defenceupdate

Publication for MDA National Members

Spring/Summer 2016

Mindfulness - No Longer Just a Buzzword

New Medical Board Guidelines for Cosmetic Procedures

My Health Record

The Essence of Family Medicine in Rural Practice

Medico-legal Feature: How Does My Doctor Rate?

MDA National CaseBook

Editor's Note

In August 2016, the Medical Board of Australia released an Interim Report[1] to guide discussion and debate on the introduction of revalidation. Feedback on the proposed revalidation approach is due by 30 November 2016. By mid-2017, a final recommendation will be made to the Board for a pilot phase or the full rollout of revalidation for Australian doctors. You are encouraged to provide your feedback on the revalidation proposals to the Medical Board and/or MDA National.

It is essential that any revalidation process is evaluated to ensure that underperforming doctors are appropriately identified, assessed and remediated, and that the process has no adverse impact on the vast majority of doctors who provide high-quality and safe patient care.

Revalidation is just one change on the horizon for the medical profession. In this edition, we discuss the new Medical Board guidelines for cosmetic medical and surgical procedures which came into effect on 1 October 2016 (pages 6-7), the My Health Record system (pages 8-9) and the vexed topic of online rating of doctors (pages 11-14). On a more reflective note, Dr Alexandra Smith writes about rural practice (page 10) and our Education Services team discusses the benefits of mindfulness (page 5).

This being the last edition of *Defence Update* for 2016, I would like to wish you and your families a safe and enjoyable festive season and new year. Thank you to our many Members, stakeholders and staff who have contributed and shared their experiences in our publications. I look forward to continuing the discussions in 2017.

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

1 Medical Board of Australia. Expert Advisory Group on Revalidation: Interim Report. August 2016. Available at: medicalboard.gov.au/News/Current-Consultations.aspx

Defence Update **Online**

Visit **defenceupdate.mdanational.com.au**.

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Doctors for Doctors

As doctors, we find it hard to be relegated to being part of the real world of medical care. But without a trusted GP and a regular medical practice, we run the risk of being medically abandoned in our time of need.

There have been many papers and talks about the inadequate and inappropriate health seeking practices of doctors working in first world countries. In Australia, less than 40% of doctors have an identifiable General Practitioner (GP). Barriers to finding a GP include issues of confidentiality, a culture of self-sufficiency and a perceived scarcity of time.[1-3]

In my experience, male doctors can be even more reticent than our female colleagues to seek primary health care for their own health, and specialists can prefer to self-refer to a relevant specialist.

As doctors, we are used to advising people about appropriate health care. So why then do many of us treat ourselves and our families when there are risks involved? Objectively, we know this is not the wisest option, but it is quick and convenient. Could it also be that we expect a lot more from our chosen GP than lay people do? And that finding a new GP feels difficult when we generally see ourselves as self-sufficient?

If GPs do have their own GP, it may be a colleague from their own practice. If they let their colleague treat them as a proper patient, this arrangement can work well. As long as that doctor's GP remains in practice, this arrangement can continue to work when the doctor retires – one major advantage being that the reception staff know them and will treat them with the efficiency and respect to which they are accustomed. However, it can be a problem if the retired doctor lives far from their former practice, or if that practice has changed hands.

If the reception staff are off-hand or inefficient; or the chosen GP is always booked out, rarely available, has overly long periods of waiting time, or fails to live up to the GP-patient's "high standards", the latter will rapidly become a lapsed patient.

As doctors, we find it hard to be relegated to being part of the real world of medical care. But without a trusted GP and a regular medical practice, any unwell or elderly patient – once a doctor or not – runs the risk of being medically abandoned in their time of need.

So my advice is to make time for your health and take time to look around. If you are really stuck, consult your Doctors' Health Advisory Service.[4]

Emeritus Prof Max Kamien
MDA National Member

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1 Davidson, SK, Schattner, PL. Doctors' Health-Seeking Behaviour: A Questionnaire Survey. *Med J Aust* 2003;179(6): 302-305.

2 Doctors' Health Advisory Service. Having Our Own GP. Available at: dhas.org.au/wellbeing/having-our-own-gp.html

3 Australian Medical Association. Healthy Doctors: Better Medicine – AMA President Dr Andrew Pesce, Speech to 6th National Doctors' Health Conference. Available at: ama.com.au/media/healthy-doctors-better-medicine-ama-president-dr-andrew-pesce-speech-6th-national-doctors

4 Doctors' Health Advisory Service. Available at: dhas.org.au

Notice Board

New Standards for Retroactive Cover

The Medical Board of Australia's revised standards for Professional Indemnity Insurance Arrangements state that medical practitioners with professional indemnity insurance must now have "appropriate retroactive cover for otherwise uncovered matters arising from prior practice undertaken in Australia."

What do you need to do?

1. Familiarise yourself with the registration standards on the Medical Board of Australia website at: **medicalboard.gov.au/Registration-Standards.aspx**.
2. If you haven't done so already, ensure you have appropriate indemnity cover for your current practice and any prior practice. Your Certificate of Currency includes your current retroactive cover and can be accessed on our Member Online Services at **mdanational.com.au**.
3. Contact our Member Services team with any questions on **peaceofmind@mdanational.com.au** or **1800 011 255**, Monday to Friday from 8.30am to 8.00pm (AEST).

Sponsorship of Dr YES

We are pleased to announce our recent sponsorship of Dr YES, an AMA (WA) Foundation program that supports adolescent youth through their interaction with medical students in WA. It is a school-based health initiative.

The Dr Yes program currently sends over 150 highly trained volunteer medical students into WA metropolitan and rural high schools to have frank, open discussions on topics concerning youth such as drugs and alcohol, sexual health and mental health.

This sponsorship is aligned with our corporate objectives of supporting doctors and promoting good medical practice, as well as our focus on doctors' wellbeing. It is another way in which MDA National supports the profession over and above medical indemnity.

Have Your Say on Revalidation

The Medical Board of Australia has released a discussion paper on the introduction of revalidation, available at: **medicalboard.gov.au/News/Current-Consultations.aspx.** Feedback on the proposed approach is due by **30 November 2016**. You can provide your views via written submission to the Board, contribute to the online discussion on the Board's website, or take a short survey. By mid-2017, a final recommendation will be made to the Board for a pilot phase or full rollout of revalidation for Australian doctors.

Revalidation is defined by the Medical Board of Australia as "a process that supports medical practitioners to maintain and enhance their professional skills and knowledge and to remain fit to practise medicine". The purpose of revalidation is to ensure public safety.

