# defenceupdate

Quarterly Publication for MDA National Members

Autumn 2014

Think Before You Sign an Employment Contract

Avoiding the Unfair Dismissal Trap

Remember Your Wellbeing When Discussing Difficult News

Social Media in Modern Medicine

Medico-legal Feature: Advance Care Planning & Advance Care Directives

MDA National CaseBook

# Editor's Note

One of our Members recently asked me to use my Editor's Note to stimulate discussion about the interaction between MDA National as a mutual organisation and our Membership. Quite rightly, the Member stated that MDA National should be part of the medical profession. Indeed, MDA National is a service organisation which is owned by our medical practitioner Members. At our core, our Group provides medical indemnity insurance, and medico-legal advisory and advocacy services. We partner with and service our Members through education, risk management services and other support.

Our challenge is to ensure that we continue to have meaningful engagement with all of our Members, not just with those Members who seek assistance under their Professional Indemnity Insurance Policy and/or via our Medico-legal Advisory Service. Along these lines, MDA National recently sought feedback from our GP Members in relation to their concerns and comments about the impact of PCEHR on them and their practices. We were delighted with the numerous, thoughtful responses we received from our Members which helped to inform our submission to the government's recent review of the PCEHR.

*Defence Update* is designed to keep you up to date about recent medico-legal developments which have an impact on contemporary clinical practice, and to raise awareness about emerging and perennial medico-legal risks. In particular, on page 15 of this issue of *Defence Update*, we discuss a controversial disciplinary case concerning a medical practitioner's duty to offer emergency Good Samaritan assistance and I invite your comments about the finding in this case of "improper conduct in a professional respect" against the medical practitioner.

We are seeking your general feedback about *Defence Update* and I encourage all readers to complete the short online survey (see details on page 4). Members are also welcome to contact me at sbird@mdanational.com.au or on 1800 011 255.

MDA National's aim is to serve our Members. Your feedback is a vital part of ensuring this vision is achieved. We look forward to hearing from you.

**Dr Sara Bird**
**Manager, Medico-legal and Advisory Services**

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# From the President

## Throwing stones at our colleagues hurts us all

**"Criticism of others is thus an oblique form of self-commendation. We think we make the picture hang straight on our wall by telling our neighbour that all his pictures are crooked."** *Fulton J Sheen*[1]

A Member recently explained that she had been the subject of a complaint. She was relieved when the care she had provided was considered, by several experts, to reveal no discernible error or any breach of her duty of care. However, she was disappointed that the patient had made a complaint that had no merit. But more hurtfully, the comments prompting the patient's complaint had been made by another doctor!

Indeed, our Claims and Advisory team has observed that complaints and claims not infrequently arise from the injudicious comments of other doctors. While some of these can be justified and seen as "setting the record straight" to clearly inform a patient of their present condition, prognosis and treatment options, others can be interpreted as nothing more than careless or intentional self-commendation.

Remarks like "you should have come to me sooner", or "I would never recommend that treatment, but now I will look after you", appear to raise the stature of a practitioner in the eyes of patients and/or their referrers in the mistaken hope of creating greater trust or confidence. But when we unfairly demean our colleagues, we often cause great harm and unnecessary distress to our patients.

As doctors, we must remain mindful of the importance of displaying professionalism and respect for others. Doctors are now taught that ascribing blame for poor outcomes demoralises their colleagues, undermines patient trust in the health system and ultimately compromises patient outcomes. Therefore such remarks harm everyone, including our ability to receive trust and respect from our patients and the wider community.

Surely, I thought, the doctor who had trashed our Member was out of line, his comments aberrant or perhaps an isolated example of professional jealousy? However, I could recall seeing other cases like this where doctors had been overtly critical about other doctors' work.

Researchers in a recent study in the *Journal of General Internal Medicine* enlisted people to portray patients with advanced cancer.[2] They then covertly recorded their conversations with 20 community-based oncologists and 19 general practitioners. The actors carried records of previous treatment, reflecting universally accepted standards of care, but avoided comments that would solicit opinions about the nature or appropriateness of this treatment.

On reviewing the transcripts of these encounters, researchers first identified exchanges in which doctors spontaneously volunteered comments about a patient's previous doctor. These exchanges were then categorised as neutral, supportive or critical. Of the 34 doctor-patient encounters, 14 (41%) included comments about a patient's previous care. These comments totalled to 42, of which 12 were deemed supportive, 28 critical and 2 neutral. The majority of negative comments were unabashedly critical, with doctors' remarks ranging from "Hell, you don't want to trust doctors" to "That guy's a complete idiot!" And the typical negative comment was a doctor in one specialty criticising a doctor in another.

The study authors concluded: "This behaviour may affect patient satisfaction and patient care. Healthcare system policies and training should discourage this behaviour." When the lead author of the study, Dr Susan H McDaniel was interviewed by the *New York Times*,[3] she remarked: "Doctors will throw each other under the bus," and added: "I don't even think they realise the extent to which they do that or how it can affect patients."

This phenomenon was also confirmed in a 2013 report of malpractice in the US that showed that doctors, particularly hospital-based specialists, could gratuitously denigrate the care of general practitioners before patients and their families.[4] Sadly this tendency was cited by many respondents, including nearly 3,500 doctors interviewed across 25 specialty areas, as a prime reason for malpractice lawsuits.

So while I'm sure that the majority of doctors understand how their clinical decisions will affect patient outcomes, at times such decisions are not really that clear. Not infrequently, judgement calls must play a role in choosing therapies for patients given that the best available data might be imperfect. So as with other professions, it is much easier to offer decisions and treatment choices with "retrospective bias", while looking back on a case after the passage of time and past treatment choices, than being in the trenches of an ongoing illness.

To help remedy this problem, Dr McDaniel began a coaching program at the University of Rochester Medical Centre. To date, she and her team have worked with approximately 150 doctors, observing them with patients and colleagues, then offering feedback and support. She added: "There's a lot of attention focused on the patient experience, but I think we need to work on improving the clinician experience as well." And perhaps we can all make a start on this by not throwing so many stones at our colleagues.

**A/Prof Julian Rait**
**MDA National President**

For a full list of references, visit:
**defenceupdate.mdanational.com.au/from-the-president.**

# Notice Board

## Thank You Doctor Campaign

Nearly every doctor will at some stage receive a gift from a thankful patient, which raises ethical and medico-legal issues.

MDA National has partnered with the AMA Queensland (AMAQ) Foundation to launch their Thank You Doctor Campaign which offers doctors the opportunity to receive "gifts" from patients without transgressing ethical boundaries, while supporting a worthwhile cause.

