
**CODE OF ETHICS
CODE OF CONDUCT
POLICY ON
REASONABLY NECESSARY TREATMENT**

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PREFACE

The current Code is presented as three separate documents:

- Code of Ethics;
- Code of Conduct; and
- Policy on Reasonably Necessary Treatment – the Peer Review Panel.

The Code of Ethics outlines the profession's ideals and aspirations.

The Code of Conduct is more prescriptive and consists of a series of statements about professional practice directed at the practitioner, and describes the minimum acceptable standard of professional conduct.

The issue of what constitutes 'reasonably necessary' treatment is a matter of concern, not only to patients, but also to third party payers such as health funds and workers compensation bodies. In response to calls for a profession-based response to this issue, AACMA has established a Peer Review Panel to investigate and make determinations on complaints about inappropriate servicing and other matters where treatment that is not reasonably necessary has been alleged.

The previous AACMA Code of Ethics was drafted in 1977, at a time when these Codes were intended to be prescriptive rather than idealistic. It contained a number of provisions that would be considered unnecessary and, in parts, anti-competitive in the present day.

Although there were several amendments of the previous Code of Ethics to address emerging issues, it was time to consider a fresh approach and bring the AACMA Code of Ethics in line with the Codes of other established health professions. In 2004, a review of the previous Code of Ethics was commissioned by the AACMA Board.

The Board of the Australian Acupuncture and Chinese Medicine Association Ltd wishes to acknowledge the contribution to the review of Mr Stephen Janz, a Past President of AACMA and past Chair of the National Academic Standards Committee for TCM. Mr Janz was commissioned by the AACMA Board in 2004 to undertake a review of the previous AACMA Code of Ethics. This Code of Ethics, Code of Practice and Policy on Reasonably Necessary Treatment – The Peer Review Panel) are the result of that project.

A Draft was released for broad-based consultation in early 2005. Feedback was sought from AACMA members, third party payers for acupuncture and Chinese medicine services, and other interested parties. Following consideration of the feedback, key issues in the Draft Codes were discussed at the Annual General Meeting held on 14 May 2005 and further considered by the AACMA Board.

The new Code of Ethics and Code of Conduct were submitted and approved by the membership at the 2006 Annual General Meeting (held in Adelaide on 20 May 2006).

The Policy on Reasonably Necessary Treatment – The Peer Review Panel was then ratified by the incoming AACMA Board after the 2006 Annual General Meeting.

PART A CODE OF ETHICS

Pre-amble

The AACMA Code of Ethics expresses the profession's ethical ideals. These ethics underpin the Code of Conduct, which sets minimum standards of professional conduct for members.

The Code of Ethics is structured as a set of principles, with explanatory notes. The explanatory notes should not be considered a complete application of the ethical principles. The notes are intended as clear examples of each principle's everyday application.

As autonomous moral agents members should consider these ethical principles in all of the settings in which they interact with the patient, other professionals and the community. These principles aim to bring into focus the nature of what a member is doing or not doing, and as a result make it easier to embrace conduct which is acceptable to the profession and the community, and avoid conduct which is unacceptable.

The Code of Ethics is not prescriptive. It is intended to be used for reflection when identifying and resolving ethical dilemmas. Where a practitioner encounters an ethical dilemma it is advisable for them to seek the advice of one or more other practitioners to assist them to resolve the ethical dilemma. Where a conflict is still unresolved then the advice of the association should be sought.

Principles

1. Members shall respect the patient's autonomy

- (a) Autonomy refers to the right of the patient to make their own decisions regarding their health care.
- (b) Health care is a partnership between practitioner and patient, however it is often an unequal partnership as the practitioner usually has more health knowledge than the patient.
- (c) Practitioners must provide a sufficient explanation of the patient's condition, treatment options and the risks of treatment to enable patients to make their own decisions and to be able to give informed consent for treatment.
- (d) Treat your patient with compassion and respect.