Reaching out to Papua New Guinea

MDA National's strategic alliance with the Australian Orthopaedic Association (AOA) has led to funding for Orthopaedic Outreach, the AOA's humanitarian arm. This has helped enable the first Orthopaedic Outreach visit to Lae in Papua New Guinea where the local hospital has no Orthopaedic Surgeons.

The objectives of this initial visit to Lae were fourfold:

- clinical – patient assessments and advice
- surgical – to undertake as many surgical procedures as possible
- teaching – particularly of registrars both in clinics and the operating theatre
- establishing directions for future visits.

A charitable donation, a component of the alliance, has provided much needed financial backing to enable AOA Surgeons to continue to work with their colleagues in remote communities, providing clinical guidance and surgical care. This is just one example of MDA National's support of our Members within the medical community.

AMA Queensland Dinner for the Profession

MDA National's strategic alliance with the Australian Medical Association of Queensland (AMAQ) benefits Members of both organisations. The AMAQ's Dinner for the Profession was an opportunity for MDA National to support the AMAQ and build relationships with stakeholders including the Hon Cameron Dick, Queensland Minister for Health.

Left to right: Sandra Reed, AMAQ CEO Jane Schmidt, AMAQ President Dr Chris Zappala, Dr Beres Wenck, Joanne Webb and Kylie Philippzig.

Mindfulness

No Longer Just a Buzz Word

"Healthy doctors, healthy patients". As the empirical support for the benefits of mindfulness continues to grow, MDA National encourages you to make up your own mind by trying strategies to improve your wellbeing.

Mindfulness is "...about paying attention with openness and curiosity to both internal experiences such as your thoughts, emotions and body sensations, and to external experiences going on around you, and accepting them in a non-judgemental way".[1]

Why should I try mindfulness?

The most recent *beyondblue* study of doctors' and medical students' mental health comprised 12,252 doctors and 1,811 medical students who reported higher rates of distress when compared to the Australian population.[2] Mindfulness promotes adaptive responses to stressful situations by increasing awareness of negative thoughts, emotions and physical sensations as they arise.[3]

This has been shown to:

- increase work engagement and resilience in high-stress work environments (such as the intensive care unit)[4]
- significantly decrease levels of depression and anxiety symptoms.[5]

You can also encourage your patients to experiment with mindfulness to reduce, for example:

- pain-related distress[6]
- hedonically-motivated eating[7]
- fear and anxiety of recurrence in cancer survivors.[8]

What exercises can I try?

1. **Be present during automatic everyday tasks**: For example, tooth brushing. Focus on the feel of the brush in your hand and on individual teeth, the taste of the toothpaste, and any sounds. Staying present during such a mundane task should provide limited opportunities for judgement.
2. **Breathe**: Pay attention to one part of the breath cycle, e.g. expansion of the abdomen. When thoughts arise, let them go and keep focusing on the breath.[1,9]
3. **Objectively observe strong emotions**: Stop what you are doing and focus on the present. Ask yourself, "What is going on with me at the moment?" Label emotions, e.g. "sad" or "angry" and let them float away without becoming caught up in them or the memories they may evoke. Redirect your attention to your breathing.[10]
4. **Scan your body**: Focus on one part of the body at a time, e.g. start at your toes and work up to your head. Then scan the major parts of the body, e.g. leg, arm, torso. The aim is to observe sensations present at the time of attention, such as temperature, touch of clothing or pulse. Consciously release any tensions experienced.[9]

How can I fit it into my already busy schedule?

You can practise mindfulness during everyday tasks. It can also be helpful to schedule a regular time to practise mindfulness such as before bed, after your morning shower or before dinner.[9]

It really does not take long to incorporate mindfulness into your daily routine to make a big difference to your patients' wellbeing as well as yours.

Where can I get more information?

- Download audio mindfulness exercises from Living Well: **livingwell.org.au/mindfulness-exercises-3/**
- Review techniques and a special note for General Practitioners from the Black Dog Institute: **blackdoginstitute.org.au/docs/10.MindfulnessinEverydayLife.pdf**
- Keep up to date with research, newsletters and courses at Monash University: **med.monash.edu.au/scs/psychiatry/southern-synergy/mindfulness/**

For detailed references visit **defenceupdate.mdanational.com.au/articles/mindfulness-not-just-a-buzzword**.

New Medical Board Guidelines for **Cosmetic Procedures**

New guidelines[1] released by the Medical Board apply to all medical practitioners who perform cosmetic procedures from 1 October 2016. The guidelines address issues relating to patient consent and management, as well as facilities and financial arrangements.

What procedures do the guidelines apply to?

Under the guidelines, cosmetic medical and surgical procedures are:

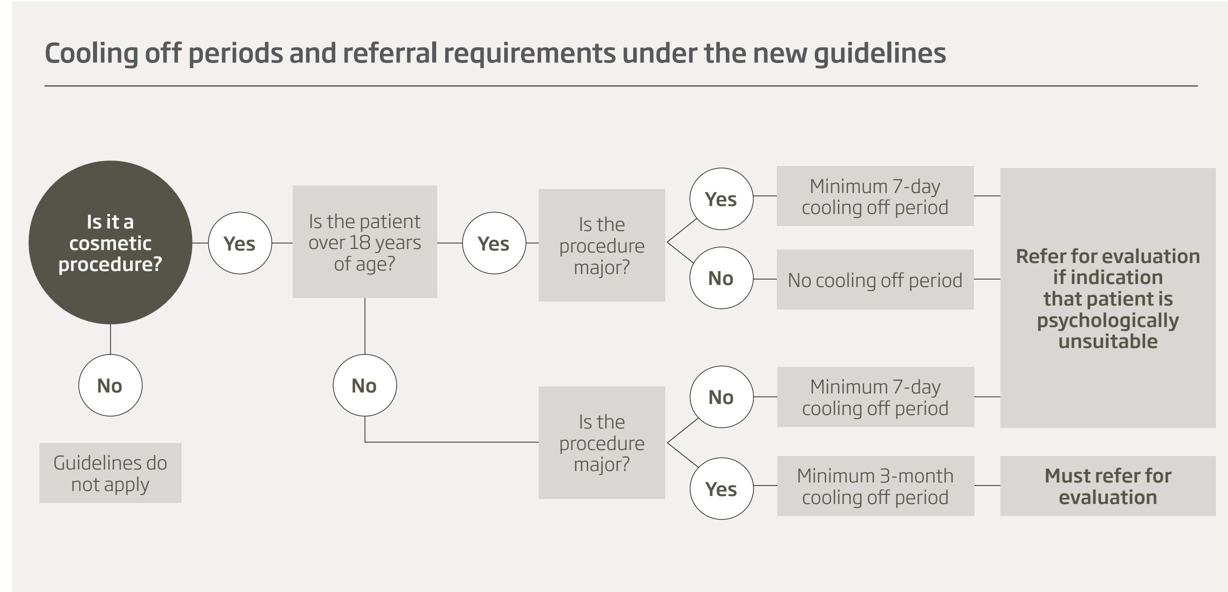
"operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient's self-esteem".

