WINTER 2021

Defenceupdate

FOR MEDICAL PRACTITIONERS

BEING SUED:
A painful journey

FAMILY MATTERS:
Navigating family disputes

CASE BOOK

- Keeping an eye on patient privacy
- Don't let a black mark stain your reputation

FIRST DEFENCE
Feature section for doctors in training

MDA National

WELCOME

This edition of *Defence Update* brings an important message from our President, Dr Michael Gannon, with information about the medico-legal landscape and how that may affect our Members.

How does it feel to be sued? One of our Members who has lived through that harrowing experience has written from the heart describing his personal journey – from 'being served' with the first notification letter, the preparation, his day in court, and the outcome.

Our Medico-legal Feature is about family disputes. We receive a surprising number of calls about situations involving warring parents in the midst of an acrimonious split. Doctors can be unwittingly caught in the crossfire, so it is important to be aware of the pitfalls and proceed cautiously.

Our Case Book highlights the problem of iron infusions leading to skin staining, and we discuss the elements of a robust consenting process and how to minimise the risk of staining. There is also information on privacy and confidentiality, with a focus on information disclosure to third parties.

Dr Jane Deacon
Manager, Medico-legal
Advisory Services

The First Defence section contains useful strategies for dealing with angry patients, as well as some common questions inspired by calls we have taken from junior doctors. We also have an article on clinical leadership for doctors in training, written by Dr Mellissa Naidoo and Dr Hashim Abdeen.

The Department of Health has been active recently with an increase in targeted compliance and audits – so we introduce the Medicare Committee we have formed at MDA National to ensure we have the necessary expertise to assist you, if you are unlucky enough to receive such a letter.

I hope you enjoy 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**

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

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

It's time to renew your policy and membership!

To continue to be a part of a doctor-owned mutual that supports you in the moments that matter, here's what you need to do by 30 June 2021:

- **Check your Renewal Notice** to ensure the information is accurate.
- **Ensure you have notified us** of all claims, complaints, investigations, employment disputes, or any incidents you are aware of, that may lead to a claim for indemnity under your Policy. Early notification is a requirement under your Policy. It enables us to support you better and can help prevent matters from escalating.
- **Review the risk category changes** to ensure you have selected the most appropriate risk category and estimated the most accurate Gross Annual Billings for your practice, as this may affect the cover under your Policy.
- **Advise us of any changes** to the information on your Renewal Notice by contacting our Member Services team via email: peaceofmind@mdanational.com.au or phone: 1800 011 255.
- **Make your payment online at payonline.mdanational.com.au** using your reference number – or refer to your Renewal Notice for other payment options. If you are on a direct debit arrangement, your premium will be deducted on 1 July 2021.

Please read the *Combined Product Disclosure Statement, Policy Wording and Financial Services Guide V.13* and *Significant Changes to the Professional Indemnity Insurance Policy 2021/22* included in your renewal pack for details of all changes prior to renewing.

COVID-19 vaccinations: what's expected of health practitioners

Ahpra and the 15 National Boards have published a joint statement to help health practitioners understand what's expected of them in relation to:

- being vaccinated against COVID-19 unless medically contraindicated
- being appropriately trained and qualified to administer COVID-19 vaccines if authorised
- providing accurate advice and information about COVID-19 vaccination including in social media and advertising.

Social media content must not contradict public health campaigns or messaging. Breaches of this may be subject to investigation and possible regulatory action by a National Board.

Advertising that includes false, misleading or deceptive claims about COVID-19, including anti-vaccination material, may result in prosecution by Ahpra.

Vaccines (being prescription medicines) usually cannot be advertised to consumers, but the TGA has made exceptions for:

- government-produced advertising materials (federal, state or territory governments) about COVID-19 vaccinations
- factual information about COVID-19 vaccination services: location; times or opening hours; whether an appointment is needed and how to make one.

Advertisers must not use self-developed advertising material, and must not add:

- vaccine tradenames or active ingredients
- implications that harm will result from not receiving the vaccine
- implications that the vaccine offered is superior to other vaccines
- incentives to obtain the service or vaccine.

Are you covered for participating in the COVID-19 vaccination program?

Read the latest COVID-19 Vaccine Program FAQs on our Support Hub: **mdanational.com.au/mda-national-coronavirus-advice#vaccine**.

