

Exposure to blood or body fluids in the workplace
If an incident occurs involving a break in the surface of the skin through which infectious bodily fluids may have entered, flush with lots of running water and then wash with soap and warm water. If eyes are contaminated, rinse eyes with lots of tap water or saline and if blood gets into the mouth, spit and then repeatedly rinse with water.

After taking the appropriate first aid steps outlined above, the incident should be reported to the nominated person in your hospital/unit and the incident recorded and reported via the appropriate incident reporting procedure.

Immunisations
The following immunisations are recommended for healthcare workers:
• Hepatitis B vaccination (HBV)
• Diphtheria and Tetanus (ADT Booster immunisation)
• influenza vaccine of which one brand is Fluvax (given annually)
• Measles, mumps, rubella (MMR)
• Varicella (chickenpox) – for non-immune staff only.

Infectious diseases
All hospitals in WA have processes and protocols which must be followed if you are exposed to an incident that places you at risk of a transmissible disease (such as a needle stick injury).

All medical practitioners and medical students should know their Human Immunodeficiency Virus, HBV and Hepatitis C Vaccination antibody status. As medical staff are at risk from contracting infections from their patients, they should protect themselves and their patients by:

• adhering to current infection control guidelines and protocols
• being immunised against HBV at the earliest possible opportunity in their career and preferably before commencing clinical contact. They should ensure that they have responded by having post-vaccination testing
• following post-exposure protocols, including seeking expert advice about early management and practice modification.
Responsibilities of treating medical practitioners

Medical practitioners who treat healthcare workers should observe the same standards of clinical practice and record keeping as they would when caring for any other patient. The infected healthcare worker has the same rights of clinical care, counselling and confidentiality as any other patient; unless the treating doctor believes that the infected healthcare worker is putting the public at risk. In this case the matter must be referred to the appropriate registration body.

In caring for an infected healthcare worker, the treating doctor should assess and monitor the patients’ physical, emotional and cognitive status and his or her safety to practise medicine and/or maintain patient contact.

Medical practitioners who are managing doctors or students with infectious diseases can approach the Director of Medical Services if they would like help in assessing whether an infected practitioner should be practicing medicine and whether his or her practice should be limited. An expert advisory group can be convened to assess the case and provide advice.

6.8 Taxation and insurance

Taxation

In general, anyone earning an income in Australia is required to pay tax. A tax file number (TFN) is issued to individuals and organisations by the Australian Taxation Office (ATO) to assist with the administration of tax and other Australian Government systems. It is not compulsory to have a TFN, but if you don’t have one to provide to your employer, more tax may be withheld than is required, or you may not be able to receive the government benefits you are entitled to. A TFN is issued only once during your lifetime, regardless of any changes in name, residency or any other circumstances.

Salary packaging

Salary packaging enables you to use pre-tax income towards benefits and reduces the amount of tax you pay, giving you increased disposable income. Items available to package include car leases, superannuation, laptop computers, general living expenses, meal entertainment, mortgage repayments, rent, credit card payments and education resources.

The items you can package depend on the applicable Industrial Award and Agreement. Limits and varying Fringe Benefits Tax conditions apply depending on the item to be packaged, and you should seek advice from your financial advisor.

Superannuation

Superannuation is money set aside over your working lifetime to provide for your retirement. For most people, superannuation begins to accumulate when you start work and your employer starts paying contributions for you. These payments are known as super guarantee contributions or concessional contributions. You may also be entitled to choose the fund your super is paid into.

Superannuation funds invest your money in areas such as shares, property and managed funds. Complying super funds receive more favourable tax treatment than individuals and companies. The minimum employer contribution is 9.5% of your “ordinary time earnings” which
is generally what you earn for ordinary hours of work including: over-award payments; commissions; allowances, and paid leave.

You can increase your superannuation by making your own contributions and you may be eligible for government contributions. You may also want to consider a salary sacrifice arrangement to grow your superannuation and achieve taxation benefits by doing so.

Further information:

Australian Taxation Office
Government Employee’s Superannuation Board (GESB)
Australian Securities and Investment’s Commission

General insurance and income protection
All subclass 457 visas granted on or after 14 September 2009 are subject to condition 8501 requiring visa holders to maintain adequate arrangements for health insurance for the duration of their stay in Australia. Visa holders who fail to comply may have their visas cancelled.

Visa applicants who have enrolled with Medicare in Australia and hold a valid Medicare card issued under a Reciprocal Health Care Agreement (RHCA) will satisfy minimum requirements for adequate health insurance.

Professional indemnity insurance
The MBA’s registration standard on professional indemnity insurance states that practitioners must be insured or indemnified for each context in which they practice. In private practice, this is usually professional indemnity insurance. The MBA requires that this be with an approved insurer. The following insurers have been approved by the MBA to meet the minimum product standards that apply to all medical indemnity insurers as defined in the Medical Indemnity (Prudential Supervision and Products Standards) Act 2003 (Commonwealth):

- Avant
- Medical Indemnity Protection Society Limited (MIPS)
- Medical Insurance Group (MIGA)
- MDA National
- Guild Insurance Limited

The Australian Prudential Regulation Authority contains a register of general insurers.

Medical officers employed by WA Health are eligible to apply for medical indemnity cover through the Western Australian Department of Health’s contractual indemnity scheme. Under the scheme, each salaried medical officer is provided with individual indemnity covering medical treatment liability claims that might arise during the course of his or her employment. In return, the indemnified practitioner must provide full and open support for quality improvement practices such as medical audit and the reporting and investigation of adverse events, thereby formalising arrangements already occurring.

If as a salaried medical officer with WA Health you are treating patients who do not fall within the scope of the indemnity provided, you may need to purchase medical indemnity cover from a private Medical Defence Organisation (MDO). Should your MDO also offer insurance against
general legal costs (e.g. advice and representation at inquiries), you may also wish to purchase this cover as these fall outside the scope of the indemnity.

Further information: Australian Government Department of Health

**WorkCover Western Australia Authority**

The WorkCover Western Australia Authority is responsible for governance of Workcover WA; the provision of independent advice to the Minister and State Government; and the approval of certain service providers. Constituted under section 94(1) of the *Workers’ Compensation and Injury Management Act 1981*, the WorkCover WA Authority is authorised to use and operate under the trading name WorkCover WA.

WorkCover is the workers’ compensation and injury management scheme, reliant on health providers, employers and insurers working together to achieve the best outcome for the injured worker. WorkCover WA is the government agency responsible for overseeing and regulating the workers’ compensation and injury management scheme in WA.

The Clinical Framework for the Delivery of Health Services (Clinical Framework) is an evidence-based guide designed to support healthcare practitioners delivering services to people with compensable injuries. The Clinical Framework reflects contemporary research and has been widely endorsed by Australian workers’ compensation jurisdictions, as well as peak health associations. WorkCover WA endorses the use of the Clinical Framework by medical and allied health practitioners delivering services to injured workers in WA.

WorkCover WA produces a number of resources to assist all scheme participants to better understand their rights and obligations within the WA workers’ compensation and injury management scheme.

**Insurance Commission of Western Australia**

The ICWA is the State’s insurer providing injury insurance to motorists and self-insurance to Government. It is a statutory corporation and Government Trading Enterprise owned by the Western Australian Government.

### 6.9 Medico-Legal

The Department's Legal Policy Framework specifies the requirements that all HSPs must comply with in order to ensure an effective and consistent legal approach across the WA health system.

The purpose of this policy framework is to ensure:

- a systemwide approach to the provision of legal advice concerning the WA health system
- consistency of legal advice across the WA health system
- awareness of the availability of legal advice and how to obtain it
- provision of high quality legal advice and support across the WA health system
- effective and timely access to legal advice and support for HSP and staff
- minimisation of HSPs exposure to legal risk
- compliance with the WA Government’s legislative and policy requirements.