2. All treatment shall be for the benefit of the patient

- (a) Treatment shall be reasonably necessary. Reasonably necessary treatment is treatment which aims to benefit the physical, emotional or psycho-social health and well-being of the patient.
- (b) Frequency and nature of treatment will be determined by considering the individual needs of the patient, independent of the financial, personal or business interests of the practitioner.

3. Members shall not harm the patient

- (a) Members shall maintain a safe and hygienic environment suitable for their practice.
- (b) Members undertake to maintain their professional competence and keep abreast of professional developments through continuing professional education.
- (c) Members will not lead patients into financial or emotional distress.
- (d) Recognise where a patient is not responding adequately to treatment and discuss and review options with the patient including the option of referral to another health practitioner.

4. Members shall act fairly in all dealings with their patients, other professionals, their peers and the community

- (a) Members shall refrain from discriminating against patients on the basis of their religion, gender, race, ethnicity, political views, trade union or professional association membership, sexual identity, age, nature of presenting condition, impairment, disability, or criminal record.
- (b) Members shall not engage in misleading or dishonest advertising.
- (c) Members shall treat other professions with professional respect and courtesy.
- (d) Members will not abuse the role of third party payers such as health funds and workers compensation insurers.
- (e) Members will at all times act lawfully.

5. Members shall hold patient information confidentially

- (a) Health information is often of a sensitive and intimate nature, which a person may not ordinarily disclose. Patients disclose this information in order to benefit from its use. Personal information should be used sensitively and for the purpose it is intended.
- (b) Members will keep up to date on their statutory obligations regarding privacy and patient access to their health records.
- (c) The member's privacy policy will detail the manner in which the practitioner cares for the patient's confidential information.

6. Members shall adhere to the NHMRC National Statement on Ethical Conduct Involving Humans

- (a) Members will only participate in human research if the project has been given ethical clearance by an appropriately constituted human research ethics committee that complies with the National Statement on Ethical Conduct in Research Involving Humans.

PART B CODE OF CONDUCT

Pre-amble

The practice of Acupuncture and Chinese medicine (ACM) supports the health care of an increasing number of Australians. Acupuncture and Chinese medicine is an holistic system of treatment which is individualized to the needs of the patient/client. ACM is a dynamic practice of the art and science of health care which incorporates innovation and research with traditional principles and practice.

Members of AACMA are tertiary educated professionals, and are a mix of self-regulated and statutory registered practitioners. Most members' services are provided in the context of independent private practice.

This Code of Conduct outlines the minimum standards of practice for members. This document should be considered alongside the associated Code of Ethics which identifies the ethical ideals of the profession.

Members are accountable to AACMA in accordance with its Memorandum & Articles of Association (Constitution) for breaches of the Code of Conduct and for unethical practice.

The standards outlined in this Code of Conduct are statements directed at the practitioner.

Definitions

Patient/Client A person who is the recipient of health care services from a member.

Third Party Any legal entity that has a financial interest in services rendered by the member or to the patient/client. Third parties include: private and government health insurers, workers compensation insurers, accident and injury insurers, statutory compensation schemes, legal representation for the patient/client or plaintiff; parents or guardians.

The Association The Australian Acupuncture and Chinese Medicine Association Ltd (AACMA).