There are different requirements in the guidelines for major and minor procedures:

- Major procedures are defined as procedures which *"involve cutting beneath the skin"*. Examples include: breast augmentation, breast reduction, rhinoplasty, surgical face lifts and liposuction.
- Minor procedures do not involve *"cutting beneath the skin, but may involve piercing the skin"*. Examples include: non-surgical varicose vein treatment, laser skin treatments, use of CO_2 lasers to cut the skin, mole removal for the purposes of appearance, laser hair removal, dermabrasion, chemical peels, injections, microsclerotherapy and hair replacement therapy.

Requirements for patients under the age of 18

Medical practitioners must assess and be satisfied of the patient's capacity to consent and, to the extent that is practicable, have regard to the views of a parent and whether they support the procedure.



During the cooling off period, the patient should be encouraged to discuss their reasons for wanting the procedure with their General Practitioner.

The guidelines impose a mandatory cooling off period of at least:

- three months for major procedures
- seven days for minor procedures.

Further, before any major procedure, all patients must be referred for evaluation to a Psychologist, Psychiatrist or General Practitioner who works independently of the medical practitioner to evaluate any underlying psychological problems which may make them an unsuitable candidate for the procedure.

During the cooling off period, the patient should be encouraged to discuss their reasons for wanting the procedure with their General Practitioner.

Requirements for adult patients

Other than for minor procedures, there should be a cooling off period of at least seven days, the duration of which should take into consideration the nature of the procedure and the associated risks.

If there are indications that a patient has significant underlying psychological problems which may make them an unsuitable candidate for the procedure, they should be referred for evaluation to a Psychologist, Psychiatrist or General Practitioner who works independently of the medical practitioner.

Schedule 4 (prescription only) cosmetic injectables

Schedule 4 (prescription only) cosmetic injectables must not be prescribed by a medical practitioner unless they have consulted with the patient, either in person or by video. The prescribing practitioner must be contactable and able to respond if not administering the injection themselves.

Patient management and facilities

The guidelines make clear that the medical practitioner must ensure there are adequate staff, facilities and equipment, including for emergency care and treatment, during and after a procedure. Adequate written information must be given to patients on discharge, including the medical practitioner's contact details.

Financial arrangements

Written information should be provided to patients, including the total cost of the procedure as well as possible further costs for revision surgery. Patients should be advised that most cosmetic procedures are not covered by Medicare. No deposit should be payable until after the cooling off period and the medical practitioner should not offer financing schemes.

Conclusion

The guidelines impose significant new obligations, particularly in relation to cooling off periods and for patients under the age of 18. Medical practitioners who perform cosmetic procedures are advised to review and be aware of their obligations under the guidelines.

Karen McMahon
Medico-legal Adviser (Solicitor)
MDA National

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1 Medical Board of Australia. Available at: medicalboard.gov.au/News/2016-05-09-media-statement.aspx

My Health Record

Recent changes are forcing patients and doctors to pay more attention to My Health Records.

What is My Health Record?

My Health Record:

- is a national digital health record system
- was previously known as Personally Controlled Electronic Health Records (PCEHR) or eHealth records
- is a summary of an individual's key health information that can be shared securely online between the individual and their healthcare providers
- does not replace a doctor's own records.

The opt-out trial

Originally, My Health Record was an opt-in system and patients had to actively register. Now, an opt-out model has been trialled in Northern Queensland and the Nepean Blue Mountains area. People with a registered Medicare address in these areas had until 27 May 2016 to opt out of having a My Health Record automatically created for them. The opt-out rate was 1.9%, meaning that almost one million extra records have been added. This brings the total number of registrants to over 3.8 million at 30 June 2016.

Practice participation

For practices, participation in the My Health Record system requires a number of initial steps, and ongoing compliance with legislative requirements.[1]

Issues to be addressed include:

- computer security
- software functionality and secure messaging capability
- data quality in the medical records[2]
- training staff and appointing specific responsible staff[3]
- written policies and procedures.

Training

- Online training is available, including specific modules for general practice and specialist practice at the My Health Record website.[4]
- Software training and downloadable guides are also available from the Australian Digital Health Agency (ADHA).[5]
- Face-to-face training can be organised through local Primary Health Networks.

Incentive payments for general practices

General practices can claim an incentive payment for participating in My Health Record. There are a number of criteria they must comply with to receive the full benefit, including uploading a minimum number of Shared Health Summaries.[6] The RACGP also has some useful resources.[7]

Medico-legal issues

Consent

- When registering for My Health Record, patients are required to give a "standing consent" for the upload of documents. The patient must be adequately informed before giving consent. There is no requirement for a provider to obtain consent on each occasion prior to uploading clinical information, except that specific consent is required to upload sensitive information such as HIV status.
- Written consent is recommended from the patient when they register at a practice – that they understand what will be in the record and who can access it. Verbal consent can be obtained prior to uploading any information to the record.
- Patients can control which healthcare providers have access to their My Health Record and they can remove documents themselves. They cannot edit a document that a doctor has uploaded.
- In an emergency, a provider can assert emergency access functionality which will override the existing access controls for a specified period.

Main information sources for My Health Record

Patient	Health professional	Medicare
• Medications and allergies • Personal health notes (cannot be viewed by providers) • Child development • Advance care directives • Emergency contacts	• Shared health summary* • Event summary^ • Discharge summary • Referrals and specialist letters • Prescriptions and dispensing • Diagnostic imaging	• Medicare claims • Pharmaceutical Benefits Scheme • Australian Childhood Immunisation Register • Australian Organ Donor Register • DVA claims

* Shared health summary: details allergies, medications, immunisations and significant medical conditions. Uploaded by the patient's regular provider, most commonly a GP. Patient must approve the content.

^ Event summary: details a significant healthcare event by a provider who is not the patient's regular provider, e.g. an after-hours medical service.

Table courtesy of Katrina Otto, TrainIT Medical, Consultant to Australian Digital Health Agency.

Privacy

System security includes strong encryption, firewalls, secure login/authentication and audit logging ("bank-strength" security). Access to My Health Record is limited by law to specific situations, e.g. registered healthcare providers delivering health care. Practices must meet specific privacy and security requirements, including having a policy setting out access and security procedures. Worksheets and templates to help practices are available.[8]

The Office of the Australian Information Commissioner (OAIC) assessed seven GP practices in Victoria and NSW as being at medium to high risk of breaching privacy laws when using the My Health Record.[9] Passwords were too weak or not changed often enough, a record of the master copy was kept at the clinic, and computers did not have self-locking screen savers turned on.