The Health Services Act 2016 refers to policy frameworks in ss. 26-27, 34(2)(c), 32, 34, 41(7), 41(8), 237 and s. 238. Any mandatory requirement document that references the Hospitals and
Health Act 1927 must be interpreted as a requirement under the Health Services Act 2016. The following legislation may also apply:

- Coroner’s Act 1996
- Competition and Consumer Act 2010 (Cwith)
- Human Reproductive Technology Act 1991 (WA)

**Medical records**

The patient’s medical record documents their assessment and treatment during each medical encounter, whether in a hospital stay or visit, or a general practice consult. It provides an account which can be reviewed in order to assess and evaluate the care given to the patient. The medical record also serves as a means of communicating with other staff involved in the care of that patient to plan the ongoing care, treatment and therapy, and it protects the legal interests of both the patient and staff.

Wherever you are employed, whether in a public hospital or in private general practice, you should ensure that you are familiar with the forms and documentation used. They may be shown to you during orientation, but if not, find out where they are kept, what they look like and who usually completes them.

A medical record must include:

- patient identification data
- presenting problem
- medical history
- physical examination
- diagnostic and treatment orders
- observations and findings
- diagnosis and discharge summary.

The medical record must be kept up to date, be relevant and concise. The medical record is a confidential document.

Your employing health service will have policies regarding access and management of medical records.

**Medico-legal reports**

“Medico-legal” describes a report of the examination and opinion of a non-treating doctor obtained for the purpose of legal proceedings. You should not give opinions or information in such cases, but should forward all requests directly to the Medico-Legal Officer in the Patient Information Service for processing, and your supervising doctor or the senior clinician in your area.

**Medical litigation**

If for any reason, you perceive that a patient or third party is contemplating legal action, please advise the Manager, Medico-Legal Services as soon as possible.

**Patient confidentiality**

Health professionals have a duty to maintain the confidentiality of all information that comes to them in the course of their relationship with patients. The duty protects information created,
disclosed or acquired directly or indirectly in the context of the patient and the health service provider relationship. All persons, including administrative staff, who come into contact with the information as part of the health care process, have a duty to maintain the confidentiality of that information. The duty continues beyond the cessation of the professional relationship, and beyond the death of the patient.

The Patient Confidentiality Policy provides a broad overview to WA Health employees about:

- The Common law duty of confidentiality that is owed to WA Health patients; and
- The exceptions to that common law duty of confidentiality
- The statutory duty of confidentiality and permissible disclosures introduced by the Health Services Act 2016.

The policy is binding and applies to health professionals and any other clinical and non-clinical workers who come into contact with a patient's health information in the course of providing health (and support) services to the patient. This includes persons working in a permanent, temporary, casual, contracted, termed appointment or honorary capacity.

Further information: Legal Policy Framework

Notifiable conditions

There is a mandatory legal requirement that health professionals report certain medical events, conditions and diseases to the Department. This information is vital in assisting the Department to monitor medical events and develop appropriate health responses and policies. The legislation in which these statutory notifications are prescribed:

- Health Act 1911
- Poisons Act 1964
- Regulations made under the Health Act 1911 and Poisons Act 1964

The Regulatory Support Unit, Public Health deals with the following notifiable conditions:

- Acute rheumatic fever
- Addiction to drugs
- Adverse events following immunisation (AEFI)
- Anaesthetic deaths (In addition to the coroner, these deaths must be reported to the Executive Director, Public Health, preferably within 48 hours)
- Cancer
- Cervical cancer testing
- Death of a woman as a result of pregnancy or child birth (must be reported to the Executive Director, Public Health, preferably within 48 hours)
- Developmental anomalies
- Infectious diseases and related conditions
- Intussusception
- Lead poisoning
- Mental health (unexpected deaths, serious incidents, application of delegation)
- Midwife private practice
- Midwife reporting of birth events / cases attended
- Perinatal and infant deaths (Whenever any child of more than 20 weeks gestation is stillborn or any child under the age of one year dies from any cause whatsoever, the Executive Director, Public Health must be notified of the event)
Prescribing a stimulant medication
Termination of pregnancy

Patient rights
Patients in Australian public hospitals are entitled to expect and receive high quality services. WA Health has developed a Public Patient Hospital Charter which sets out the patients’ rights and obligations as a patient of WA Health. Copies are available in every public hospital in WA and in languages other than English.

Summary of public patient’s rights in WA public hospitals

1. Choose to receive free public hospital services as a public patient, or to choose to be treated as a private patient in a public hospital with an associated cost.
2. Receive treatment based on your health needs, and, if you need to wait for this treatment, to be told how long you can expect to wait.
3. Have access to a range of public hospital services regardless of where you live in WA.
4. Have access to an interpreter.
5. Agree or refuse to participate in medical/nursing student training or medical research.
6. Be treated with respect, dignity and consideration for your privacy and special needs.
7. Be accompanied by a family member, friend, carer or person of your choice where appropriate.
8. Receive safe and high quality health care provided with professional care, skill and competence.
9. Receive a clear explanation of any proposed treatment, including possible risks and alternatives, before agreeing or refusing to have the treatment.
10. Seek a second opinion.
11. Be given information about your continuing health care before you leave the hospital and to have your contact details kept up to date.
12. Apply for access to your medical records under the Freedom of Information (FoI) Act 1992 and to have personal information kept confidential.
13. Compliment, comment or complain about the health care you receive, and to be given information about how to lodge a complaint, without compromising your health care.

Patient complaints
Patients who are dissatisfied with any aspect of their treatment are entitled to make a formal complaint. As patients become more aware of their rights, have higher expectations and as resources are limited patient complaints can become more common. It is important not to take complaints personally and to maintain objectivity as you deal with the patient.

Complaints are best handled in the workplace and you should not hesitate to refer the patient to senior staff if required. Most hospitals and health services have dedicated complaints officers that should be the first point of contact. In hospitals where there is no complaints officer you should refer the complaint to the chief executive or general manager of the hospital/health service.

As part of their safety and quality obligation, the Department of Health and health services are required to:

- Manage complaints in a timely and appropriate manner.
• Review their complaint data
• Identify systemic and recurring problems
• Develop strategies to improve clinical practice and the delivery of health care services across the organisation.

The *WA Health Complaint Management Policy OD 0589/15* outlines the process for engaging with health consumers and carers and is fundamental to the delivery of quality health care.

Further information: complaints management

It is important to understand the protocol for managing patient dissatisfaction. Many issues can be resolved at an early stage and two key processes can assist in minimising the risk of patient complaints.

• Communication – many incidents that lead to legal action could be prevented if there is a good relationship with patients. This means freely providing information that is asked for, encouraging questions and active participation in the decision-making process and offering emotional as well as medical support.
• Keeping good records – this is essential, both for patient care (especially if patients do not see the same doctor on each visit) and for legal protection. Make special note of any discussions or advice relating to optional treatments and risks, especially phone calls.

Further information: consumer engagement

The *Health and Disability Services (Complaints) Act 1995* established a dispute resolution process to provide a formal channel through which consumers of health services can make their grievances known and for clinicians and administrators to respond. The *Health and Disability Services Complaints Office* is established under Section 6 of the Act.

Patient consent to treatment

It is mandatory to gain a patient’s consent (agreement) prior to undertaking any treatment or procedures. In addition to gaining consent, it is essential that the patient is informed by the doctor adequately explaining (discloses) what the procedure involves, any relevant benefits and risks associated with the procedure, and any options or alternatives available, including no treatment.

It is helpful if the patient understands the likely outcome of each option. If a patient could successfully argue that they would have made a different decision if they had received more detailed explanations, the doctor may be found negligent for “failure to warn”. The patient may claim negligence if they suffer an adverse consequence, even if the procedure is skilfully performed and the patient suffers a recognised complication.

It is a Department requirement that you comply with the *WA Health Consent to Treatment Policy 2016*.

The informed consent process involves a number of steps including:

• Step 1. Determine which health professional is responsible for seeking consent.

