SOCIETY OF CANNABIS CLINICIANS
AUSTRALIAN CHAPTER

AMCA
Australian Medicinal Cannabis Association

Code of Conduct

1. All clinical practice must comply with the relevant Code of Conduct published by AHPRA. The Good Medical Practice: a code of conduct for doctors in Australia is applicable for medical practitioners. A shared Code of Conduct published by AHPRA applies to pharmacists. However, pharmacists are regulated by the Code of Ethics issued by the Pharmaceutical Society of Australia. The Telehealth Guidance for Practitioners applies to all registered health practitioners, ensuring that principles of good medical practice apply notwithstanding whether a patient's consultation occurs online or in person.

2. Initial and follow-up clinical encounters should be performed in-person where possible. Text based consultations are not appropriate unless the patient is non-verbal and a live chat option is used in real time. Remote or telehealth visits should be for patients with no local access or for patients who have difficulty travelling to a cannabinoid prescriber due to their health or social restrictions. Telehealth services should comply with Medicare (where rebates are sought) and good clinical practice guidelines for medical practitioners, nurses and nurse practitioners as published by AHPRA. Therefore, telehealth consultations should not be shorter than in-person consultations and must assess telehealth patients to the same standards expected in an in-person consultation.

3. Medicare guidelines stipulate that for telehealth consultations a patient must visit the medical practitioner at least once every 12 months with exceptions, such as patients with acute active COVID infections, in order to obtain a Medicare rebate for the consultation. If possible, non-Medicare patients should also be seen in person at least once every 12 months. Cannabinoid consultations are typically complex, and the clinician should allow enough time for the complexity of the consultation as outlined by the Royal Australian College of General Practitioners and other specialist bodies i.e. 30 minutes or more for GPs (with a minimum of 20 minutes). Fifteen-minute consultations are not deemed sufficient for an initial assessment and to educate the patient, especially for Schedule 8 and / or unregistered medicines. Follow up consultations should be arranged as required.

4. Stricter guidelines should be in place for the prescription of medicinal cannabis. Notwithstanding the length of the SAS B approval, prescribing practitioners should follow up in person with patients to determine whether circumstances have changed, assess the effectiveness of the cannabis prescribed on the patient, and where appropriate, to consider alternate treatment approaches for the treated condition and to review whether another cannabinoid combination is more appropriate. As practitioner's are prescribing a non-approved good, practitioners should take an active approach in assessing patients and hence, short consultations are not appropriate.

5. The clinician should be familiar with research and evidence supporting the use of cannabis-based medicines for specific diagnoses or symptoms. A decision to recommend cannabis must be supported by the patient's subjective history, physical examination, and review of medical records, if available. Real-Time Prescription Monitoring systems should be utilised where possible to corroborate information provided. A comprehensive medical assessment should be performed before providing any new diagnosis or medicinal cannabis prescription. Thorough documentation

of the patient's past history and what treatments have been trialled for their condition must also be attended to. The clinician should adhere to state and federal regulations for cannabis approvals and prescriptions. The Royal Australian College of General Practitioners has drafted a 'Prescribing Medicinal Cannabis Products Checklist' which can be used to standardise the process of prescribing medicinal cannabis.

6. The potential risks (including potential side effects and risks of iatrogenic cannabis use disorder with THC based medicines) and potential benefits of treating with cannabis must be evaluated and discussed with the patient in a balanced manner and compared to the risk / benefit considerations of conventional treatment. The patient must be informed that most cannabis medicines are currently unapproved, and not registered on the Australian Register of Therapeutic Goods. As medicinal cannabis is unapproved, the authorised prescriber must advise patients that the TGA has not evaluated the safety, quality and efficacy of the medicinal cannabis, and that there is a possibility of unknown side effects. The patient must be informed that for some conditions, the prescription of medicinal cannabis may not be supported by current evidence, or that the evidence regarding efficacy may be weak or limited.

7. Documentation of the cannabis consultations should conform to Good Clinical Practice guidelines, including relevant history, physical examination findings, a diagnosis where possible, a measurable holistic management plan, and an explanation of the decision-making process which supports the recommendation of cannabis treatment, specific goals of treatment, and a plan for the patient describing suggested cannabis dosing and delivery methods.

