SUMMER 2021/22

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FIRST DEFENCE
Feature section for doctors in training

MDA National

WELCOME

Dr Jane Deacon
Manager,
Medico-legal Advisory Services

Welcome to our Summer 2021/22 edition of *Defence Update*.

While the COVID-19 pandemic continues, our reliance on telehealth and technology-based consultations increases, and it is timely to consider IT security. Our Medico-legal Feature (pages 13-16) provides an update on the important topic of ransomware and how to safeguard your medical records when working remotely.

Maintaining privacy and confidentiality is the cornerstone of the doctor–patient relationship. There can be serious consequences if confidentiality is not considered when responding to requests for information from third parties, even the police. In our Case Book section, we report on a case where a doctor's unguarded conversation with the police led to a complaint to the Privacy Commissioner (pages 20-21), and on pages 22-23 we discuss the importance of doctors being honest in their communication with patients, even in the face of adverse events.

Have you had the sad experience of a patient committing suicide? On pages 8-9, we present some suggestions on dealing with this situation, including medico-legal considerations and personal support available for doctors during such times.

On pages 4-5, Dr Monique Heinke shares some insights about how the sport of rowing helped her become a better doctor, and the team approach needed for both rowing and medicine.

Do you ever treat practice or hospital staff with whom you work? Although providing care to your work colleagues can seem like a helpful gesture, and it can be difficult to refuse, our article in First Defence (pages 26-27) outlines why this situation should be avoided.

I hope you enjoy reading this edition of *Defence Update*.

Have an editorial enquiry?
Interested in contributing an article?
Contact our Marketing team:
marketing@mdanational.com.au

In this issue

You can find our *Defence Update* articles as well as more medico-legal resources online: **mdanational.com.au/advice-and-support/library**

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The articles in *Defence Update* contain topical, practical and expert insight to support you in providing safe patient care.

We thank all our authors for their valuable contributions to this edition.

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CPD changes for medical practitioners

Sam Lowther
Medico-legal Case Manager, MDA National

On 30 July 2021, the Medical Board of Australia announced changes to continuing professional development (CPD) requirements for doctors effective from 1 January 2023.

Doctors will be required to complete **50 hours of CPD** each year:

- **25 hours** of active CPD
- **12.5 hours** of traditional educational activities
- **12.5 hours** of CPD of the doctor's choice.

Active CPD includes activities of reviewing performance or measuring outcomes. Doctors must complete at least five hours of performance review activities and five hours of outcome measurement activities. The remaining mix of these activities to make up 25 hours of active CPD can be chosen by the individual doctors.

Traditional educational activities include reading and attending lectures and conferences.

The remaining 12.5 hours can be any mix of performance review activities, outcome measurement activities or traditional educational activities.

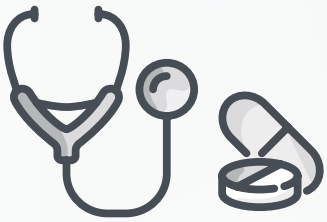
Doctors will be required to prepare a written annual professional development plan outlining how they will meet the above requirements. These plans must include self-evaluation of the learning goals and achievements from the previous CPD cycle and planned CPD activities to meet that year's requirements.

The changes will also introduce the concept of 'CPD homes' – organisations approved by the Australian Medical Council to provide CPD programs that meet Medical Board requirements. Every doctor must meet the requirements of their CPD home and inform the Medical Board of their CPD home in their annual registration renewal.

If you are a specialist, your CPD home will be relevant to your specialty, e.g., your professional college. If you have general registration, you can choose a CPD home relevant to your scope of practice.

These changes aim to ensure doctors engage in learning that is relevant, effective and evidence based.

View the Medical Board's updated registration standard relating to CPD: medicalboard.gov.au/registration-standards.aspx



Voluntary assisted dying in WA

As of 1 July 2021, voluntary assisted dying (VAD) became a choice available to eligible people in Western Australia under the *Voluntary Assisted Dying Act 2019* (the Act).

All WA doctors need to be aware of their obligations under the Act. Any medical practitioner who receives a 'First Request' for access to VAD during a medical consultation must take a number of steps,[1] even if they do not want to be involved and have a conscientious objection.

Whatever your response is to this 'First Request', it is important to document it well in the patient records, including the reason for your objection. Conscientious objectors must immediately advise the patient.

Medical practitioners who meet the eligibility criteria and who have completed the WA Voluntary Assisted Dying Approved Training,[2] may undertake roles in the VAD process under the Act.

A practitioner's MDA National Policy will cover the provision of healthcare services related to VAD in WA when undertaken in accordance with all relevant legislation, in keeping with the terms and conditions of the Policy.

References

1. Department of Health. *Voluntary assisted dying in Western Australia – What every medical practitioner needs to know.* ww2.health.wa.gov.au/~/media/corp/documents/health-for/voluntary-assisted-dying/what-every-medical-practitioner-needs-to-know.pdf
2. Department of Health. *Voluntary Assisted Dying:* ww2.health.wa.gov.au/voluntaryassisteddying

Connecting the dots between sports & medicine

Dr Monique Heinke
Training for the Athens Olympics, 2004

> *The sport of rowing provided me with many non-clinical skills and attributes which I've been able to transfer into medicine, and these have certainly helped make me a better doctor.*

DOCTORS FOR DOCTORS

Dr Monique Heinke (MDAN Member)
Radiation Oncologist

Watching the Tokyo Olympics and Paralympics this year provided both relief and joy from the current COVID-19 situation worldwide. For me, as an Olympic rower, having competed at the Sydney and Athens Games, it was a time of reflection on achievement, success, and the overlaps between my sporting and medical careers.

I fell in love with the sport of rowing when I first picked up an oar in 1994, in my final year of an undergraduate science degree. Over the next couple of years, I progressed through the ranks and was selected for my first national team in 1999, and subsequently in the women's quadruple scull for the Sydney Games and the women's eight in Athens.

Following the Athens Games, I had planned to retire from rowing and switch careers. That's when I started a graduate medicine degree, which eventually led me to my current role as a consultant radiation oncologist.

The overlaps between sport and medicine may not be immediately apparent. Of course, the goals of elite rowing to win a race or medal seem quite superficial in comparison to the humanitarian goal of patient care.

But there are a number of skills and characteristics common to both professions – including the ability to perform in high pressure environments, high levels of motivation, sacrifice, goal setting, intensive training and skill development.

Four-year cycles and setting goals

Rowing, as an Olympic sport, works in four-year cycles leading up to each Olympic Games event. In the intervening years, there are large goals such as team selection and performance at world championships – and smaller goals on a weekly and daily basis, including ergometer times, on-water speeds, and perfecting the rowing technique.

I've used this same approach of goal setting in my medical career. The bigger goals have also been in four-year blocks – four years at medical school, eight years as a JMO and registrar, and now embarking on the first four-year cycle as a consultant. Each of these cycles was broken into smaller segments or goals which needed to be achieved to progress to the next stage – exams, case reports, research, etc.

At every stage, I needed a plan or timetable to ensure each activity was completed appropriately. This was particularly important when preparing for fellowship exams while juggling work and family life.

The ultimate team sport

Rowing is often referred to as the ultimate team sport – as all crew members need to support one another and row in perfect synchronisation for the boat to glide through the water at maximum speed. Aside from my crew mates, there were other essential team members who got us to the start line, including coaches and medical support personnel.

Each member of the team was vital for peak performance, just as teamwork in medicine is also crucial. In my day-to-day work as a radiation oncologist, I am only one part of the broader team needed to support a patient through their care.

Interactions with other doctors including surgeons, medical oncologists and a range of medical specialists ensure patients receive appropriate treatment in a timely and coordinated manner. Within a radiation oncology department, I work with a team of radiation therapists, physicists, nurses, allied health and admin staff who all play an essential role in patient care.