We encourage our Members nationally to promote this campaign in medical practices to help educate patients. Patients can choose to make a donation to the Foundation and request an appreciation letter to be sent to their doctor regarding the donation made to "thank" them.

*As doctors we see people in genuine need falling through cracks in the system. Being a nimble charity, we can direct funds to where they are most needed; often to places overlooked by others.*
Dr Steve Hambleton, AMAQ Foundation President.

The AMAQ Foundation has achieved many successes in supporting doctors' health and wellbeing as well as relieving sickness, suffering and disability among patients.
For more information, visit **amaqfoundation.com.au**.

## Changes to Privacy Law – 12 March 2014

Members are reminded that all medical practices must now have a privacy policy which clearly specifies what information will be collected, how it will be used, and a process for individuals wishing to complain about privacy breaches. For more information on the impact of these legislative changes and the required content of a privacy policy, visit **defenceupdate.mdanational.com.au/privacy-law-reforms** or the Office of the Australian Information Commissioner's website at **oaic.gov.au/privacy/privacy-act/privacy-law-reformau/notice-board-autumn-2014**.

## Have Your Say and You Could Win a $500 VISA gift card!*

You are invited to complete a short online evaluation survey for *Defence Update* at **surveymonkey.com/s/defenceupdate** before **12 May 2014**.

*Defence Update* aims to keep you up to date on the latest medico-legal issues, case studies and industry news. We're interested in your thoughts with a view to improving the publication and ensuring it remains pertinent and informative.

*Terms and conditions at mdanational.com.au/termsconditions/defence-update-autumn-2014-tc.aspx.

## Random Audits of Compliance with Registration Standards

Commencing in 2014, the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia will undertake random audits of medical practitioners to ensure compliance with the following Mandatory Registration Standards: **Continuing Professional Development; Criminal History; Professional Indemnity Insurance;** and **Recency of Practice**.

If selected for an audit, you will receive an audit notice in the mail from AHPRA. This will include a checklist outlining the documentation required to demonstrate that you meet the standard(s) being audited (e.g. evidence of CPD activities or Professional Indemnity Insurance). We encourage you to contact our Medico-legal Advisory Service if you have any questions.

Further information:

- Mandatory Registration Standards: **medicalboard.gov.au/Registration-Standards.aspx**
- Audits: **medicalboard.gov.au/Registration/Audit.aspx**

## Congratulations to Jim Freemantle

Congratulations to Jim Freemantle on his richly deserved Queen's Birthday honours and appointment as an Officer in the General Division of the Order of Australia (AO).

As Director of the MDA National Insurance Board since 2003, Jim has added significant value to our organisation. He is a Fellow of the Australian Institute of Company Directors and a Senior Fellow of the Financial Services Institute of Australia. Jim is also a Director or consultant to a number of non-related companies and several community service organisations. We are proud to have Jim "on board" with us at MDA National.

# Think Before You Sign an Employment Contract

Starting a new job is exciting, but you should be sure your employment contract protects your interests and does not leave you exposed if things don't work out. So what should you be looking for before you sign an employment contract?

### Do I need an employment contract?

Your new employer seems nice, and just as keen as you are to get you working as soon as possible. You have talked about the role and you are sure you understand each other. Why not just start straight away without bothering with tedious formalities like a written contract?

STOP! An employment contract not only protects your employer, but your interests as well. If things fall apart, you will be relying on your employment contract to protect you. If you haven't signed a written contract, any dispute becomes a costly game of "he said – she said". A written employment contract is your best protection when it comes to disputes over employment, including pay and termination.

### Read it – yes, the whole thing!

We all know legal contracts can put you to sleep, but you need to know what you are signing up for before you start work. Read the whole document and make sure you understand it. If you have any questions or concerns about the terms of the contract, you should discuss them with your prospective employer.

### Indemnity and liabilities

Most contracts for medical services will set out who is responsible for liabilities – in particular, medical indemnity insurance for claims made by patients. Check this section carefully to determine whether the employer will indemnify you, or if you will need insurance cover for the patients you see. If you need additional cover, contact MDA National and we will do our best to arrange this for you.

### Breach, termination and penalties

Most contracts will set out the process for terminating the contract, specifying notice periods and any other relevant requirements. Check this section carefully to ensure that if you need to terminate the contract, you know exactly how much notice is required. Some contracts may create penalties for early termination or breach of contract, so make sure you check before you sign.

### Restraint of trade

Some contracts contain provisions which restrict where you can work AFTER the contract is terminated. A restraint of trade clause usually relates to a geographic area around the practice, for a specified period of time. Employers often pursue doctors to enforce these restrictions, so be very careful when signing a contract which includes a restraint of trade provision. If you don't check before you sign, you could be limiting your future ability to work in your chosen area or exposing yourself to potential legal action.

More information on this subject can be viewed online:

**defenceupdate.mdanational.com.au/how-restrained-are-you/**

### Independent legal advice

If there are parts of your contract that you don't understand, or you need assistance in negotiating changes to the contract before you sign, seek independent legal advice. While MDA National cannot provide this advice, we can recommend solicitors with appropriate experience in employment law who can advise you at your own expense.

**Taking the time to understand your contract before you sign can save you a time-consuming and costly dispute in the future.**

That way, if your new job doesn't work out, you can move on with confidence.

**Rachel Northcott, Underwriter, MDA National**

# Avoiding the Unfair Dismissal Trap:

## Dismissing Employees Fairly

Dismissing an employee can be an uncertain and difficult process. Employers should be aware of their obligations to ensure that any dismissal is lawful and fair, and to place themselves in the best position to defend any legal claims which may subsequently arise from the dismissal.

### Who is protected from unfair dismissal?

The workplace relations system in Australia is complex. In Victoria, ACT and NT, the federal workplace relations system applies to all employees and employers. In NSW, Queensland, South Australia and Tasmania, all private sector employers and their employees are covered by the federal workplace relations system. In Western Australia, a private sector employer may fall either within the state or federal jurisdiction depending on whether they are a Constitutional Corporation.

Under the federal legislation, the *Fair Work Act 2009* (FW Act), an employee is protected from unfair dismissal if they meet all the following criteria:

- employed by a national system employer
- earn less than the high income threshold (currently $129,300) or are covered by an award or an enterprise agreement
- employed for more than six months (more than 12 months in the case of employers with fewer than 15 employees).

Under the WA legislation, an employee is protected from unfair dismissal if they meet both criteria below:

- employed under the state system
- earn less than the high income threshold (currently $145,800) or covered by an award or industrial agreement.