Where a team of health professionals is involved in the process, the most senior health professional responsible for providing the treatment must be satisfied that valid consent has been obtained prior to conducting the treatment. While this health professional has overall responsibility for the consent process he/she may request assistance by another clinical
member of the treating team who has sufficient clinical knowledge of the proposed treatment and understands and can communicate the risks and benefits involved.

- Step 2. Assess the patient’s capacity.

A mentally competent patient (i.e. who has capacity) can either consent or refuse treatment. If the patient has been provided with the information relevant to the treatment and understands its consequences, including the consequences of not having the treatment, then the patient’s decision to proceed or not must be respected regardless of whether their decision appears illogical or irrational to others. Competent adults can make decisions which appear unreasonable to others.

- Step 3. Provide sufficient information so the patient can make an informed decision.

Health professionals must assess how to effectively communicate information to the patient and provide the patient with opportunities to clarify the information. The patient must be provided with and be able to understand information relevant to their circumstances so that they can reach an informed decision to consent or not to the proposed treatment.

- Step 4. Verify that the patient understands the information given and all their queries have been addressed.

They can do this by verifying that the patient:

- Understands the effect of the treatment decision
- Understands that a choice can be made
- Has had sufficient time to consider and clarify the information presented
- Can communicate their decision back
- Had all their questions answered

If the patient is not fluent in English or doesn’t understand the medical terminology, you should use the service of a professional interpreter to gain the patient’s consent. It is not wise to use the services of staff or family in the doctor/patient relationship.

- Step 5. Seek a decision from the patient about the proposed treatment.

If a patient with capacity to make a voluntary and informed decision declines a particular treatment, their decision must be respected and the health professional must not proceed with treatment.


In general, consent must meet the following criteria to be legally valid:

- Voluntary – the decision to either consent or not to consent to the proposed treatment must be made by the patient themselves, and must not be unduly influenced by health professionals, friends or family
- Informed – the patient must receive sufficient information about the proposed treatment to enable them to make an informed decision
- Given by a patient who has capacity to understand the information presented to them and to make a decision. Capacity may be diminished by illness, age, medication, drugs and alcohol (amongst other things)
• Current – consent must be reviewed if, after consent was obtained, the patient’s circumstances (including treatment options and risks) have changed
• Covers the treatment to be performed - treatment provided must fall within the scope of consent that has been given by the patient.

Hospitals and health services have consent forms available, which must be completed where written consent for a procedure is required. The discussion between the doctor and patient around risks and benefits should be detailed in the patient’s medical record by the doctor. Generic consent forms have been developed for the most commonly occurring situations to support the documentation of consent.

Whether or not medical treatment is to take place is a decision for the patient and treatment may not take place without a patient’s consent. Failure to obtain consent may render the practitioner liable for an action in battery or even in extreme cases, to criminal sanctions.

Advanced Care Planning
Advance care planning involves a patient thinking about, discussing with their family and close friends, and possibly documenting the types of health care they may or may not wish to receive - if they become seriously ill and/or unable to speak for themselves. This means specific treatment wishes as well as goals, values and beliefs are known and can be respected by health providers and those closest to the patient.

In WA the components of an advance care plan are:

• Enduring Power of Guardianship: to appoint a substitute decision maker
• Advance Health Directive: to legally record your wishes regarding future medical treatments.
• Advance Care Plan: to document your wishes to inform your substitute decision maker and doctor to assist them in making decisions for you.

Enduring Power of Guardianship
An Enduring Power of Guardianship is a legal document that authorises a person to make important personal, lifestyle and treatment decisions on your patient’s behalf should your patient ever become incapable of making such decisions for themselves. This person is known as an enduring guardian.

Advanced Health Directive
Some patients may have set in place an Advanced Health Directive (AHD) or “living will” which gives direction on health matters and comes into force if they are unable to make reasonable judgments about their treatment later on.

In 2008 the WA Acts Amendment (Consent to Medical Treatment) Act was passed. The Guardianship and Administration Act 1990 was amended to include an Advance Health Directive to refuse treatment for a current condition or terminal illness as well as the provision to appoint an Enduring Power of Guardianship as a substitute decision maker.

The amendments to the Criminal Code provide exemption from criminal responsibility for the administration in good faith of reasonable medical treatment (including palliative care) even when death ensues. Legislative protection from criminal responsibility will also be extended to the withdrawal and withholding of medical treatment where the non-provision or cessation of that treatment is done in good faith and is reasonable in all the circumstances, in the event
where death ensues. The patient’s relatives cannot over-rule a valid AHD. If in doubt you should seek advice from Medical Administration or senior staff.

Further information: Training in AHD

Advance Care Plan
An Advance Care Plan (ACP) is a non-statutory document which could be considered legal under common law, as a common law directive. The law requires health professionals to follow an Advance Health Directive and a common law directive. It informs health professionals about treatments a patient may or may not want.

An ACP may also include personal wishes that are not necessarily health related, which guide health professionals and family as to how the patient would like to be treated and may include any special requests or messages.

Guardianship
The Guardianship and Administration Act 1990 (the GA Act) contains provisions designed to ensure that adults with decision-making disabilities which may be the result of intellectual disability, mental illness, acquired brain injury or dementia are not deprived of necessary medical treatment because they are unable to consent to treatment.

Under the GA Act, the State Administrative Tribunal has the legal power to appoint a guardian for an adult with decision-making disabilities, as well as giving adults with full legal capacity the power to appoint enduring guardians (see advanced care planning). It is good practice to ask to see the appointing document and to take a copy of this document for the patient records. There are some decisions a guardian cannot make.

The GA Act sets out a list of the persons who may provide consent to such treatment in order of priority. Where treatment is required urgently such that there exists a significant threat to the patient’s health if treatment is delayed, the practitioner may provide treatment without consent if, in the opinion of the practitioner, it is not possible to obtain consent from persons on the list within the time available.

Medical procedures involving children and mature minors
The process of obtaining consent may vary in certain circumstances. This includes where the patient is a child.

In cases of conflict between parents (if there is any doubt as to which parent may consent on behalf of a child), or between parents and child (as to whether a child is competent to consent on their own behalf), and attempts to resolve the disagreement are unsuccessful, consideration should be given to making an application through the Court system for a decision. If the practitioner is concerned as to who may consent on behalf of the child, assistance should be sought from the hospital executive.

Children
Generally, parents may authorise treatments on behalf of their children, where the treatment is in the child’s best interests. However, as a child gets older, if they are assessed as having sufficient intellectual and emotional maturity and competence to understand information relevant to a proposed treatment, including its risks, benefits and alternatives, then they can consent to or decline that treatment on their own behalf. Responsibility for treatment decisions may not
remain with parents if children are in the care of the CEO of the Department of Child Protection and Family Services as set out in the *Children and Community Services Act 2004*.

If a health professional believes that a treatment decision made by a parent or substitute decision maker is not in the child’s best interest, this should be referred for legal assistance as necessary. For instance, consent must be obtained through the Court system for procedures such as sterilisation of a child, or gender reassignment.

**Mature minors**

An assessment of a child as a ‘mature minor’ must be made in the context of the treatment in question, that is maturity in relation to one treatment decision does not necessarily equate to maturity for all treatment decisions. There is no specific age at which a child becomes a ‘mature minor’.

A minor who fully understands the nature and consequences of the proposed treatment is capable of effective consent or withholding consent.

Further information:
- [Assessing Capacity to Consent in Minors](#)
- [Working with Youth](#)

**Freedom of information**

Under section 10 of the *Freedom of Information Act 1992* (the FOI Act) a person has the right to receive access to the documents of an agency (other than an exempt agency). An agency may refuse access to a document if the document is an exempt document. See section 23 of the FOI Act.

Patients who wish to [gain access to their health information](#) (including X-rays) should be asked to make a written request to the WA Health freedom of information contacts. Doctors are not involved in this process.

**Sexual harassment and unlawful discrimination**

In WA it is unlawful to discriminate against a person on the following grounds:

- gender
- marital status
- pregnancy
- gender history
- family responsibility
- age
- family status
- sexual orientation
- ethnicity
- religious or political beliefs
- impairment/disability
- spent convictions.