Physical and mental stimulation

In both my rowing days and now as a doctor, I recognised the importance of having balance in my life. When possible, while rowing, I also worked part time. This provided me with an outlet outside of sport and gave me much needed mental stimulation. Since working in medicine, I've continued to remain active and participate in sport – whether rowing, running, cycling, or just spending time outdoors.

As doctors, we're often explaining the benefits of being active to our patients. And there's a growing body of evidence showing improved outcomes in cancer patients who exercise regularly. This is an area I'm keen to expand on as I build my practice over the next few years.

The sport of rowing provided me with many non-clinical skills and attributes which I've been able to transfer into medicine, and these have certainly helped make me a better doctor.

Shared decision-making
& the five-question model

Deborah Jackson
Medico-legal Advisory Counsel
MDA National

Implementing shared decision-making (SDM) is essential to enabling a patient's preferences to be incorporated into a consultation – improving patient knowledge, risk perception, accuracy, and patient–clinician communication. It reduces decisional conflict and feeling uninformed.[1]

What is SDM?

SDM is a consultation process where a clinician and patient jointly participate in making a health decision – having discussed the options, their benefits and harms, and having considered the patient's values, preferences and circumstances.

Australia is drastically lagging behind many other countries in all aspects of SDM – policies, lobbying, advocacy, research funding, training, resources and implementation.[2]

SDM is supported by evidence from 86 randomised trials showing knowledge gain by patients, more confidence in decisions, more active patient involvement and, in many situations, informed patients elect for more conservative treatment options.[3]

SDM is not a single step to be added into a consultation, but it can provide a framework for communicating with patients about healthcare choices to help improve conversation quality. It is a mechanism for applying evidence with an individual.[4]

SDM can be viewed as a continuum along which the extent that a patient or a clinician takes responsibility for the decision-making processes varies.

Exploring what matters most to your patients is crucial to reducing the incidence of complaints and claims.

The five-question model

The principles of SDM are well documented, but there is a lack of guidance about how to accomplish the approach in routine clinical practice.

Overseas studies have shown that up to 80 per cent of the medical information patients are told during a consultation is forgotten immediately, and nearly half the information retained is incorrect. There is a 19 per cent higher risk of non-adherence among patients whose clinician communicates poorly than among those whose clinician communicates well.[5]

The preferred process to facilitate SDM is the five-question model.[6]

Q1. What will happen if we watch and wait?

If the problem or diagnosis is clear and a decision on the next step is necessary, the next step is to describe the nature of the condition, preferably including information regarding the natural history of the condition. What will happen without intervention, i.e., watch and wait?

Eliciting the patient's expectations about the management of the condition, and discussing previous approaches and experiences along with fears and concerns, allows for correction of misperceptions.

Q2. What are the best treatment options?

This triggers a discussion about the options and helps to identify those the patient would like to hear more about.

Q3. What are the benefits and harms of these options?

Descriptively discuss the benefits and harms of each option, and the probability of each occurring (which should be provided, if known).

Decision support tools can be useful, particularly for your patient demographic. Simple visual graphics can help to communicate numbers.[7,8]

Principles of effectively communicating statistical information to patients should be followed, e.g., using natural frequencies such as 'out of 100'. Be aware of framing effects and using multiple formats.

Discussion of harms should extend beyond the risk of side effects. It should include other impacts the option could have on the patient, e.g., cost, inconvenience, interference with daily roles, and reduced quality of life.

Q4. How do the benefits and harms weigh up for you?

This step includes eliciting the patient's preferences and working with them to clarify how each option may fit in with their values, preferences, beliefs and goals. Some decision aids include formal clarification exercises that may supplement the conversation and/or enable the patient to reflect further following the consultation.

Using the 'teach-back' method is an effective way to clarify the patient's understanding of what has been discussed so far, and can help identify whether any information needs to be repeated or explained in another way. During 'teach-back' you ask the patient to explain in their own words what they need to know or do to take care of their health. You ask them to 'teach-back' what you have told them.[9]

Q5. Do you have enough information to make a choice?

This provides a further opportunity to find out if the patient has additional questions. Patients may feel ready to decide at this stage, or it may be jointly decided to defer the decision and plan when it should be revisited. Before making a decision, the patient may wish to seek further information, discuss with family, or take time to process and reflect on the information received.

More information

NSW Clinical Excellence Commission
Teach Back
cec.health.nsw.gov.au/__data/assets/pdf_file/0006/618387/teach-back.pdf

View the references online: **mdanational.com.au/shared-decision-making-5-question-model**

Coping with patient suicide

Dr Kiely Kim
Medico-legal Adviser, MDA National

When Dr A's practice manager called on her day off from the practice and asked her to find a quiet place to talk, she braced herself for bad news.

A regular patient, a young high-achieving university student had died by suicide. Dr A had seen him a week ago. Shocked and with an overwhelming feeling of sadness, she sat down with many thoughts racing through her head.

The death of a patient by suicide can be one of the most stressful moments in a GP's career. While needing to provide support to the bereaved family, you may be managing your own sense of loss.

And this can be accompanied by a sense of professional responsibility. *Could I have prevented this? Will I be blamed? What will the family think?*

In an already devastating situation, medico-legal concerns can add to the stress.

Talking to the family

It's common for bereaved families to want to speak with the doctor to gain an understanding of what occurred. However, a duty of confidentiality to the patient remains, even after death.

According to the Medical Board's code of conduct:[1]

4.13.11: When your patient dies, being willing to explain, to the best of your knowledge, the circumstances of the death to appropriate members of the patient's family and carers, unless you know the patient would have objected.

If a request is made for a release of the deceased patient's medical records,[2] we recommend you contact MDA National for advice. The General Practice Mental Health Standards Collaboration (GPMHSC) resource, *After suicide*,[3] may be helpful for GPs in responding to questions and supporting the bereaved.

Documentation and medical records

The details of notification of the suicide should be documented in the patient's medical records. It's important not to alter the medical records.

If you need to add something to a previous entry, make an addendum including the time and date, explaining what entry it refers to. Ensure the additional information is not gratuitous or defensive.

Coronial investigations

All suicides are reported to the coroner, whose primary role is to determine the identity of the person who died, the date and place of death, and the manner and cause of death. The coroner may ask a treating doctor for their medical records and/or a statement to assist in their investigation.

Occasionally, after reviewing the available evidence, the coroner may decide to hold an inquest. The coroner's role is not to lay blame on any person or organisation. They may make recommendations with a view to improving public health and safety or preventing similar deaths.

We recommend you contact MDA National for advice if you're asked to provide information to the police or the coroner regarding a patient's death.

Getting support

Dr A's practice manager organised a debriefing meeting with the practice staff to have an open, supportive discussion about the events surrounding the suicide.

A psychologist at the practice had also seen the patient, and the receptionists who knew him well were particularly affected.

While Dr A found this helpful, she had ongoing thoughts of what had occurred and a sense of personal failure. A large part of her practice involved managing mental health issues, and she found herself questioning whether she should continue in general practice.

She found it difficult to talk to her GP colleagues about what had happened. A sense of guilt or shame can make it difficult to reach out for support.

Speaking with a trusted colleague helped Dr A view the situation differently.

She recognised that suicides are multifactorial and began feeling less personally responsible. She also thought of ways to manage her workload.

Dr A found a regular peer group to discuss difficult cases and spoke to the practice about sharing the load of complex patients.

- MDA National provides a confidential peer support service for Members during a medico-legal matter.
- Doctors are encouraged to seek formal support services if required – from their GP or the DRS4DRS service[4] in their state or territory.
- The RACGP offers the GP Support Program[5] – a free service to foster self-care among general practitioners.

If you're dealing with a patient suicide, contacting MDA National can help reduce your stress by gaining an understanding of medico-legal concerns and processes, particularly if a coronial statement is requested.

View the references online: **mdanational.com.au/patient-suicide**

12 commandments
to mitigate Ahpra notifications

Daniel Spencer
Senior Associate, Panetta McGrath Lawyers

Despite the instant anxiety brought on by the word 'notification', practitioners can take positive steps to ensure they're well placed to deal with one that (inevitably) comes their way.