An employee may not be protected from unfair dismissal if they meet any of the following criteria:

- employed on a casual basis
- employed on a specified term contract or for a specified task
- employed on a training contract.

### Substantive and procedural fairness

For a national system employer to effect a best practice dismissal so they are in a good position to defend a legal claim, they should ensure the dismissal is procedurally and substantively fair. Under the WA system, the principles are similar in that an employer must not exercise their legal right of dismissal so harshly or oppressively that it is an abuse of that right.[1]

### Substantive fairness – valid reason for dismissal

If an employee makes an unfair dismissal claim, a tribunal will consider whether the employer had a valid reason for dismissal. The reason must be "sound and defensible and well founded."[2] Reasons for dismissal cannot be "capricious, fanciful, spiteful or prejudiced."[2]

As a general rule, there are only three valid reasons (or a combination of those reasons) for which an employer can dismiss an employee:

- capacity (poor performance)
- conduct
- genuine redundancy (operational reasons).

Employees should only be summarily dismissed (dismissed without notice) if they have engaged in serious misconduct. The conduct needs to be so serious that employment during the period of notice is unreasonable.

### Unlawful reasons for termination

It is unlawful for an employer to terminate an employee due to:

- temporary absence from work because of illness or injury
- membership or non-membership of a trade union
- acting as a representative of employees, or seeking to do so
- filing of a complaint or participation in proceedings against the employer
- discriminatory grounds, such as race
- absence from work during maternity or parental leave
- temporary absence due to the carrying out of an emergency management activity.

### Procedural fairness

If an employee makes an unfair dismissal claim, the tribunal will consider whether the employer has provided procedural fairness to an employee when making the decision to dismiss them. An employee must be notified in sufficient detail of the reasons for dismissal and must be given an opportunity to respond to those reasons.

If an employee is being dismissed on the basis of their capacity, the employee should have received warnings about their performance and subsequently failed to improve. The employer should notify the employee of the performance problem, outline where improvement is required, and provide the employee with a reasonable opportunity to improve.

If an employer wishes to dismiss an employee for misconduct, they should conduct an appropriate investigation into the alleged misconduct. Procedural fairness requires that the employee be provided with at least the specific details of the alleged misconduct and the opportunity to respond to the allegations. The employer must then determine if the misconduct has occurred and what the appropriate disciplinary action, if any, should be.

### Personal circumstances

Before an employer dismisses an employee, the employer should consider the individual circumstances of that employee. These include work related circumstances such as length of service and employment record. It also includes the employee's personal circumstances such as age and the effect of the dismissal on the employee.

### Notice obligations

An employer must provide an employee with a written notice of termination. Employees in both the WA and Federal systems are entitled to the minimum notice periods set out in the FW Act National Employment Standards (NES), which are based upon the employee's length of service.

An employer may choose to pay the employee notice in lieu, as an alternative to requiring the employee to work out their notice period. If an employee's contract of employment contains a longer notice period than the NES, the employee is entitled to the longer notice period.

### Employee entitlements upon termination

Upon termination an employer must pay an employee all of the following:

- any accrued annual leave and annual leave loading
- any accrued or pro-rata long service leave
- any outstanding wages
- redundancy pay (if applicable).

An employer does not need to pay out any unused personal leave entitlements unless there is a requirement in the contract of employment or relevant award or industrial agreement to do so.

> The *Fair Work Act 2009* anti-bullying laws came into effect on 1 January 2014. Depending on the circumstances, employers may need to factor the anti-bullying laws into any pre-dismissal and dismissal processes.

**Renae Harg, Solicitor and Jon Long, Director**
**HLS Legal**

*This article is a general overview and not provided for the purposes of legal advice. In the event of dismissing an employee, please seek advice from your own legal adviser.*

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1 *Miles v Federated Miscellaneous Workers Union of Australia, Hospital Service and Miscellaneous, WA Branch* [1985] 65 WAIG 385.

2 *Selvachandran v Peteron Plastics Pty Ltd* [1995] 62 IR 371.

# Social Media in Modern Medicine

Is social media a help or a hindrance in modern medicine? Dr Edwin Kruys, a GP from Queensland's Sunshine Coast, provides a personal perspective on the subject.

### Should medical professionals engage with social media?

Social media is here to stay. A lot of registrars and young doctors have one or more social media accounts, and I have yet to meet a medical student who is not on Facebook. Patients are already sharing online (health) information via Facebook, Twitter and other social media accounts – so sooner or later health professionals will need to decide whether or not to participate.

### What are the potential benefits of using social media in the medical profession?

Social media is increasingly used for medical education, and sharing knowledge and information such as tips, resources, literature and links.

It's also useful to build an online community. Clinics can share health information and other practical information.

Social media is more interactive than a website and you can reach a wider audience in real time. Another benefit is the value of health promotion and lifting the profile of a medical practice or organisation.

I'd like to mention the use of blogs, pictures and videos. I find they are a great way to communicate a message, and I use my social media accounts to let my followers know when I've posted something new.

### How can doctors make the most of social media?

You need to be prepared to put aside time to manage your online presence, and there is no easy way out here. It takes time to post useful material and interact with others. Social media is a two-way street and not just another promotional channel. If you use social media for branding or promotional purposes only, you may lose followers.

Your online presence should have a consistent approach. Too many organisations set up a Facebook account without first developing a clearly defined strategy. It is recommended to take some time to plan and figure out the purpose of the social media campaign, which medium to focus on, and how to keep it sustainable and current. This usually requires a motivated person within the organisation.

Preparation is key, and implementing a social media policy should be part of the preparation. Some things to include in the policy are, for example, how to respond to negative feedback and/or complaints received via social media; and how to comply with AHPRA regulations.[1] The AMA has a useful document[2] that outlines the risks. I also felt that the social media workshops organised by MDA National are an excellent way to become familiar with the common pitfalls.

### Is social media for you?

Due to the time commitment, and the effort it takes to set up and maintain social media accounts, it may not be ideal for everyone. For those who want to contribute to online health promotion or interact and share health information with their patients or other health professionals, social media is not without risks, but it can be an effective tool if used wisely.