Sexual harassment in employment is also unlawful. The law relating to discrimination and sexual harassment is set out in the *Equal Opportunity Act 1984*.

Employers should provide their employees with an environment that is free from harassment and unlawful discrimination. The *WA Health Substantive Equality Policy OD 0634/15* addresses all forms of systemic discrimination in service delivery, as per the *Equal Opportunity Act 1984*. You must understand and comply with this policy.
All complaints of sexual harassment or unlawful discrimination should be treated seriously and should be investigated quickly and confidentially. Action must be taken to ensure that the harassment/discrimination stops.

Further information: Equal Opportunity Commission

**Violence, aggression and bullying in the workplace**

Workplace bullying is unlawful under the *Occupational Safety & Health Act 1984 (WA)*. Some bullying behaviours may also be unlawful under other legislation, for example the *Equal Opportunity Act 1984 (WA)* covers discrimination, including sexual and racial harassment. You are expected to comply with the [WA Health Preventing and Responding to Workplace Bullying Policy OD 0437/13](#).

**6.10 Deaths in hospital**

Each Health Service has administrative policies/procedures for certifying the death of a patient. You should familiarise yourself with these policies as soon as possible on commencing your employment.

**Deaths reportable to the coroner**

The Coronal Liaison Unit aims to improve communication between the Department and the coronial system.

A **Handbook for Medical Practitioner and Medical Students** has been produced by Dr Robert Turnbull, Medical Advisor to the State Coroner. This handbook highlights the importance for all practitioners to have a clear understanding of what constitutes a "reportable death" and the responsibilities that are incumbent upon the practitioner to fulfil the requirements of the *Coroners Act 1996* and is available from the Coroner’s Court of Western Australia.

Part 2 of the *Coroners Act 1996* established the Coroner’s Court of WA and a State coronial system to inquire into deaths in WA. The coronial system includes a State Coroner and a Deputy State Coroner. In addition, every magistrate is contemporaneously a coroner and is able to conduct coronial investigations and hold coronial inquests throughout WA. An inquest is a formal hearing by the Coroner’s Court into the circumstances surrounding a reportable death in WA.

The **Death in Hospital Forms and Guidelines IC 0188/14** highlight the mandatory and statutory reporting obligations that may arise following an inpatient hospital death, in particular reporting requirements under the *Coroners Act 1996* and *Health Act 1911*.

The **Coroners Act 1996 Information Circular IC 0008/07** provides information regarding coronial processes and operation of the Coroners Act 1996, including reportable deaths.

Any person can make a report to a Coroner or member of the WA Police Force where they believe a ‘reportable death’ has or may have occurred.

The *Coroners Act 1996* imposes a legal obligation on the following persons to report deaths that are or may be ‘reportable deaths’ under the *Coroners Act 1996*.

- Any person who has knowledge of an actual or possible ‘reportable death’ must immediately he or she becomes aware of it, report the death to a Coroner or a member of the WA Police
Service unless there are reasonable grounds to believe the death has already been reported.

- Any medical practitioner present at or soon after an actual or possible ‘reportable death’ must report the death immediately to a Coroner if:
  - the medical practitioner is unable to determine cause of death; or
  - in the opinion of the medical practitioner, the death has occurred under any suspicious circumstances.

If more than one medical practitioner is present at or soon after the death and one reports to a Coroner, the others need not do so but must give to the Coroner investigating the death any information that may help the investigation.

- Where immediately before death the deceased was a person held in care, the person under whose care the deceased was held must immediately report the death to a Coroner.

Failure to report a death that is or may be a ‘reportable death’ is an offence in respect of which a fine may be imposed.

**If there is any doubt as to whether a case should be reported or not, the advice of the Coroner should be sought.**

**Certification of death**

The *Assessment of the Extinction of Life and the Certification of Death* is a guide to public hospitals and health services on the assessment of the extinction of life, and the certification of death where patients die in health facilities such as hospitals and nursing homes or where deceased persons are brought to hospitals.

It is recommended that hospitals/health services make a distinction between the **assessment of the extinction of life**, and the **certification of death** and deal with them as two procedures.

This operational directive has two attachments:

- **Where medical officer is not immediately available**
- **Where medical officer is immediately available**

**Organ transplantation**

Organ and tissue donation involves removing organs and tissues from a donor (someone who has died) and transplanting them into a recipient (someone who, in many cases, is very ill or dying because an organ is failing). The recipient can range in age from babies and children to older people. People who need a tissue transplant can also be of any age. In some cases, tissue can save lives. More often, it greatly improves the recipient’s life. In Australia, State and Territory health services provide solid organ transplant services for heart, lung, kidney, liver and pancreas transplantation.

Australia has an “opting in” system of organ and tissue donation. Individuals are asked to indicate whilst alive, their consent to donation by written means (either through the Australian Organ Donor Register or other state registers). Donor Coordinators undertake and complete the consent process for organ and tissue donation. These procedures will be completed before a Donor Coordinator approaches a Designated or Delegated Officer to seek authority for donation of organs and/or tissues.

**Donor Coordinators are available 24 hours on 08 9346 3333**
The *Australian Organ and Tissue Donation and Transplantation Authority Act 2008* established the Australian Organ and Tissue Donation and Transplantation Authority (known as OTA) as an independent statutory authority to implement activities of a national reform programme.

OTA, together with a national network of DonateLife Agencies known collectively as the DonateLife Network, in partnership with State and Territory governments, eye and tissue banks, community organisations and the broader donor and transplant sector, act to meet the twin objectives of the national reform programme.

In WA the legislation dealing with the donation of organs and tissue after death is defined in the *Human Tissue and Transplant Act 1982 (Amended 1997)* (The Act). The Act deals with:

- Donation of tissue by a living person
- Blood donations
- Donation of tissue after death
- Post mortem examinations (unrelated to organ and tissue donation)
- Prohibition of trading in tissue
- Clinical certification of death
- Privacy of donor/recipient

The Act requires that, before tissues or organs are removed from the body of a deceased person for transplantation, a Designated or Delegated Officer for the hospital where the person has died (or the dead body has been brought) must have authorised the removal of organs or tissue. In WA a Designated Officer is a medical administrator or medical practitioner nominated by the Executive Director of Public Health and subject to the Coroner’s jurisdiction. This Designated Officer may ‘delegate’ his or her duties under the Act. Most hospitals have a list of current authorised Designated and Delegated Officers available from medical administration.

DonateLife Western Australia is part of the WA Department of Health (North Metropolitan Area Health Service) coordinating all organ and tissue donor activities across WA. Information for health professionals working in the donation sector is available from DonateLife, including:

- a Professional Education Package
- Other Professional Education Workshops
- Professional Statements from The Australian and New Zealand Intensive Care Society
- Eligibility criteria and allocation protocols
- Scholarships
- Family Study
- Clinical Governance Framework

Further information: [Donate Life](https://www.donatelife.com.au)

Transplantation services available in WA include:

- The Advanced Heart Failure and Cardiac Transplantation Unit (Fiona Stanley Hospital)
- The Advanced Lung Disease and Lung Transplant Unit (Fiona Stanley Hospital)
- Kidney transplantation (Fiona Stanley Hospital, Sir Charles Gardiner Hospital, Princess Margaret Hospital – paediatric service)
- Liver transplantation (Sir Charles Gardiner Hospital)

Immunology and infectious diseases support services are provided by PathWest Division of Clinical Pathology located at Fiona Stanley Hospital and Sir Charles Gardiner Hospital (QEII).
Further information:

- WA Heart and Lung Transplant Foundation
- WA Kidney Transplant Service
- The Liver Foundation of WA
- PathWest Immunology

6.11 Working in general practice

Restrictions to medical practice – the 10 year moratorium

To work as a GP or a specialist and treat private patients, a medical practitioner must have a Medicare provider number so patients can access the Medicare rebate. Under section 19AB of the Health Insurance Act 1973 (the Act) IMGs and Foreign Graduates of Accredited Medical Schools (FGAMS), who gained their first medical registration or became permanent Australian residents or citizens on or after 1 January 1997, are restricted in their access to Medicare benefit arrangements for a period of usually 10 years from the date of their first Australian medical registration.