While the receipt of a notification is not within your control, what you do in caring for your patients – from an initial consult through to discharge – certainly is. And while it's the quality of care that is critically important, the documentation of such care is equally so.

We believe there are a number of 'controllables' for practitioners in seeking to mitigate any adverse finding by the Medical Board. While these may seem onerous at the time, your future self may just praise you for going the extra distance.

A cheat sheet for practitioners to help your future self and reduce the risk of patient complaints.

The 12 commandments

1 Keep full, accurate and contemporaneous clinical records.

This is a challenge with the busyness of everyday practice. It's critical to record the process of taking informed consent and the actual risks discussed (rather than simply stating they were discussed) and making a note of any documentation you've provided to the patient. Templates can assist in this regard, provided they are thorough and up to date.

2 Communicate clearly with patients and colleagues.

This cannot be overstated. Try to document all conversations, or follow up important conversations with an email, where there's potential for dispute (pretty much always!).

3 Be open and honest, and apologise if something goes wrong.

Importantly, do not actively dissuade aggrieved patients (or anyone) from making a notification. That said, be careful about apologising where it could be construed as an admission of liability (see commandment 12).

4 Seek advice from colleagues or mentors when unsure.

This may help you defend your decision-making and assists in developing a collegiate profession.

5 Respect professional boundaries.

Be aware of boundaries with patients and colleagues. Seek to terminate a therapeutic relationship at the first sign of a relationship evolving into something personal.

6 Use a chaperone where appropriate.

Chaperones are there to protect you (as well as the patient). Their presence can be critical when defending allegations of sexual misconduct – which can mean being out of practice for 12 months or more.

7 Be informed and cognisant of Medicare requirements.

Be aware of requirements regarding the billing of items. Regularly review Medicare updates and engage in open discussion with colleagues. Don't assume your billing is fine "because everyone else is doing it". This defence won't fly with Medicare.

8 Don't self-prescribe, and don't prescribe for your friends and family.

The various codes of conduct stipulate this should be avoided wherever possible. If you have to do so, be prepared to justify your decision, make a clear record of what you have done, and advise the patient's GP in writing, including your clinical reasoning (unless the patient objects).

9 Use social media with caution.

Be very careful when using social media (even on your personal pages), when authoring papers, or when appearing in interviews. Health practitioners are obliged to ensure their views are consistent with public health messaging. This is particularly relevant in current times.

10 Engage regularly with a GP and/or psychiatrist or psychologist.

As well as maintaining good mental health, this can assist you if concerns are ever raised that you may have a health impairment affecting your practice. It can mean the difference between sitting on the sidelines and continuing to practise.

11 Be a good colleague and allow your colleagues to support you.

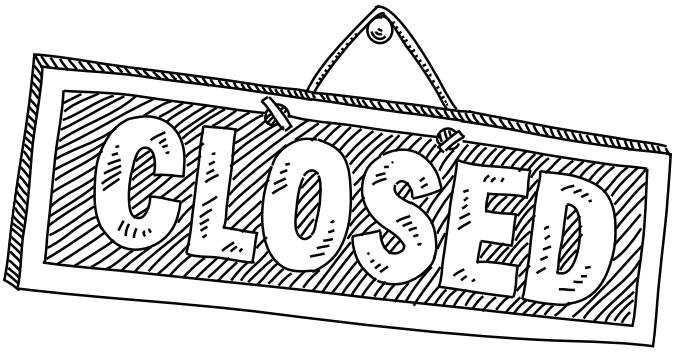
Asking for help can prevent a situation escalating out of control.

12 Your MDO is your lifeline.

Seek advice from your medical defence organisation (MDO) before responding to any complaint. They have generally been there and done it. Put your faith in them and trust their advice.

Winding up your medical practice

Karen Stephens
Risk Adviser, MDA National



The Medical Board's code of conduct includes certain expectations when you close or relocate your medical practice.

Advance notice

You can notify patients during consultations, through practice and website signage, by post or email. In the ACT,[1] public advertisement and informing ACT Health are required. A local newspaper notice is needed in Victoria.[2] Communicate the date you will cease practice; whether you will sell or close the practice; options for ongoing care; and how to arrange transfer of records.

Continuing medical care

This depends on what will happen with the records, but a formal handover to another doctor may be needed for complex patients. Ideally, it's best to stop seeing patients or ordering investigations well before finishing up, or be available to review incoming results for a short time afterwards. You might copy in a colleague when ordering a test, and let patients know who will follow up on results.

Medical records

If leaving a group practice where your patients will see other doctors within the practice, no specific arrangements are necessary.

If selling your practice, the contract of sale can include that the medical records will be owned by the purchaser, and you can inform patients of this in your advance notice. It's wise to include a clause in the sale contract allowing you access to the records, in case of a later claim or investigation.

If the above does not apply, give patients the option of providing a copy of their records to a doctor of their choice or to themselves.

Records remaining in your possession should be stored securely for seven years from the date of last entry or, for a child, until the patient turns 25. You must delete or destroy records securely. In the ACT, NSW and Victoria, a register of this must be kept.

Informing others

As appropriate, notify:

- your employer (according to contractual terms)
- colleagues, hospitals, pathology and radiology services
- Medicare (cancel your provider number)
- drugs and poisons regulator
- Ahpra (maintaining Ahpra registration carries obligations such as CPD and mandatory reporting. Non-practising registration allows use of the title 'medical practitioner', but you **must not** provide medical treatment or opinion to an individual including yourself, prescribe medication or issue referrals).

Other matters

- Financial and tax advice
- Leases, equipment, insurance policies, utilities and mail
- Disposal of medications, script pads, stationery, websites, domain names and other IT systems
- Employers' obligations – see the Fair Work Commission guidelines.[3]

More information

Medical Board's code of conduct – Section 4.16
medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

MDA National medico-legal booklet
mdanational.com.au/-/media/files/mdan-corp/medico-legal/medical-records-booklet.pdf

RACGP: Closing a medical practice – Module 13
racgp.org.au/fsdedev/media/documents/running%20a%20practice/practice%20resources/management%20toolkit/closing-a-medical-practice.pdf

View the references online: **mdanational.com.au/winding-up-medical-practice**

MEDICO-LEGAL FEATURE

RANSOMWARE

Ransomware is a type of malicious software (malware). When it gets into your device, it makes your computer or files unusable. Cybercriminals use ransomware to deny you access to your files or devices. They then demand payment to regain your access.

Ransomware:
a real & credible threat

Karen Stephens
Risk Adviser, MDA National

Ransom demands are reported to be climbing, from an average of US$6,000 in 2018, to US$84,000 in 2019, and US$178,000 in 2020. The funds are usually requested to be transferred electronically, often in untraceable cryptocurrency such as Bitcoin.

Prevalence

Between 2018 and 2020, **70 per cent of claims** made under MDA National's practice policy cyber cover related to a ransomware attack.

According to the *Notifiable Data Breaches Report January-June 2021* from the Office of the Australian Information Commissioner (OAIC):

- ransomware made up **24 per cent** of the 192 cybersecurity incidents notified as a data breach to the OAIC from January to June 2021
- data breaches from ransomware incidents increased to **46 notifications** from 37 in the last reporting period
- across all types of breaches, the **health sector was the highest reporting industry sector**, notifying **19 per cent** of all breaches.

View the references online: **mdanational.com.au/ransomware**

Impact

Being unable to access computer files will have immediate and severe impact on the running of most medical practices.

- A cardiology practice in Florida hit by ransomware in 2021 had its phone lines and IT systems shut down, and was still operating at a reduced capacity several months later.
- Victorian hospitals hit by a ransomware attack in 2019 had to cancel some elective surgery and appointments.
- In 2017, WannaCry – a global ransomware attack – infected the NHS in England, causing thousands of appointments and operations to be cancelled. And in five areas, patients had to travel further to Accident & Emergency departments.