### Useful links

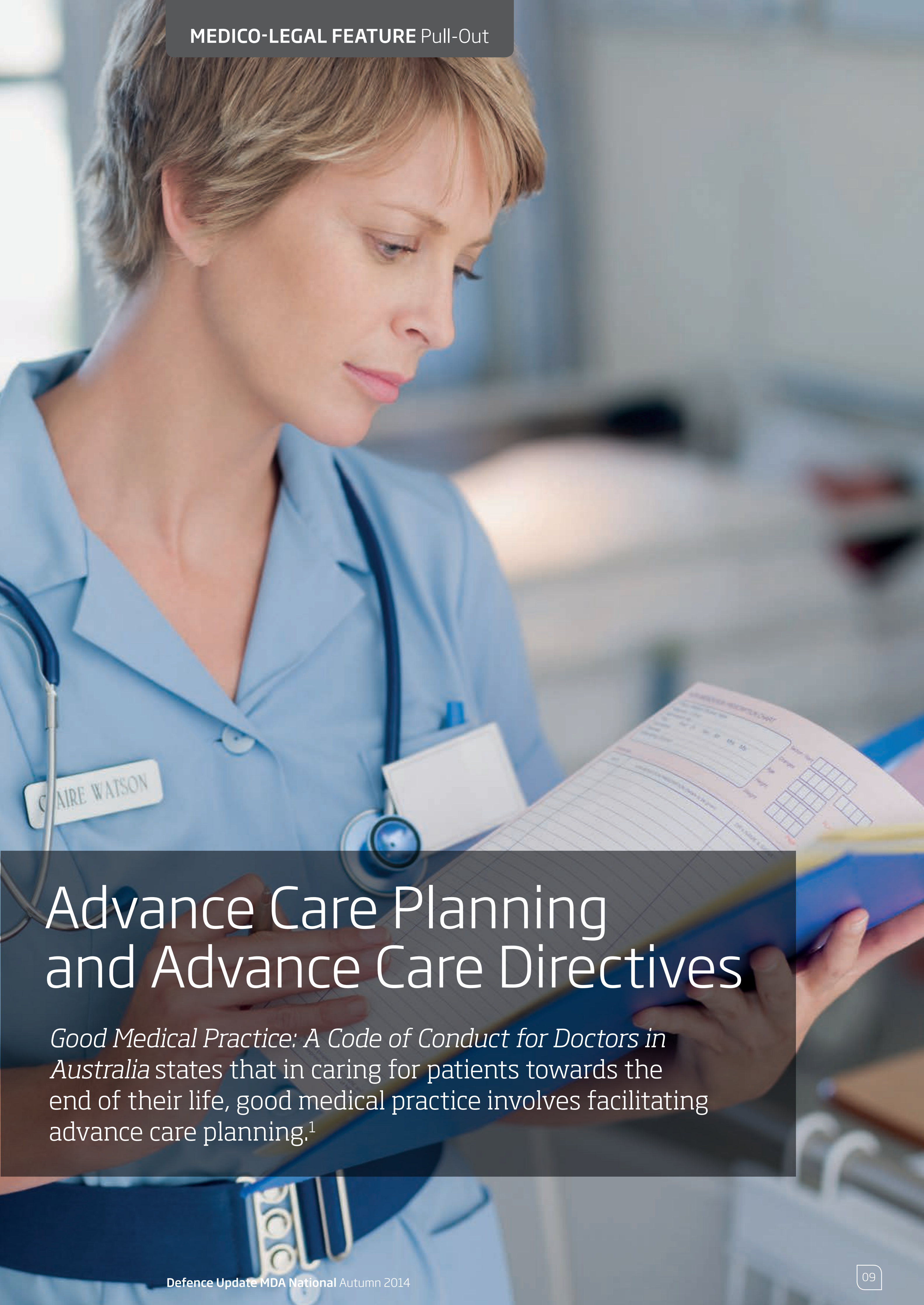
- For information on social media workshops run by MDA National in 2014, visit our What's On page at **mdanational.com.au** or email **events@mdanational.com.au**.
- A new "Social Media Policy" has just been published by the Medical Board of Australia. It was developed jointly by the National Boards to help registered health practitioners understand their obligations when using social media. Available at **medicalboard.gov.au/Codes-Guidelines-Policies.aspx**.

  Medical practitioners should only post information that is not in breach of their obligations by:
  - complying with professional obligations, including the Medical Board of Australia's Code of Conduct and Advertising Guidelines
  - complying with confidentiality and privacy obligations, e.g. not discussing patients or posting pictures of patients, procedures, case studies or sensitive material which may enable patients to be identified, without having obtained consent in appropriate situations
  - presenting information in an unbiased, evidence-based context
  - not making unsubstantiated claims.

**Dr Edwin Kruys is a practising GP who blogs at doctorsbag.wordpress.com.**

1 Medical Board of Australia. *Good Medical Practice: A Code of Conduct for Doctors in Australia* and *Medical Guidelines for Advertising Regulated Services.* Available at: medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

2 A Guide to Online Professionalism for Medical Practitioners and Medical Students. Available at: ama.com.au/social-media-and-medical-profession.



# Advance Care Planning and Advance Care Directives

*Good Medical Practice: A Code of Conduct for Doctors in Australia* states that in caring for patients towards the end of their life, good medical practice involves facilitating advance care planning.[1]

# Advance Care Planning and Advance Care Directives

## What is advance care planning?

Advance care planning is a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known so they can guide decision-making at a future time when that person cannot make or communicate his or her decisions.[2] Advance care planning is based on principles of self-determination, dignity and avoidance of suffering.[3]

## What is an Advance Care Directive?

Advance care planning will often lead to the completion of an Advance Care Directive (ACD). An ACD is a means by which a competent adult can determine the medical treatment that he or she wants to accept or refuse in the future if decision-making competence is lost.[4] An ACD is generally a written document intended to apply to future periods of impaired decision-making capacity, which provides a legal means for a competent adult to record preferences for future health and personal care and/or to appoint and instruct a substitute decision-maker (SDM).[5] ACDs are not clinical care or treatment plans; but clinical care and treatment plans can and should be informed by ACDs.[2]

## When is an ACD valid?

In general terms, an ACD is valid when it meets the following criteria:

- It is made by a competent adult.
- It is made free of undue influence.
- It applies to the situation at hand.

## Use of ACDs

In recent years there has been a greater focus on the role of advance care planning and ACDs. This policy has been driven by a number of factors including Australia's ageing population, medical and technological advances which prolong life, increased emphasis on autonomy and patient-centred care, and the provision of quality care at the end of life.

