Summer 2020

Defenceupdate

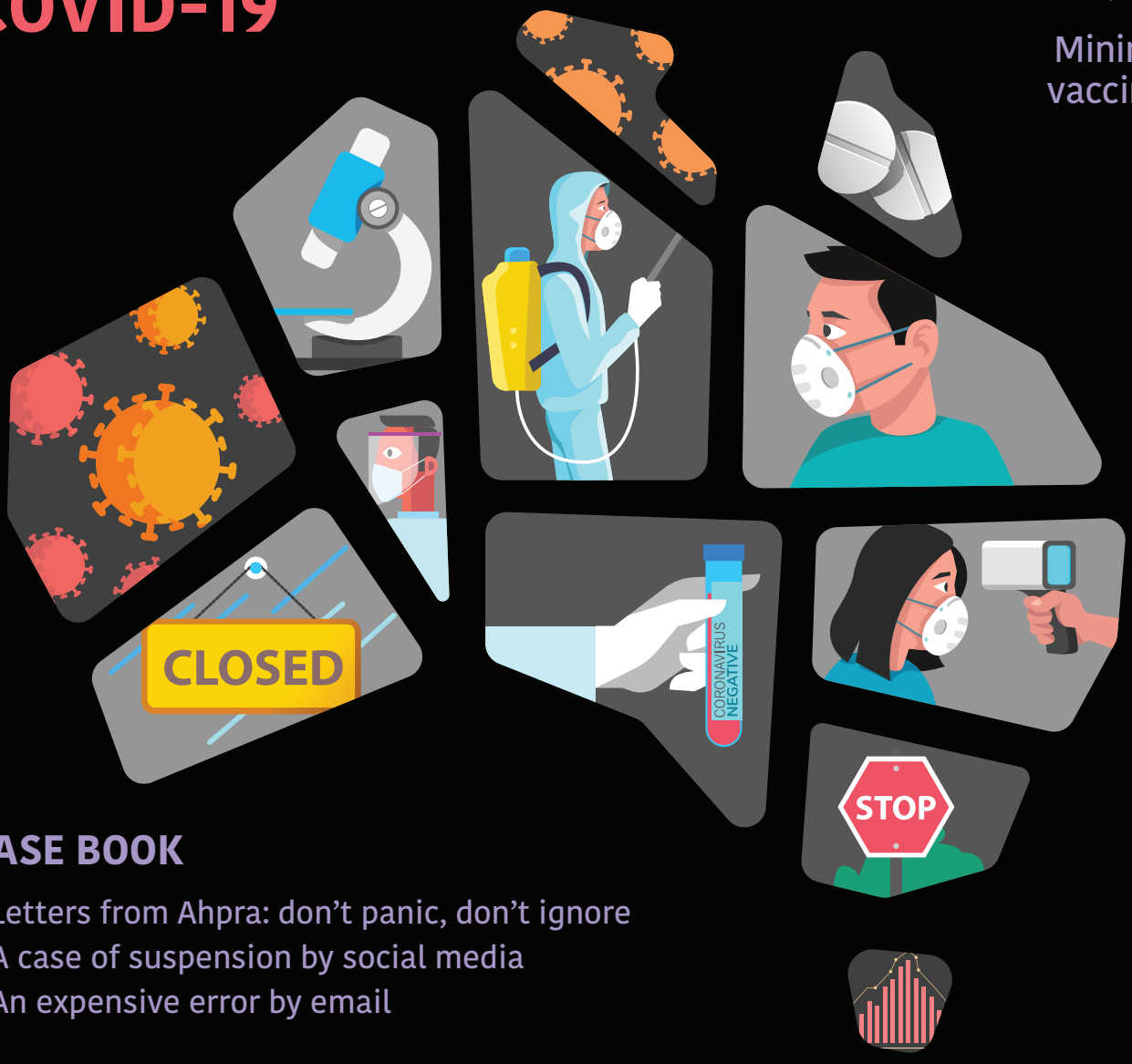
FOR MEDICAL PRACTITIONERS

A NATION'S CAPACITY: COVID-19

The pandemic's connection paradox

Ahpra notifications – one doctor's journey

Minimising vaccination errors



CASE BOOK

- Letters from Ahpra: don't panic, don't ignore
- A case of suspension by social media
- An expensive error by email

Medical certificates: what you need to know

FIRST DEFENCE

Feature section for doctors in training

MDA National

WELCOME

Welcome to our Summer 2020 edition of *Defence Update*.

The COVID-19 pandemic has continued to affect all our lives this year, both professionally and personally. In this edition, we hear from Dr Nick Coatsworth who was involved in guiding the national pandemic response as Deputy Chief Medical Officer.

On a more personal level, guest authors Dr Caroline Elton and Dr Katie Moore discuss the effect of the pandemic on doctors' mental health and some tips for coping.

Our medico-legal feature (pages 13-16) is focused on writing medical certificates, something that generates many questions for our Medico-legal Advisory Service.

Social media and emails are commonly used within the medical profession, but this can be the cause of problems for doctors and medical practices – as shown in our Case Book section (pages 17-23).

It's easy to press 'send' and dispatch an email into cyberspace, but there can be unfortunate consequences when emails go astray. Social media also has its pitfalls, and we review a recent case referred to Ahpra which highlights the need for caution. Your professional character may be judged by the content you post or 'like' online.

Dr Jane Deacon
Manager, Medico-legal Advisory Services

While the pandemic has been playing out, medical practice continues, and some practitioners may find themselves in a situation involving a letter from Ahpra. One of our Members has kindly agreed to share his experience on this, and we provide further information about Ahpra and the notification process.

In our First Defence section (pages 24-28), we present a review of the year for doctors in training, plus some tips for tricky conversations.

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

- *Defence Update* articles can be found online on our library webpage: **mdanational.com.au/advice-and-support/library**

CONTRIBUTING AUTHORS

Dr Nick Coatsworth
Deputy Chief Medical Officer, Australian Government

Dr Caroline Elton
Counselling and Occupational Psychologist

Dr Katie Moore
Paediatric Oncologist, Monash Children's Hospital

Dr Sara Bird
Executive Manager, Professional Services, MDA National

Gayle Peres da Costa
Medico-legal Adviser, MDA National

Marika Davies
Medico-legal Adviser, MDA National

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

Nerissa Ferrie
Medico-legal Adviser, MDA National

Kym Gardner
Medico-legal Adviser, MDA National

Janet Harry
Medico-legal Adviser, MDA National

Nicole Harvey
Education Manager, MDA National

Gae Nuttall
Risk Adviser, MDA National

Dr Julian Walter
Medico-legal Adviser, MDA National

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.

Update on Voluntary Assisted Dying (VAD)

Gayle Peres da Costa
Medico-legal Adviser, MDA National

VAD laws came into effect on 19 June 2019 in Victoria. A VAD Review Board was established to ensure compliance and to monitor permit applications for the VAD substance. Here are the key points from the Board's report on the first half of 2020:

50% increase in eligible applications

30% increase in the number of medical practitioners ready and able to use the portal

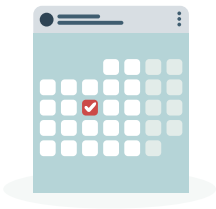
Increased number of applications from regional areas due to improved access.

422 medical practitioners have completed training and registered in the portal. They comprise:

- 50% general practitioners
- 16% oncologists
- 5% neurologists
- 3% palliative medicine specialists.

More than **120** people have died as a result of VAD medication. Of permit holders who died:

- 58% through self-administration of a VAD substance
- 11% from administration by a medical practitioner
- 31% didn't use VAD medication.



25% of applicants have progressed between the first and last request within 11 days, with 50% within 19 days. Medications were dispensed within two business days for 42% of requests.

- There is still high compliance with the legislation.
- Telehealth is not an option for people wishing to access VAD.
- There is an increase in community awareness and conversations around VAD.
- It has been difficult to find evidence to meet the requirement that a patient has been a resident of Victoria for at least 12 months.

The WA *Voluntary Assisted Dying Act 2019* is expected to commence in mid-2021.

Voluntary assisted dying – what you need to know (June 2019)
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/voluntary-assisted-dying

How do medico-legal processes affect doctors' mental health?

The University of Melbourne is recruiting doctors with a physical or mental illness for an ethically approved research project. The project aims to investigate the impact of medico-legal claims, complaints and disciplinary processes on the mental health, emotional wellbeing, treatment and recovery of impaired doctors.

They are seeking expressions of interest from doctors:

- with a lived experience of cognitive impairment, mental illness, drug or alcohol difficulties, and
- who have experienced a medico-legal claim, complaint or disciplinary process in the last two years.

Eligible candidates will be required to:

- read some information about the study
- sign a consent form if willing to take part
- participate in a fully de-identified 90-minute interview.