Legislation requires mandatory notification to the OAIC if a breach of privacy occurs, and the OAIC has a guide to mandatory notifications.[10] There are significant sanctions for misuse of the information, but not where a mistake is made.

Useful websites

- My Health Record: **myhealthrecord.gov.au**
- Australian Digital Health Agency (formerly NEHTA): **digitalhealth.gov.au/**

Helpline

- Help centre: phone **1300 901 001**
  Email: **help@digitalhealth.gov.au**

Karen Stephens
Risk Adviser, MDA National

For a full list of references visit **defenceupdate.mdanational.com.au/articles/my-health-record**.

The Essence of Family Medicine in **Rural Practice**

I was stuck behind a tractor on my way home today, in one of those quintessentially "country" moments, driving along at 30km per hour past paddocks of sheep and cows. I didn't mind as I wasn't in a rush, and I found myself thinking that I actually know a lot more about the fellow driving the tractor than he realises.

Dr Alexandra Smith

It's one of the pleasures of general practice, and rural practice in particular, that we are allowed to get to know whole families and their stories. I knew this particular young man had bought the tractor he was driving with his own hard-earned cash as it had an air-conditioned cabin for comfort in summer – good for sun protection (he has a strong family history of skin cancer). But he is teased mercilessly about this by his grandfather who is also my patient and the source of this country gossip.

Rural general practice in particular allows us to form relationships with our patients that I feel our urban colleagues at times miss out on, particularly in tomato season when our staff room starts to smell like a passata-making party!

Providing a "medical home"

I practice in the Huon Valley, Tasmania, a picturesque region 40 minutes south of Hobart, quickly becoming renowned for cider and as a foodie destination. Like much of Tasmania, the demographic is varied but does include an ageing population as well as a cohort of people at the lower end of the socio-economic spectrum. This means a lot of our patients have a chronic disease burden contributed to by their poor social determinants of health. Despite the "foodie" reputation of our area, fruit and vegetables are relatively expensive, and there is a constant flow of people in and out of the local fried food shop.

I believe that our role in general practice, by establishing and nurturing the therapeutic relationships we have with our patients, allows us to effect change in the community at a grassroots and individual level, or even at a family level. This may be part of what is often referred to as the "medical home", the concept of having a person or place to continually come to – who knows you and your medical history, and is able to coordinate your care and put this into the context of your social situation as well as your frame of mind.

There is a limit, of course, to how much of an effect we can have at a grassroots level – and the gap is filled by public health and workforce measures, which are important to reduce the discrepancy between health outcomes in the city and the country. I am involved in advocacy not only for my colleagues, but also for my patients. I can't force shops to sell fruit and vegetables more cheaply, but if people who can't afford it have to pay more to see the doctor, it's less money they have for fresh and healthy food, a gym membership, or access to the local pool.

Maintaining the essence of family medicine

At our practice, despite the rural location, we are always looking for new and innovative ways of treating our patients, increasing engagement with them, and offering services to benefit the community. We have a dietician, exercise physiologist and psychologist on site, and recently employed a full-time clinical pharmacist, the first in Tasmania to work in general practice. We are very proud of the quality of care this enables us to offer.

It was never our intention to become a "superclinic", but to increase access to services for our patients who would otherwise have to travel. It is a fine line, and we try very hard to make sure that we continue to maintain the family practice feel. If we lose that, we lose the essence of family medicine – the cradle to grave therapeutic relationship.

Dr Alexandra Smith
FRACGP (MDA National Member)
President, Rural Doctors Association of Tasmania
Managing Director, Huon Valley Health Centre

Photo courtesy of The Royal Australian College of General Practitioners.

How Does My Doctor Rate?

Patients are increasingly posting online reviews about their medical care, including rating their doctors. In 2011, the UK Health Minister said: *"I wouldn't think of going on holiday without cross referencing two guide books and using TripAdvisor. We need to do something similar for the modern generation of health care."*

Do we? This article discusses the nature and use of these doctor rating websites, and provides some strategies on what to do if you are the subject of an adverse rating.

How Does My Doctor Rate?

There are a number of websites that allow users to anonymously post ratings and commentary about doctors. These rating websites have been described as "the 21st century's answer to word of mouth or over-the-garden-fence chit chat"[1] and "chaotic and unregulated activity which brings to mind the notorious witch trials of Salem".[2]

The most common website that our Members seek advice on is RateMDs which is hosted overseas. Recently there has been some discussion about Whitecoat, an Australian website that has been dubbed the "TripAdvisor for Australian health care".[3] The site provides an online healthcare provider directory and over 250,000 "customer" reviews of Australian healthcare practitioners.

What are patients saying?

The vast majority of online reviews about doctors are positive. A review of 33 doctor rating websites found 88% of comments were positive, 6% were negative and another 6% neutral.[4] However, the small proportion of negative online reviews can be a source of great distress to the doctors who are the subject of these reviews.

Most medical practitioners find doctor rating websites fundamentally flawed

- How can a handful of ratings properly represent an appropriate assessment of a doctor who may see several hundred patients each month, and many thousands over a career?
- The anonymity means there is generally no ability to identify the person who has posted the rating. Is it a patient, a person with a grudge, or even a colleague in "competition" with them?
- Is this an appropriate method of assessing a practitioner's skills as a doctor? There is very little evidence about the association between quality of medical care and online ratings. At best, there may be an association with other measures of patient experience and a weak association with clinical quality.[5] However, a study published in the *Journal of the American Medical Association* (JAMA) in 2015 found no evidence that doctor rating websites were associated with clinical quality measures.[6]

Who is using doctor rating websites?

- A 2012 survey conducted in the US found that 42% of respondents had used social media to access health-related consumer reviews, including 11% who reviewed doctor rating sites.[7]
- A 2015 survey of patients at the Mayo Clinic revealed that 16% had visited a doctor rating website.[8]
- It appears these sites are used less frequently in the UK where only 14.5% of respondents surveyed in 2012 were aware of the sites, and only 3% had actually used them.[9]
- The proportion of Australian patients accessing doctor rating websites is not known.
- It has been suggested that people who use doctor rating websites may be more extreme (positive or negative) in their views, be younger than the general population, and may vary in their health status.
- More importantly, "gaming" may occur – competitors may post adverse comments and practitioners (or their representatives) may provide favourable ratings.[10]

Case study

The doctor was "Googling" his name when he came across the following review:

The worst doctor I have ever seen. I took my daughter to see him when she was very sick. He missed the diagnosis and was deliberately rough with her because he was hassled. It was like we were imposing on his time. I'd ask a taxi driver for medical advice before seeing this animal of a doctor. Never see him if you are ill – or well.