MDA National is your organisation. We are proud of our history and heritage. We will always act in the interests of our membership, while continually striving to improve the safety and quality of the medical care we collectively deliver to the Australian people.

Dr Michael Gannon
Head of Department, Obstetrics & Gynaecology,
St John of God Health Care, WA

A message for Members

Dr Michael Gannon
MDA National President

Last year, the MDA National leadership team wrote to our Members explaining the decision of our Board to freeze premiums for over 99 per cent of Members. It was a period of great fear and uncertainty – however, it was the right decision at that time. Unfortunately, it delayed an inevitable increase to the premium pool, and it is much harder to explain an increase to Members.

Medical defence premiums are not an inconsiderable cost for private medical practitioners trying to run a small business. The premium is just as important for doctors in specialist training, other junior doctors, and doctors in the public system.

The policy provides comfort to doctors in their time of need. It funds education programs which reduce the likelihood of a claim. It supports Members having investigations brought by the regulator or health services. Many doctors will, at some stage in their career, have a civil claim.

It is growth in these claims that has troubled your Mutual Board and the insurance experts we work with. We have seen massive growth in claims in specialties like neurosurgery, orthopaedic surgery and bariatrics. The recent reforms to the medical indemnity industry make it easier to individually price the risk of individual Members.

This is not a move away from our commitment to mutuality. Indeed, that has never been stronger. Rather, our sophisticated approach to pricing is a step towards improving the alignment between risk and premium.

We are keenly conscious that this might be seen as a move away from the principles of mutuality; and we are aware of how this reflects on our history and what it means for our future. But it is simply unfair to not make the premiums reflect the risk of individual crafts and, for that matter, individual practitioners.

The Mutual Board of MDA National is made up of your peers. We are keenly aware of, and very sensitive about, the implications of the decisions we make on pricing. While we seek to smooth premiums across a specialty group, we have to be conscious of the competitive environment that we set our prices in.

A single civil claim does not mean that a doctor is a bad one. However, the reality is that the increasingly generous nature of our courts and the increasingly pernicious attitude of the regulator are such that we have to manage the rise in the costs of claims and investigations with the rise in the premiums we charge.

My closest colleagues have often heard me talk about how writing a quarterly cheque for $25,000 or thereabouts has always focused my attention on the medical indemnity industry.

I can only try to assure you, our Members, that the Board strives hard to manage our investment portfolio in a way to maximise return on investment and protect our capital reserves. And that we are studiously careful when it comes to managing costs within our offices across Australia. At the same time, we seek to promote and protect the industry-leading levels of service we provide in terms of delivering education and supporting colleagues in their time of need.

On behalf of the Mutual Board, the Insurance Board and the executive of the organisation, I thank you, our Members, for your ongoing loyalty and trust.

MDA National is your organisation. We are proud of our history and heritage. We will always act in the interests of our membership, while continually striving to improve the safety and quality of the medical care we collectively deliver to the Australian people.

Ahpra notifications – a new approach

Lindsay Roberts
Medico-legal Adviser, MDA National

From December 2020, the Australian Health Practitioner Regulation Agency (Ahpra) has been resetting its approach to managing notifications – enabling the Board to close concerns about low-risk practitioners faster and to concentrate investigations on practitioners who represent higher risk.

The new approach includes considering the role other health practitioners and workplaces play in managing risks posed by individual practitioners – and focusing attention on matters where gaps in practice create an ongoing risk to the public which may require a regulatory response.

In considering whether regulatory action is required, more emphasis is being placed on actions taken by the practitioner and their workplace (if applicable) in managing any potential risk, and how those actions combine to prevent future risk to patients.

There is also a greater emphasis on factors beyond the concerns raised in a notification, including an individual's scope of practice, practice setting (e.g. access to peers and support; patient cohort), and the nature and frequency of any past regulatory history.

Ahpra is also focused on speaking with practitioners soon after receipt of a notification, to explain the notifications process and gather information early.

When responding to a notification, Ahpra suggests that you:

- acknowledge the concerns raised by the notifier, and try to understand the concerns from their perspective
- acknowledge any errors that may have occurred, and offer an apology if appropriate
- state what has been done, or could be done, to address the concerns
- mention any changes or actions taken as a result of the concerns raised
- provide supporting documentation for any additional training or CPD you have done to address the concerns.