This project is entirely independent of MDA National. Should you wish to participate, you will be liaising directly with the researchers who will not disclose your details to us.

To find out more, please contact **Dr Owen Bradfield owenmb@student.unimelb.edu.au**.

The presence of clinical leaders, within hospital administration and health bureaucracy, is critical in navigating some of the issues and providing confidence that the guidelines and policies we work to are indeed best practice.

Dr Nick Coatsworth

DOCTORS FOR DOCTORS

A nation's capacity: COVID-19

Dr Nick Coatsworth (MDAN Member)
Deputy Chief Medical Officer,
Australian Government

Writing this article is one of the last things I'll be doing as a full-time Deputy Chief Medical Officer of Australia. For me, like so many of us, the past six months have felt like years in terms of the pace of change and the need to adapt to COVID-19, both personally and professionally.

Each of us has experienced the pandemic in a different way. However, collectively as a profession, it has provided immense challenges in delivering timely and safe care while coming to terms with an unfamiliar feeling for most doctors – that our workplace is a potential hazard to ourselves, our colleagues and our families.

I started working for the Federal Department of Health on 23 March 2020. Opportunity often comes up at odd times. Like many doctors working in the public system I was feeling tired and burnt out, wondering which direction my career would head in – and in desperate need of a break after a torrid summer of east coast bushfires. The call from Professor Paul Kelly was out of the blue. Paul and I had been colleagues in ACT Health and knew each other from my previous role as Executive Director of the National Critical Care and Trauma Response Centre in Darwin. In a short instant, I was on the phone to my wife, excited and daunted by the prospect of working nationally to guide the pandemic response.

My first day in the National Incident Room (NIR) at the Department of Health in Canberra felt similar to other emergency responses I had been involved in, just on a far grander scale. The NIR is named for the late and great Professor Aileen Plant, the mother of field epidemiology in Australia. It was a hive of activity, the engine room of a 'whole of government response'. What was clear from the first instant was the sheer amount of human capital being brought to bear on this problem. Far from being a creaky, lumbering bureaucracy, what I saw gave me immense confidence in the nation's capacity to manage COVID-19.

But the mood was very different out in the profession and in the general public. Early restrictions were being introduced, and stories were emerging of health systems being overwhelmed and large numbers of healthcare worker infections. The immediate thought that entered my mind was how to convey to my colleagues the confidence I felt at seeing the inner workings of the national response to the community.

What followed was six months of providing a link between hospital-based clinicians and the Department of Health, and more time than I thought possible in front of TV cameras. A lot of my work ended up being trying to facilitate good ideas which required government support.

Working alongside the National COVID-19 Clinical Evidence Taskforce and helping the Australian and New Zealand Intensive Care Society and Ambulance Victoria roll out a national ICU bed capacity monitoring system were but two of many highlights during this time.

As I head back to the 'frontline' so to speak, the issue of healthcare worker infections weighs heavily, with more than 3,400 health and aged care workers in Victoria contracting COVID-19. One of the things we must do better is to provide confidence that lessons are learned that will protect us in the workplace. The debate over airborne transmission of COVID-19 has been particularly polarising.

The presence of clinical leaders, within hospital administration and health bureaucracy, is critical in navigating these issues and providing confidence that the guidelines and policies we work to are indeed best practice.

COVID-19 is here to stay, and we all need to work together to adapt to it.

The pandemic's connection paradox

Resolve to act as part of a positive legacy

Dr Caroline Elton
Psychologist specialising in supporting doctors

Nicole Harvey
Education Manager, MDA National

Dr Katie Moore
Paediatric Oncologist, Monash Children's Hospital

The population's health in the COVID-19 crisis depends on maintaining physical space between people where possible, importantly between colleagues at work. Yet the mental health of clinicians during the pandemic needs each of them to feel closely connected and supported, rather than feeling isolated and alone in their challenging work.

And when staff thrive, their patients have better clinical outcomes. It's vital that we tackle the paradox of bringing teams closer together while staying physically remote from one another.

Australian clinicians are learning from experiences here and overseas. The recent outbreak in Victoria challenged healthcare workers at a time when the usual informal support mechanisms were unavailable. How can we best support our colleagues when there's no close tearoom chat or comforting hug after a difficult shift?

For starters, it's worth remembering that psychological connectedness doesn't necessarily require physical proximity. Consider Lifeline's work providing many hundreds of thousands of crucial calls each year – people in extremis receive essential support from volunteers possibly thousands of kilometres away.

First things first

As vital as psychological connectedness is for staff wellbeing, other basic factors must already be in place. Maslow's hierarchy of needs reminds us of the importance of ensuring that clinicians are not thirsty, hungry or exhausted so that the care they offer to patients isn't compromised. The reality is that meeting these basic physiological needs can't be taken for granted – particularly in a pandemic.

Maslow also reminds us that people need physical and psychological safety to thrive. Mental health risks among staff increase when they feel that, in caring for patients, they are potentially jeopardising their own health or those of vulnerable family members at home – e.g. by risking becoming infected with SARS-CoV-2. Adequate personal protective equipment is a must.

Third in Maslow's needs hierarchy is belonging. This is where psychological connection comes in. Earlier this year, the *British Medical Journal* published an article by Prof Greenberg et al[1] describing ways to manage pandemic-related mental health challenges for healthcare workers. Notably, much of the advice from Greenberg et al relates to the need for belonging, or interconnects with both belonging and safety (as shown under 'practical tips' on the right).

Opportunity for post-traumatic growth

The concept of post-traumatic stress is well known, but we would like to emphasise another possible consequence of great stress – post-traumatic growth. While there's the potential for poorly supported doctors to experience psychological difficulties later, well-supported doctors may experience psychological growth, bolstered personal resilience, and strengthened self-esteem.

Give connection attention

The pandemic could lead to a reimagining of how we care for one another at the individual, departmental or organisational level. It's heartening that in recent years, staff wellbeing has received increasing attention. Now is the time to ensure words and intentions are put into action. There are many wonderful initiatives already in place, e.g. 'kindness cafés', peer support groups, Schwartz Rounds. For the most part though, these rely on staff volunteering their time. We ask all medical organisations to think about appropriately resourcing such initiatives with funding and time.

A well-managed response to supporting staff during a crisis is both a practical and moral imperative. Wouldn't it be wonderful if, as a legacy of this time of relative physical isolation, the issue of psychological connection receives the attention it desperately needs?

Reference

1. Greenberg N, Docherty M, Gnanapragasam S, et al. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. Br Med J 2020;368:m1211. Available at: bmj.com/content/368/bmj.m1211.

Practical tips to foster safety and belonging

From Greenberg et al[1]

- Prepare staff adequately. It makes a positive difference if they have an idea of what they may face at work, including when the situation is going to be difficult.
- Provide opportunities for staff to discuss both practical and emotional challenges. Opportunities for reflection and validation may be informal and incidental, or planned and formal, e.g. Schwartz Rounds bring together clinical and non-clinical staff, reduce feelings of isolation and, where necessary, can be held virtually.
- Address the potential for, and anguish resulting from, any distress which can occur if staff have to act at odds with their personal ethics, e.g. if suboptimal choices must be made due to the unavailability of resources or competing demands. Clinical ethics committees can help resolve issues of moral distress.
- Be alert to those who don't attend staff discussions. Avoidance is a common mechanism for managing distress, so it's possible that someone who's always "too busy" or "not available" might be struggling with the emotional demands of the work. If this is the case, they'll need particularly sensitive help or referral to an appropriate support service.
- Single session psychological debriefing is not advised – it can augment rather than decrease distress.
- Senior managers need to support their juniors' wellbeing. All team members are strongly influenced by the attitudes of their seniors.
- Once any immediate crisis is over, senior staff "... should ensure that time is made to reflect on and learn from the extraordinarily difficult experiences" the team may have encountered. Staff should continue to actively check on each colleague's wellbeing.

Ahpra notifications – one doctor's journey

Nerissa Ferrie
Medico-legal Adviser, MDA National

Medico-legal advisers frequently hear the anger, fear and doubt doctors may experience in the face of a notification from Ahpra. Some allegations are more difficult to handle than others, but any matter that progresses past the initial investigation stage can extend the timeframe for resolution, and therefore the anxiety it creates.

Ahpra released some helpful resources[1] in 2018 to explain the notification process and link practitioners to the support services available to them. While this information helps to normalise the process, each individual doctor will deal with the situation differently.

Here is a first-hand account from one of our longstanding Members.

I am an obstetrician and gynaecologist working in both private and public practice at a large tertiary teaching hospital.

Last year, I received notification from Ahpra that I was being investigated following a patient complaint. I was accused of making inappropriate sexual comments and failing to ensure a patient's privacy.