### Tips for successful advance care planning conversations[6]

- The individual needs to be ready for the conversation and mentally capable of participating – conversation cannot be forced; at the same time clinicians, in most instances, need to take the lead in initiating such conversations.
- Capacity to engage in conversation must be maximised by treating any transient condition affecting communication and optimising sensory function (e.g. by ensuring the patient's hearing aid is being worn).
- Conversations need to take place on more than one occasion (over days, weeks and even months) and should not generally be completed on a single visit.
- Conversations take time and effort and cannot be completed as a simple checklist exercise.
- Conversations should take place in comfortable, unhurried surroundings; time is a key factor.
- Conversations should be devoid of medical jargon, language should be positive, and trust must be built using empathic listening skills.
- A step-by-step approach to identifying and resolving issues should be used, coupled with "time out" periods where doctors withdraw from the encounter to allow the patient and family to discuss among themselves the care options being presented.
- Individuals should be given realistic information on prognosis and treatment options with emphasis on how their illness is expected to impact on their daily function.
- Conversations should avoid focusing initially on medical interventions (e.g. cardiopulmonary resuscitation, intubation) but rather determine values, goals and preferences (e.g. prolonging life and preserving mentation versus minimising suffering and avoiding undignified states or an unacceptable functional status).
- Look out for cues suggesting individuals are becoming uncomfortable talking about certain issues or may wish to end the conversation.
- Encourage patients to identify a surrogate decision-maker and to discuss their wishes with that individual; if desired, offer to facilitate a conversation between the patient and their surrogate or other family members; identify whether patients have specific desires for how information is shared among family members.
- Summarise and check the patient's and, if present, their surrogate's understanding of what has been discussed at the end of sessions.
- Encourage patients and surrogates to have conversations documented, but reassure them that these documents are not necessarily final or binding.
- Plan for a review as clinical circumstances change.

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However, to date, ACDs have not proved to be a popular planning tool. This is despite the fact that individuals are encouraged to discuss with their families how they would like their health care to be managed if they are no longer able to make their own decisions, and for doctors to incorporate advance care planning as part of routine health care, including raising the topic with all older patients.[2]

Some of the concerns that have been raised in relation to the use of ACDs are:

- validity and reliability – the person making the ACD may lack the information required to make an informed choice, especially where the ACD is made prior to the onset of an illness for which a treatment decision must be made, and the way in which the ACD is written may be influenced by the manner in which questions are posed
- durability – an individual's treatment choices can change over time such that an ACD made at a particular time may not accurately reflect the person's wishes at a later date, and may not reflect advances in medical practice
- efficacy – the person's true wishes may not be accurately ascertained from an ACD with sufficient clarity to guide clinical management
- accessibility – it may not be possible to locate an ACD when needed
- portability – each state and territory has a different legislative framework for ACDs.

As a result of these factors, medical practitioners may be concerned about following an ACD, especially where they do not believe it represents "good" medical decision-making, or that the ACD may not represent the true wishes of the patient. Practitioners may also be concerned about potential liability, especially where there is conflict with the wishes of the patient's family.

## Code of ethical practice for ACDs[2]

1. ACDs are founded on respect for a person's autonomy and are focused on the person.
2. Competent adults are autonomous individuals and are entitled to make their own decisions about personal and health matters.
3. Autonomy can be exercised in different ways according to the person's culture, background, history or spiritual and religious beliefs.
4. Adults are presumed competent.
5. Directions in ACDs may reflect a broad concept of health.
6. Directions in ACDs can relate to any future time.
7. The person decides what constitutes quality of life.
8. The substitute decision-maker (SDM) has the same authority as the person when competent.
9. The SDM must honour residual decision-making capacity.
10. The primary decision-making standard for SDMs is substituted judgement.
11. A SDM should only base his or her decision on "best interests" when there is no evidence of the person's preferences on which to base substituted judgement.
12. An ACD can be relied upon if it appears valid.
13. A refusal of health-related intervention in a valid ACD must be followed, if intended by the person to apply to the situation.
14. A person, or their legally recognised SDM, can consent to the treatment offered, refuse the treatment offered, but cannot demand treatment.
15. A valid ACD that expresses preferences or refusals relevant and specific to the situation at hand must be followed.

## Legal framework for ACDs

The common law recognises, as part of the right to self-determination, that an individual can complete an ACD that will bind a health practitioner who is treating that person, even if the directive refuses life-sustaining treatment. A 2009 NSW Supreme Court judgment (see "ACDs and the Law" on page 12 of this issue) confirmed that if an ACD is made by a capable adult, is clear and unambiguous, and extends to the situation at hand, it must be respected.[7]

Legislation governing ACDs has been enacted in every state and territory, except NSW and Tasmania where the common law would apply with regard to ACDs. However, the legislation is complex and varies considerably in scope. **The legislative name of ACDs varies between jurisdictions and differing restrictions affect their operation, as outlined below:**

**ACT – Health Direction**

**NT – Direction**

Effective only when person suffers from a terminal illness.

**QLD – Advance Health Directive**

For directions to withhold/withdraw life-sustaining measures:

1. direction cannot operate unless there is no chance of the patient regaining capacity and any of the following:
   - terminal illness/incurable condition and expected to die in one year
   - permanent coma/post-coma unresponsiveness
   - illness/injury so severe that no reasonable prospect of recovery without life-sustaining measures
2. for directions regarding artificial nutrition/hydration (ANH), commencing or continuing ANH would be inconsistent with good medical practice.

**SA – Anticipatory Direction**

Effective only when person is in terminal phase of a terminal illness, or in a persistent vegetative state. (*Still legally effective after 1 July 2014.*)

**SA – Advance Care Directive**

Effective from 1 July 2014.

**VIC – Refusal of Treatment Certificate**

Does not cover procedures that would be considered palliative. Applies only to a current condition.

**WA – Advance Health Directive**

A treatment decision will not operate if circumstances exist that the person would not have reasonably anticipated at the time of making the directive and would have caused a reasonable person to change their mind about the treatment decision.

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For useful links and the full list of references visit **defenceupdate.mdanational.com.au/advance-care-planning.**

# Advance Care Directives and the Law

Dr Sara Bird

The NSW Supreme Court decision in *Hunter and New England Health Service v A*[1] confirmed that a valid Advance Care Directive (ACD) must be respected.

## Case history

On 1 July 2009, Mr A was admitted to hospital suffering from septic shock. His condition continued to deteriorate and he was transferred to the Intensive Care Unit where he was ventilated and commenced on dialysis.

On 14 July 2009, the hospital became aware of an unsigned document which Mr A had apparently prepared in 2008 indicating that he would refuse dialysis. The document was a pro-forma worksheet prepared for Jehovah's Witnesses to indicate their attitude to various forms of medical treatment. On the worksheet, Mr A had ticked "I refuse" for dialysis and a number of other medical treatments.

The hospital sought orders from the Court as to whether the document was a valid ACD, and if the hospital would therefore be justified in ceasing dialysis in accordance with the wishes expressed by Mr A in the pro-forma worksheet.