Standards

1. The Practitioner and the patient/client

- (a) Practise the art and science of ACM to your full ability.
- (b) Put the health of the patient/client before all other considerations.
- (c) Respect the principles of informed consent.
- (d) Where treatment involves a minor, obtain the consent of the parent or guardian prior to commencing treatment.
- (e) Respect the patient/client's right to reject or accept advice and to make their own decisions about treatment and procedures.
- (f) Discuss treatment goals with their patient/client and ensure that their goals coincide with the patient/client's goals.
- (g) In a group practice, recognise your patient/client's right to consult the practitioner of their choice.
- (h) Practise only within the scope of practice determined by your qualifications and experience.
- (i) Refer the patient/client to another suitably qualified practitioner where a patient/client requires care which is outside of your scope of practice.
- (j) Ensure that other health professionals that you involve in your patient/clients care are appropriately qualified.
- (k) Undertake life-long continuing professional education to improve your professional skills.
- (l) Maintain patient/client confidentiality. Exceptions to this duty should be carefully considered and limited to: where required by law, where a risk exists to the patient/client or another person, or where there is an overwhelming public interest.
- (m) Ensure security of storage, access and utilization of patient/client information.
- (n) Refrain from discriminating against a patient/client on the basis of their race, religion, gender, sexual preference, political views, impairment or disability.
- (o) Ensure that you can communicate clearly with your patient/client in a common language either directly, through an interpreter, or via a telephone interpreter service. Where it is not possible to communicate in a common language, wherever possible, the patient/client should be referred to a practitioner where language is not a barrier.
- (p) Understand that you have the right to decline or terminate a therapeutic relationship providing that the situation is not an emergency and that access to the services of another health care provider is available.
- (q) Where you discontinue an existing therapeutic relationship, inform your patient/client of this so that they may seek help elsewhere.
- (r) Where personally held religious or moral beliefs prevent you from offering a treatment, inform the patient/client of this so they may seek care elsewhere.
- (s) Recognise where a patient/client is not responding adequately to treatment and discuss and review options with the patient/client including the option of referral to another health practitioner.
- (t) Do not exploit your patient/client for any reason.
- (u) When referring your patient/client to institutions or services in which you have a financial interest, fully disclose your interests first.

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- (v) Do not have sexual relationships with current patient/clients and avoid sexual relationships with former patient/clients. Refer to Position Statement of Health Professional Boards on Sexual Relationships between Health Practitioners and their Patients for guidance or contact the association for a determination on appropriate relationships in a given case.
 - (w) Refrain from inappropriate servicing:
 - (i) Treatment shall be reasonably necessary. Reasonably necessary treatment is treatment which aims to benefit the physical, emotional or psycho-social health and well-being of the patient/client.
 - (ii) Frequency and nature of treatment will be determined by considering the individual needs of the patient/client, independent of the financial, personal or business interests of the practitioner.
 - (iii) Do not abuse the role of third party payers such as health funds and workers compensation insurers.
 - (x) Place an appropriate value on professional services when determining any fee. Consider time, skill, and experience involved in the performance of those services together with any special circumstances.
 - (y) Ensure that the patient/client is aware of your fees wherever possible. This may be achieved by displaying a schedule of fees at your place of practice.

2. Record keeping

- (a) Maintain accurate, legible contemporaneous clinical records of each visit.
 - (i) As a minimum, each clinical patient/client record must be labelled with the patient/client's identifying details and:
 - relevant health history, including details of presenting condition(s);
 - the date of each service;
 - the details of each service rendered, including
 - points used and methods applied
 - therapeutic goods prescribed with dosage
 - any advice or instructions given
 - details of any referrals made;
 - the outcome of treatment and/or progress noted; and
 - details of any telephone or other non-face-to-face consultations.
 - (ii) Where records are maintained in a language other than English, should a copy of a patient's records be required by the AACMA Disciplinary Committee or Peer Review Panel or an authorised third party, it is the responsibility of the member to provide at their own expense an English translation of the patient's records.
- (b) Maintain accurate, legible contemporaneous accounting records of each visit.
 - (i) As a minimum, each accounting record must be labelled with the patient/clients identifying details and:
 - the date of each service;
 - itemised fees charged; and
 - details of all payments including the date of the payment.
 - (ii) Issue an itemised receipt for each payment, indicating the date of payment, name of the practitioner who provided the service, address where the service was provided with contact telephone number, name of the patient who received the treatment, date of service, and treatment(s) provided and product(s) supplied with charge(s).
- (c) Periodically review and document patient/client progress in the clinical records. The frequency of a review should be appropriate to the nature of the patient/client's condition.
- (d) Provide a report of the patient/client's treatment and progress to another health practitioner where requested by the patient/client.
- (e) Upon request by the patient/client, provide the patient/client with access to and or copies of records relevant to the patient/client. A reasonable fee reflecting the time and costs associated with this request may be charged to the patient/client.