The complaint related to a brief consultation 12 months prior in a public gynaecological outpatient clinic.

The patient had made an informal complaint to the hospital about two months after I had seen her. My head of department made me aware that the patient had complained about my manner, and my failure to properly cover her during an examination. The patient was seeking an apology and financial compensation.

I examined the patient's chart and noted that a nurse chaperone had assisted me throughout the minor procedure.

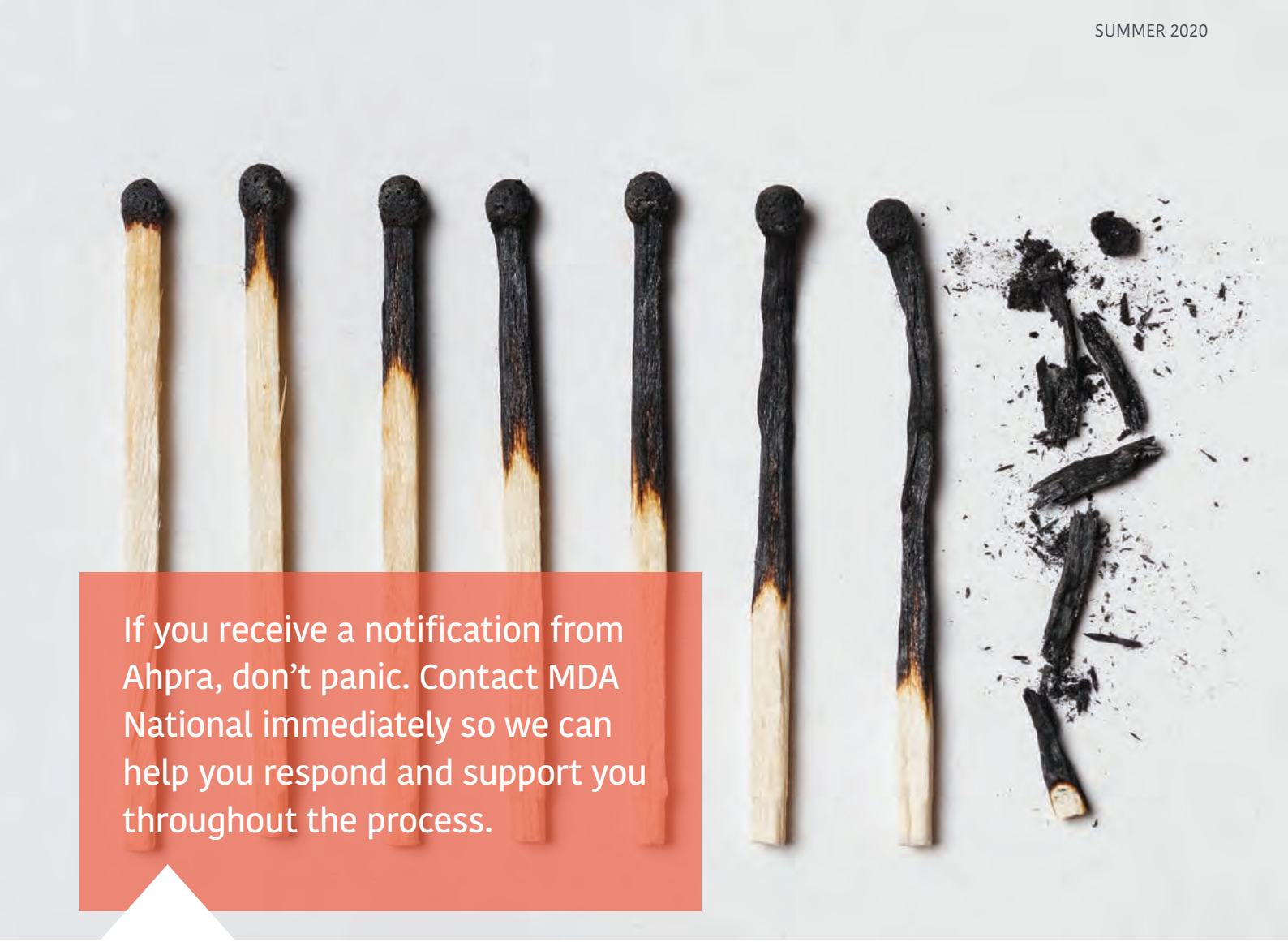
At the time, I suggested that the head of department contact the nurse chaperone for further clarification as I had no personal recollection of the consultation. I did not accept the allegations due to my invariable practice of preserving a patient's modesty. However, I offered the patient a conditional apology for any unintentional distress as a gesture of goodwill. I also suggested that her care be transferred to one of my colleagues. The head of department subsequently advised me that the complaint had been investigated by the hospital and they considered the matter closed.

I was therefore shocked to receive a notification from Ahpra many months later. I immediately contacted MDA National for advice. In compliance with Ahpra regulations I advised my employer, and any hospital that I had admitting rights to, that I was being investigated.

I felt humiliated.

I responded to the complaint with MDA's assistance, explaining that I had no recollection of the consultation. I outlined my usual practice during a consultation and examination, and I explained the role of nurse chaperones during this process.

I reassured Ahpra that following the complaint, I had reviewed my usual practice to ensure that I was complying with AMA, MDA and hospital guidelines regarding patient–doctor boundaries and conducting intimate examinations, and I was conforming to the



If you receive a notification from Ahpra, don't panic. Contact MDA National immediately so we can help you respond and support you throughout the process.

Medical Board's Code of Conduct. I was confident that I was compliant and up to date.

About six months after my response, I received notification from Ahpra that they proposed to issue me with a caution.

I was devastated.

I started to question my competence, and I could barely sleep for more than two hours without waking and worrying about the case. I became very wary of each patient encounter. COVID-19 and telehealth came as a welcome relief at the time, as I no longer needed to see patients face to face.

With assistance from MDA, I responded to Ahpra's proposal to caution, strongly denying any wrongdoing. I provided testimonials from medical and nursing colleagues, and I asked for the opportunity to present in person to the Medical Board.

Permission was granted, and I subsequently had a Zoom hearing with the Medical Board and my MDA representative.

Several weeks later, I received notification from Ahpra of its decision 'to take no action in relation to the matter'. A few months on, I remain somewhat distrustful of patients and their motives.

I appreciate that Ahpra has a role in protecting patients and upholding the ethics of the profession, but it felt like my guilt was assumed and everything that the complainant alleged was true – however implausible or unlikely.

We are really grateful to our Member for his candour. Doctors often feel alone and avoid talking to family members or trusted colleagues for fear of having their reputation diminished by virtue of a notification.

Dr Deacon's article on page 18 discusses Ahpra statistics in more detail. It's important to note that the majority of notifications are resolved with no further action against the medical practitioner – but this is cold comfort when you're the one being investigated.

You should never ignore a notification, but nor should you let it cloud your judgement to the point that you're no longer effective as a doctor. Trust, communication and mutual respect are vital in any good therapeutic relationship, and we find that many notifications arise due to a misunderstanding or miscommunication.

Reference

1. Ahpra & National Boards. Further information: ahpra.gov.au/notifications/further-information.aspx

Minimising vaccination errors

Gae Nuttall
Risk Adviser, MDA National

MDA National has received an increasing number of calls and formal complaints regarding vaccination errors, which can be distressing to patients, parents and practitioners.

This increase may be due to an ever changing and increasingly complex national immunisation schedule and public awareness regarding immunisation. Most errors occur either during vaccine selection and preparation, or history checking and scheduling.[1]

What can you do to limit errors?

Preparation

- Check patient details:
  - three points of ID, especially DOB for children to ensure the correct age and schedule
  - the correct patient file
  - previous immunisation history.
- Pre-vaccination assessment of the patient – if this is done by a nurse with a doctor involved, then the doctor should confirm no contra-indications noted and document the required vaccine order.
- State-appropriate national immunisation schedule – keep an up-to-date schedule visible to confirm the vaccination order. All states and territories have their own legislation and requirements which you must comply with.
- Child vaccinations – view the child's state health record with the parent or guardian to explain which immunisations are due to be given and the procedure that the clinic follows.
- Seek informed consent:
  - discuss the benefits of the vaccine (e.g. influenza type covers various strains)
  - discuss limitations (e.g. influenza vaccine won't prevent all respiratory virus)
  - discuss more common potential side effects (e.g. fever, tenderness at injection site)
  - discuss unlikely potential side effects (e.g. anaphylaxis)
  - answer any questions or concerns.
- Assemble the vaccines – wherever possible, have a second clinician to check, and check again that you have the correct vaccines including the expiry date.
- Use correct infection control standard protocols – patients notice when practitioners don't wash their hands!
- Labelling in vaccine fridge – have different vaccines clearly separated, don't rely on container labels having correct contents.
- Check vaccine expiry dates regularly.