The doctor was very distressed. He did not know who had made this comment about him. He wanted to know what he could do to have the online comment deleted.

What are your potential options if you are the subject of an adverse website rating?

- Do nothing.
- If you can identify the patient, consider contacting the patient directly to discuss their concerns and see if they will remove the post.
- Respond online (see below).
- Utilise the website policy for removal of posts.
- Send a letter to the patient and/or website proprietor seeking removal of the post.
- Threaten or commence defamation proceedings.

In order to seek a legal remedy against the person who posted the comment, the poster must be able to be identified. If their identity cannot be adequately proven, there is likely very little a medical practitioner can do.

A letter sent to the website proprietor requesting removal of the post may result in its removal. However, on occasion, this step may result in more attention being drawn to the existing adverse rating, and that letter may be then included on that website and others. There are specific websites that post these types of letters to try to embarrass and further criticise medical practitioners.

Can and should you respond online to a patient review?

Most negative comments are not worth responding to online. If you feel you must provide an online response:

- be very careful not to breach patient confidentiality and privacy
- make sure you do not respond when angry
- ensure your reply is caring and demonstrates a willingness to take on feedback and continually improve
- seek advice from a colleague and/or MDA National about your proposed response
- keep any response simple, for example: *Thank you for your feedback. I am committed to improving my practice and have taken your comments into consideration*.

It is worth identifying if there is any constructive criticism in the negative rating:

- Is there anything you could do differently to improve your practice?
- Should the concerns raised in the review be considered at a practice meeting? A number of complaints on these sites are about waiting times, parking and other practice management matters.[11]

If you can identify the patient who has posted the comment, consider whether it is appropriate to contact the patient to discuss and address their concerns. Again, it is worth discussing the comments and circumstances with a colleague and/or MDA National.

Doctor rating websites appear to have less impact on patient choices than other factors. A 2014 US survey found that 59% of respondents reported doctor rating sites were "somewhat important" or "very important" when choosing a doctor, although the sites were endorsed less frequently than other factors, such as word of mouth from family and friends.[12]

Beware advertising testimonials

Consumer and patient information sharing websites that invite public feedback/reviews about their experience of a health practitioner are not considered "advertising of a regulated health service" under the Medical Board of Australia guidelines.[13]

However, it is important to be aware that it is not acceptable to use testimonials in your own advertising, such as on your website or Facebook site. This means you cannot use or quote testimonials on a site or in social media that is advertising a regulated health service, including patients posting comments about a practitioner on the practitioner's business website.

Doctors should therefore not encourage patients to leave testimonials on websites they control, and should remove any testimonials or positive reviews that are posted there.

Conclusion

Whether or not there is any association between online ratings and the quality of care provided by doctors is not known. Some commentators recommend that there is value in monitoring your online presence and reading patient stories, suggesting these stories are "nuggets of qualitative data on patients' attitudes regarding the quality of care and their needs and preferences in their relationships with their doctors".[14]

However, most doctors find adverse postings on these websites immensely distressing, upsetting and anxiety provoking, especially since there is little that can be done to remove, or even respond to, these negative posts.

As another commentator has concluded:

The hard truth is that there probably isn't a lot doctors can do to protect themselves from this kind of cyber attack, apart from doing their best to ensure any criticism is undeserved.[15]

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

Summary points

- Online doctor rating websites are becoming increasingly popular.
- The vast majority of online reviews about doctors are positive.
- Seek advice before you respond to a negative online rating.

For a full list of references visit **defenceupdate.mdanational.com.au/articles/rate-my-doctor**.

Missed Test Results in Hospitalised Patients

A recent coronial inquest highlighted the tragic outcome of failure to follow-up test results for hospital patients.[1]

Case history

Thursday, 27 December 2012

Dr Peter Domachuk, 33 years of age, presented to the Emergency Department (ED) in the evening complaining of left knee and ankle pain, abdominal pain, nausea and vomiting. He had been taking NSAIDs for the joint pain. His past history included type II diabetes for which he was taking metformin. On examination, his pulse was 116/min and BP 97/61. There was a left knee effusion. Blood tests revealed Hb 185, WCC 13.9, Na 129, K+ 4.8, lactate 4.01, urea 20.3 and creatinine 194. An ultrasound of the kidneys and renal tract revealed no abnormality. A provisional diagnosis of gastritis was made secondary to NSAIDs. The possibility of gout or rheumatoid arthritis was also considered. The patient was admitted to the ward with a management plan of IV fluids, a protein pump inhibitor and cessation of NSAIDs.

Friday, 28 December 2012

The patient was seen by the physician, medical registrar and RMO on their ward round at about 2.30pm. At this time, the registrar considered the possibility of Addison's disease and instructed the RMO to order an early morning cortisol test. No notation was made in the medical records that the test had been ordered. In the registrar's handover notes to the weekend registrar, no mention was made of Addison's disease as a differential diagnosis; however a note was made that if the joint pain persisted and there was decreased mobility the following day, prednisone 50 mg for three days should be prescribed.

Saturday, 29 December 2012

The cortisol test was performed. At noon, Dr Domachuk was seen by the weekend registrar. Repeat blood tests had revealed an improvement in his renal function, consistent with improving hydration. His pain was decreasing. Although the registrar was aware of the plan to prescribe prednisone 50 mg, she considered this too high a dose in a person with diabetes and reduced the dose to 5 mg daily. He was discharged home that afternoon.

Sometime the next evening or following day, Dr Domachuk died at home. The death was reported to the coroner.

Medico-legal issues

An autopsy was performed on 5 January 2013 which revealed coronary artery disease. At this time, the forensic pathologist was not aware of the low serum cortisol result. A cardiology expert reviewed the post-mortem report and opined that the acute cause of death was most likely due to cardiac arrhythmia secondary to coronary artery disease.

Subsequently, the patient's family became aware of the results of the cortisol test and these results were forwarded to the forensic pathologist. With this information and the histological changes observed in the adrenal glands at autopsy, the pathologist concluded that the patient had Addison's disease. She could not determine whether the Addison's disease or coronary artery disease was the primary cause of death, but she was of the opinion that both conditions had played a part.

The coroner was critical that there was no documentation about adrenal insufficiency being considered as a possible differential diagnosis. She noted this was not documented in the progress notes or the registrar handover documents. Nor was the fact that the cortisol test had been ordered or performed recorded in the notes.