Prevention

Protective measures are outlined in the Australian Cyber Security Centre's (ACSC) ransomware prevention and protection guide. These involve seven steps:

1. Update your device and turn on automatic updates.
2. Turn on multifactor authentication.
3. Set up and perform regular backups.
4. Implement access controls.
5. Turn on ransomware protection.
6. Prepare your cyber emergency checklist.
7. Remain vigilant and informed.

Backups are vital

Recovering from ransomware is almost impossible without comprehensive backups – preferably both to an external storage device and to the cloud. Backups should be done regularly to minimise gaps in the data, and this can usually be automated via your system settings. Backups should also be checked regularly to ensure they have worked.

You can get more guidance on backups from the Australian Digital Health Agency (ADHA) and the Royal Australian College of General Practitioners (RACGP).

What to do if it happens to you

The ACSC has an emergency response guide which provides simple step-by-step instructions on what to do. Outlined steps include immediately disconnecting the infected device, running a malware scan, and seeking professional IT assistance.

The ACSC recommends **not** to pay the ransom. There is no guarantee that paying the ransom will fix your devices, and it can make you vulnerable to future attacks.

Refusing to pay the ransom requires that your backup can recover all or most of the files or data. Without sufficient backup, you may have no option but to pay the ransom. Unfortunately, paying the ransom won't guarantee getting everything back.

A recent global survey found that on average only 65 per cent of the encrypted data was restored after a ransom was paid, and only eight per cent of organisations were able to restore all of it.

CASE STUDY

As it happened at a practice insured by MDA National

One morning at a specialist practice, the receptionist started the computers and tried to open the records and billing software (BlueChip). When she couldn't get it to open, she phoned the practice's IT provider who sent a staff member to the practice straight away.

He found that the files on the shared drives had been encrypted, and a ransom in bitcoin had been demanded to provide a decryption key. He identified one machine as the source of the infection and shut it down.

Later that day when the IT provider tried to restore data from the backup server, he found that the backup server's internal data and external backup drive had also been locked. The police were notified.

The practice owner decided to pay the ransom. Communication with the scammers over several days led to two attempts to decrypt the data, but the data was not completely restored.

Three weeks' worth of patient reports were never recovered. It took five days for the practice system to be functional. Fortunately, there was no evidence that patient records had been accessed by the scammers.

To prevent this happening again, the practice now only allows remote access through a secure VPN. The administrator passwords and file-share permissions to the backup server were changed, and additional backups now include multiple offsite and offline copies of data kept in rotation – so there are at least four copies of business data less than 10 days old at any time.

Safeguards for remote access

Where doctors provide telehealth from home, or work at multiple locations and access records remotely, good cyber security practices are vital. Practices should have a policy outlining the permitted use of devices, including the required behaviour from employees.

Cybercrime has soared in Australia, with the increase in people working from home due to COVID-19 restrictions. The Australian Cyber Security Centre's (ACSC) *Annual cyber threat report 2020-21* reveals an increased volume of cybercrime reports, equating to one every eight minutes. Cybercriminal activity has also increased in complexity and sophistication.

The ACSC recommends the following:

Train staff to beware of scams

Be alert for phishing emails. Be wary of opening messages and attachments or clicking on links from unknown senders. Exercise caution with requests for personal details, passwords or bank details – particularly if the message conveys a sense of urgency.

Never provide an unknown third party with remote access to your computer. If in doubt, delay any immediate action and re-establish communication later using contact methods you have sourced yourself.

Use strong and unique passphrases

Passphrases are harder to crack than passwords. They should be enabled on portable devices such as laptops, mobile phones and tablets. Use a variety of passphrases across multiple accounts.

Implement multifactor authentication

Multifactor authentication makes it much harder for unauthorised users to access your system. Biometric identification, e.g., fingerprint scan, provides an additional level of security.

Allow automatic updates on your devices and system

Software updates are often developed to address recently identified security issues.

Use a Virtual Private Network (VPN)

A VPN securely connects portable devices to a work network. Most practices will need an external IT service provider to set up a VPN and procedures for its use.

Use trusted Wi-Fi

Free wireless internet can expose your browsing activity to cybercriminals. Home internet or mobile internet service from a telecommunications provider is considered a trusted connection.

Secure devices when not in use

Don't leave a device unattended. Lock your computer when not in use, even if it's only for a short period of time.

Don't lend laptops to children or other household members using your work profile or account.

If you share computers or devices with your household, maintain separate profiles so each person logs in with a unique username and passphrase.

Avoid using portable storage devices

When transporting work from the practice to home, portable storage devices like USB drives and SD cards are easily misplaced. And if access isn't properly controlled, they can harm your computer systems with malware.

If you need to use them, protect them with encryption and passphrases. Cloud storage or collaboration solutions are considered more secure.

CASE BOOK

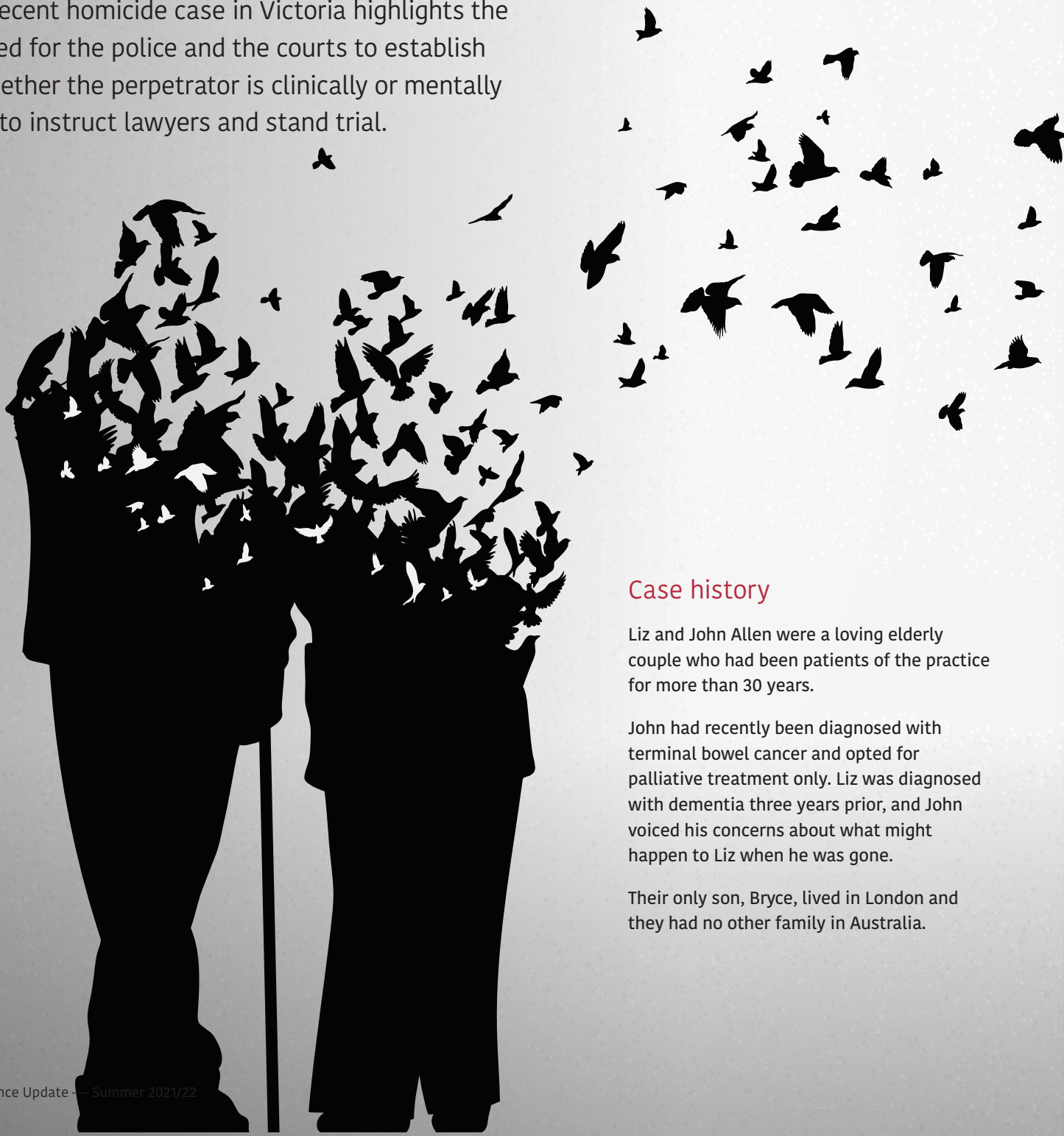
- The aftermath of tragedy
- When the police come calling
- Honesty is always the best policy

The aftermath of tragedy

Nerissa Ferrie
Medico-legal Adviser, MDA National

When a patient becomes the perpetrator or the victim of murder, it's shocking and stressful for everyone involved.