Vaccine administration

- The injection site is dependent on age.
- If the patient is a child, ensure they are in a safe and appropriate position with the assistance of a parent or guardian.

Post vaccination

- Provide the patient or guardian with a common reactions sheet.
- Complete all documentation including batch numbers and the site of the vaccine administration.
- Advise the patient or guardian when the next vaccinations are due and add a reminder on your system.
- Monitor the patient for any adverse reactions for 15 minutes before discharge.

Vaccine intervals

The National Immunisation standard protocol is a four-week interval between vaccines. The *Australian Immunisation Handbook* section on 'Principles of catch-up vaccination' states the following:[2]

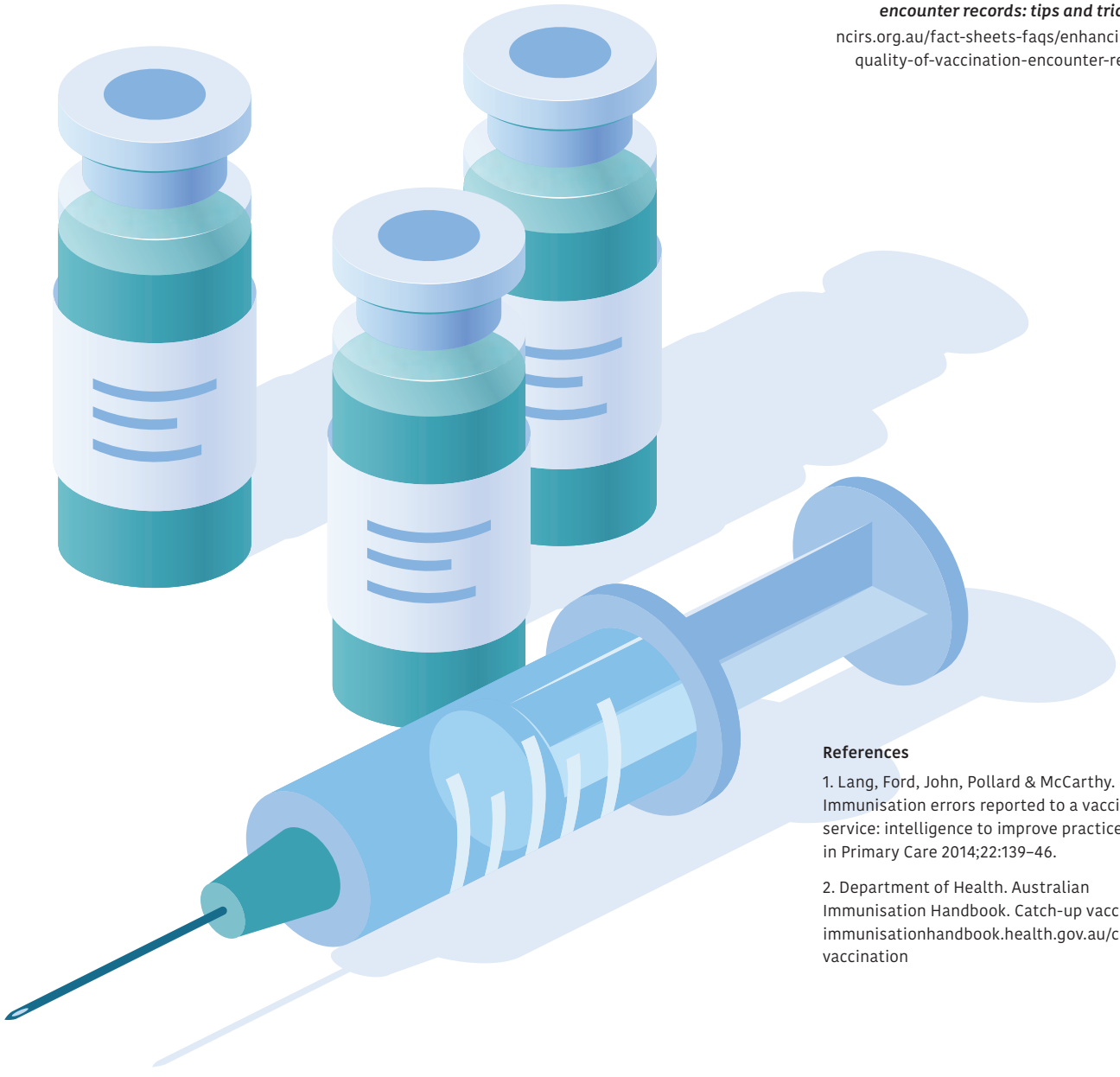
As a general rule, healthy individuals can receive inactivated vaccines at any time before or after, or at the same time as, all other vaccines registered in Australia. Please refer to disease-specific chapters for exceptions. People can receive multiple live parenteral vaccines either at the same time or at least four weeks apart.

Practice responsibilities

- Ensure practice vaccine protocols are up to date and appropriate.
- Nurses should have completed appropriate courses and attended annual updates.
- All clinical staff must have appropriate professional indemnity insurance.
- Vaccines must be stored appropriately, with clear labelling, temperature log, etc.

Billing

If billing via the MBS, the doctor must consult with the patient.
The usual consultation criteria apply.



More resources

Department of Health
National Immunisation Program Schedule
health.gov.au/health-topics/immunisation/immunisation-throughout-life/national-immunisation-program-schedule

State and territory immunisation contacts
health.gov.au/health-topics/immunisation/immunisation-contacts#state-and-territory-health-services

Immunisation
health.gov.au/health-topics/immunisation

National Vaccine Storage Guidelines – Strive for 5
health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5

NCIRS
Fact sheets, FAQs and other resources
ncirs.org.au/health-professionals/ncirs-fact-sheets-faqs

Enhancing data quality of vaccination encounter records: tips and tricks
ncirs.org.au/fact-sheets-faqs/enhancing-data-quality-of-vaccination-encounter-records

References

1. Lang, Ford, John, Pollard & McCarthy. Immunisation errors reported to a vaccine advice service: intelligence to improve practice. Quality in Primary Care 2014;22:139–46.

2. Department of Health. Australian Immunisation Handbook. Catch-up vaccination: immunisationhandbook.health.gov.au/catch-up-vaccination

Make work experience a smooth experience

Dr Julian Walter
Medico-legal Adviser, MDA National

Having a work experience student at your practice who is interested in becoming a healthcare professional is a great opportunity to nurture the next generation of healthcare workers. But careful planning is important to minimise risks for the student, patients and staff.

Managing students at the practice

Setting expectations is vital, and it's helpful to have an information sheet for the student, patients and staff.

PATIENTS

- Consent is paramount. Allow patients to 'opt in' (the student won't attend a consultation unless the patient agrees) rather than 'opt out'. This consent conversation should happen without the student present.
- Inform your patients that they can request the student to leave at any time.
- Put up abundant signage and explanations, for example:

  We have a work experience student at the practice today. If you are comfortable with the student observing your consultation, please let the reception staff know. Patients are under no obligation to agree to student observation and can change their mind at any time.

STUDENTS

- Ensure the student understands when they will or won't be attending patient care, and that they may need to step out for parts of a consultation (e.g. intimate examinations) if their presence interferes with care.
- Indicate your expectations (typically limited to discussion after a consultation). Where will they sit or stand? Ask them to indicate what they expect to gain from the work experience.
- Ensure a safe workplace – explain what they should do if they feel faint or unwell. Make sure the student is covered by public liability (slip and trip) and indemnity insurance policies. Consider what consultations pose too high a risk (e.g. aggressive patients, infectious risks, immunisation status).

STAFF

- Ensure staff are aware of the student's attendance, what the student is seeking to gain, and what activities are appropriate or inappropriate. Demarcate roles and what the facility expectations are.
- Discuss infection control, e.g. importance of hand hygiene and not touching sharps.
- If student participation interferes with the staff's ability to provide safe health care, staff should communicate this to the facility immediately.

Confidentiality and privacy

Privacy breaches may occur when a student discusses an identifiable patient outside of the practice. This can result in claims, complaints to the facility, or privacy and healthcare complaints. Patient trust and rapport may also be affected, resulting in adverse public relation outcomes (e.g. social media posts).