The coroner also found it was unlikely that the patient was informed that a blood test had been performed to investigate the possibility of adrenal insufficiency. It was also noted that low cortisol results were not included in the critical result notification list for the pathology laboratory, where the requesting clinician is contacted by the laboratory with the results.

The coroner's recommendations included that:

- *the Ministry of Health consider publishing a Patient Safety Watch to Local Health Districts with the aim of increasing awareness of the potentially catastrophic outcome of undiagnosed adrenal insufficiency/ Addison's disease*
- *the Ministry of Health Chemical Pathology, Chemical Stream, continue with the proposed implementation of a state-wide critical result notification policy and the development of a state-wide guideline for notifiable thresholds for all critical results, including cortisol.*

Risk management strategies

In this case, there were a number of opportunities where the outcome could have been averted:

- recording differential diagnoses and investigations ordered in the medical records
- handover between team members
- informing the patient of differential diagnoses
- follow-up of outstanding test results
- notification of critical results by the laboratory.

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

1 Coroners Court of New South Wales. Inquest into the Death of Dr Peter Domachuk, Coroner's Court, Glebe, 2 December 2015.

CaseBook

Access to **Deceased Patients' Records**

The professional and legal duty of confidentiality owed by a doctor to their patient continues after they have died. As the following case demonstrates, requests for copies of a deceased patient's records may involve the consideration of complex and competing issues, particularly the question of "who stands in the shoes" of the deceased patient?

Case history

As Olive's GP, you were aware she favoured her oldest nephew, Primo. You had even documented that she left her house to him in her will. Olive had never married, so Primo brought Olive to her appointments and attended the consultations. Olive confided to you that she only trusted Primo to know about her health.

After Olive's death, the relatives disputed the will. Primo's brother Ultimo has written to the practice requesting a copy of the records, wanting to dispute the distribution under the will and Olive's capacity to write it.

Medico-legal issues

ACT and Victoria – absent dispute over the will or right of access

In the ACT[1] and Victoria[2] there is specific legislation to deal with access to the medical records of a deceased patient (the Victorian Act excludes those dead for more than 30 years).

Both ACT and Victorian legislation (possibly also in NSW[3] as an "authorised representative") provides that the legal representative of the deceased patient can exercise the powers formerly conferred on the patient. A legal representative is defined in both Acts as the executor of the will where probate has been granted, or the administrator of the estate of the deceased.

A recent (part heard) Victorian Civil and Administrative Tribunal case[4] found that as the legal representative "stands in the shoes" of the deceased, the prior wishes of the patient cannot stop the legal representative from obtaining access to the records. The deceased's wishes in relation to disclosure to other third parties should still prevail.

Where there is no legal representative (or if there is one, with the legal representative's consent), you may provide a limited disclosure of information to an immediate family member of the deceased for compassionate reasons (there is some recognition of close friends or nominated receivers of health information), where the disclosure is not contrary to any prior wish of the deceased.

In both Acts the right of a legal representative is exercisable as far as "circumstances reasonably permit", recognising that the law may not provide a solution in all circumstances.

Outside of the ACT or Victoria – absent dispute over the will or right of access

In all other states and territories there is no specific applicable legislation.[5] In the absence of a dispute over who is the legal representative (e.g. over the will) or clear inconsistency with the deceased's wishes, it is reasonable to give access to the medical records of a deceased patient to the legal representative. Where there is no legal representative, you can consider disclosure limited to the purpose of the request on compassionate grounds to an immediate family member, as per the ACT and Victoria.

When records are requested or provided

A request for a copy of the records of a deceased patient should be in writing and include the relevant documentation, such as a certified copy of the will proving the legal representative's position, or proof of identity for an immediate family member. You should make a brief note that the records have been provided, to whom, and on what basis they were provided.

The prior wishes of your patient are paramount when considering release of their medical records to other parties.

Limited disclosure for compassionate reasons

The Medical Board Code of Conduct[6] envisages that limited disclosure of the patient's health information, in the absence of their prior objection, can be made to explain the death to family and carers. This would not typically extend to the release of the entire records. Where there is a legal representative, they should first be consulted in the ACT, Victoria and NSW. This is good practice elsewhere in Australia.

Disputes over the will or right of access

Where you are clearly aware of a dispute about the will, legal representative, right of access, or access being counter to the deceased's wishes, you should seek advice from MDA National. We are aware of complaints and legal cases arising out of such matters, so obtaining advice is important.

Outcome

In Olive's case above, the doctor sought advice from MDA National. As there was another earlier will, the dispute over the will meant that it was not possible to identify the legal representative. There were two possible alternative executors, depending on which will was valid, and neither had obtained grant of probate. MDA National obtained agreement between all the parties (potential executors) for consent to release. The matter was also discussed with Primo, as a suitable immediate family member. The doctor could have insisted on a court order being issued by the parties. However, the above solution was timelier and avoided additional costs for the parties.

Dr Julian Walter
Medico-legal Adviser
MDA National

Summary points

- You have an ongoing legal duty of confidentiality to your deceased patient.
- Access to the medical records of a deceased patient can generally be provided to the legal representative of the patient (typically the executor of the will or administrator of the estate).
- The prior wishes of the patient are paramount when considering release to other parties.
- In the absence of a dispute over the will and no legal representative, limited release of records may be appropriate, if requested by an immediate family member on compassionate grounds. There is some leeway in the definition of immediate family members, so requesting parties, e.g. previously appointed guardians, close relatives or friends, or previously nominated health information receivers, might need to be considered.
- Limited disclosure in a bereavement situation, or for the purpose of the provision of health care to relatives of the deceased patient, may be appropriate under similar principles, presuming this is not contrary to the prior wishes of the deceased or the legal representative.
- Seek advice where there is a dispute over the will – no legal representative, disagreement about who should have access to the records, or a request contrary to prior patient wishes.

1 *Health Records (Privacy and Access) Act 1997* (ACT) s12; s13B; s27; Dictionary. Available at: austlii.edu.au/au/legis/act/consol_act/hraaa1997291/

2 *Health Records Act 2001* (Vic) s3; s95; s31; HPP2.4. Available at: austlii.edu.au/au/legis/vic/consol_act/hra2001144/

3 *Health Records and Information Privacy Act 2002* (NSW). Available at: austlii.edu.au/au/legis/nsw/consol_act/hraipa2002370/ It is not clear from s8(1)(d) whether an executor/administrator of an estate would meet the definition, as they do not act for an "individual".

4 *Wolstencroft v Zola (Human Rights)* [2015] VCAT 1790 (12 November 2015) at [46]–[48]. Available at: austlii.edu.au/cgi-bin/sinodisp/au/cases/vic/VCAT/2015/1790.html?stem=0&synonyms=0&query=zola

5 The *Commonwealth Privacy Act 1988* does not apply to deceased records.

6 Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. 2014. 3.12.11. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

Patient or Consumer?