3. The practitioner and the profession

- (a) Build a professional reputation based on ethical conduct and professional competence.
- (b) Recognise that your personal conduct influences the community's view of the profession.
- (c) Keep up to date with relevant professional knowledge and legal responsibilities.
- (d) Comply with the association's policies, procedures, regulations and articles of association.
- (e) Maintain a safe and hygienic environment consistent with the association's infection control guidelines and other statutory requirements.
- (f) Maintain Professional Indemnity Insurance at the level required by the association.
- (g) Maintain First Aid skills at the level required by the Association.
- (h) Members either working for or employing another practitioner should have a written agreement between the parties setting out their rights, obligations and responsibilities including a process for dispute resolution.
- (i) Comply fully with all laws and regulations governing the practice of ACM in Australia.
- (j) Do not undertake conduct which brings the profession into disrepute.
- (k) When teaching your skills to others, ensure that you do not undermine the practice of ACM or the professional standards of the association.

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- (l) Refrain from making comments which needlessly damage the reputation of another health professional.
 - (m) Accept responsibility for your own physical and psycho-social health as it may affect your professional ability.
 - (n) Recognise that an established therapeutic relationship between the patient/client and another health professional should be respected.
 - (o) Report suspected unethical or unprofessional conduct by another member to the association.
 - (p) Where a patient/client alleges unethical or unprofessional conduct by another health practitioner, respect the patient's right to complain and assist them in resolving the issue.
 - (q) Only use titles and forms of address to which you are entitled by reason of qualifications, an act of parliament or professional convention.
 - (r) If you are entitled by way of professional convention or qualification to use the title Doctor, avoid giving the impression that you are a medical practitioner unless you are registered as a medical practitioner in an Australian state or territory.
 - (s) Recognise your responsibility to pass on your professional knowledge and skills to practitioners and students.

4. Clinical teaching

- (a) Ensure that all patients/clients have given informed consent before participating in a teaching process.
- (b) Respect the patient's/client's right to withdraw consent from participating in clinical teaching at any time without compromising the practitioner-patient/client relationship or appropriate treatment.
- (c) Avoid compromising patient/client care in any teaching episode. Ensure that the patient's/client's dignity is maintained and that the best available therapy is provided.
- (d) Where relevant to clinical care, ensure that it is the treating practitioner who imparts feedback to the patient/client.
- (e) Do not exploit students or colleagues under your supervision in any way.

5. Advertising and the media

- (a) Advertising should not bring the profession into disrepute.
- (b) Ensure that all advertisements are accurate to the best of your knowledge and belief.
- (c) Confine advertising of professional services to the presentation of information reasonably needed by patients or colleagues to make an informed decision about the availability and appropriateness of your services.
- (d) Exercise caution in endorsing any particular commercial goods, devices or services.
- (e) Do not use the association name in any advertising or promotion of any commercial goods/devices or training program without the express written consent of the association.
- (f) Advertising should not denigrate, belittle or bring into disrepute any other person, profession or treatment.
- (g) Do not use testimonials in advertisements.
- (h) When communicating with the media do not hold yourself out to represent the association, or its position on an issue, unless you are explicitly authorised by the association to do so.

6. Referral to other practitioners

- (a) Communicate and co-operate with colleagues and other health care practitioners and agencies in the best interests of your patient/client and the community.
- (b) Obtain the opinion of an appropriate colleague acceptable to your patient/client if diagnosis or treatment is difficult or obscure, or in response to a reasonable request from your patient/client.
- (c) When referring a patient/client, obtain the consent of your patient/client to forward all relevant health information to the practitioner and indicate to the practitioner if you seek their opinion only, or for them to assume the continuing care of the patient/client.
- (d) When another health practitioner has requested an opinion, report in detail your findings to the referring practitioner.