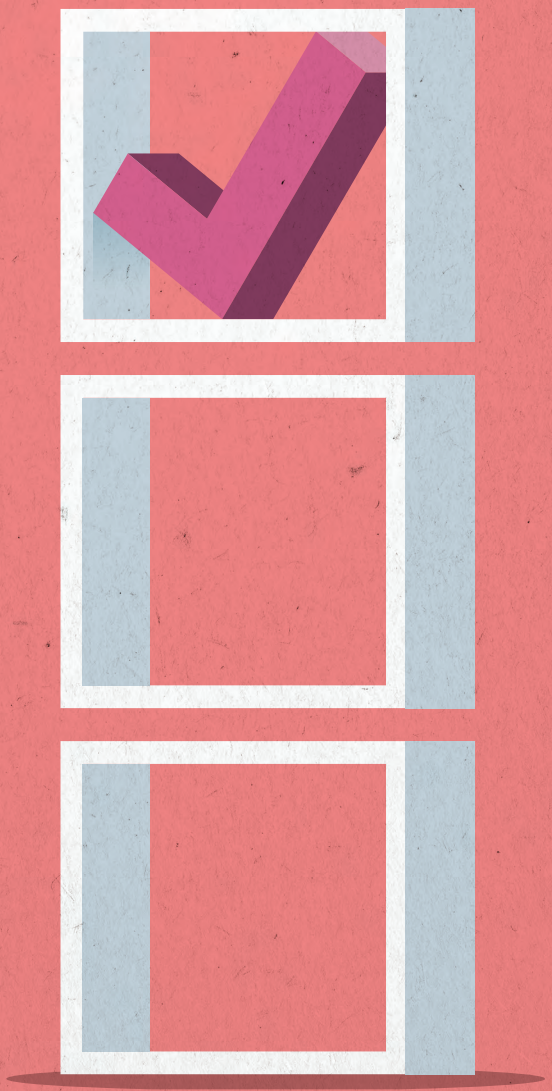
It's common practice for a student to sign a confidentiality agreement. This highlights to the student the importance of patient privacy, rather than being a legally enforceable obligation. The student is not bound by any professional duty of confidentiality, nor are they subject to an employment contract.

- Work experience students should not provide health care, and they are not registered to do so.
- Take care to prevent the student being indirectly exposed to identifiable information, where the patient has not provided consent (e.g. reading records, discussion about patients at handover and case meetings).
- Complaints typically involve patients who:
  - did not consent to the student being present
  - felt they were coerced into having the student present
  - were uncomfortable with the student's presence (particularly during intimate examinations, which you may not be able to anticipate at the time of booking).

MEDICAL CERTIFICATES

What you need to know

Medical practitioners are entrusted with the authority to sign medical certificates, exempting patients from a wide range of activities. But the provision of these certificates by doctors generates many questions for our Medico-legal Advisory Service at MDA National.



Tips for writing medical certificates

Dr Julian Walter
Medico-legal Adviser, MDA National

Medical certificates can lead to complaints by patients and those receiving the certificate (e.g. employers, courts, education facilities). Whether to issue a certificate, or what to say, can pose challenging dilemmas.

When should I avoid issuing a certificate?

You must reasonably believe that the certificate you're issuing is accurate and not misleading. In some circumstances, saying 'no' to the request will be appropriate, despite the patient's protests.

You should decline issuing a certificate in situations where you're concerned about the accuracy of the information (e.g. insufficient evidence of illness, concern about veracity of the information) or where the request is outside the scope of your care or expertise.

Managing a refusal to provide a certificate can be challenging, as it represents a conflict between your role in supporting your patient and your professional obligation of accuracy. You can seek advice from our Medico-legal Advisory Service if you feel uncomfortable about providing a certificate.

Do not issue a certificate for yourself, and avoid issuing a certificate for close friends and family. Where issuing a certificate, you should have consulted with the patient and made an entry in the records.

Remember that medical certificates are legal documents, and you may be required to give evidence about a certificate you have issued. Signing a false or misleading certificate can result in disciplinary consequences and legal action.

What should I record on the certificate?

The certificate should not be addressed 'To whom it may concern' as this poses the risk of it being used for a different purpose to what you had expected. Address it to the intended audience – even if it's just 'Dear Court', 'Dear Workplace, or 'Dear University'.

Certificates should be written in layperson's language. Include your name and address, and the name of the patient. Consider including whether the patient should be absent from the activity, or is able to attend in a reduced capacity.

Generally, a medical certificate should not reveal a diagnosis, unless the patient consents to this. However, a patient's partial consent cannot justify the issuing of a misleading certificate or missing critical information. There are circumstances (e.g. workplace health and safety) where clinical information is required – however, the patient must still consent, otherwise you risk breaching patient trust and confidentiality.

Any dispute over how much clinical information needs to be included, in the absence of patient consent, is between the patient and the party they are presenting the certificate to. Avoid the provision of employment advice (e.g. commenting on the employers' right to request information) – this should be sought externally by the patient.

Where providing clinical information (with consent), indicate the source of the information (e.g. "The patient discussed..."; "My examination revealed..."; "Review of records...").

How should I date a certificate?

A certificate should be dated and signed on the day the certificate was issued – the 'issue date' should never be backdated. The certificate may also refer to several other dates, if these are different to the issuing date (e.g. the consultation date; the date of the illness as stated by the patient; the dates the patient is off work).

Care should be taken in deciding to issue a certificate covering a historic time period, where the initial consultation occurs significantly after the illness. In this case, you may need to explain the difference between the date of illness, consultation date and certificate issue date. A letter of support may be more appropriate.

What consultation notes should I capture?

As doctors, we're not just a mouthpiece for the patient's claim. In circumstances of subjective illness (e.g. mental health concerns), we have a professional responsibility to consider the clinical issues relevant to the patient's presentation, and to make reasonable enquiries to verify information and the accuracy of the certificate.

You are still obliged to take a history and relevant examination – and this information should be captured in the records. The Board may consider your records and consultation if a complaint is made about the certificate.

- What are the events leading up to the event requiring certification?
- Are the symptoms serious enough to require follow-up or referral?
- Is the patient at risk?
- Have you recorded basic observations and a relevant physical examination (e.g. that 'gastro' might just be the beginning of appendicitis)?
- Have you considered objective tests and other investigations (e.g. K10 for mental health concerns)?
- What safety-net advice have you provided?

What if I can't issue a certificate?

You may be able to issue a 'letter of support' – ideally label the document as such and refer to not being able to certify a condition. This is a document that seeks the favourable consideration of the patient's request and may discuss their credibility. With consent, you can include indirect supportive information. While letters of support often just reiterate the patient's request, without you being able to objectively add to the situation, they may still be of assistance.

What should I consider when certifying fitness?

These requests can be complex and may require specific advice. It's much simpler to certify (with consent) the presence of pathology, or specific negative findings, than attesting in an open-ended fashion to a patient's general fitness. Consider carefully what you're being asked to certify, as there's a risk that certifying fitness transfers legal risk to the practitioner. Also consider that it may not be possible to provide the requested certification.

Some requests require information not available to the doctor (e.g. what fitness standard is relevant; what a role entails, inability to simulate the required activities). Other requests will be outside the expertise of the doctor. Any limitations to your certificate should be noted.

You could decline to follow the requested wording, choosing only what information you can provide. It can be helpful to refer to accepted standards and whether the patient met them. Use of double negatives may assist in meeting the request – e.g. "There is no evidence that the patient is unfit to return to work" – as this avoids certifying fitness. Recommendations as to further testing may be helpful.

The Medical Board has high expectations of practitioners who issue certificates, as stated in the Code of Conduct (at 10.9):

10.9 Medical reports, certificates and giving evidence: *The community places a great deal of trust in doctors. Consequently, doctors have been given the authority to sign a variety of documents, such as a medical certificate of cause of death (death certificates) and sickness certificates, on the assumption they will only sign statements that they know, or reasonably believe, to be true. Good medical practice involves:*

- 10.9.1: *Being honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate.*
- 10.9.2: *Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately.*
- 10.9.3: *Preparing or signing documents and reports if you have agreed to do so, within a reasonable and justifiable timeframe.*
- 10.9.4: *Making clear the limits of your knowledge and not giving opinion beyond those limits when providing evidence.*

More information

Exercise caution: fitness certificates and medico-legal risks
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2013/12/exercise-caution-fitness-certificates-and-medico-legal-risks

Sample medical certificates

Certificate issued for historic period with differing consultation and issue dates

[Issue date]

Dear Workplace

Jill was seen on 20 December 2020, for a medical condition requiring time off work between 16-19 December 2020 inclusive.

Fitness certificate

Dear Workplace

Jack does not meet the current [date] Commonwealth Department of Health [link] guidelines for a suspected COVID-19 case, and there is no current indication for further testing. I can find no reason why he should not return to work.

Dear Gym

Other than mild asthma, Jill is not known to have other significant illnesses. She had a negative stress test in 2015 and has a normal blood pressure, BMI, and resting pulse. Based on the history, examination, and investigations, I can find nothing that would preclude Jill from joining the gym. I can arrange referral (e.g. exercise physiologist) if a more specific assessment is required.