Case history

A UK journalist lamented about a recent visit to her GP where she was "told aged 35 that they'd no longer prescribe the contraceptive pill because I smoked and thus sat badly on the contraindications graph for heart attacks. I pleaded that, as an ageing gambler with a professional understanding of mathematical risk, I should be allowed to make that decision for myself – but no dice. So I gave up and got prescriptions privately at enormous expense".[1]

Discussion

Paternalism in medicine is dead. In its place, patients, often (well) informed by Dr Google, expect to be in control of their own health care. Patient autonomy and the "customer knows best" have replaced the "doctor knows best". In part, this change has been driven by the law, with the principle of autonomy being one of the central values of our legal system.

And yet, at times, there is a tension between patient autonomy and the responsibility of doctors to make sound clinical decisions and provide good medical care. When patients see themselves as consumers of health care, and doctors acquiesce to this model, problems can arise, including risks to patients' health and medico-legal risks for doctors.

A common theme in serious disciplinary cases against doctors is inappropriate prescribing.[2] These cases often involve doctors who have prescribed drugs of dependence in response to the direct requests of their patients, where peer opinion does not support the use of these medications. Indeed, the medico-legal landscape is littered with doctors who have allowed the pendulum to swing too far towards patient autonomy and lost focus on their professional responsibilities as a medical practitioner.

Code of conduct

Doctors have a professional obligation to make the care of patients their first concern, and to practise medicine safely and effectively. The Code also tells us that providing good patient care includes recognising and respecting patients' rights to make their own decisions. We are also told that making decisions about health care is the shared responsibility of the doctor and the patient.[3]

But what does this actually mean in practice? What if a patient's view of what is in their best interests does not align with yours? In shared decision-making, the intention is that patients and their doctors share both the process of decision-making and the ownership of the decisions made. Ultimately this may involve the doctor offering a range of options, including no intervention, and the patient making a choice based on their values and beliefs. In most cases a mutually acceptable outcome can be negotiated, but sometimes this won't be possible. Patient dissatisfaction in this situation is not necessarily a sign of bad medical practice, or bad doctors.[4]

"Saying no", nicely

Mastering the art of "saying no" is one of the most important strategies to reduce medico-legal risk. Every doctor will develop their own strategies, which will vary depending on the individual patient and the particular situation. Some suggested strategies include the following:

- Start a discussion, rather than just "saying no" – there may be value in exploring why the patient wants a particular investigation, treatment or medication.
- Be willing to negotiate – explain the reasons why a patient's request is not in their best interests or the best option for their management, and offer other options.
- Show empathy – try to understand and acknowledge the patient's perspective.[5]
- Deflect the blame – it may be appropriate to rely on "the system", e.g. legislation, or saying, "doctors' professional guidelines prohibit me from prescribing that medication".
- When necessary, be firm in "saying no" in simple and respectful terms, e.g. I don't prescribe oxycodone.[6]

Patient autonomy does not mean you have to comply with a patient's request. Indeed, there are risks for your patients, and to you, if you do so.

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

This article originally appeared in Good Practice July 2016.

For a full list of references visit **defenceupdate.mdanational.com.au/articles/patient-or-consumer**.

Education Activity
Spring/Summer 2016

You can receive professional development (PD) recognition for this *Defence Update* issue by completing the questionnaire below. See page 22 for more information.

Activity learning outcomes

By the end of this activity participants should be able to:

- describe considerations for doctors thinking of responding to a critical online review by a patient
- identify workplace systems that safeguard patient privacy when using the My Health Record system
- summarise requirements for releasing copies of a deceased person's medical records.

Questionnaire

1 **Rate the extent to which you agree with the following statements (this is a personal reflection exercise).**

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
It is important that the medical profession contributes to providing resources that help people choose healthcare services that align with their needs (in a similar way that guide books and recommendation websites help people choose other services and experiences).	☐	☐	☐	☐	☐
I find doctor rating websites fundamentally flawed.	☐	☐	☐	☐	☐
Mindfulness exercises can increase work engagement and resilience in high stress work environments.	☐	☐	☐	☐	☐
Mindfulness exercises can reduce anxiety.	☐	☐	☐	☐	☐

2 **Respond true or false to the following statements**.

Statement	True	False
Doctors should not encourage patients to post favourable online reviews about the medical care they provide.	☐	☐
Patients give a "standing consent" for the upload of documents to their My Health Record when they register for the system, i.e. doctors do not need to obtain consent each time they upload standard clinical information to My Health Record.	☐	☐
Patients cannot edit a document that a doctor has uploaded to their My Health Record.	☐	☐
Patients can control which healthcare providers have access to their My Health Record.	☐	☐
Under the new Medical Board of Australia guidelines for cosmetic procedures, the required cooling-off period is at least seven days for a person:		
• 16 years of age who was having a mole removed because of how it looks to others	☐	☐
• 17 years of age having liposuction	☐	☐
• 25 years of age having breast reduction.	☐	☐
Information given to people considering cosmetic procedures does not need to include detail about possible further costs for revision surgery.	☐	☐
A deceased patient's next of kin can be provided with a copy of the deceased's medical records.	☐	☐
As long as the patient is aware of the risks involved, I can provide them with the treatment they request.	☐	☐
The *beyondblue* study of medical practitioners' mental health found (2013) that Australian doctors reported higher rates of distress compared to the general population.	☐	☐

3 **Write short notes to answer the following questions.**

Recall a time you experienced tension between patient autonomy and your professional responsibility to make sound clinical decisions and provide good medical care. In hindsight and after reading the strategies listed on page 18, do you think you may try a different and potentially more constructive path to resolution of a similar issue in future? If so, make brief notes about what you may do differently next time.

You discover a review about yourself on a doctor rating website. It is not favourable, e.g. "This doctor jumped to conclusions about what was going on and refused to listen to me describe my symptoms properly. I felt frustrated and scared. I now have to pay to go and have the same, though hopefully better, consultation with another doctor. If you want slap dash treatment, go here."

Make notes below on what you would do if you could not identify the person who posted the review.

If you could identify the patient, what might you do differently?

What is the main patient safety and risk management strategy message that you "take away" from the coronial inquest into the death of Dr Peter Domachuk (page 15) relating to the follow-up of test results?

If your workplace was/is newly participating in the My Health Record system, what processes and steps would you recommend implementing to support patient safety and privacy?

What were the important examples of problems The Office of the Australian Information Commissioner found at the seven general practices in NSW and Victoria that were at medium to high risk of breaching privacy laws when using the My Health Record?