8. The clinician must obtain informed consent for the treatment of patients including minors by their legal guardian and must carefully consider any additional risks associated with cannabinoids especially the use of THC during child and adolescent development. When obtaining informed consent, patients should be informed of, and agree to, the continuous obligations relating to their treatment. Continuous obligations include attending regular reviews with doctors and healthcare providers alongside undertaking regular blood tests or other investigations if required.

9. The clinician must provide the patient with information to facilitate the safe and effective use of medicinal cannabis, with educational material (either verbal or written) to inform the balance of benefits and risks. This information must be given at all initial consultations and when any changes are made to the therapy of an existing patient.

10. Patients should be required to follow up with the prescribing practitioner for monitoring of their medicinal cannabis treatment and evaluation of the treatment's efficacy on a case-by-case basis. This should be at least once a month initially and then may be less frequently (e.g. 3- 6) months once the safe and effective dosage is established. More frequent visits may be required depending on the individual case and patient's clinical response to treatment. These visits should be with the prescribing practitioner to ensure that the patient takes their medicine as prescribed and is not having any adverse events, especially cannabis naïve patients or those at risk, e.g. older patients, polypharmacy.

11. The clinician must declare a willingness to communicate with other treating healthcare providers, law enforcement, public health officers, and relevant authorities as required. Where there is an absence of client consent, doctors must satisfy themselves that any disclosure made is permitted by the Privacy Act. Subject to compliance with the Privacy Act, and all other applicable laws, clinicians may need to communicate to:

- verify the validity of the medicinal cannabis recommendation.
- collaborate in the coordinated care of the patient.
- provide a copy of the SAS B approval and the patient's prescription, if needed (and as entitled under the law) to support their legitimate use of legally prescribed medicinal cannabis.

12. The clinician agrees to pursue annual continuing professional development and education and communicate with colleagues in the emerging field of cannabinoid medicine, such that they may remain up to date on best practices and research in relation to medicinal cannabis treatment.

13. The clinician must clearly disclose to the patient any professional or financial relationships that they have with a clinic and / or the cannabis industry that may present a conflict of interest. Disclosures must be made clear and should be searchable. Disclosures should specifically establish the type of financial relationship, who It is with, and the monetary value. For example, prescribers must not receive inducements to prescribe a certain number of prescriptions per week, nor prescribe only products in which they have a commercial interest. Clinics should also have no financial interest in the amount of products prescribed for a patient, the brand of products prescribed, or product affiliations with a partner pharmacy. Any arrangement that can be seen as an inducement, that includes any financial benefit, and that is not disclosed to a patient, is a breach of Section 139B of the National Law and would constitute professional misconduct or unsatisfactory conduct on the part of the practitioner.

14. Any decision to prescribe medicinal cannabis for a patient must be based on sound clinical judgement made by the health practitioner. Consultations should address the clinical need to justify the need for medicinal cannabis and the prescriber discussing the options, pros and cons with the patient. Before prescribing medicinal cannabis, previous treatments used by the patient and whether all approved treatments have been tried or considered to treat the condition must be considered and documented. Medicinal cannabis should only be prescribed where all alternative approved treatment options have been considered and determined to be unsatisfactory, either due to safety concerns, lack of effectiveness, and/or patient consent.

15. Schedule eight prescriptions MUST be written within the prescribed scope of practice. Nurses cannot be substitutes for medical practitioners, but can act upon the instructions of a medical practitioner if deemed to be clinically necessary (i.e. circumstances where medical practitioners in rural, regional towns are limited). Nurse practitioners' scope may vary, though must abide by the relevant state or territory regulations.

N. B. This document was produced as a joint initiative by the Society of Cannabis Clinicians Australian Chapter (SCCAC) and the Australian Medicinal Cannabis Association (AMCA). SCCAC and AMCA would welcome any feedback provided by the medical community, including government organisations and professional bodies.

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Next review: subject to Telehealth Guidance changes