## Medico-legal issues

On 15 July 2009, the Court made the declarations as sought by the hospital. In his judgment, Justice McDougall outlined the following principles which applied to ACDs:

- A person may make an "advance care directive": a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an ACD is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the ACD (though there may be a qualification if the treatment is necessary to save the life of a viable unborn child).
- There is a presumption that an adult is capable of deciding whether to consent to or to refuse medical treatment. However, the presumption is rebuttable. In considering the question of capacity, it is necessary to take into account both the importance of the decision and the ability of the individual to receive, retain and process information given to him or her that bears on that decision.
- If there is genuine and reasonable doubt as to the validity of an ACD, or as to whether it applies in the situation at hand, a hospital or medical practitioner should apply promptly to the Court for its aid. The hospital or medical practitioner is justified in acting in accordance with the Court's determination as to the validity and operation of the ACD.
- Where there is genuine and reasonable doubt as to the validity and operation of an ACD, and the hospital or medical practitioner applies promptly to the Court for relief, the hospital or practitioner is justified, by the "emergency principle",[2] in administering the treatment in question until the Court gives its decision.
- It is not necessary, for there to be a valid ACD, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment. Nor does it matter that the person's decision is based on religious, social or moral grounds than upon (for example) some balancing of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by any discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misinterpretation, by a capable adult.

**Dr Sara Bird**
**Manager, Medico-legal and Advisory Services**
**MDA National**

1 *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

2 The "emergency principle" means emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person's consent if the person's condition is such that it is not possible to obtain his or her consent, and it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment to be carried out.

# Remember Your Wellbeing **When Discussing Difficult News**

Communicating difficult news can be an emotionally charged experience. Providing care at a demanding time for patients is a privilege which, although rewarding, can be very stressful. While there is no "one way" of communicating difficult news, keep in mind some important principles which may reduce the emotional impact on you, as a doctor, during these challenging conversations.

"Difficult news" is any information that negatively affects someone's expectations for their present or future, or changes their impression of the past. It is anything thought to be hard to talk about or "process" by either the recipient or the messenger of the news.

**How difficult news is conveyed can have long lasting impacts**

Communication skills have consequences for both patients and doctors. In terms of medical practitioners, how well a doctor discusses difficult news affects:

- their level of personal and professional satisfaction
- ongoing information exchange with patients
- levels of stress and burnout
- time efficiency[1] – communicating difficult news poorly is likely to result in ongoing problems that continually need to be addressed.

### Ways to reduce personal challenges

- Take time to identify your own feelings about illness, death, and when you can no longer cure or substantially clinically help a person.
  - Explore how these feelings affect how you talk to patients about these topics. You will then be more genuine in your communication with patients.[2]
  - Studies "... have shown that reflecting on one's own feelings is an essential element in overcoming the tendency to react in non-adaptive ways to patients' strong emotional reactions in the face of bad news ... [making] physicians less likely to use such strategies as giving false hope, providing premature reassurance or offering ineffective therapies".[3]
- Acknowledge clinical limitations and remember there is no need for you to "know it all".[4]
- Take time to prepare yourself for each difficult news conversation.
  - Consider using Meitar et al's (2009) "preparatory SPIKES" framework.[4]
- Try to avoid having difficult conversations when you are tired.
- Have another health professional present (with the patient's consent)[5] – a colleague can provide support and assistance for both you and the patient.
- After a difficult news discussion, take time to work through your feelings and ensure you are calm before seeing the next patient.
  - Also use such time to reflect on the strengths and weaknesses of the conversation you just had to help you improve on the next occasion.
  - If possible, talk to other staff about the experience.[6]
- Ensure continuity of care amongst the team about the patient's emotional issues as well as the clinical ones.[7]
- Enhance communication skills through ongoing training and mentorship.
- Take good care of yourself – try to have an appropriate workload, pursue interests outside of work, take annual leave, take time for professional development and look after your health.
- Seek assistance if you feel the quality of your work is at risk from the demands of your role (see information on following page).

### Responding to a sense of failure or guilt

Separate the message from the messenger – remember that the health issue is to blame. Focus on being the best doctor you can be for that person rather than only on successfully treating the condition. If you see your role as purely medical, try to expand your purpose to providing both medical and psychosocial care.[8]

### Do not delay for fear of causing grief

It is important to have difficult conversations as soon as practicable. If you wait because of a fear of causing distress, you may lose the opportunity to find out useful information and to provide vital support before a situation worsens. So while doctors may avoid giving bad news to minimise distress, this can leave people "confused, depressed and sometimes angry".[6]

### Are you worried about being wrong?

Early conclusions can lead to inaccuracy, so it is prudent to avoid specific prognosis estimates. If you are confident in the patient's specific circumstance, use more general terms that are still accurate, e.g. "weeks rather than months" is less likely to cause a future problem than "two weeks".[9]

If you cannot provide an immediate answer to a patient's question, undertake to return to the issue when you next see the patient, or refer them to someone who can answer the question. Where necessary, acknowledge that not all questions can be answered, e.g. "The uncertainty must be hard for you, but I'm afraid we just don't know."[10]

If you find a patient's question difficult to answer, think about the reason behind the question – it may relate to an underlying issue, e.g. ask the patient "Why do you ask that now?"[10] Reflect on your feelings and expectations about your work, role and medical uncertainty.

### Communication skills and self-awareness benefit both you and your patients

Communicating difficult news is a demanding aspect of practising medicine, and you need to strengthen the aspects that you have control over. An important part of this is being aware of your own emotions and taking good care of yourself. This will improve the service you provide and enhance your own wellbeing.

### Sources of further assistance

- Doctors' Health Advisory Service:
  - ACT 0407 265 414
  - NT call the NSW DHAS hotline
  - NSW 02 9437 6552
  - QLD 07 3833 4352
  - SA 08 8366 0250
  - VIC 03 9495 6011
  - WA 08 9321 3098
- Australian Medical Association Peer Support Service: TAS and VIC call 1300 853 338
- Employee assistance programs (hospital based employees)
- MDA National Doctors for Doctors Program: 1800 011 255

**Nicole Harvey, MDA National Education Services**

Meitar D, Karnieli-Miller O, Eidelman S. The Impact of Senior Medical Students' Personal Difficulties on Their Communication Patterns in Breaking Bad News. *Acad Med* 2009;84(11):1582-94.