To be granted a Medicare provider number during these 10 years (known as the ten year moratorium); IMGs and FGAMS may apply for an exemption to section 19AB of the Act. To be eligible for an exemption and to be granted a provider number, an IMG on limited registration must be employed in a District of Workforce Shortage (DWS). The DWS process is administered by the Australian Government and refers to an area that according to the Australian Government statistics has access to less medical services than the national average.

Further information: Doctor Connect

Initially, most IMGs and FGAMS are restricted to obtain limited registration with the MBA and must undertake a period of supervised employment in an Area of Need (AoN). An AoN is a location in which there is a recognised lack of specific medical practitioners or where there are medical positions that remain unfilled even after recruitment efforts have taken place over a period of time. In WA, AoN for GPs is generally restricted to rural and outer metropolitan regions but can be applied to positions in either the public or private sector. The AoN process is administered by the WA Department of Health. GPs and specialists treating private patients require a Medicare provider number; therefore they also require DWS approval by the Australian Government.

Working in rural general practice

Working in private general practice in rural WA can be immensely rewarding and challenging. The GP generally sees a wide range of patients requiring acute and non-acute care, ranging from treatment of acutely ill children, diabetes assessment, counselling the bereaved, arranging in-home care for the elderly, and managing minor injuries. In private practice, GPs charge their patients a fee-for-service and develop an ongoing relationship with their patients which can greatly enhance their clinical practise.

Most GPs in country WA work in group practices where a number of GPs share the resources of one practice and support to each other in delivering services. In smaller country towns many GPs still operate as a solo practitioner. For these GPs the services of a locum doctor is essential to provide support during busy times or to allow them to take some time away from their work.
Group practices will often share on-call rosters, and may also organise rosters to share after-hours anaesthetics and obstetrics care. For some smaller practices these arrangements may be in place within the same town or between towns that are geographically close together.

In addition to the work performed in their private practice, some GPs may also treat patients in the local hospital. While hospital Emergency Departments in larger towns may be staffed by salaried doctors employed by the hospital, these doctors may be supported by local GPs who participate in providing medical services to gain additional income, maintain skill levels and share and balance their workloads. In smaller hospitals, the local GP may be the sole provider of hospital services.

The GP provides these services as a Visiting Medical Practitioner (VMP) and is contracted by WACHS through a Medical Service Agreement (MSA).

**Visiting Medical Practitioners**

VMPs provide contracted medical services under an MSA and are paid on a fee for service basis. The medical practitioner’s scope will be defined through the credentialing process which will be reflected in the MSA. As contractors, VMPs must abide by all hospital policies and procedures for the delivery of safe quality health care and practice within the Memorandum of Understanding between the Minister for Health and the AMA (WA) signed in 2015.

Under the WACHS medical credentialing system, VMPs granted admitting rights will also be approved for relevant and appropriate clinical privileges. These will be based on their qualifications and skills, in addition to the range and level of services applicable in the one or more WACHS hospitals the practitioner is enabled to provide services to. The MSA schedules the payments to be made to the doctor in addition to the fee for service payments for ED and admitted patient attendances. The schedules also specify the particular type, and in some cases volumes, of activity or services to be provided and paid for under the contract.

In many hospitals the services provided by VMPs and salaried doctors are further supplemented by visiting specialists who provide services on an occasional or regular programmed basis. Typically, the visiting specialists will be a specialist from a metropolitan tertiary hospital or private practice who has been engaged by WACHS and/or Rural Health West to supplement local and regional specialist services.

**Support for country doctors**

GPs and hospital salaried doctors in country hospitals are well supported by doctors working in tertiary hospitals in metropolitan Perth.

Historically many WACHS hospitals have had special relationships with specific hospitals in Perth through regular rotations of senior doctors in training to these country hospitals or the visiting specialists programs. Medical advice by specialist colleagues is continually available to help manage any acute or complex cases which may present.

As a country doctor it is important that you are familiar with the referral and consultation patterns for the hospital you work in and to establish a relationship with your clinical colleagues in Perth.

Rural Health West provides a recruitment and orientation program for IMGs working in rural general practice and AMSs. The organisation will undertake clinical interviews as required and
provide support in relation to Medical Board registration, immigration and visas and orientation on arrival. RHW also provides career development support through:

- continuing professional development opportunities
- mentoring programs
- Family Support Program
- the Five Year Overseas Trained Doctor Scheme or Exam Support Program

**Telehealth**

The **Statewide Telehealth Service** provides the infrastructure and support for the rollout of Telehealth across WA. It is funded jointly by the WACHS and the State Government’s Southern Inland Health Initiative.

Telehealth is used within the WA public health system, in a number of different service delivery areas, but is most commonly used for the Emergency Telehealth Service provided by emergency medicine specialists in Perth using videoconferencing equipment to support regional clinicians treating very acute emergency patients; and outpatient consultations between metropolitan-based specialists and regionally-based public patients via videoconference. See emergency telehealth.

Telehealth contacts:

Statewide Telehealth Service General Enquiries - 6383 1850

Statewide Telehealth Service Desk – 1300 367 166

Regional Telehealth Contacts - Please contact the Telehealth Coordinator in your region to discuss booking appointments via telehealth:

- Goldfields 9080 5682
- Great Southern 9892 2475
- Wheatbelt 9690 1632
- Kimberley 9166 4381
- Pilbara 9174 1387
- Midwest 9956 2345
- South West 9781 2024

**General practice organisations**

**Royal Australian College of General Practitioners (RACGP):** aims to maintain high standards of general practice through education, training and research by offering vocational training, continuing education and research, and maintaining a commitment to the development and promotion of standards and quality assurance programs.

**Australian College of Rural and Remote Medicine (ACRRM):** is the peak professional association for rural medical education and training in Australia. It is responsible for setting standards for rural medicine as a separate and distinct discipline. ACRRM’s core function is to determine and uphold the standards that define and govern competent unsupervised rural and remote medical practice. It is committed to providing sound training and continuing medical education.

CPD is available to rural doctors through the ACRRM Professional Development Program that includes [Rural and Remote Medical Education Online](https://www.racgp.org.au/rrmeo) (RRMEO).
WA General Practice Education and Training (WAGPET): is the sole provider of the Australian General Practice Training Program for GP Registrars in WA and one of 17 Regional Training Providers in Australia. IMGs with general registration can apply to WAGPET to access a fully supported training program.

The Association of Australian General Practitioners (AAGP): an Independent organisation founded and led by GPs with the aim of representing all Australian GPs.

The United General Practice Australia (UGPA): An organisation comprising the following entities:

- The Royal Australian College of General Practitioners (RACGP)
- The Australian Medical Association (AMA)
- The Australian General Practice Network (AGPN)
- The Rural Doctors Association of Australia (RDAA)
- General Practice Supervisors Australia (GPSA)
- The Australian College of Rural and Remote Medicine (ACRRM)
- General Practice Registrars Australia (GPRA)
Section 7 Living in Western Australia

- About Western Australia: local councils, general information
- What to do soon after arrival: tax file number, Medicare, bank account, English classes, school enrolment, driver’s licence
- Housing and utilities
- Personal health insurance
- Non-government and higher education
- Employment for partners
- Childcare
- Emergency services
- Transportation
- Information for seniors

7.1 About Western Australia

WA has diverse landscapes and environments throughout its regions. White sandy beaches along the west coast, lush green vineyards and forests in the state’s south west and rugged red earth of the north-west regions provides a variety of places to experience and live.