7. Professional independence

- (a) You must safeguard your professional independence and integrity from demands from society, third parties, individual patient/clients and government.
- (b) Refrain from entering into any contract which may conflict with your professional integrity, clinical independence or duty to your patient/client.
- (c) If you work as an employee, place your professional responsibilities to your patient/client above the commercial interests of your employer.

8. The practitioner and the community

- (a) When presenting any personal opinion which is contrary to the generally held opinion of the profession, indicate that this is the case.
- (b) Take opportunities within your capacity to promote the role and benefits of ACM in your community.
- (c) Make available your special knowledge and skills to assist those responsible for the allocation of health resources.
- (d) When it is suspected that an adverse reaction has occurred as a result of a medicine, supplement or therapeutic device or product, communicate this to the appropriate authority and inform the association.

PART E POLICY ON REASONABLY NECESSARY TREATMENT

The following policy on ‘reasonably necessary’ treatment outlines the process for investigating allegations of inappropriate servicing arising under the Code of Conduct, items 1(s), 1(t) and 1(w).

Principles

- Inappropriate servicing wastes scarce resources that can otherwise be deployed for greater social benefit.
- Inappropriate servicing can place funding pressure on third party payers and result in negative impacts on individual health consumers and the membership at large.
- A determination of inappropriate servicing requires a peer review process to consider the particular circumstances of each client.
- The primary goal of these procedures is to investigate allegations of inappropriate servicing and to assist the member to develop and maintain appropriate servicing conduct.
- Sanctions should only be imposed where a member continues to service inappropriately, or where there is evidence of fraudulent conduct.

Process

The AACMA Board shall convene a Peer Review Panel (PRP). The PRP will be made up of at least three (3) but not more than five (5) practitioners with extensive and diverse experience in the practice of Acupuncture and Chinese medicine.

Complaints may be received from a variety of sources, including the public, statutory board, third party payers, practitioners or professional association or may be referred by the AACMA Disciplinary Committee.

The Peer Review Panel will examine the servicing history of the practitioner in the context of the nature and severity of the specific clients concerned.

In considering the appropriateness of the servicing pattern the Panel will consider:

- the availability and accuracy of written client notes and account history; and
- progress notes recording the progress of the client throughout their course of treatment.

If the Peer Review Panel believes that there is a prima facie case of inappropriate servicing, the practitioner is invited to make a written or verbal submission identifying the rationale for the pattern of servicing.

Where the PRP identifies that the pattern of servicing is not consistent with contemporary Australian practice standards, a counsellor will be appointed to the practitioner to counsel them on appropriate servicing.

Where the PRP believes that there is evidence of fraud then the case will be referred to the Disciplinary Committee.

A review will be carried out 6 months after initial counselling to determine if servicing patterns are consistent with contemporary standards.

Practitioners who continue to service inappropriately will be referred to the Disciplinary Committee for sanctions in accordance with the Articles of Association.

The complainant shall be advised of the outcome of the complaint.