What do you need to receive before releasing medical records of a deceased patient to their legal representative?

Will you resolve to try a mindfulness exercise you don't currently regularly use?

Which mindfulness technique will you try to do more?	*When will you try to use this technique?*
☐ Being present during a mundane task	
☐ Paying attention to one aspect of breathing	
☐ Objectively observing strong emotions	
☐ Body scanning	
☐ Other (insert detail):	

Activity evaluation

1 **Please rate to what degree the activity learning outcomes were met.**

	Not met	Partially met	Entirely met
Describe considerations for doctors thinking of responding to a critical online review by a patient.	☐	☐	☐
Identify workplace systems that safeguard patient privacy when using the My Health Record system.	☐	☐	☐
Summarise requirements for releasing copies of a deceased person's medical records.	☐	☐	☐

2 **Rate to what degree your personal learning needs were met.**

☐ Not met ☐ Partially met ☐ Entirely met

3 **Rate to what degree this activity was relevant to your practice.**

☐ Not relevant ☐ Partially relevant ☐ Entirely relevant

4a **Has the content in *Defence Update* Spring/Summer 2016 caused you to consider making any change(s) to your practice?** ☐ Yes ☐ No

4b **If you answered "yes" to question 4a, what change(s) do you envisage making?**

5 **How likely is it that you would recommend this activity to a friend or colleague?**

✗	0	1	2	3	4	5	6	7	8	9	10	✓
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

6 **Please rate the quality of the following in relation to *Defence Update* Spring/Summer 2016.**

	Very poor	Poor	Neutral	Good	Very good
Magazine content	☐	☐	☐	☐	☐
Magazine presentation (hard copy)	☐	☐	☐	☐	☐
Questionnaire content	☐	☐	☐	☐	☐
Questionnaire presentation	☐	☐	☐	☐	☐

7 **What could be done to improve this activity?**

8 **What future educational resources would you like MDA National to produce? Feel free to nominate any topics and any delivery formats, e.g. "responding to errors, online presentation", "cross-cultural communication, face-to-face workshop", "managing staff, *Defence Update* article".**

9 **Please indicate your career stage:**

Pre-Fellowship: ☐ Student ☐ Prevocational ☐ Vocational trainee

Post-Fellowship: ☐ Early career ☐ Mid-career ☐ Late career ☐ Retired

10 **If chosen, please indicate your specialty:** ____________________

Your details

Name	
Email	Phone
Address	
Name of college PD program in which you participate	
RACGP/ACRRM identification number (if applicable)	MDA National Member number

Please sign and date here

Signed	**Date (DD/MM/YYYY)** / /

☐ Tick here if you do not wish to receive your completion certificate by email.

In completing this form you consent to your comments being used for promotional purposes by the MDA National Group.

☐ Tick here if do not consent to your evaluation comments being used anonymously by the MDA National Group for promotional purposes.

Activity directions

- Read *Defence Update* Spring/Summer 2016.
- Complete the education activity questionnaire in hard copy . Fill out the activity evaluation and provide your details.
- Submit your activity by:
  - **email** peaceofmind@mdanational.com.au
  - **fax** 1300 011 244
  - **post** Level 3, 100 Dorcas Street, SOUTHBANK, VIC 3006
- Receive your completion certificate.
- Report to your college's PD program if it is a self-reporting program.
- MDA National will report relevant points for the following programs on your behalf:
  - Royal Australian College of General Practitioners (RACGP) Quality Improvement and Continuing Professional Development (QI&CPD) Program
  - Australian College of Rural and Remote Medicine (ACRRM) Professional Development Program (PDP).

Accreditation details

Visit **mdanational.com.au/resources/learning-activities/print-activities/defence-update-cpd-activities** for this activity's PD recognition details.

This activity is usually accredited with colleges for General Practice, Emergency Medicine, Obstetrics and Gynaecology, and Radiology. Other specialists can receive PD recognition too.

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What's On?

Upcoming local education events

All activities below are recognised for continuing professional development with multiple medical colleges.

November 2016

5	Practical Solutions to Patient Boundaries **Canberra, ACT**
12	The Challenging Emotions of Difficult News **Ballarat, VIC**
26	Win-Win Conflict Resolution: Positive Communication in Practice-based Teams **Brisbane, QLD**

For more information or to register, visit **mdanational.com.au**, call us on **1800 011 255** or send an email to **events@mdanational.com.au**.

We continually add education sessions to our events calendar. Avoid missing out - keep an eye on **Upcoming Events** at **mdanational.com.au**.

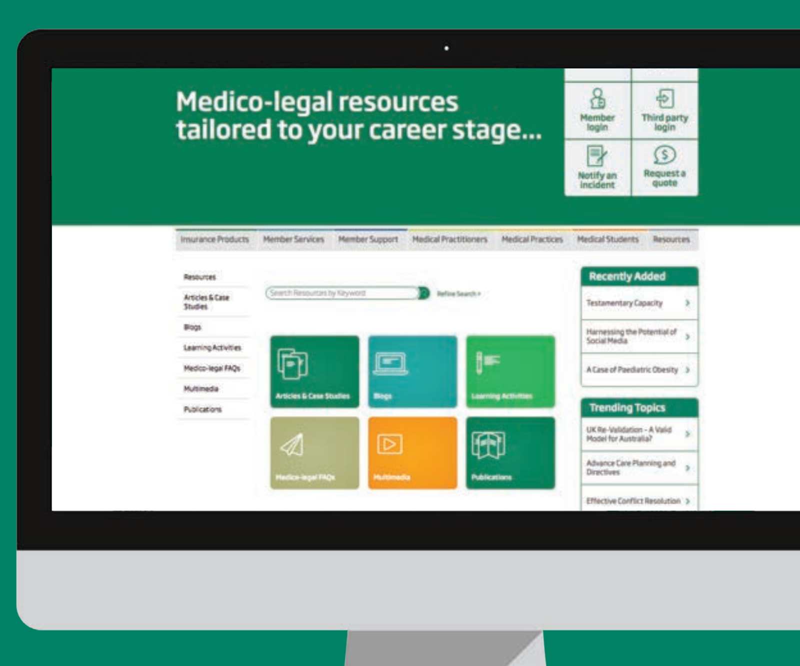
New online activity available now!

The Challenging Emotions of Difficult News:

- Learn and earn CPD recognition at your convenience and pace.
- Designed for doctors at all stages of their career; medical students may also benefit.
- Use your Member login at **mdanational.com.au**, following links through the "Education" menu option.

MORE FOR YOU
with online resources

Check out our online **Resources** section at mdanational.com.au for more convenient access to articles, blogs, case studies, medico-legal FAQs, videos and more.



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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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