- If you get a phone call from Ahpra about a new notification, it's prudent to reschedule the call and contact MDA National for advice. We can help you determine whether a verbal response is likely to be the best way to resolve the matter, or whether a more formal written response is required.
- If you receive a notification, you should thoroughly review the concerns raised. Consider whether you could have done anything differently, or what changes you could make moving forward.
- Don't panic! Receiving a phone call or letter from Ahpra is stressful for doctors – but most notifications are dismissed with no further action. Please contact us for advice and support. We can help you review the notification and ensure your response adequately addresses the concerns raised.

More resources

Ahpra & National Boards
Newsletter December 2020 – investigations reset
ahpra.gov.au/publications/ahpra-newsletter/december-2020.aspx#investigations-reset

How we manage concerns
ahpra.gov.au/notifications/how-we-manage-concerns.aspx

MDA National
Letters from Ahpra – don't panic, don't ignore
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2020/12/letters-from-ahpra

Introducing... the MDA National Medicare Committee

Nerissa Ferrie
Medico-legal Adviser, MDA National

An increase in targeted compliance and audits administered by the Department of Health led to the establishment of a specialist committee to ensure we are across Medicare issues that matter to you.

Who are we?

The Medicare Committee is made up of four staff members:

- **Alice Cran – Medico-legal Adviser** (Sydney)
- **Nerissa Ferrie – Medico-legal Adviser** (Perth)
- **Dr Kiely Kim – Medico-legal Adviser** (Sydney)
- **Gae Nuttall – Risk Adviser** (Perth)

What is our purpose?

The Medicare Committee was formed to facilitate and ensure consistent, high quality and comprehensive management of Medicare-related matters. We meet monthly to share information and expertise, and to ensure MDA National provides consistent and timely member-centric advice. We remain up to date with changes and publish relevant billing information across our various communication channels.

Current challenges

'Review and Act Now' letters and other targeted compliance exercises have been keeping everyone busy. Targeted compliance often involves a self-audit process and a repayment of any inappropriately claimed items.

We also see a number of referrals to the Practitioner Review Program (PRP) and Professional Services Review (PSR) each year. In 2019-2020, the PSR recovered over $27M through Negotiated Agreements and PSR Panel and Peer Review Committees. Familiarise yourself with these two audit processes and read up on some of the case outcomes.

Top 10 tips from the Medicare Committee

1. Make sure you are aware of the item descriptor and relevant explanatory notes at MBS online for each item you bill. Ignorance is a poor defence to inappropriate billing.
2. You are responsible for your provider number – you should be aware of what is being billed against it.
3. Most doctors who come to the attention of the DoH are statistical outliers. If you have a sub-specialty which means you bill specific items more than your peers, make good notes and check MBS online to confirm you are meeting the entire descriptor for that item.
4. Big ticket items for GPs include chronic disease care plans. Are your systems and processes up to date?
5. Specialist referrals have been the subject of targeted compliance in the past – ensure you have rigorous processes in place.
6. Keep up to date with changes to the MBS.
7. Make good notes! If you need to brush up on your record keeping, complete our e-learning course: *Noteworthy: The How, What, Where and Why of Medical Documentation.*
8. Don't try to manage an audit alone. If you receive any DoH communication relating to your Medicare billing, contact MDA National for advice.
9. If you need to clarify an item number, send a well-worded question to **askmbs@health.gov.au** and keep a copy of the written response.
10. Finally, log in to Member Online Services and watch our webinar, *Protecting your Provider Number,* for more helpful tips.

Tips on writing a treating doctor's report

Janet Harry
Medico-legal Adviser, MDA National

Doctors receive requests for treating doctor reports from a variety of sources including patients, their lawyers, insurers, employers and the police. These are important documents.

In general terms, there is no legal obligation for doctors to provide a report, although some statutory bodies (e.g. Guardianship Board) can direct you to do so. However, a treating doctor has a professional and ethical obligation to assist by providing factual information concerning a patient's condition or injury at the patient's request to the patient's legal advisers or, with the patient's authority, to other nominated third parties. Importantly, although there is an ethical obligation to assist the patient by providing a factual report, you are under no obligation to provide an opinion in your report outside of your knowledge and expertise.