Certificate with consent

Dear Workplace

The following has been provided with Jack's consent. He will be off work from 1-3 January 2021, following surgery for appendicitis on 26 December 2020.

After this, he would be able to return to a role with no lifting or more than gentle ambulation for two weeks, and may require reduced hours based on discomfort from prolonged sitting. Further guidance can be provided at that time.

Letter of support

Dear University

Jill has been my patient for 10 years and has requested this letter of support. She informs me she was unwell in January for two weeks and unable to sit for her exams. I did not review Jill at the time, so I cannot issue a medical certificate.

Jill does have a known significant illness and has required certificates for time off for similar past episodes. Could you consider this information in deciding whether to grant Jill an exam re-sit?

CASE BOOK

- Letters from Ahpra – don't panic, don't ignore
- A case of suspension by social media
- An expensive error by email

CASE BOOK

Letters from Ahpra – don't panic, don't ignore

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

It's a situation every doctor dreads – a letter from Ahpra advising of a 'notification'. If this happens, don't panic. But don't ignore the letter either.

The complaint

Dr Lim was partway through a busy morning in his general practice when he received a phone call from Ahpra advising that a notification had been received about him. Dr Lim was very shaken by the phone call and afterwards could not recall exactly what he had been told, except that he would soon receive a letter from them. He thought the matter must be serious because they had called him, and he expected the worst.

In due course, Dr Lim received a letter from Ahpra. The complaint was from the mother of a child whom he had seen earlier in the year.

I took my baby to Dr Lim as she was obviously unwell with a fever and crying. He told me there was nothing wrong with my baby, and she didn't need antibiotics. Two days later, she was no better and I took her to another doctor who said she had an ear infection and needed antibiotics. Dr Lim should have done his job properly and given her antibiotics.

Dr Lim reviewed his notes from the consultation and found them to be thorough. He had clearly documented his findings, including his examination of the baby's ears which were not red. He had also suggested that the mother bring the child back for another review if she was not improving in 24 to 48 hours.

Dr Lim contacted MDA National and we assisted him with providing a response to Ahpra. He provided an explanation of his assessment, explaining that at the time he saw the child there was no sign of an ear infection, and it was likely that the ear infection developed after he had seen the child. Ahpra decided to take no further action.

Receiving a phone call or letter from Ahpra can cause an emotional reaction and stress for many doctors. But remember that receiving a complaint is fairly common for doctors, and most notifications are dismissed with no further action.

Notifications to Ahpra

In the National Scheme, a concern raised about a registered health practitioner or student is called a notification. Ahpra manages notifications in partnership with the National Boards. Anyone can notify about a doctor's health, performance or conduct. In our experience at MDA National, difficulties with communication are often a contributing factor.

Ahpra has changed the way doctors first hear about notifications, and the first contact may be a phone call – as it was for Dr Lim. The fact that it's a phone call does not mean Ahpra considers the matter to be especially serious or trivial.

Responding to a notification

However trivial or without basis a complaint may seem to a doctor, a notification from Ahpra should always be responded to. We strongly recommend that you contact us immediately upon receiving a phone call, complaint or notification from Ahpra (or any other regulatory body) so that we can support you in a timely manner and guide you through the process. We can help you draft a response, ensuring all issues of concern are addressed objectively and appropriately.

Following preliminary assessment, the medical practitioner will be notified of what further action, if any, will be taken. This may include:

- taking no further action
- investigating the notification
- requesting a health assessment or a performance assessment of the practitioner
- referring the matter to a health or performance panel hearing
- referring the matter to a tribunal hearing
- issuing a caution
- accepting undertakings
- imposing conditions on the practitioner's registration
- taking immediate action on the practitioner's (or student's) registration.

Data from the Ahpra 2018/19 Annual Report:[1]

There are **118,996** registered medical practitioners in Australia.

6,970 registered medical practitioners (or 5.9%) had notifications made about them – based on Australia-wide data, including HPCA and OHO.

Overall, **1.7%** of all health practitioners were the subject of a notification (which meant doctors received more notifications than other health practitioners). Of those notifications, **73.8%** had no further action taken.

The most common source of a notification is a patient, relative or member of the public. Notifications are also received from other health practitioners and employers of doctors.

Most common type of complaint:

Clinical care	**56.2%**
Medication	**10.2%**
Communication	**6.1%**
Behaviour	**5.2%**
Documentation	**4.8%**
Other	**17.6%**

Reference

1. Australian Health Practitioner Regulation Agency. 2018/19 Annual Report: ahpra.gov.au/publications/annual-reports/annual-report-2019.aspx

CASE BOOK

A case of suspension by social media

Dr Sara Bird
Executive Manager, Professional Services
MDA National

A GP's registration was suspended as a result of his social media commentary on clinical issues and his opinions about certain religions and other groups.[1]

Case history

The Practice Manager made a notification to Ahpra about the GP. The notification prompted an investigation into the GP's use of social media, including his personal Facebook page and four Facebook pages of entities he established or represented.

His posts expressed views about clinical issues including vaccination, chemotherapy, and treatment of COVID-19. There were disparaging comments about medical practitioners and the hospital system. One post stated: "IF YOU SEE A PSYCHIATRIST YOU MAY AS WELL SEE AN UNDERTAKER!!" Some of the posts were denigrating and demeaning to the LGBTQI community and the religion of Islam. Other posts included anti-abortion sentiments.

Medico-legal issues

Ahpra issued a notice of proposed immediate action. In response, the GP offered an undertaking to close his social media accounts; that he would not reopen any of the accounts or post on social media; and that he would make all efforts to delete his social media commentary. Despite this offer, a decision was made to suspend his registration.

The GP appealed this decision to the Tribunal and the findings were handed down on 10 August 2020. The Tribunal considered the following questions:

- Did the GP pose a serious risk to persons?
- Was it necessary to take immediate action to protect public health or safety?
- Was immediate action otherwise in the public interest?

The Tribunal found the GP had published statements about clinical issues that were without basis, contrary to medical practice, or untrue or misleading. He had publicly disparaged medical practitioners, including psychiatrists, the hospital system and pharmaceuticals.

The Tribunal concluded the GP's social media commentary had at least the potential to deter members of the public from obtaining vaccinations for themselves or their children, and from having chemotherapy. The comments had also encouraged the public to rely on unproven protocols for the prevention or treatment of COVID-19 and undermined their confidence in doctors and hospitals.

The Tribunal noted that the coronavirus pandemic had increased the risk that vulnerable or unqualified persons would, out of fear or desperation, turn to 'advice' from unreliable sources.

The Tribunal concluded the GP did pose a serious risk to persons and it was necessary to take immediate action to protect public health or safety.

The GP was found to have given *"misleading or otherwise unsatisfactory responses to the concerns raised about his social media commentary from the time the Medical Board gave him notice of proposed immediate action up until the time he gave evidence at the Tribunal".*

The Tribunal also considered it necessary for immediate action to be taken to reassure the public that the regulatory system was safe and adequate, to protect the public and the reputation of the medical profession.

Risk management

The Medical Board of Australia's guidance on social media states the following:

- *While you may hold personal beliefs about the efficacy or safety of some public health initiatives, you must make sure that any comments you make on social media are consistent with the codes, standards and guidelines of your profession and do not contradict or counter public health campaigns or messaging. A registered health practitioner who makes comments, endorses or shares information which contradicts the best available scientific evidence may give legitimacy to false health-related information and breach their professional responsibilities. Practitioners need to take care when commenting, sharing or "liking" such content if not supported by best available scientific evidence.*
- *As a registered health practitioner, your views on clinical issues are influential. Comments on social media that reflect or promote personal views about social and clinical issues might impact on someone's sense of cultural safety or could lead to a patient feeling judged, intimidated or embarrassed.*
- *You should communicate effectively, courteously, professionally and respectfully with, and about, other healthcare professionals.*
- *The Medical Board may consider social media use in your private life (even where there is no identifiable link to you as a registered health practitioner) if it raises concerns about your fitness to hold registration.*

Reference

1. *Ellis v Medical Board* (Review & Regulation) [2020] VCAT 862 (10 August 2020).

CASE BOOK

An expensive email error

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

A recent case[1] heard by the Australian Information Commissioner is a timely reminder for practices to take care with email communication – as simple errors can have serious consequences.

A married same-sex couple (SD and SE) were attending a practice which had a particular focus on sexual health and HIV-positive persons.

SD and SE had previously been part of a global study into HIV. The couple were considering participating in a further study and had previously provided their email addresses. SD's email address was clearly his work email and contained reference to his place of employment. SE's email address contained his first and last name, as well as his middle initial.

On 22 December 2017, the practice sent an email to SD's work email address. An email intended for SE was also sent, but it went to an incorrect email address due to an error caused by his middle initial being omitted.