Perth has more hours of sunshine than any other capital city in Australia. The Mediterranean climate means people in Perth enjoy mild winters, warm to hot summers and blue skies most of the year. The city is situated on the Swan River and the metropolitan area stretches along the Indian Ocean coastline, north and south of the city centre. The Perth life-style is focussed on the outdoors and people enjoy a range of sporting activities which involve the ocean or the river.

There are 3 time zones in Australia:

- Australian Eastern Standard Time (AEST). Greenwich time +10 hours. It applies to the ACT, NSW, VIC, TAS and QLD.
- Australian Central Standard Time (ACST). AEST – 30 minutes. It applies to SA and NT.
- Australian Western Standard Time (AWST). AEST – 2 hours. It applies to WA.

Further information: Living in Western Australia and Tourism WA

Local councils

Local government in WA works with the State Government to develop communities at the local level. Local councils are made up of a group of suburbs, a town, a town and its surrounding countryside or a rural area. Your local council can provide information about services available in your area including library and recreation services.

General information

The Department of Immigration and Border Protection offers a book about Life in Australia, including Australian values statement. The book is available in more than 20 languages and covers the following information:

- Australian values and principles
- The nation and its people
- Australian society
- Living in Australia
- Australian citizenship
7.2 Visa requirements
Once you have secured employment in Australia you will need to apply for an appropriate visa for yourself and any family members who will be accompanying you to Australia. Your employer, or the recruitment agency you have been dealing with regarding your appointment, will generally provide guidance and assistance in obtaining the correct visas.

The Australian Government Department of Immigration and Border Protection are responsible for the processing and assessment of visa applications, ensuring compliance with Australia’s immigration laws. The Department of Immigration and Border Protection website provides information on the types of visas available, the application process and access to forms and the online application process.

7.3 What to do soon after arrival
The following information is important and should be followed as soon as possible after arriving, if you are new to Australia.

- Apply for a tax file number (TFN)
- Register with Medicare
- Open a bank account

Apply for a tax file number
See section 6.8 taxation and insurance

Register with Medicare
As the basis of Australia’s healthcare system, Medicare covers many health care costs. To register with Medicare, you should wait approximately 10 working days after your arrival in Australia and then go to your nearest Medicare office with your passport and travel documents. For initial enrolments, all people 15 years of age and over on the application must go with you to a Medicare Service Centre. If you live in an area remote from a Medicare Service Centre, or there is a reason for not being able to attend, you can send your application together with certified copies of documents to the address listed on the application form.

If registration requirements are met, you will be advised of your Medicare number and your Medicare card will be posted to you. Section 1.1 of this manual provides information on Medicare, the Medicare levy, and the Medicare surcharge.

Opening a bank account
In Australia, most income including salary or wages and government benefits are paid directly into a bank account. You will need to provide simple details like your name and birthday and produce identification documents. Some examples of identification documents include your driver’s licence, birth certificate, passport or Medicare card.

For information: Open a bank account

The following could be important depending on your circumstances.

Register with Centrelink
Social security payments and services are provided through the government agency called Centrelink. Newly arrived residents can register with Centrelink to get help with looking for work, having overseas skills recognised and accessing relevant courses. Depending on the visa
class, most newly arrived residents are subject to a waiting period before being eligible to receive payments.

You can contact Centrelink to find out if you are eligible for a social security payment. To be paid from the day you arrive in Australia you must make contact with Centrelink on the day you arrive and lodge a claim within 14 days.

If you have children, you may be eligible for government funded Family Assistance payments to help with the cost of raising your children.

Centrelink also has tax file number application forms and can help you to lodge your application with the Australian Tax Office, so that access to any payments is not delayed.

**Contact the Health Undertaking Service**

These are services to ensure that visa holders with significant health conditions receive the care needed. If you signed a Health Undertaking (Form 815) at the request of the Department of Immigration and Border Protection, you must contact the Health Undertaking Service between 9 am and 5 pm AEST Monday to Friday within 28 days of your arrival in Australia.

- Health Undertaking Service 1300 794 919

**Register for English classes**

There are many organisations that offer [English language training](#) and can provide help with English for family members who may be entering Australia with you.

People with very limited English skills may qualify for the Adult Migrant English Program and receive access to up to 510 hours of free English lessons, with [additional tuition if required](#). Eligibility is according to [temporary visa type](#). The program teaches basic English and is designed for adult migrants and refugees 18 years and over to help them settle in Australia, find sustainable employment and become an independent member of society.

Adult English lessons are also available from many local community colleges as well as colleges of Technical and Further Education (TAFE). Contact your local agencies for details.

If a family member has difficulties communicating in English, the national [Translating and Interpreting Service (TIS)](#) provides telephone assistance. TIS can be contacted on 13 14 50 for immediate phone interpreting 24 hours 7 days a week. The operator will ask what language they speak and the number of the organisation they wish to contact. They will then assist with making the call.

The [Centrelink multilingual phone service](#) can be contacted on 13 12 02.

**Enrol your children in a school**

Australia has four levels of education:

- kindergarten and pre-primary
- primary school
- secondary school (also known as high school)
- tertiary or higher education – university or TAFE.

Government schools are owned and operated by state and territory governments. The Australian Government provides supplementary funding. The WA education system comprises
over 800 government schools in communities across WA. The Schools of Isolated and Distance Education provide education from kindergarten to year 12 with specialist teachers based in Leederville, Perth. Enrolment is based on certain criteria of eligibility.

In WA, education is compulsory for children from pre-primary through to when they are aged 16 in secondary school. Children begin their compulsory schooling (pre-primary) in the year that they will be 5 years old by the 30th June. Primary school (years 1-6) begins in the year the child will be 6 years old by the 30th June. Secondary school (years 7-12) begins in the year the child will be 12 years old by the 30th June. A child will finish year 12 secondary school in the year that they will be 17 by the 30th June.

Further information: enrol your child in school.

In 2015 the WA Government introduced a tuition fee for families on 457 Visas (temporary skilled workers) whose children attend public schools in this state. The fee is $4000 per family each year, regardless of the number of children a family have enrolled in public schools. You will receive an invoice for $4,000 from TAFE International Western Australia, the State Government agency responsible for overseas fee paying students attending Western Australian public schools. You can elect to pay the tuition fee upfront or in instalments (weekly, fortnightly or monthly) via direct debit. There is no restriction on who pays the tuition fee, for example, your employer can pay the fee. You will no longer be eligible to pay the fee if your children leave the public school system or your visa status changes.

See section 7.6 for more information on non-government and higher education.

Apply for a driver’s licence

In Australia you must have a driver’s licence to drive and the vehicle must be registered with the government. It is illegal to drive without a driver’s licence and to drive an unregistered vehicle. Drivers are allocated a number of merit points which validate their license. The WA Police will issue demerit points to drivers for driving offences.

If you are an overseas visitor to WA, you may drive only those vehicles that you are authorised to drive on your overseas licence, for as long as it remains valid in the country of issue. If your overseas licence ceases to be valid, you must apply for a WA licence if you wish to continue driving. If your overseas licence is not in English, you must carry an international driving permit or an approved English translation of your licence with you when you drive.

If you are a permanent resident and have a current overseas driver's licence, in English or with an official translation, you are allowed to drive in WA for your first three months after arrival. Permanent residents can find out how to transfer an overseas licence at the Government of Western Australia Department of Transport website.

If you do not hold a licence from another country you will need to pass a Driver Knowledge Test to get a learner's permit. A learner’s permit allows you to learn to drive. Once you have the appropriate skills, you can then apply for a driver’s licence.

7.4 Housing and essential services

Finding a suitable place to live will depend on where you want to live and whether you intend to rent or buy. It is wise to speak with colleagues and friends who may have first-hand experience of areas you are looking at for prospective housing.
Your employing health service may offer assistance with finding temporary accommodation upon your arrival. Otherwise, short-term accommodation can be arranged over the internet or by phone through a reputable real estate agent. For any long-term arrangements ensure that either you or someone you know inspects the property before signing any rental contracts.

The **Australian Government Department of Social Services (Settlement and Multicultural Affairs)** works to improve the lifetime wellbeing of migrants and refugees settling in Australia by responding to their specific needs, encouraging their independence and participation in the Australian community, including housing support.