Key Principles from the Code of Conduct when considering inappropriate servicing

1. Practitioner and client

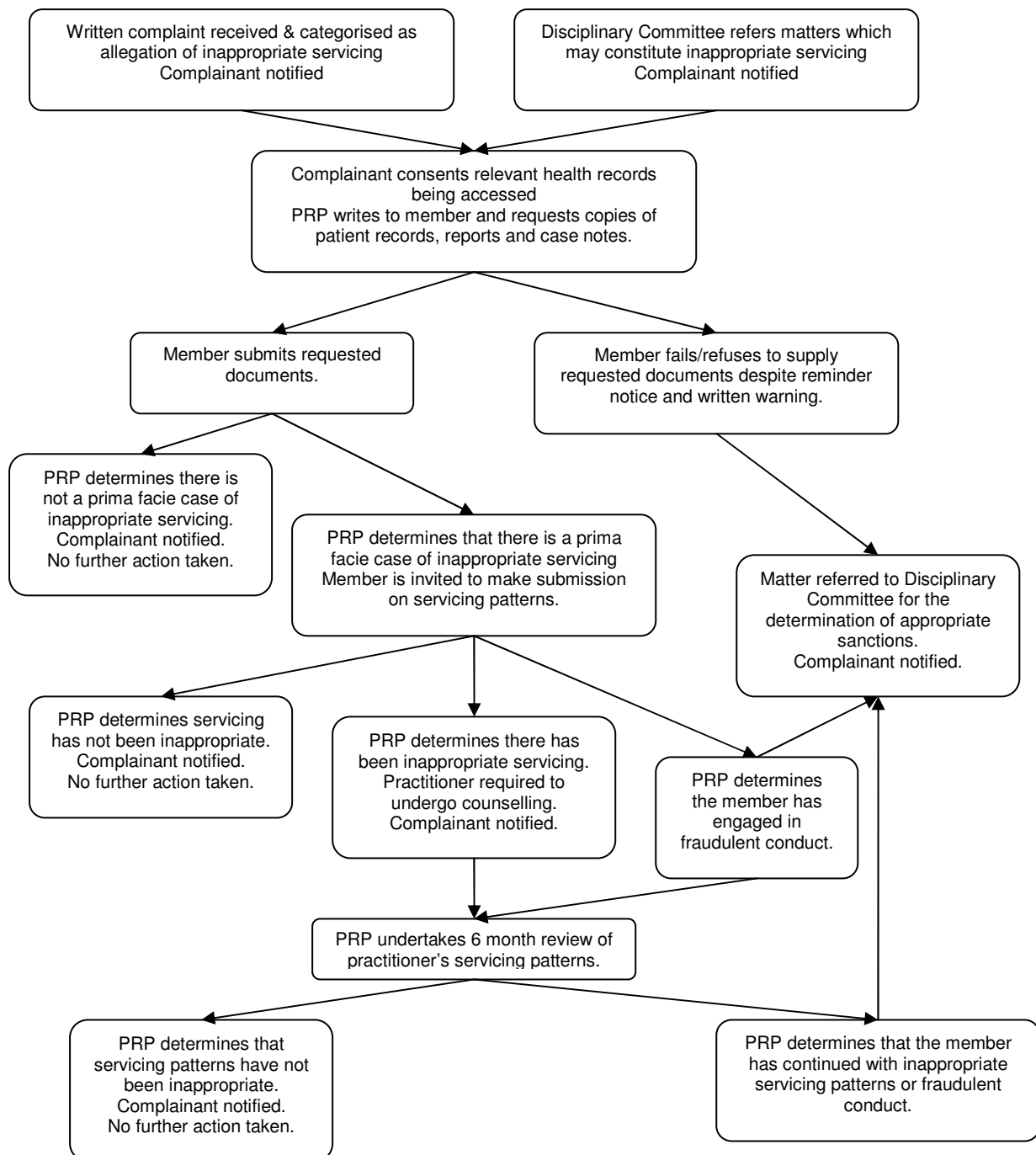
- (s) Recognise where a client is not responding adequately to treatment and discuss and review options with the client including the option of referral to another health practitioner.
- (t) Do not exploit your client for any reason.
- (w) Refrain from inappropriate servicing.
 - (i) Treatment shall be reasonably necessary. Reasonably necessary treatment is treatment which aims to benefit the physical, emotional or psycho-social health and well-being of the client.
 - (ii) Frequency and nature of treatment will be determined by considering the individual needs of the client, independent of the financial, personal or business interests of the practitioner.
 - (iii) Do not abuse the role of third party payers such as health funds and workers compensation insurers.