A recent homicide case in Victoria highlights the need for the police and the courts to establish whether the perpetrator is clinically or mentally fit to instruct lawyers and stand trial.



Case history

Liz and John Allen were a loving elderly couple who had been patients of the practice for more than 30 years.

John had recently been diagnosed with terminal bowel cancer and opted for palliative treatment only. Liz was diagnosed with dementia three years prior, and John voiced his concerns about what might happen to Liz when he was gone.

Their only son, Bryce, lived in London and they had no other family in Australia.

Criminal investigations can be time-sensitive. Doctors and practice staff should be aware of the rights and responsibilities of the police before releasing personal health information of patients involved in a serious crime.

Too close to home

Dr Jackson was watching the late news when he saw a breaking story about an attempted murder-suicide. He put it out of his mind until his practice manager came into his consulting room early the next morning.

"Two detectives from Major Crimes are waiting in reception," the practice manager said. "They have demanded a copy of Liz and John Allen's medical records. They say John murdered his wife, and he's in a coma following an overdose. What should I do?"

Dr Jackson asked the practice manager if the police had produced any paperwork.

"No," the practice manager said. "They just said it was urgent and wanted the notes handed over immediately."

Dr Jackson advised the practice manager to do nothing until he sought advice.

When in doubt, call your MDO

After calling his medical defence organisation (MDO), Dr Jackson was reassured that in the absence of patient consent, the police would need to provide a legal authority, such as a search warrant or a notice to produce, before the notes could be released.

Dr Jackson relayed this information to the practice manager and the detectives left shortly after.

Don't gossip about your patients

Later that morning, Dr Jackson overheard the receptionist talking to a patient.

"Yes, they were both patients of the practice," Dr Jackson heard the receptionist say. "It was John Allen – you know, the retired teacher. He murdered his wife, Liz."

Dr Jackson interrupted the conversation and took the receptionist aside.

"I know everyone is talking about the sad situation that unfolded yesterday, but the police haven't released any details yet," the GP said. "It's not appropriate to disclose confidential information you've gained through working at the practice."

He also pointed out that it was insensitive to discuss patients in reception where friends of the family may overhear the discussion.

Medico-legal discussion

Privacy and confidentiality are vital when building trust in the therapeutic relationship. There are limited exceptions that allow for disclosure, but these exceptions can be complex. Advice should be sought before complying with a request for medical records without patient consent.

The Office of the Australian Information Commissioner's *Guide to health privacy* is an excellent resource which offers practical scenarios to assist doctors in navigating the principles of patient privacy.

The outcome

Bryce contacted Dr Jackson to say he didn't consent to his parents' personal health information being released to the police.

Dr Jackson expressed his sympathy, but he explained that the police had attended the practice later in the day and medical records were provided following receipt of a signed search warrant.

John passed away shortly after, and the case became a matter for the State Coroner.

When the police come calling

Janet Harry
Medico-legal Adviser, MDA National

You're in the middle of a busy day at the practice when a police officer contacts you. She says she was called to the home of one of your patients and he was "talking incoherently and behaving strangely". She asks you if he has any mental health issues.

What do you do?

It is generally not appropriate to breach patient confidentiality, unless you have the patient's authority or the police produce a court order, e.g., a search warrant or notice to produce.

The police may be able to provide a signed authority, which should be less than six months old. If you still see the patient, you could inform them directly about the request and obtain authority which you can note in your records.

You should record any disclosure in the patient records, including information given by the police and the matters considered when determining whether the information could or should be provided to them. If the request is not urgent, you can ask the police to put it in writing so that you can consider and obtain advice if necessary.

In some circumstances, it may be appropriate to release information to the police where the disclosure is permitted under 6.32 of the *Australian Privacy Principles* – where it's stated that you can use or disclose personal information if a "permitted general situation" exists in relation to it.

Keep in mind that it's easy to fall foul of the law, and consult MDA National before relying on any of the exceptions – as demonstrated in the decision below in '*EZ' and 'EY' [2015]*, a privacy complaint made by a patient against his general practitioner.

Revealing sensitive patient information to the police "in good faith" is not sufficient cause to justify disclosure.

Case history

In 2006, Queensland police officers visited Mr Z to investigate his allegations of a neighbour's harassment and property damage. They noted that he explained his concerns in a "highly excited and at times paranoid fashion". He told police he suffered from post-traumatic stress disorder, anxiety disorder, and severe back and knee pain.

The police called Mr Z's treating doctor, Dr Y, but she was unavailable. They spoke to another doctor, who noted the police were concerned that Mr Z was acting strangely. The sergeant spoke to Dr Y a few days later and asked whether she thought Mr Z was psychotic. She advised it was possible, but further assessment was needed.

Mr Z lodged a complaint under the Privacy Act, alleging Dr Y had interfered with his privacy by:

- improperly disclosing personal information contained in his medical records to police (alleged breach of NPP 2.1)*
- disclosing inaccurate personal information about him to police (alleged breach of NPP 3.1)*
- failing to have adequate security safeguards to protect his personal information from improper disclosure (alleged breach of NPP 4.1).*

Dr Y argued that she had made the disclosure in good faith. As the police officer had spoken of a neighbourhood dispute, she felt there was a concern for public safety.

She also claimed that because "the police were concerned enough to telephone to ask if Mr Z was psychotic, this suggested it was an urgent matter of public and Mr Z's safety, and so a response was appropriate and justified".

The outcome

The Privacy Commissioner considered the position under the National Privacy Principles* and rejected these arguments.

Given Dr Y's regular involvement (having treated Mr Z for two years prior to the event) and lack of more detailed questioning of the police about the reasons for the request, he was not satisfied Dr Y could have formed a reasonable belief that Mr Z at the time posed a serious and imminent threat to himself or to public safety, or that he was involved in any unlawful activity.

Dr Y had not asked the police about the nature of their enquiry or if they suspected him of a serious unlawful activity. There was no court order or direction compelling or authorising the disclosure of the private information to the police.

The Privacy Commissioner concluded that Dr Y had given insufficient consideration to her obligations under the various policies, and the need for rigour in considering when it was permitted to disclose personal health information as articulated in various policies, guidelines and legal requirements.

While Dr Y had made the disclosure "in good faith", this was not sufficient cause to justify disclosure of private information.

The Privacy Commissioner found that Mr Z suffered injury to his feelings and distress due to the interference with his privacy by Dr Y. He determined that Mr Z's complaint was proven, and Dr Y had breached the NPPs 2.1 and 4.1 by disclosing his personal information to police.

Dr Y was ordered to apologise to Mr Z in writing and pay him $6,500 in compensation.

* The Australian Privacy Principles replaced the National Privacy Principles in March 2014.

Honesty is always the best policy

Dr Jane Deacon
Manager, Medico-legal Advisory Services
MDA National

Doctors have a responsibility to be open and honest in their communication with patients, even in the face of adverse events.

Case history

The patient attended Dr X to undergo endovenous laser ablation of her varicose veins. Dr X worked at a clinic which provided non-surgical treatment for varicose veins.