The **Government of Western Australia Department of Commerce** provides information on housing and accommodation including renting a home and buying and selling a home.

Whether you are renting or buying a house, you will need to connect to essential household utilities. There are several providers for utilities.

- **Electricity** – you can compare providers at [Compare the Market](http://www.comparethemarket.com.au/).
- **Gas** – you can compare providers at [Compare the Market](http://www.comparethemarket.com.au/).
- **Telephone** – there are a number of telecommunications suppliers in Australia so it is wise to compare the prices and packages that they offer for landlines and mobile phones and ensure you get the services that you need.
- **Collection of garbage and recyclable materials** - generally managed by local government. There are usually separate garbage bins for ordinary household rubbish and recyclable material such as bottles, cans, paper and cardboard. To check garbage and recycling collection days contact your local council or ask your neighbours.

Further information: [Department of Immigration and Border Protection – Settling in Australia](http://www.immi.gov.au/).

### 7.5 Private health insurance

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

As a privately insured patient you may insure against some or all of the costs of health services not covered by Medicare, such as:

- hospital expenses (theatre fees or accommodation) in either a public or private hospital
- dental treatment
- ambulance
- chiropractic treatment
- home nursing
- podiatry
- physiotherapy, occupational, speech and eye therapy
- glasses and contact lenses
- prostheses
- other ancillary services.
People with employer sponsored temporary visas (and their dependents) must have adequate medical insurance cover.

A register of private health insurers is available from the Australian Prudential Regulation Authority.

7.6 Non-government and higher education
Non-government schools receive the majority of their public funding from the Australian Government with state and territory governments providing supplementary funding.

Private/independent schools
There is a large non-government school sector in WA which is funded by Government subsidies and collection of student fees.

Further information: Private Schools Directory

Tertiary education
There are five universities in WA offering undergraduate education through to post-graduate levels of study.

Information for each of the universities can be found on their respective websites:

- Curtin University
- Edith Cowan University
- Murdoch University
- Notre Dame University
- The University of Western Australia

Vocational education
The WA Department of Training and Workforce Development is the government agency responsible for managing vocational education and training (VET) in Western Australia. The VET sector is important to WA’s economy for the development of the State’s workforce. It enables students to gain qualifications for all types of employment, and specific skills to help them in the workplace, focusing on the development of skills and knowledge that are based on business and industry needs.

7.7 Employment for partners
To determine if your partner or other members of the family will be eligible to work in Australia, you need to check with the Department of Immigration and Border Protection to confirm whether their type of entry visa allows them to work. Some visas might have restrictions, in which case they might have to apply for a different type of visa.

The Australian labour market can be very competitive. There are several ways you can look for a job.

- The daily newspaper advertise ‘job vacancies’ or ‘positions vacant’
- Jobs within the WA public sector, including health, can be viewed on the Jobs WA website.
- Register with Centrelink. You may like to talk to a Centrelink Career Information Centre employment counsellor.
- Department of Training and Workforce Development Career Centre
Register with a Jobactive provider to help you connect with employers.

7.8 Childcare
Australia’s online child care portal: mychild provides information on different types of child care and how to get assistance with the cost of child care.

There are also playgroups where children and their parents can get together to play, make friends and share information. Playgroup WA has more information on how to access these services.

7.9 Emergency services
In an emergency situation you can contact emergency assistance by dialling 000 (three times zero) on your phone to contact:

- ambulance
- fire brigade
- police

When the emergency service operator answers your call, be prepared to give your name, location and telephone number and the type of service you require.

Ambulance service
Ambulance services provide emergency transport to the nearest hospital for emergency medical attention. Interpreters are available. Please note that there is a fee involved for ambulance service. However, the cost may be discounted to people who have a Health Care Card, receive a government pension or are covered by insurance.

Fire service
The Department of Fire and Emergency Services respond to a range of hazards – bush and structural fires, incidents involving hazardous materials (chemical, biological, radiological), floods, storms, cyclones and earthquakes.

Police service
To contact your local police service for a non-emergency situation call 131 444.

State Emergency Service
The State Emergency Service (SES) is a volunteer organisation which provides services to help members of the community cope with the impact of a disaster, including repairs on buildings, restoration of essential services and transporting people and cargo through flood waters. For SES assistance in these circumstances call 132 500.

7.10 Transport
Public transport
The Perth metropolitan public transport system combines the use of trains, buses and ferries and includes a free Central Area Transit (CAT) bus system that services the Perth and Fremantle central business districts.

Transwa operates passenger services to over 240 destinations in regional WA. For information and bookings contact 1300 662 205.
**Taxi services**

In WA all taxis are meter operated by time and distance, and in Perth taxis operate twenty four hours a day.

Taxis are indicated as being vacant by an illuminated sign on the roof and can be pre-booked by phone or on the internet. It is recommended that you phone and book your taxi in advance so as to avoid delays, particularly on weekends.

Taxis can also be hailed on the street or found at taxi ranks throughout the city.

- Black and white taxi services 131 008
- Swan taxis 13 13 30
- Disabled taxi service 08 9422 2240

**Uber**

Uber is a worldwide online transportation network company. The pricing is similar to that of metered taxis, although all hiring and payment is handled exclusively through the Uber app and not with the driver personally.

Further information: [Uber Perth](#)

**Private vehicles**

Private transport is your own vehicle. Many people in WA use cars or motor bikes for private transport. Others choose to ride a bicycle or walk.

New and second-hand vehicles are advertised for sale in newspapers and online and are also available from new car showrooms and second-hand car yards. The purchase price of a car does not usually include the cost of registration, stamp duty (which is like a sales tax) and compulsory insurance. These costs usually have to be paid separately by the buyer. The [Royal Automobile Club (RAC)](#) in WA can assist you with this process.

### 7.11 Information for seniors

There are many community organisations that provide services for people over 50 years of age. The Australian Government’s website [My Aged Care](#) provides information for seniors, including types of services available.

Information on [benefits available to seniors](#) is available from the WA Government Department of Local Governments and Communities.
# Appendix 1  Medication terminology

## Dose frequency or timing

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>mane</td>
<td>morning</td>
</tr>
<tr>
<td>midi</td>
<td>midday</td>
</tr>
<tr>
<td>nocte</td>
<td>night</td>
</tr>
<tr>
<td>b.d.</td>
<td>twice daily</td>
</tr>
<tr>
<td>t.d.s</td>
<td>three times daily</td>
</tr>
<tr>
<td>q.i.d</td>
<td>four times daily</td>
</tr>
<tr>
<td>4 hourly (or q4h)</td>
<td>every 4 hours</td>
</tr>
<tr>
<td>6 hourly (or q6h)</td>
<td>every 6 hours</td>
</tr>
<tr>
<td>8 hourly (or q8h)</td>
<td>every 8 hours</td>
</tr>
<tr>
<td>p.r.n.</td>
<td>when required</td>
</tr>
<tr>
<td>stat.</td>
<td>immediately</td>
</tr>
<tr>
<td>a.c.</td>
<td>before food</td>
</tr>
<tr>
<td>p.c.</td>
<td>after food</td>
</tr>
</tbody>
</table>

## Route of administration

<table>
<thead>
<tr>
<th>Abbreviation (MA)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>metered aerosol (puffer)</td>
</tr>
<tr>
<td>T/H</td>
<td>Turbuhaler</td>
</tr>
<tr>
<td>A/H</td>
<td>Accuhaler</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
</tr>
<tr>
<td>IT</td>
<td>intrathecal</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>NG</td>
<td>naso-gastric</td>
</tr>
<tr>
<td>PO</td>
<td>oral</td>
</tr>
<tr>
<td>PV</td>
<td>per vagina</td>
</tr>
<tr>
<td>PR</td>
<td>per rectum</td>
</tr>
<tr>
<td>TOP.</td>
<td>topical</td>
</tr>
<tr>
<td>SUBCUT.</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>NEB.</td>
<td>nebulised</td>
</tr>
</tbody>
</table>
Unit of measure