For a full list of references visit:
**defenceupdate.mdanational.com.au/discussing-difficult-news.**

# Duty to Offer Emergency Assistance

## Case history

A Radiologist, Dr D, was stopped at a road junction when she was involved in a "near miss" car accident in April 2002 at around 6.30pm.[1] Another vehicle travelling at an excessive speed had veered towards Dr D's stationary car. She took evasive action by driving onto an embankment on the other side of the road. The second vehicle passed just behind her car, mounted the embankment on the other side and rolled into a ditch abutting the road.

Dr D and her passenger heard the noise of the impact but could no longer see the other vehicle. Dr D reported that she was in a state of shock and terrified as she thought she had almost been killed. It was dark, with no street lighting. Dr D had no torch, no mobile phone, no first aid kit and no medical equipment. At her passenger's suggestion, she drove to the nearest police station and reported the incident.

## Medical Tribunal decision

The matter came to the attention of the (then) Medical Board of Western Australia that Dr D may have been guilty of "infamous or improper conduct in a professional respect" as a consequence of her failure to stop and render assistance after the "near miss". The Board submitted that Dr D's conduct was sufficiently linked with the profession of medicine because she was aware of the possibility that another person may be in need of urgent medical treatment and, in these circumstances, a practitioner would be reasonably expected to employ their medical skills by rendering assistance.

The complaint proceeded to a State Administrative Tribunal of WA hearing 11 ½ years after the incident. At the hearing, the Medical Board of Australia submitted that "the practitioner was under a professional duty, as a medical practitioner, to stop and attend in circumstances where an injury might have occurred following the incident and that there is no competing or countervailing duty or obligation which might excuse the practitioner from not having done so".

On 14 November 2013, the Tribunal handed down their decision and found Dr D guilty of improper conduct in a professional respect. In particular, the Tribunal found the following:

- "A medical practitioner's conduct may be 'in pursuit of the practitioner's profession' even where it does not occur in the carrying out of medical practice, provided that there is a sufficiently close link or nexus between the conduct and the profession of medicine."
- The fact that Dr D was "in a state of shock", "petrified" and "freaked out" after the incident did not excuse her professional duty as a doctor. Because she was a member of the medical profession and physically unharmed:

  *her professional duty required that she overcome or at least put aside the shock and provide assistance… Although the practitioner's shock may be relevant in relation to penalty, it does not have the consequence that her conduct would reasonably be regarded as anything other than improper (or, had she not immediately reported the matter to the police or other emergency services, disgraceful or dishonourable) by professional colleagues of good repute and competency.*

## Medico-legal issues associated with providing Good Samaritan assistance

### 1. What is the legal definition of a medical Good Samaritan?

A medical Good Samaritan is defined as a doctor who comes to the aid of an injured person, or person at risk of injury, with emergency medical assistance or advice, without expectation of payment or other reward, where a prior doctor-patient relationship does not exist.

### 2. Is a doctor obliged to offer assistance in an emergency situation?

Under common law, there is no legal duty on any individual, regardless of whether he or she is a doctor, to rescue where there is no prior relationship. However, there are some exceptions to the general presumption that there is no legal obligation to provide emergency aid as a Good Samaritan.

A doctor should take into account a range of issues, including their own safety, skills and the availability of other options when considering whether or not to offer emergency assistance.

In the Northern Territory, Section 155 of the *Criminal Code* states:

*Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously fails to do so is guilty of a crime and is liable to imprisonment for seven years.*

In Australia, the conduct of doctors is regulated by the *Health Practitioner Regulation National Law Act 2009* (the National Law). The definitions of "unprofessional conduct" and "professional misconduct" in the National Law do not include a specific reference to failure to render professional assistance to a person in need of urgent medical attention. However, the *Health Practitioner Regulation National Law (NSW)* defines "unsatisfactory professional conduct" for NSW medical practitioners as:

*Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a medical practitioner if the practitioner has reasonable cause to believe the person is in need of urgent attention by a medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another medical practitioner attends instead within a reasonable time.*

Professionally, the conduct of doctors practising in Australia is assessed in accordance with the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia.*[2] Section 2.5 of the Code states:

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

Therefore, as highlighted by this WA Medical Tribunal decision, doctors may be subject to disciplinary action for failing to offer emergency assistance.

## Conclusion

While this decision has caused considerable concern amongst the medical profession, it does not set a precedent that other courts must follow.

**Importantly, if a doctor has "reasonable cause" not to offer Good Samaritan emergency assistance, then failing to offer urgent attention does not constitute unsatisfactory professional conduct.**

As outlined in the Code of Conduct, a doctor should take into account a range of issues, including their own safety, skills and the availability of other options when considering whether or not to offer emergency assistance.

**Dr Sara Bird**
**Manager, Medico-legal and Advisory Services**
**MDA National**

1 *Medical Board of Australia and Dekker* [2013] WASAT 182.

2 Medical Board of Australia. *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

# Managing Urgent and Life Threatening Test Results

Two recent court cases highlighted the importance of having appropriate procedures in place to deal with urgent and life threatening test results which need to be communicated to a patient.

## Case 1

A patient's sexual partner was successful in his medical negligence claim against two GPs and a medical practice for failing to inform the patient in a timely manner that she had tested positive for HIV.[1]

One of the GPs had been phoned by the pathology laboratory and informed that the patient's HIV test was equivocal. The laboratory urgently faxed the results to the practice and recommended that the patient undergo retesting for HIV. The GP asked the practice's administrative staff to send a recall letter to the patient asking her to attend the practice as soon as possible.

Five weeks later, the staff informed the GP that there had been no response to the letter. The GP asked the staff to phone the patient and also send her another letter. The next day, the staff informed the GP that the telephone number listed in the patient's medical record was incorrect.

Two months after the initial phone call to the GP from the pathology provider, the patient attended the practice. The local sexual health clinic had made contact with the patient's father and asked him to tell his daughter to attend the practice. Retesting confirmed that the patient was HIV positive but, by this time, she had engaged in unprotected sexual intercourse with her partner, who subsequently also tested positive for HIV.

## Case 2

A recent Coronial Inquest into the death of Ms Lambert, a 69-year-old woman, reported the cause of death as a left pontine haemorrhage, in circumstances where there had been a delay in informing her of abnormal findings on a CT brain.[2]

Two weeks before Ms Lambert's death, she had complained of slurred speech to her GP. The GP ordered a CT brain and a follow-up appointment was made for the patient to see the GP two weeks later.

Nine days after the GP appointment, the patient underwent the CT brain which suggested the possibility of a bleed or hypercellular tumour. The patient had left the radiology clinic by the time the scans had been reported and so the radiologist phoned the patient's GP to inform him of the results.