The procedure involved introducing a guide wire into the saphenous vein, followed by a catheter inserted over the wire. The catheter allows for the insertion of a laser filament directed to just below where the saphenous vein comes off the femoral vein. After an anaesthetic solution is injected around the saphenous vein, the laser is activated and gradually pulled back along the course of the vein with the heat of the laser cauterising the inside of the vein. Over time, the vein scars and disappears.

Unfortunately, in this case, the catheter and optical fibre were damaged during the procedure. A 9 cm segment of the catheter and a 47 cm length of optical fibre became detached and were retained in the patient's leg.

Despite being aware of this, Dr X did not inform the patient – either at the time of the procedure or at the post-procedure visit two weeks later.

About a month after the procedure, a 20 cm long thin plastic wire protruded from the patient's unhealed wound on her leg, and the patient was able to remove 47 cm of the wire from her leg. The patient telephoned Dr X's rooms, but he did not speak with her that day.

The patient then reported her concerns to her GP who referred her for an ultrasound – this revealed a 9 cm length of tubing still within her calf.

The GP arranged for a radiologist to remove the retained tubing. By that time, the catheter had been in her leg for approximately 40 days.

The patient then returned to see Dr X who apologised, acknowledging that he knew the foreign bodies had been left in situ.

The complaint

Subsequently, the patient made a complaint to the Medical Board who sought an explanation from Dr X. His reasoning was that he considered the patient to be an anxious person and he didn't want to add to her anxiety by telling her about the foreign body in her leg.

He felt it could stay within the scar of the vein for a long time without major problem, according to some studies that had been done on the subject – and hence decided it was best for the patient to hide the incident from her. In retrospect, he acknowledged it was the wrong decision, and that it would have been easy for him to refer the patient to the local hospital for surgical removal.

The Medical Board obtained an expert opinion which stated that the correct decision would have been to inform the patient immediately of the problem and put in place a plan to correct it – which would include removing the retained material in the most appropriate manner.

The doctor's deliberate decision not to inform the patient of the retained piece of catheter in her leg was undoubtedly in breach of provisions of the Medical Board's code of conduct.

The outcome

The Medical Board made a finding of unprofessional professional performance in relation to the damaged catheter.

The Board was more critical of the doctor's conduct after the event in that he did not advise the patient of what had occurred; make suitable arrangements to investigate and treat the retained length of catheter; or refer the patient to another health practitioner for investigation or treatment. The Board was also critical that the doctor did not speak to the patient himself, even when she rang to report that a length of wire had protruded from her leg.

A finding of professional misconduct was made on the part of the doctor, and he received a reprimand.

Medico-legal issues

When adverse events occur, doctors have a responsibility to be open and honest in their communication with patients; to review what has occurred; and to report appropriately.

When something goes wrong, good medical practice involves recognising what has happened and acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.

The patient should be informed as promptly and fully as possible about what happened and the anticipated short-term and long-term consequences.

In this case, the doctor received a more serious sanction than he would have, had he been open and honest with the patient in the first instance.

More information

Queensland Civil and Administrative Tribunal
archive.sclqld.org.au/qjudgment/2021/QCAT21-242.pdf

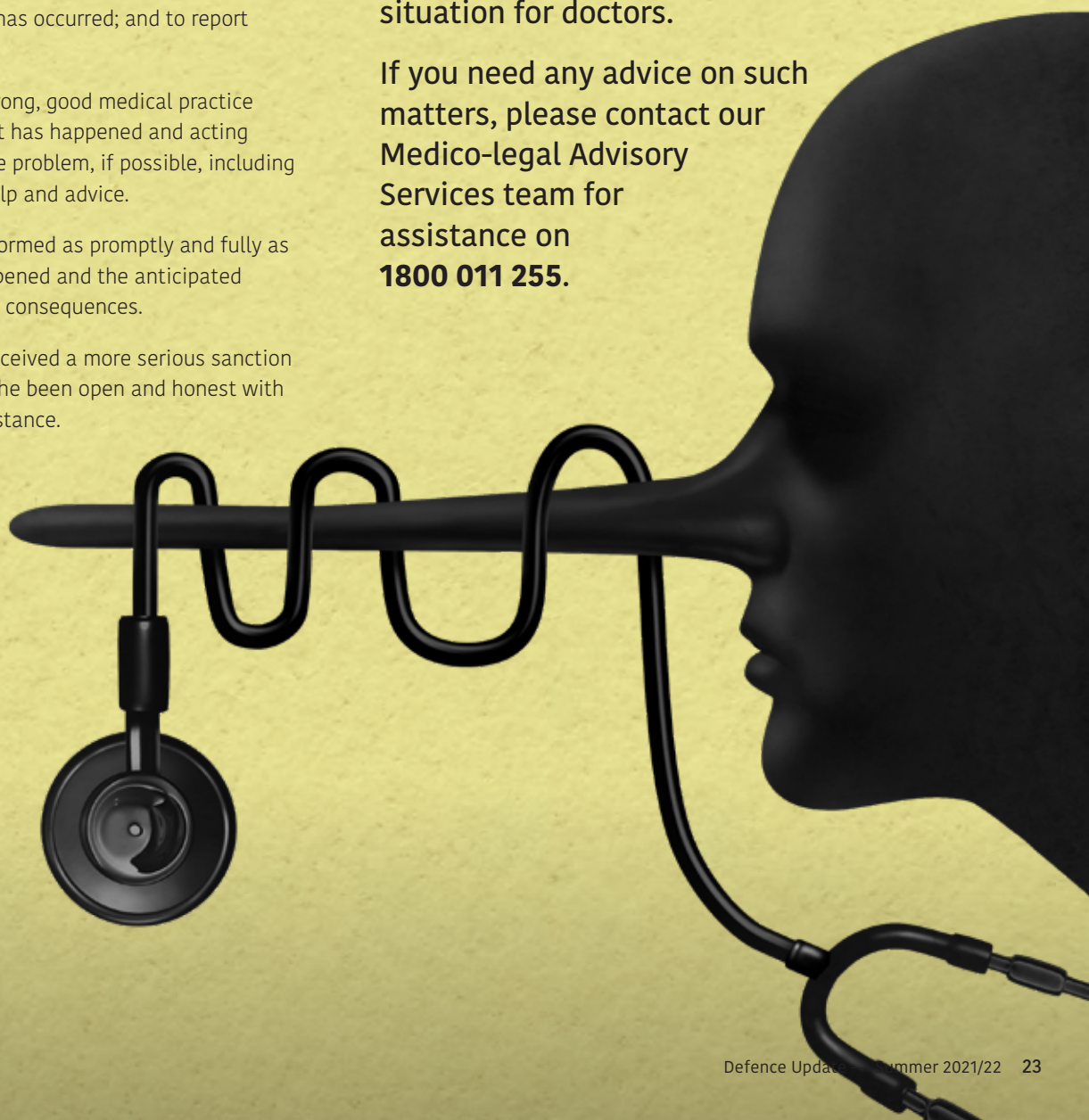
MDA National
Risk hotspots for hospital specialists & how to respond when things go wrong
mdanational.com.au/miscellaneous/risk-hotspots-qanda?accordion=20b919d9-e23a-4565-9b7d-9c93b475c3f8

Medico-legal feature – Open disclosure
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2012/12/open-disclosure

Medical Board of Australia
Good medical practice: a code of conduct for doctors in Australia
medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

An adverse event can be a challenging situation for doctors.