What is expected and how to prepare the report

- Allocate adequate time to review requests and prepare reports. Rushing or trying to attend to this important task between patients is not good practice, and it increases the risk of providing an inadequate or incorrect report.
- Be familiar with any practice policies regarding report writing. A schedule of fees and prepayment of the fee may be required.
- If unsure of fees, consult your professional body. Some useful guides are RACGP's *How to write a medical report* and the AMA NSW and Law Society schedule of fees. Statutory bodies who can direct the provision of a report often have a prescribed fee schedule which may be provided with the direction or order.
- A treating doctor may be asked to provide a report and abide by an Expert Witness Code of Conduct. Ask the requesting party to give you a copy of the relevant code and seek advice if you are unsure of your obligations.
- Ensure you have an up-to-date authority from the patient, or an order/direction from the appropriate statutory body.
- Read the request carefully and check any due date. If unable to comply with that, advise the requesting party immediately.
- Ensure it is appropriate for you to write the report, and that it is within your area of expertise or knowledge.
- Consider the work involved and, if appropriate, provide an estimate of the report fee and get agreement to be prepaid.
- Understand the difference between a medico-legal report by a treating doctor, an expert opinion, a letter of support, or a police statement.
- Be familiar with your professional obligations in *Good medical practice: a code of conduct for doctors in Australia* to provide a report that is honest, accurate, contains all relevant information, and makes clear the limits of your knowledge.
- Be clear on the nature and purpose of the report and the expected audience.
- Use the medical records to prepare the report. Do not rely on your memory or the information provided by the requesting party. You can include information in the records written by other doctors – for example, if a colleague saw the patient while you were on leave – provided you make that clear.
- Generally, you should address the report to the requesting party, and not "to whom it may concern".
- It is quite acceptable and may be appropriate to answer a question with, "I don't know".
- Include in your report any specific questions from the requesting party and your responses below so that it is a 'standalone' document.

- Remember that you may be cross-examined on your report – only write what you would be prepared to say under oath in court.
- Do not alter your report at the request of your patient or a third party – if you receive additional information or you have made a mistake, provide a supplementary report.
- Explain medical abbreviations, terms and concepts in language that can be understood by non-medical people.
- Do not record the patient's history of events as 'fact'. Say, "the patient reported that …".
- Do not act as an advocate for your patient, and do not deliberately omit any relevant information.
- Avoid emotive language.

Suggested format

- Headings and numbered paragraphs can be useful if the report is long
- Your credentials – professional address, qualifications, experience, and position at the time you were involved in the patient's management
- The requesting party's name, date of the request, purpose of the report, and date of authority given by the patient
- Patient's name and date of birth – refer to the patient by name, e.g. 'Ms Smith'
- Clinical information – presentation (history and symptoms), examination findings, investigations, provisional diagnosis, treatment/management, current condition, treatment plan and prognosis
- Response to questions (if any)
- Your opinion, where appropriate
- Sign and date the report.

More information

View a detailed version of this article on medico-legal report writing at **mdanational.com.au/medico-legal-report-writing-tips**

Remember you can contact our Medico-legal Advisory Service for assistance on 1800 011 255.

Being sued – a painful journey

MDA National Member

As medical practitioners, we really want to do our best for our patients. And despite the massive weight of expectations we work with and under, we do care. I could not conceive of willingly doing any harm to anyone.

You have been served

Imagine a day like any other day in a medical practice. You get called to reception and a man walks up to you. He thrusts an envelope into your hands, tells you that you have been served, and walks away. Just like that. The nightmare has begun and it doesn't go away.

In the envelope you find formal solicitor's papers informing you of an intention to sue – that a patient has found your treatment unacceptable and harmful; that you have caused them wilful and unnecessary harm; that you have been negligent and not shown reasonable skill and duty of care. And they are claiming a huge amount of money as compensation.

Your day has irrevocably changed. Somehow, getting to the end of the day, I checked the relevant patient records. Fortunately, my notes had sufficient information to confirm that what they had claimed did not happen. So settling down, I wrote and sent a letter to MDA National.

Grappling with reality

As the gravity of the situation sank in, all my responses rose to the surface. How could this person possibly think I was so incompetent? After all my years in practice, and the countless times I've done this... and so on. And the fear starts. Fear of being destroyed. Fear of being humiliated. Fear of the unknown.