2. Record keeping

- (a) Maintain accurate, legible contemporaneous clinical records of each visit.
 - (i) As a minimum, each clinical patient/client record must be labelled with the patient/client’s identifying details and:
 - relevant health history, including details of presenting condition(s);
 - the date of each service;
 - the details of each service rendered, including
 - points used and methods applied
 - therapeutic goods prescribed with dosage
 - any advice or instructions given
 - details of any referrals made;
 - the outcome of treatment and/or progress noted; and

- details of any telephone or other non-face-to-face consultations.
- (ii) Where records are maintained in a language other than English, should a copy of a patient's records be required by the AACMA Disciplinary Committee or Peer Review Panel or an authorised third party, it is the responsibility of the member to provide at their own expense an English translation of the patient's records.
- (b) Maintain accurate, legible contemporaneous accounting records of each visit.
 - (i) As a minimum, each accounting record must be labelled with the patient/clients identifying details and:
 - the date of each service;
 - itemised fees charged; and
 - details of all payments including the date of the payment.
 - (ii) Issue an itemised receipt for each payment, indicating the date of payment, name of the practitioner who provided the service, address where the service was provided with contact telephone number, name of the patient who received the treatment, date of service, and treatment(s) provided and product(s) supplied with charge(s).
- (c) Periodically review and document client progress in the clinical records. The frequency of a review should be appropriate to the nature of the client's condition.

PEER REVIEW PANEL FLOW CHART



GLOSSARY OF TERMS

AACMA	Australian Acupuncture and Chinese Medicine Association Ltd
ACM	Acupuncture and Chinese Medicine
AGM	Annual General Meeting
PRP	Peer Review Panel

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APPENDIX BACKGROUND TO THE CURRENT CODES

Included below are the explanatory notes for the Review of the AACMA Code of Ethics that resulted in the new Codes. Reference to the 'current' code in this section is reference to the previous and now superseded Code.

Introduction

The current AACMA Code of Ethics (1977, as amended) is not a true code in its strict sense. Ethics are considered to refer to the ideals and aspiration of a profession rather than a set of prescriptive rules. The current Code is a set of rules which also incorporates the disciplinary structure of the association. This format is out of step with contemporary practice.

Current best practice is to separate the Code of Ethics (the ethical ideals of the profession) from a Code of Conduct (also called a code of practice). The latter is prescriptive, and sets minimum standards for professional conduct. By definition, ethical dilemmas are often not black and white and can require soul searching, discussion and deliberation to choose the correct path. In contrast, a member either conforms to items of a Code of Conduct or they are subject to professional discipline.

Some Codes of Ethics are actually a combination of ethical ideals and a Code of Conduct with little or no distinction between the two. The AMA Code (2004) still follows this format. The dieticians and physiotherapists have separated the two codes. In undertaking this review, we have drawn heavily on the AMA Code and discarded much of our (AACMA's) current Code. Following the first stage of the review, AACMA decided to distinguish the Code of Ethics from the Code of Conduct – that is to split into the two Codes.

In the Code of Ethics, descriptors have been chosen under each ethic to either clarify the meaning or give a concrete example of the main application of this ethic often using a specific Code of Conduct point. In taking this approach, an item in the Code of Conduct (for example, confidentiality) may be repeated, but not where it seems redundant (for example, under research). In our view, this format is more effective even though it is slightly different to current formats. The rationale is that to be worthwhile these documents should not be abstract or unclear.

Although each Code serves a different purpose they are intimately related so they should be seen as companion documents. The Code of Ethics outlines the ideal and Code of Conduct fills in the detail. Any area not covered by the Code of Conduct can be considered by the practitioner in terms of the overarching ethical principles. Where uncertainty exists the Code of Ethics guides the practitioner back to another colleague or the association.

Writing Style

Most of the Code of Conduct is written in the second person (you or your). This is the style of the AMA Code. This style involves the reader and encourages ownership of the principles more than when written in the third person (eg the member, the practitioner). The third person style can be seen as something someone else does. Some elements are clumsy if written in the second person so there is a mix of second and third person.