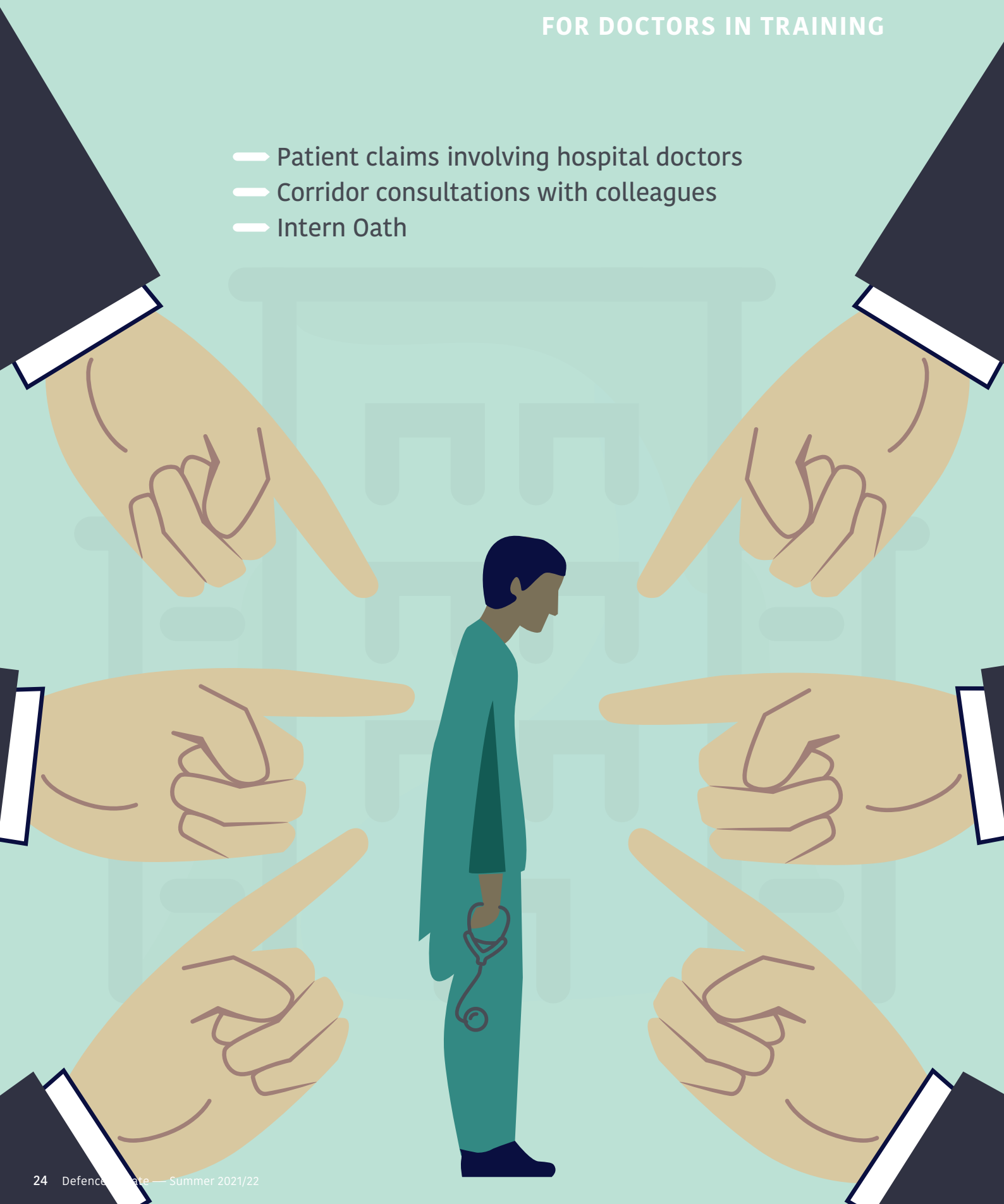
If you need any advice on such matters, please contact our Medico-legal Advisory Services team for assistance on **1800 011 255**.



Firstdefence

FOR DOCTORS IN TRAINING

- Patient claims involving hospital doctors
- Corridor consultations with colleagues
- Intern Oath



Patient claims involving hospital doctors

Janet Harry
Medico-legal Adviser, MDA National

From time to time, doctors employed in the public hospital system are contacted by lawyers acting on behalf of the hospital.

When a patient makes a claim

Patients can make a claim against a doctor or a hospital, alleging they received negligent treatment.

'Negligence' is a legal term, and the patient must prove negligence on the part of the doctor or the hospital by demonstrating:

- they were owed a duty of care
- the duty of care was breached, and
- the breach caused the damage or injury to the patient.

If the claim is against you

If you receive a letter from a lawyer asking to meet with you, prior to responding you should:

- contact MDA National for advice
- confirm that the lawyer is acting for the hospital
- confirm that you're entitled to hospital indemnity in the proceedings.

Once your indemnity has been confirmed, agree to liaise with the lawyer.

Prior to the meeting, review the medical records (it's vital not to make any changes to the records) or ask the lawyer to provide you with an advance copy of the records.

Bring any other relevant documents, such as separate or contemporaneous notes you may have made.

At the meeting, the lawyer will obtain detailed information about your role in treating the patient. Depending on the extent of your involvement, the lawyer will prepare a draft statement for your review.

You should check that the statement is a complete and clinically accurate description of your role in the patient's treatment. MDA National can help you by reviewing the draft statement, even in hospital-based matters.

Once you're satisfied with the statement, you can sign and date it and return it to the lawyers.

What happens next?

You may hear nothing more regarding the matter. The majority of medical negligence claims are either discontinued or settled without any hearing or trial, on a confidential basis.

In fact, less than one in twenty medical negligence claims proceed to a hearing – and matters of this nature can take up to three years to be resolved.

If the claim is against the hospital

If the lawyer is acting for a patient who is suing the hospital, you should first contact MDA National or the hospital's administration or legal team for advice.

Generally, in this instance, the advice will be that you should not speak to the lawyer.

Whether it's MDA National or your hospital requesting information, it's important to cooperate with whoever is indemnifying you – as it's in their best interests to protect your best interests.

A request for a statement is not a reflection of your care. The purpose of your input is to help the lawyer acting on behalf of the hospital to piece together the whole story, so they can determine the best way to manage the matter.

Corridor consultations with colleagues – an ethical dilemma

Dr Julian Walter
Medico-legal Adviser, MDA National

It was a simple request from a staff member on the team. "Do you mind taking a look at a freckle on my leg?"

The doctor was chuffed at being consulted for advice by a colleague. Surely it would be churlish to decline.

Seeing staff as patients

Time-poor hospital staff and easy access to doctors means you will inevitably have to deal with requests to provide health advice and care to your work colleagues.

How could you not write a script if their contraceptive has run out, or prescribe sleeping tablets in the middle of a run of nights? It's always 'just' a pathology test, a referral, or a quick question to save them the hassle of booking a GP.

What we so easily overlook is that when you provide health advice and care in these situations, your colleague becomes your patient, whether you like it or not. And if your colleague is now your patient, how do you manage the doctor–patient boundaries when they invite you down to the pub?

Most 'corridor consultations' are a shadow of proper care

We cannot emphasise enough that serious complaints, employment matters and claims do arise from such care. Healthcare workplaces should have a policy discouraging, or carefully managing, clinical care being provided by staff to staff wherever possible.

In the rare case where this care is necessary and unavoidable, such as at a remote placement, do yourself and your colleague a favour and treat them properly as a patient. Structure the care as you would any other patient consultation, making it clear that this is non-negotiable.

The expected level of care

The Medical Board, your hospital or workplace, the coroner and the courts will all expect a certain level of care.

Did you:

- take a full history?
- properly examine your patient?
- objectively consider the differentials?
- document your findings?
- inform the usual treating doctors to maintain continuity of care?
- obtain informed consent?
- ensure appropriate follow-up occurs?

And the list goes on.

A stark warning

The Medical Board's code of conduct provides a stark warning. They are the 'bad cop' you can refer to when responding to a 'corridor consultation' request, if there's no other way out.

According to *Good medical practice: a code of conduct for doctors in Australia*:

4.15 Providing care to those close to you

Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with, and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the patient and doctor.