After more correspondence and meetings with MDA and their external specialist team, the upshot was that this case would be defended. Information gathering began. What was alleged? What actually happened in the consulting room? What evidence supported their claim or my counterclaim?

They later told me that my clear input and instructions from the start, acknowledging what was right and what was not, were instrumental in helping them build my defence.

I liked the team and the work they did. They fully explored the topic, found strong experts, and sent the plaintiff to some of them for their opinion. Some wider areas (seemingly irrelevant to me) were investigated, and I was told that success depended on covering all bases and all aspects of the area of medicine in question. This truly served us well later.

Despite reassurances that the case was unlikely to proceed further, we kept getting closer and closer to an appointed court hearing date. As time dragged on, the endless waiting chipped away at my endurance. I felt completely stuck.

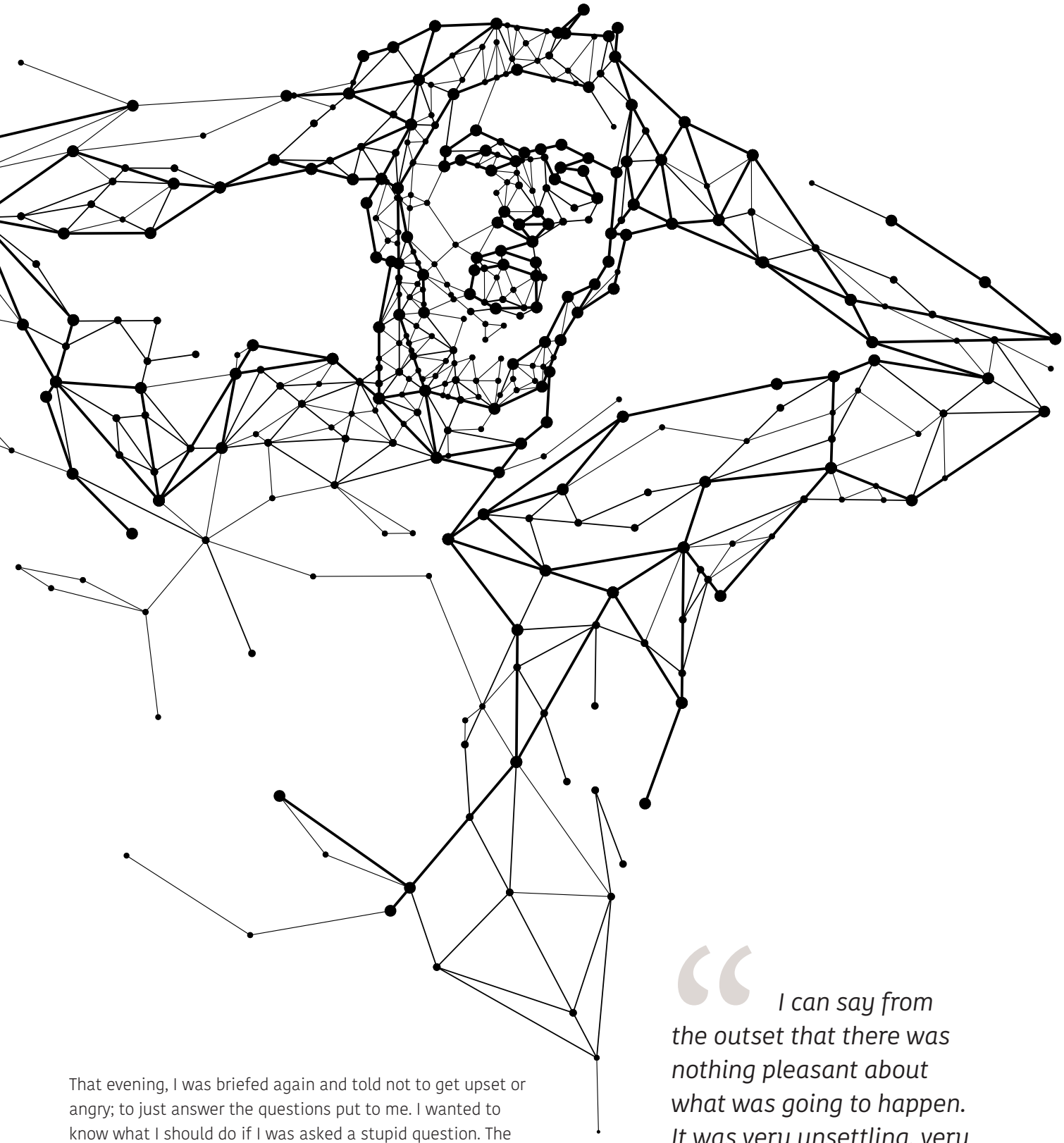
After two years, things gained momentum. I was impressed with the amount of trouble the legal team went to. Researching and finding appropriate expert witnesses, presenting the case to them and assessing their reports.