The email was noted by SD, and within a couple of minutes he sent an email to the practice requesting that an alternate, private email address be used. The practice then sent a further email to SD's personal email address, containing a consent form for a medical study. This email was once again copied to SE's incorrect email address. SD notified the practice that they had used an incorrect email address for SE.

More than a month later, SD and SE had heard nothing from the practice. SD sent a further email to the practice seeking information about their response to the disclosure.

A few days later, the practice responded with an apology for "inconvenience and disappointment" and stated they were investigating the incident.

SD and SE lodged a complaint with the Office of the Australian Information Commissioner (OAIC) two weeks later.

The complaint

SD and SE complained that personal and sensitive information had been sent to an incorrect email address, disclosing their names, details of SD's workplace, and that they were HIV positive.

The disclosure had negatively affected SD's family, career aspirations and concentration at work. He stated that he was suffering from anxiety, paranoia and humiliation, and was seeking ongoing psychological treatment.

SD sought a formal apology from the practice as well as compensation for the distress and psychological harm suffered and the cost of the psychological treatment.

SD stated that the fact the practice had not responded to him regarding the disclosure until his follow-up email more than a month later had added to his distress, and that the apology he received did not appreciate the seriousness of the breach.

Some months later, SD was advised by his treating doctor that he should find a new treating doctor due to the breakdown in trust arising out of the privacy breach.

SE had also suffered emotional anguish and stress, and the disclosure had negatively impacted on the relationship between the two of them.

The decision

When considering the matter, the Australian Information Commissioner, Angela Falk stated the following:

In coming to my decision on compensation, I have considered the nature of the information being sensitive medical information, the fact that the disclosure was to a single third party who does not appear to have used the information in any way, the impact of the disclosures on each of the complainants, and the relevant case law.

I find that arising out of the privacy breach, the first complainant (SD) found himself in a situation where the relationship of trust had broken down with his treating doctor, and it was suggested to him that he find a new treating practitioner or clinic. I consider that the circumstances of the privacy breach, together with the breakdown of trust and his perception that the clinic had abandoned him has contributed to his feelings of distress. I consider this to be causally connected to the privacy breach.

Outcome for the practice

The practice was ordered to pay compensation of $13,400 to SD, and $3,000 to SE.

The practice was also ordered to take steps to ensure the conduct was not repeated. The practice implemented a policy to avoid email communications and now requires two-step authentication for emails with sensitive information. The practice has also sought additional privacy training for its staff.

Medico-legal discussion

Email communication is increasingly being used by practices to communicate with patients. Great care should be taken with this, as it's easy to make an error with the email address.

Medical practices are legally required to take reasonable steps to protect the security of the personal information held. Practices should have a privacy policy, a data breach response plan, and a policy for internet and email communication. Staff training in this area is important.

Under the Notifiable Data Breaches scheme,[2] privacy breaches that are likely to result in serious harm, and where the harm has not been mitigated, must be notified to the OAIC.

It's likely that the poor handling of this situation after the data breach occurred contributed to the distress experienced by the two patients.

More resources

Office of the Australian Information Commissioner
Data breach preparation and response
oaic.gov.au/privacy/guidance-and-advice/data-breach-preparation-and-response

Royal Australian College of General Practitioners
Internet and email policy template
racgp.org.au/running-a-practice/security/protecting-your-practice-information/information-security-in-general-practice/introduction

MDA National
Online library of privacy-related articles

References

1. 'SD' and 'SE' and Northside Clinic (Vic) Pty Ltd [2020] AICmr 21 (12 June 2020): austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/aicmr/2020/21.html

2. MDA National. Must I report this privacy breach? 12 June 2019: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/reporting-privacy-breach-flowchart

Firstdefence

FOR DOCTORS IN TRAINING

- The LASA drug dilemma
- The doctor-in-training memoir of 2020
- Tips for tricky conversations

The LASA drug dilemma

Marika Davies
Medico-legal Adviser, MDA National

Drug mix-ups involving medications that look alike and sound alike (LASA) have the potential to cause significant patient harm as shown in the cases below.

Depo-Medrol vs Depo-Provera

A 40-year-old man with shoulder pain was seen by a GP with an interest in sports medicine, who recommended an intra-articular injection of Depo-Medrol to reduce the inflammation. The procedure was carried out the same day in the clinic treatment room.

The doctor injected Depo-Provera in error and didn't realise the error until the packaging was disposed of after the patient had left. The patient was informed, and three days later reported new onset erectile dysfunction and lack of libido. He required treatment with testosterone and tadalafil and made a full recovery.

A 21-year-old woman was seen at a family planning clinic for contraceptive advice and agreed to receive an initial injection of Depo-Provera. She gave a negative pregnancy test and the injection was administered that day.

The doctor mistakenly gave the patient an intramuscular injection of Depo-Medrol but did not realise the error at the time.

The patient returned to the clinic several weeks later reporting symptoms of pregnancy. A urine pregnancy test was positive, and an ultrasound estimated the date of conception to be approximately four weeks after the injection.

On investigating the patient's care, the lot number of the vial of Depo medication recorded in the patient's notes was found to be associated with Depo-Medrol and not Depo-Provera.

Metoclopramide vs metaraminol

Mr A was admitted as a day case for a shoulder arthroscopy. Dr B noted the patient had a history of post-operative nausea, so administered what she thought was metoclopramide.

Mr A began complaining of a headache as he went off to sleep. Dr B noted his blood pressure was 260mmHg systolic and realised she had given metaraminol instead of metoclopramide.

Mr A became acutely hypertensive and developed pulmonary oedema. He was admitted and monitored overnight by the cardiologists and subsequently discharged after a normal echocardiogram.

Medico-legal issues

In the above cases, the medications were stored alphabetically next to each other and the incorrect vial was accidentally selected due to human error.

Drug mix-ups between LASA medications can occur at any stage of the process from prescribing to administering the drug.

Strategies for reducing errors

- Take particular care when using drop-down menus, hand-writing prescriptions or storing drugs with similar names.
- Consider the use of Tall Man lettering so that LASA medicine name pairs are easier to differentiate (e.g. rifaMPICin and rifaXIMin).
- Separate LASA drugs from one another in drug cabinets and when setting up drug trolleys.
- Be vigilant when checking drugs, particularly when working in an unfamiliar environment.

If a drug error occurs, you should take steps to put the matter right where possible and inform the patient. Be open and honest, providing a full explanation and apology. Investigate how the error occurred so that lessons can be learnt and safeguards put in place – and follow any reporting procedures at your place of work.

More information

ANZCA
Guidelines for the safe management and use of medications in anaesthesia (2018)
anzca.edu.au/documents/ps51-2009-guidelines-for-the-safe-administration-o

RACGP
Medication management and supply: A guide for general practice (2019)
racgp.org.au/newsgp/professional/medication-management-and-supply

The doctor-in-training memoir of 2020

Janet Harry & Kym Gardner
Medico-legal Advisers, MDA National

The COVID 19 pandemic has thrown up a multitude of new challenges for junior medical practitioners. During these unprecedented times in health care, we have seen doctors grappling with many new questions as well as facing new and unchartered issues in their own workplaces.

Never has there been a more important time to take care of yourself and read the fine print. While no corner of the world has been untouched by this pandemic, our junior doctors – with exam worries, young families, mortgages, distance from extended families, and fears of falling sick – have certainly taken their fair share of the strain.

In this article, we look at some of the more frequent concerns we have been discussing with our early career Members.

One of the earliest and most frequent requests was from GP Registrars who were being asked to write a certificate to declare a patient as either unfit to work due to COVID 19 or fit to return to work during the pandemic. It was virtually impossible for practitioners to really know one way or another with any certainty.

Sometimes, patients put unreasonable pressure on practitioners, usually unintentionally, due to their own stress. Regardless, practitioners ultimately need to follow peer-accepted practice. In particular, we would refer them to the Medical Board Code of Conduct (at 10.9) which sets out the requirement to ensure a signed statement is reasonably true, not misleading, accurate, and that they have not omitted relevant information deliberately.

Patients may ask for things you can't necessarily give them. In such cases, we suggest it may be a situation where a letter of support is more appropriate. And it's always okay to say no.

Next, in some states, came face masks being made compulsory. Doctors, young and old, faced requests from patients for a letter to say they were exempt from wearing a mask. These were unknown waters that led to uncertainty about the best course of action.

For junior doctors, new demands and little guidance from established mentors only increased their already high stress levels. It's no wonder we're all looking forward to the end of 2020.

Although the Federal Government did what they could to make life easier, in the short term the unclear messaging and constantly changing goal posts had us all scrambling. This included the introduction of the new MBS items to enable increased provision of telehealth medical services. For any doctor in training, the MBS is a minefield to get your head around, let alone having to cope with weekly changes.