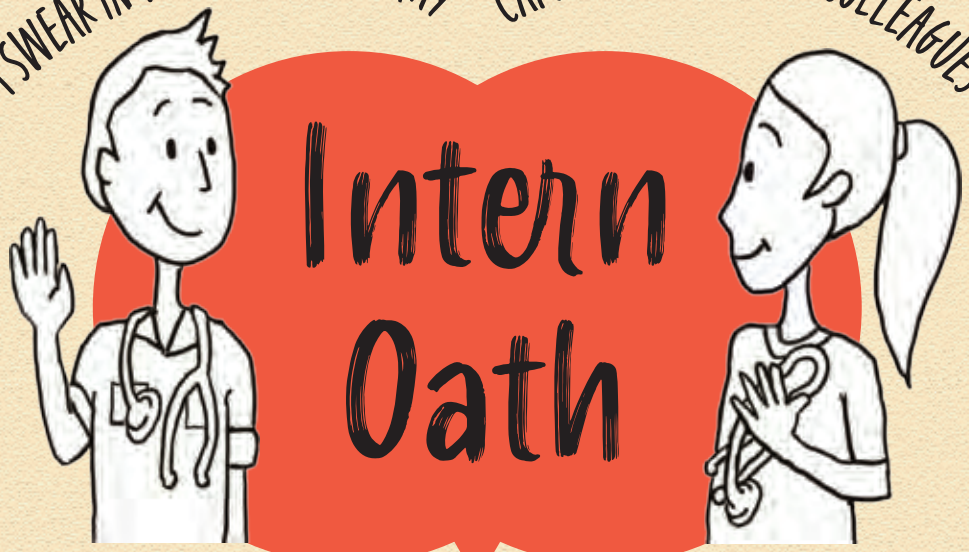
In particular, medical practitioners must not prescribe Schedule 8, psychotropic medication and/or drugs of dependence or perform elective surgery (such as cosmetic surgery), to anyone with whom they have a close personal relationship.

In some cases, providing care to those close to you is unavoidable, for example in an emergency. Whenever this is the case, good medical practice requires recognition and careful management of these issues.

The staff member was encouraged to see their own GP and was subsequently referred to a dermatologist. This was fortunate, as that freckle was an atypical melanoma.

It would have been so easy to have glibly reassured them it was nothing to worry about.

I SWEAR IN THE PRESENCE OF MY CAPABLE & ESTEEMED COLLEAGUES



Intern Oath

I WILL

1. *Look after myself and my colleagues in the face of adversity and 80 unfinished discharge summaries*
2. *Speak up against bullying, harassment or unprofessional behaviour in my workplace*
3. *Stay at home when I am sicker than my patients*
4. *Be hydrated enough not to initiate MET calls for my low urine output*
5. *First take my own pulse in an emergency, and check on my colleagues' wellbeing as part of post-resuscitation care*
6. *Ask for help if I am struggling, having a bad day, or having difficulty responding to 11 simultaneous pages*
7. *Prioritise my allocated education time over non-urgent administrative tasks*
8. *Not feel guilty over taking my half day or claiming hard-earned overtime, and support my colleagues to do the same*
9. *Be a doctor to everyone but NOT my family, friends or to myself*
10. *Have my own GP and prioritise my physical and mental wellbeing to set a good example, and to protect my patients.*

AMA WESTERN AUSTRALIA

dhaswa doctors' health advisory service

Developed by AMA (WA) Doctors in Training Welfare Committee

First published in the AMA (WA) Intern Guide 2021

Doctor drawings by **Dr Sarah Newman**

Design concept & artwork by **Niranjala Hillyard** ~ INKPOT & PIXEL

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Are you one of the many doctors who feel like a fraud?

Feeling like an imposter is common, especially in stressful occupations requiring advanced degrees.

It can lead to anxiety, social withdrawal and burnout.

- Hear from MDA National Members about imposter thinking.
- Discover strategies to respond to these thoughts.

Podcasts include:

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  Focuses on how imposter syndrome is experienced
  

- **Part two – *Taking action!***
  Explores multiple strategies for responding to maladaptive imposter thoughts
  

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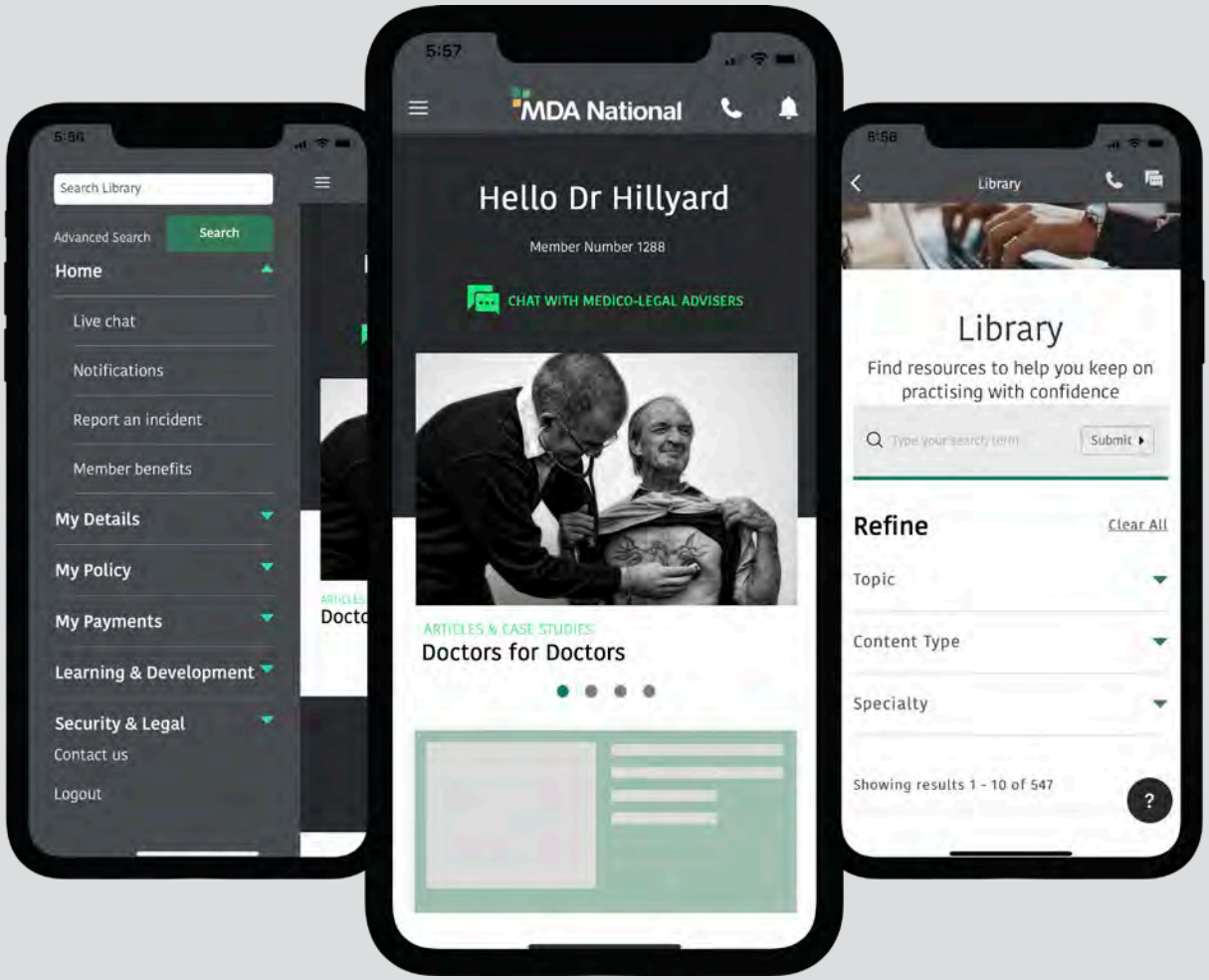
As a Member, you can access the MDA National app to update your personal and Policy details, watch videos and recorded webinars, read case studies and articles, and connect directly with our medico-legal experts via LiveChat.



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