I tried to carry on as if nothing had happened. I tried to stay detached, but it wasn't easy.

My time in court

My barrister, who was pleasant and competent, introduced me to the world of legal manoeuvring. Finally, the court proceedings began. Most of day one was spent in the logistics of the case. Seated at the back of the room, I understood nothing. I listened through a kind of fog, even though the legal team did explain things to me.

The plaintiff gave their story, and then witnesses on their behalf. Questions and cross-examination. I started getting incensed again. What were they saying? Look at all the discrepancies! My barrister seemed calm. Some lines of enquiry he pursued; others he didn't. Apparently, it was to do with not ruffling feathers at this stage.



That evening, I was briefed again and told not to get upset or angry; to just answer the questions put to me. I wanted to know what I should do if I was asked a stupid question. The advice was to state that it was a hypothetical question and explain why – this saved my skin at least once.

The days went by in a blur. It was my turn on the stand, with my barrister in the morning; the cross-examination after lunch. The opposing barrister's questions twisted and turned, trying to find a weakness to explore. I followed instructions, kept calm, and answered questions without adding anything.

> *"I can say from the outset that there was nothing pleasant about what was going to happen. It was very unsettling, very stressful, and not something that would just go away."*

A legal dance in action

The case went on for three more days. Expert witnesses were present either in person or electronically. First the general practitioners, then the other specialists. These were extremely stressful days.

When it became apparent to the plaintiff's lawyers that the initial claim did not have legs, they looked for other ways to pursue me, changing tactics to deal with the vagaries of each turn! Several amendments to the claim were made; most accepted, others not.

Hence, my team's wisdom of getting a wide view of the subject from the outset. The initial claim causing physical harm morphed into a charge of assault – I had not written "consent obtained" in the notes. It was dealt with by referring to my "normal practice" and many years of experience. Other parts of the notes indicated a clear timeline, and that was crucial.

So, my time in court. Very unpleasant. But I did learn something of my own resilience – of staying connected to the passion I feel for the profession, and staying connected to the healer I am.