<table>
<thead>
<tr>
<th>Unit</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>mL</td>
<td>Millilitre(s)</td>
</tr>
<tr>
<td>L</td>
<td>Litre(s)</td>
</tr>
<tr>
<td>mg</td>
<td>Milligram(s)</td>
</tr>
<tr>
<td>g</td>
<td>Gram(s)</td>
</tr>
<tr>
<td>microgram</td>
<td>Microgram(s)</td>
</tr>
<tr>
<td>[Never mcg or μg]</td>
<td></td>
</tr>
<tr>
<td>Unit(s)</td>
<td>International Unit(s)</td>
</tr>
</tbody>
</table>

Dose forms

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cap.</td>
<td>Capsule</td>
</tr>
<tr>
<td>Crm.</td>
<td>Cream</td>
</tr>
<tr>
<td>Inj.</td>
<td>Injection</td>
</tr>
<tr>
<td>Supp.</td>
<td>Suppository</td>
</tr>
<tr>
<td>Pess.</td>
<td>Pessary</td>
</tr>
<tr>
<td>Tab.</td>
<td>Tablet</td>
</tr>
</tbody>
</table>

Latin terms for other dose forms

The following Latin terms are included for your information only, as they are still used by some senior doctors. Avoid using these terms as many younger pharmacy and nursing staff may not be familiar with these terms.

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gtt.</td>
<td>Eye drop (guttae)</td>
</tr>
<tr>
<td>Mist.</td>
<td>Mixture</td>
</tr>
<tr>
<td>Pulv.</td>
<td>Powder</td>
</tr>
<tr>
<td>Oc.</td>
<td>Eye ointment</td>
</tr>
<tr>
<td>Ung.</td>
<td>Ointment</td>
</tr>
</tbody>
</table>

Dangerous abbreviations

Avoid using the following abbreviations on medication charts and prescriptions as they are open to misinterpretation by nursing and pharmacy staff.

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Intended meaning</th>
<th>Why?</th>
<th>What should I use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD, o.d. or d.</td>
<td>Once daily</td>
<td>‘OD’ can be mistaken as twice a day. ‘d’ can easily be missed</td>
<td>Write the time of the day for administration e.g. ‘mane’, ‘midi’, ‘nocte’ or write ‘daily’</td>
</tr>
<tr>
<td>m.</td>
<td>morning</td>
<td>Mistaken for ‘n’ (night)</td>
<td>Write mane</td>
</tr>
<tr>
<td>n.</td>
<td>night</td>
<td>Mistaken for ‘m’ (morning)</td>
<td>Write nocte</td>
</tr>
<tr>
<td>TIW</td>
<td>three times a week</td>
<td>Mistaken as three times a day</td>
<td>Write out in full and specify days</td>
</tr>
<tr>
<td>sc</td>
<td>subcutaneous</td>
<td>Mistaken for sublingual</td>
<td>Use ‘subcut’ or write ‘subcutaneous’</td>
</tr>
<tr>
<td>Avoid these abbreviations</td>
<td>Intended meaning</td>
<td>Why?</td>
<td>What should I use?</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------</td>
<td>------</td>
<td>-------------------</td>
</tr>
<tr>
<td>q.d. or QD</td>
<td>every day</td>
<td>Mistaken as Q.I.D or four times a day</td>
<td>Use ‘daily’ or specify time of day e.g. mane, noite etc</td>
</tr>
<tr>
<td>IU e.g. 3 iu</td>
<td>International unit</td>
<td>Misread as IV (intravenous) or misread as 31 U (i.e. 31 units)</td>
<td>Use ‘units’</td>
</tr>
<tr>
<td>cc</td>
<td>cubic centimetres</td>
<td>Misread as ‘u’ when handwritten</td>
<td>Use ‘mL’</td>
</tr>
<tr>
<td>µg</td>
<td>microgram</td>
<td>Misread as ‘milligram’ when handwritten</td>
<td>Write out in full</td>
</tr>
<tr>
<td>x3d</td>
<td>for 3 days</td>
<td>Mistaken as three doses</td>
<td>Use ‘for three days’</td>
</tr>
<tr>
<td>&gt; or &lt;</td>
<td>greater than or less than</td>
<td>Opposite of intended</td>
<td>Use ‘greater than’ or ‘less than’</td>
</tr>
<tr>
<td>Zero after a decimal point e.g. (5.0)</td>
<td>5 mg</td>
<td>Misread as 50mg if decimal point not seen</td>
<td>Do not use decimal points after whole numbers</td>
</tr>
<tr>
<td>No decimal point before fractional dose e.g. (.5mg)</td>
<td>0.5mg</td>
<td>Misread as 5mg if decimal point not seen</td>
<td>Always use a zero before a decimal when dose is less than one</td>
</tr>
<tr>
<td>Chemical symbols e.g. MgSO4</td>
<td>Magnesium sulphate</td>
<td>May not be understood or misunderstood e.g. morphine sulphate</td>
<td>Write out in full</td>
</tr>
<tr>
<td>Drug names; e.g. epo (many other examples!)</td>
<td>erythropoietin</td>
<td>Mistaken as evening primrose oil</td>
<td>Write all drug names out in full-generics name for single active ingredient and trade name for combination drugs</td>
</tr>
<tr>
<td>6/24</td>
<td>Every six hours</td>
<td>Mistaken as six times a day</td>
<td>Use ‘q6h’ or ‘6 hourly’</td>
</tr>
<tr>
<td>1/7</td>
<td>For one day</td>
<td>Mistaken for one week</td>
<td>Write out ‘for one day’</td>
</tr>
<tr>
<td>e</td>
<td>‘ear’ or ‘eye’</td>
<td>Misinterpreted as the other organ</td>
<td>Write ‘ear’ or ‘eye’</td>
</tr>
<tr>
<td>S/L</td>
<td>For sublingual</td>
<td>Mistaken for S/C – subcutaneous</td>
<td>Write ‘sublingual’ or under tongue</td>
</tr>
<tr>
<td>D/C</td>
<td>Discharge or discontinue</td>
<td>Misinterpreted as the other intention</td>
<td>Write out ‘discontinue’ or ‘discharge’</td>
</tr>
</tbody>
</table>

**Source:**

WACHS Kimberley Region. Medical Orientation Guide. Broome Health Service. July 2013
## Appendix 2  
**Health industry acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAD</td>
<td>Australian Antarctic Division</td>
</tr>
<tr>
<td>AAU</td>
<td>Acute Assessment Unit</td>
</tr>
<tr>
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<td>Health System Improvement Unit</td>
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ICU: Intensive Care Unit
IHF: International Hospitals Federation
IHPCA: Independent Hospital Pricing Authority
IMG: International Medical Graduate (see OTD)
ISO: International Organisation for Standardisation
IT: Information Technology

JMO: Junior Medical Officer
LGA: Local Government Area

MBA: Medical Board of Australia
MBS: Medicare Benefits Schedule
MCQ: Multiple-Choice Questionnaire
Medical Deans: Medical Deans of Australia and New Zealand
MEO: Medical Education Officer
MET: Medical Emergency Team
MEU: Medical Education Unit
MHS: Metropolitan Health Service
MJA: Medical Journal of Australia

MMM: Modified Monash Model (replaces ASGC-RA)
MSOAP: Medical Specialists’ Outreach Assistance Program
MTRP: Medical Training Review Panel

NACCHO: National Aboriginal Community Controlled Health Organisation
NASOG: National Association of Specialist Obstetricians and Gynaecologists
NCEPH: National Centre for Epidemiology and Population Health
NDIS: National Disability Insurance Scheme
NEP: National Efficient Price
NESB: Non-English Speaking Background (see CALD)
NGO: Non-Government Organisation
NHMRC: National Health and Medical Research Council
NMHS: North Metropolitan Health Service
NP: Nurse Practitioner
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