Terminology – Patient or Client?

The term 'patient' has been used throughout this document as it is the term preferred by most members. The term 'patient' can be considered interchangeable with the term 'client'.

Article Changes

The disciplinary structure in the old code of ethics more appropriately belonged in the Articles of Association, including the section on unethical appointments.

Relevant changes to the AACMA Articles of Association were presented to the members and passed at the 2005 AGM. Additional changes will be presented at the 2006 AGM.

Legal Enforceability

The issue of legal enforceability can be deceptive.

If the Articles of Association identify that a breach of the Codes can be dealt with under a process with sanctions then the association can act accordingly. The matter however is between the member and the association not a third party and certainly not the courts. A member who believes that due process has not been followed by the Disciplinary Committee might seek legal redress, and this would be a civil matter between the association and the member.

In the history of AACMA, members have generally complied with the findings and sanctions of the Disciplinary Committee, including the imposition of financial sanctions, suspension and expulsion. For this reason, the AACMA Code for all practical purposes has been and is considered to be enforceable, even though it has not been tested in the courts.

In a civil matter between a patient and a practitioner, such as negligence, the courts look to a profession's Code of Ethics and Code of Conduct in considering the question of what was the standard of care of the ordinary practitioner at the time that the

conduct occurred. In this way the Codes may be used as a standard in a legal proceedings. This is different from being legally enforceable.

Sexual Misconduct

Several Queensland health professions have adopted a comprehensive policy on sexual misconduct. Please refer to their [Statement on Sexual Relationships between Health Practitioners & their Patients](#) which can be downloaded from the following site:

[http://www.qnc.qld.gov.au/upload/pdfs/practice_standards/Statement on Sexual Relationships between Health Practitioners & their Patients.pdf](http://www.qnc.qld.gov.au/upload/pdfs/practice_standards/Statement_on_Sexual_Relationships_between_Health_Practitioners_&_their_Patients.pdf)

The AACMA Board has agreed to adopt the Statement by reference as guide when considering this issue.

Informed consent

Elements requiring informed consent are contained in both the Ethics and Conduct. The detailed elements of informed consent are not the subject of these Codes.

Inappropriate Servicing and Third Party Payers

Key aspects of conduct relating to overservicing and third party payers have been identified, while outlining the profession's independence from third parties.

The establishment of a Peer Review Panel is recommended to consider this type of conduct in the first instance.

Currently, these matters are referred to the Disciplinary Committee which also operates as the Practice Standards Committee. Under the revised process, allegations of inappropriate servicing or treatment which is not reasonable necessary, in relation to alleged breaches of items 1(u),(x)&(w) in the Draft Code of Conduct, will be referred to the Peer Review Panel first. Only adverse findings would be reported to the Disciplinary Committee for further action as appropriate, including consideration of penalties.

The Policy on Reasonably Necessary Treatment - The Peer Review Panel is included as Part D of this document.

Use of Professional Titles

The use of professional titles such as 'Doctor' was raised during the review and extensively discussed at the 2005 AGM.

There were considerable differences in attitude and usage between those states without statutory registration of the profession and Victoria where the use the title 'Doctor' was widespread and not disallowed by the statutory board. In the other states, the majority view was in opposition to use of 'Doctor' as a professional title.

Third Party Endorsements (Testimonials)

The issue of the use of third party endorsements (testimonials) was also raised during the review.

The AACMA Board is opposed to the use of testimonials as they are not able to tested or challenged. Practitioners should focus on positive statements about their practice that are able to be tested or challenged by patients.

Examples are: "In XYZ clinic, our patients are treated as individuals. The attention to detail and extra care we take with our health care is what makes us so popular", rather than a testimonial which might say "John Smith's attention to detail and extra care really made me feel my health needs were being met".

Interviews of consenting patients by a third party (such as a journalist) as part of an article about your practice are acceptable, so long as the patients consent to the release of their personal and health information.