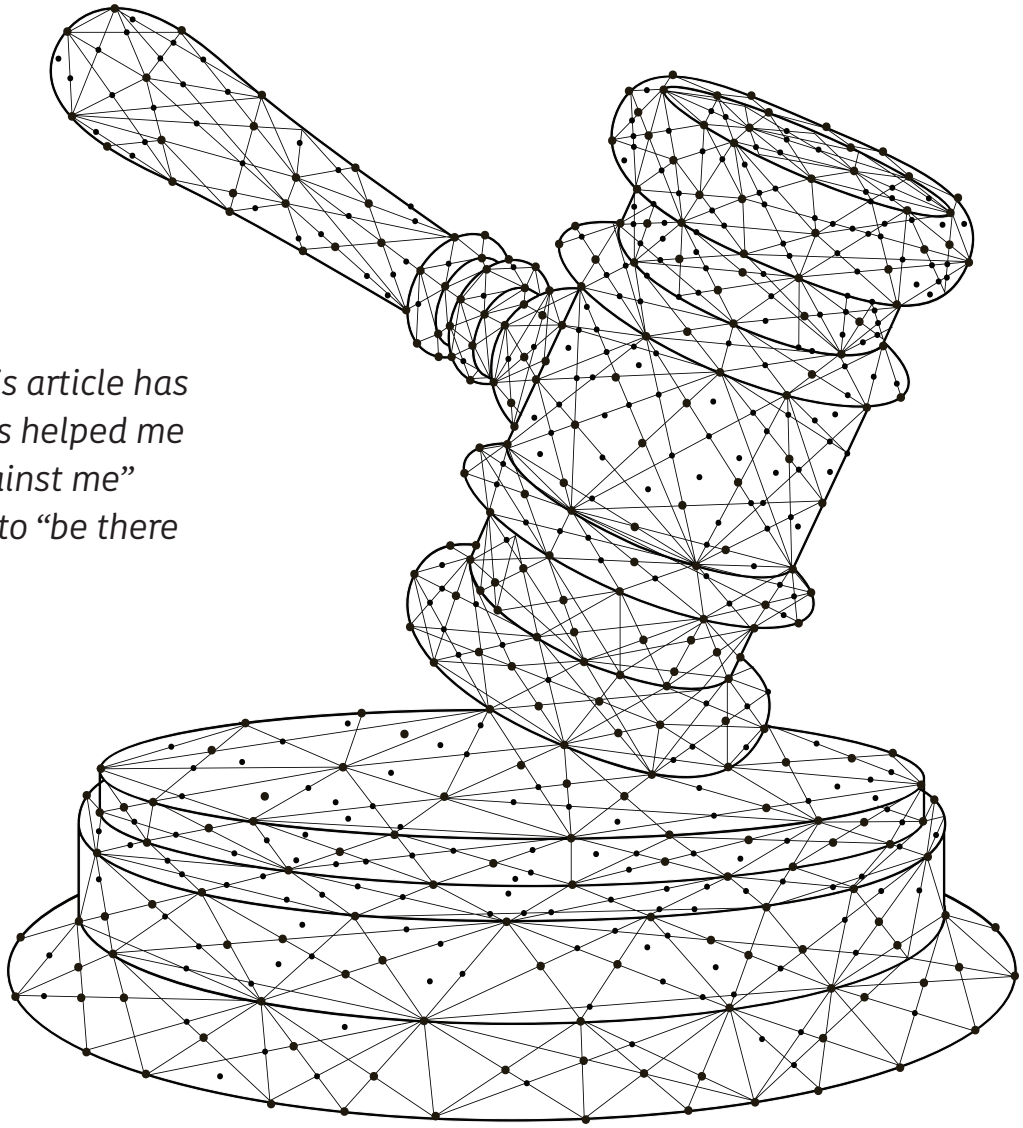
Whilst giving evidence, I looked directly at the plaintiff on several occasions. At that stage, I felt no anger or resentment; only a deep sadness at the life circumstances that had prompted them to go down this path.

The outcome

The judgment came through in less than a month. The judge found in my favour, with costs. I was told only around five per cent of cases ever get to court, with most settled beforehand – because you never know which way a judge will go. It is the great unknown.

So, if you find yourself in a similar situation, take heart. Things can work out.

You will feel fear, panic, indignation, frustration and rage – but speak to people, and get support or counselling. Trust your team implicitly and get out of their way so they can do their job.



> *"Writing this article has been cathartic. It has helped me turn something "against me" into an opportunity to "be there for others".*

MEDICO-LEGAL FEATURE

FAMILY MATTERS

Doctors from a range of specialties can get caught up in family disputes – whether they choose to or not. While a new patient may provide full disclosure of an ongoing family dispute, often a dispute or separation occurs within a family you have been treating for many years.

Your guide to navigating family disputes

Nerissa Ferrie
Medico-legal Adviser, MDA National

Why are court orders important?

In the absence of court orders to the contrary, it's generally accepted that either parent can consent to treatment or access their child's medical record. If your patient is the subject of a court order, it's important that the practice has a copy of the most recent orders on file. The court orders most often seen in family disputes are Parenting Orders (Family Court), or Violence or Misconduct Restraining Orders. The court orders usually bind the parties to the dispute, not third parties such as doctors.

What if I receive a request for a child's notes from a parent I've never met?

You are not required to respond to a request for records immediately. Ask the parent to put the request in writing, along with proof of ID and any relevant court orders. Contact the parent who usually accompanies the child and ask if there are any court orders preventing access. If there's no legal reason why the other parent should not access the notes, and none of the exceptions under the privacy legislation apply, the request can be processed. Remember that in cases of significant family violence, the custodial parent may be in hiding and a breach of confidentiality could place the family at risk of harm.

How can I avoid becoming overly involved?