In hospitals, rotations were frozen. This was wonderful for some, but heartbreaking for others – stuck in departments they didn't enjoy, with night shifts and difficult consultants. In private practice, sudden drops in income led to job uncertainty and dark clouds for the future.

Throughout this time, we have continued to support our junior doctor Members with their individual stressors – from employment uncertainty to exam delays.

Be prepared and seek support

- When faced with changes and challenges in your work conditions, keeping calm and being prepared to listen is a good starting point. You can ask that any proposed changes be provided in writing, to give you the opportunity to consider and obtain advice.
- It's useful to familiarise yourself with your employer's policies and procedures, and the terms of your contract, so you know what's expected of you in relation to rosters and how much notice you need to give of any application to change the roster. Knowing who to talk to about these things is also important.
- Take leave and avoid burnout. Make sure you have your own GP and a good support network around you, even if that means via Zoom or FaceTime!
- What's that old saying about an ounce of prevention being better than a pound of cure? Wherever you are and however your year has been, make sure you also take care of the paperwork in your life. When staying, leaving or graduating to a new role, read your contract carefully to ensure you're familiar with the terms around (in particular) the period of notice you should provide and any restraint provisions.
- Useful sources of support include the AMA in your state and your professional associations and, of course, MDA National. Don't hesitate to contact our Medico-legal Advisory team if you have any concerns, big or small. We are here to help you.

Useful resources

mdanational.com.au/advice-and-support/library/articles-and-case-studies/2017/02/contracts-what-you-need-to-know

mdanational.com.au/advice-and-support/library/articles-and-case-studies/2017/02/contemplating-change-gp-practice

mdanational.com.au/advice-and-support/library/articles-and-case-studies/2012/06/how-restrained-are-you

Tips for tricky conversations

Junior doctor Members have recently asked us for advice on whether they must do as directed by their employer during a health crisis. As an important part of the response involves having a potentially difficult conversation, we provided some helpful tips on how to approach a discussion with a senior colleague in our *Diplomacy in a hierarchy* webinar on 2 September 2020.

These are some of the main tips participants said they intend to use for a future difficult conversation with a senior colleague:

- Prepare, including:
  - go in with a solution rather than just a complaint
  - be honest with yourself about the issue at hand.
- Realise when it's best to diplomatically end a discussion, e.g. by saying, "I can see this conversation's not going well. Let's leave it for the moment and talk about it some other time".

Want more?

View the full webinar recording at
mdanational.com.au/advice-and-support/library/videos

Listen to the pre-session podcast for more strategies at
mdanational.com.au/advice-and-support/library/podcasts

Dr Kiely Kim facilitated a panel, sharing practical advice with real examples and answering participants' questions on how to effectively navigate a disagreement with a co-worker, whatever their position might be.

Here's a snapshot of their top take-home messages.

These kinds of dilemmas can be challenging, but difficult conversations are often really important ones. Be kind to yourself. It's like any type of competency or procedure. There's no way you're going to be a master at this, doing it for the first time. A supportive friend in a crisis is a powerful intervention on its own. Try your best to maximise your friend's autonomy in solution-focused plans – discuss some options and work on them collaboratively. Remember, what's right for them at this time may not be what's right for you in similar circumstances. They may approach things differently, so be respectful of individual differences.

Dr Noel Collins
Psychiatrist

Find some way to document these kinds of conversations… I always like to send an email, and I usually try and say to someone, "Okay, well I'll send an email with those suggestions or the plan we discussed"… and that (hopefully in a not very threatening way) gives you a permanent written record of the conversation having taken place that both of you have electronically.

Dr Rachel Ryan
Obstetrician and Gynaecologist

Identify and plan for any interaction to make sure it's in an appropriate setting and at a time when everyone's prepared, and they haven't been rushed or ambushed… Avoid having conversations in public spaces… not only for the privacy of the people involved in the conversation, but also if you're talking about patients.

Claudine Watson-Kyme
Manager, Cases and Advisory Services, MDA National

Keep on learning...

Education news

Podcasts

- Substantial increase in the number of people listening to our new audio resources – over 2,000 listens from July to September 2020
- Topics include:
  - difficult conversations with senior colleagues
  - telehealth
  - coronial investigation process
  - career complications/delays

Listen to them on Apple Podcasts or Spotify, and via 'podcasts' on our library webpage:

mdanational.com.au/advice-and-support/library

e-Learning

- Over 200 Members have now completed the online activity: *Noteworthy: the how, what, where & why of medical documentation*
  - 93% considering changing their practice as a result
- Other interactive, CPD-recognised, on-demand education opportunities include:
  - *Prescribing opioids*
  - *Informed consent challenges*
  - *Challenging emotions of difficult news*

More information and access:

mdanational.com.au/member-benefits/education/online-activities

Webinars

- Over 750 viewers of webinar recordings
- Topics include:
  - risk hotspots for hospital specialists
  - privacy
  - avoiding medical marketing mistakes
  - resolving conflict with a senior
  - intimate examinations
  - experiences of COVID-19
  - protecting your provider number
- More live webinars are in the pipeline

Find them under 'videos' on our library webpage:
mdanational.com.au/advice-and-support/library

Face-to-face

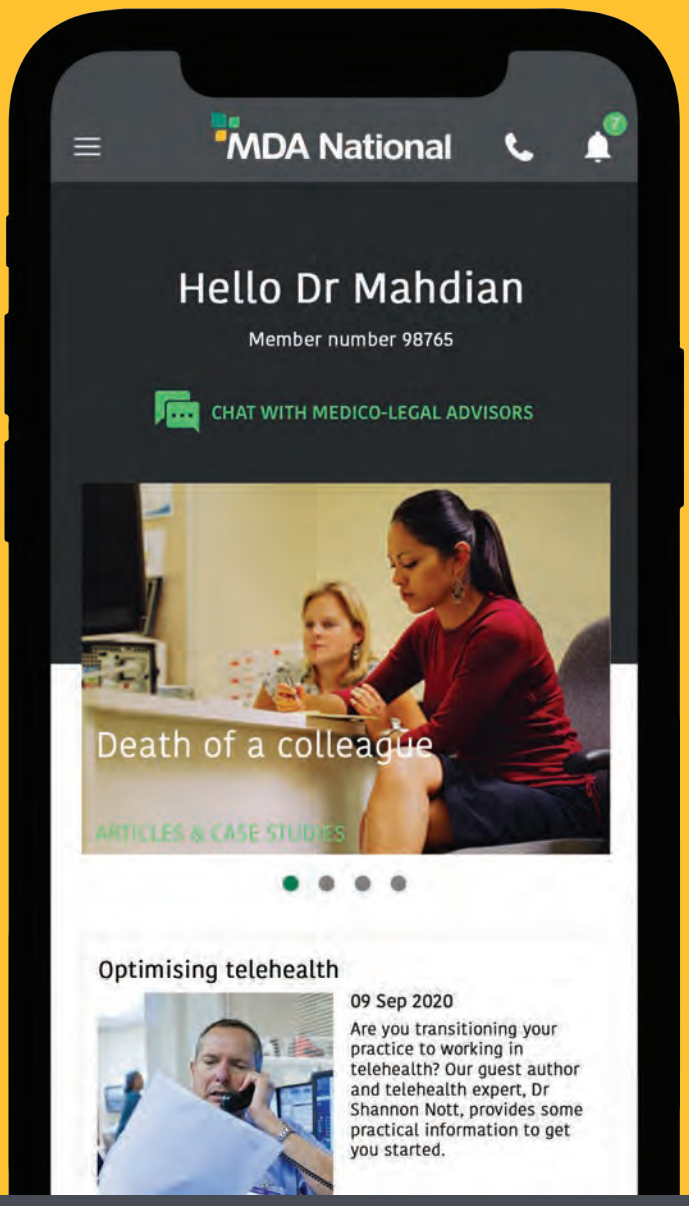
- *Practical solutions to patient boundaries* workshop (Perth, October 2020) – booked out on the day invitations were emailed
  - We look forward to supporting more Members through workshops in 2021
- First session in a while for interns in their hospital (Adelaide, October 2020) on patient consent
  - Majority of attendees chose 9 or 10 out of 10 when rating if they would recommend the session

Request an education session at:

mdanational.com.au/member-benefits/education/face-to-face-education-sessions/request-a-face-to-face-session

All our education activities are complimentary for Members – so take advantage of this opportunity!

Download the MDA National app, making it easier to keep your membership up to date and stay connected to our support services.



As a Member, you can access the MDA National app to:

- update your policy on the go
- watch videos and recorded webinars
- read case studies and articles
- connect directly with our medico-legal experts via LiveChat

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1800 011 255 — peaceofmind@mdanational.com.au