The following day, the GP's receptionist tried to contact the patient by phone. Fourteen calls were made to her home phone that day, none of which were successful. Four days later, the patient did not attend her scheduled appointment with the GP, and a further call was made to her home. Two further calls were made the next day, none of which were successful. The patient was found dead at home by her daughter later that day.

At the Inquest, the Radiologist gave evidence that she had recommended to the GP that the patient be promptly referred to a Neurologist and the GP had agreed to contact the patient. The Coroner was critical of the GP for not doing more than he did. The GP gave evidence at the Inquest that the patient needed to be contacted within two to three days. The Coroner found that the GP "appreciated the urgency and did not take sufficient steps to ensure that Ms Lambert be contacted".

Failures in the follow up of urgent results have been the subject of criticism in Coronial Inquests where patients have suffered harm through a lack of robust systems for communicating urgent information.

## Recall and follow up of patients

The RACGP *Standards for General Practices* (the Standards) state that the following factors are important in determining if something is clinically significant and therefore requires follow up:

- the probability that the patient (or other person) will be harmed if adequate follow up does not occur
- the likely seriousness of the harm
- the burden of taking steps to avoid the risk of harm.[3]

## What if you cannot contact the patient directly to inform them of urgent and life threatening test results?

In some cases, it may be appropriate to do a home visit if the patient cannot be contacted by phone.

If the patient cannot be contacted directly in a timely manner, consider contacting the:

- patient's "in case of emergency" contact or family member
- police and/or ambulance service.

If you need to contact a family member or the police, there is no need to provide clinical details. Simply ask them to either provide you with the patient's contact details or to contact the patient on your behalf to ask them to contact you urgently.

## Follow up of urgent and life threatening results out of hours

The Standards state that practices need to have arrangements in place to allow seriously abnormal and life threatening results identified outside normal practice opening hours to be conveyed to a medical practitioner in a timely manner, so the medical practitioner can make an informed and appropriate medical decision that is acted on promptly.[3]

For example, if a general practice uses a deputising service, the practice should have a defined and reliable system for the deputising practitioner to access patient health information or to contact the general practice. Pathology and radiology providers need to ensure they have up to date contact details for their referring practitioners and patients, so that in circumstances where a result is urgent and life threatening, direct contact can be made with the referring practitioner or, in exceptional circumstances, the patient directly.

### Summary points

- Failures in the follow up of urgent results, e.g. raised troponin or grossly elevated INR, have been the subject of criticism in Coronial Inquests where patients have suffered harm through a lack of robust systems for communicating urgent information.
- Ensure you keep the patient's and referring doctor's (if applicable) contact details up to date.
- If a patient cannot be contacted to inform them of urgent and life threatening results, you should contact the patient's "in case of emergency" contact or family member, the police and/or ambulance service.
- Seek advice from our Medico-legal Advisory Service if uncertain about how to proceed in a particular case.

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**MDA National**

1 *CS v Anna Biedrzycka* [2011] NSWSC 1213. A detailed discussed of this case is provided in the article 'Why Accurate and Current Medical Records Matter' published in *Defence Update* Winter 2012. Available at: defenceupdate.mdanational.com.au/medical-records-matter/.

2 Inquest into the death of Judith Lambert, Coroner's Court of SA, 13 June 2013.

3 RACGP. Standards for General Practices, 4th ed. See Criterion 1.5.3 System for follow up of tests and results, pp 40-44, and Criterion 1.1.4 Care outside normal opening hours, pp 17-20.

# What's On?

MDA National continues to support and promote your professionalism and wellbeing in 2014 with numerous workshops and educational sessions.

We believe our education is unrivalled in Australian medical indemnity today, and all our educational events are:

- complimentary for our Members
- predominantly CPD accredited
- developed by our own in-house education team, medico-legal experts and practising doctors
- delivered to both small and large groups to fulfil different learning preferences
- designed to support you in providing safe health care.

A highlight this year is our **Challenging Emotions of Difficult News** series of education events aimed at helping doctors make a positive difference at a difficult time. Gain practical advice and exchange ideas with colleagues on how to communicate difficult news in ways that benefit patient outcomes as well as your own wellbeing.

## April 2014

| | |
|---|---|
| 8 | Keys to a Healthy Practice Workshop<br>**East Melbourne, VIC** |
| 29 | Keys to a Healthy Practice Workshop<br>**Perth, WA** |

## May 2014

| | |
|---|---|
| 3 | Practical Solutions to Patient Boundaries<br>**Brisbane, QLD** |
| 8 | Social Media and Medicine – Risks, Responsibilities and Rewards<br>**Canberra, ACT** |
| 10 | Albany Education Day<br>**Albany, WA** |
| 13 | The Challenging Emotions of Difficult News<br>**Brighton, VIC** |
| 14 | Enhancing Patient Understanding – Health Literacy and Communication<br>**Perth, WA** |
| 14 | The Challenging Emotions of Difficult News<br>**Adelaide, SA** |

## June 2014

| | |
|---|---|
| 3 | Enhancing Patient Understanding – Health Literacy and Communication<br>**Hobart, TAS** |
| 3 | The Challenging Emotions of Difficult News<br>**North Sydney, NSW** |
| 4 | The Challenging Emotions of Difficult News<br>**Brisbane, QLD** |
| 10 | The Challenging Emotions of Difficult News<br>**Crawley, WA** |
| 11 | The Challenging Emotions of Difficult News<br>**Crawley, WA** |
| 21 | Practical Solutions to Patient Boundaries<br>**West Perth, WA** |
| 24 | Enhancing Patient Understanding – Health Literacy and Communication<br>**Brisbane, QLD** |

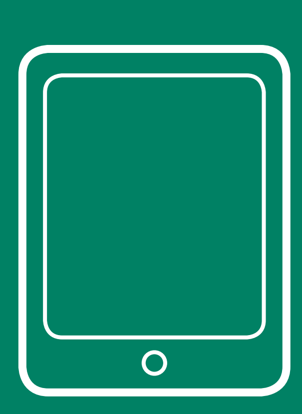
Keep an eye on our **What's On** page at **mdanational.com.au** for regular updates on state-based and national events.

# *Defence Update* Online

## Enhanced Interactivity and Practical Resources

***Defence Update* Online is designed for ease of use, with enhanced interactivity and greater environmental sustainability.**

Access a wealth of additional information such as extended versions of articles, reference material, and an archive of case studies and practical information. Respond to, or comment on, the latest news and articles on the go – from your laptop, tablet or handheld device.



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The case histories used have been prepared by the Claims and Advisory Services team. They are based on actual medical negligence claims or medico-legal referrals; however where necessary certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

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