Family disputes may involve domestic violence and severe mental anguish, but it's important that you maintain your clinical focus. Becoming overly involved, or clearly advocating for one party over another, can diminish the value of your opinion. Avoid making subjective comments or personal observations in your notes – as the notes may be subpoenaed and produced in court. Maintain factual notes and make it clear when you're quoting others.

Should I continue seeing both parents and the children in the event of a separation?

This can become really difficult, particularly where there are allegations of domestic violence or child abuse. Consider transferring the care of one of the parents to a colleague or a new practice. It can be difficult to remember who told you what information, and this can lead to inadvertent breaches of confidentiality and trust. You may prefer to have this discussion with the parent who doesn't normally attend with the children, as it may be less disruptive to transfer the care of only one patient.

One parent is being obstructive – what can I do?

Parents may have different ideas about a number of issues including the administration of stimulant or anti-depressant medication or vaccination, and counselling. Your role is to act in the best interests of the child – but if one parent refuses to administer medications when the child is in their care, it may make the clinical situation worse. Try and engage with both parents if you feel it might improve the situation. If you're at an impasse, the family may need to return to the Family Court for further orders. Although doctors are reluctant to end the doctor–patient relationship – which may feel like punishing the child for the actions of the parents – sometimes the relationship becomes so toxic that the best option is to transfer care.

What are my mandatory reporting obligations?

Mandatory reporting requirements are different in each state and territory, so familiarise yourself with the criteria relevant to your location. Be mindful that reports to child protection can be used to influence a custody outcome. Use your clinical expertise to determine when a report should be made.

In the event of an allegation of child sexual abuse, seek guidance from the hospital-based child protection unit in your state or territory. You can discuss the matter over the phone or make a referral to the child protection unit where trained staff can conduct an interview or perform a forensic examination if necessary.

Family disputes usually involve heightened emotions – so patient complaints are possible if the situation is not carefully managed.

1. **Ensure you are aware of current court orders, and how they might affect consent for treatment, access to notes, etc.**

2. **Suggest the parents bring in an exercise book into which you can add a copy of the notes after each consultation. The notebook goes with the child, which means all parties are kept up to date and remain focused on the best interests of the child.**

3. **Familiarise yourself with the mandatory child abuse reporting requirements in your state, as well as the OAIC's *Guide to Health Privacy*, the Medical Board's Code of Conduct, and the concept of Gillick competence which may apply to older children.**

4. **When writing your notes, remember there's a good chance that your notes will be subpoenaed and read out in court.**

5. **You are not legally required to provide reports or letters – but if you choose to do so, you can find guidance in our articles on writing medico-legal reports (see page 8) and writing letters of support (on our website: mdanational.com.au/advice-and-support/library).**

Case studies: family disputes

Managing restraining orders

Dr Patel was treating mum, dad and two children for several years. The practice didn't realise anything was amiss in the family until one day a loud argument erupted in the waiting room.

"You can't be here! The police said you must stay at least 100m away from me and the kids," mum screamed, shielding the children.

"But I have an appointment to see the doctor," dad pleaded with the receptionist.

The practice manager took the mum and two children into another room to find out what was going on. Mum said she had been granted a Family Violence Restraining Order (FVRO) and produced a copy for inclusion in the notes.

While dad was in with the doctor, the mum and children were asked to come back later in the day. After dad's consultation ended, the practice manager asked dad to wait in reception while she spoke to Dr Patel. They agreed on a plan, and invited dad back in to discuss the situation.

Dr Patel explained that, in view of the FVRO, it would be impossible to coordinate appointments to ensure dad would never cross paths with his wife and children. Dad was assured the practice was not "taking sides" and he accepted the practice manager's suggestion to change to another practice to prevent any further potential breaches of the FVRO.

Misuse of medical certificates in family disputes

Dr Wood was treating a 12-year-old child who had moved to the area six months prior. Dad always came in with the child, and he reported that she became increasingly anxious immediately before handover to mum, who had custody of the child every second weekend. When questioned about this, the child said very little.

Dad came on his own the Friday before handover to mum and insisted that Dr Wood write a certificate to say the child's severe anxiety prevented her from staying at mum's house.

Unsure of what to do, Dr Wood called our Medico-legal Advisory Service for immediate advice.

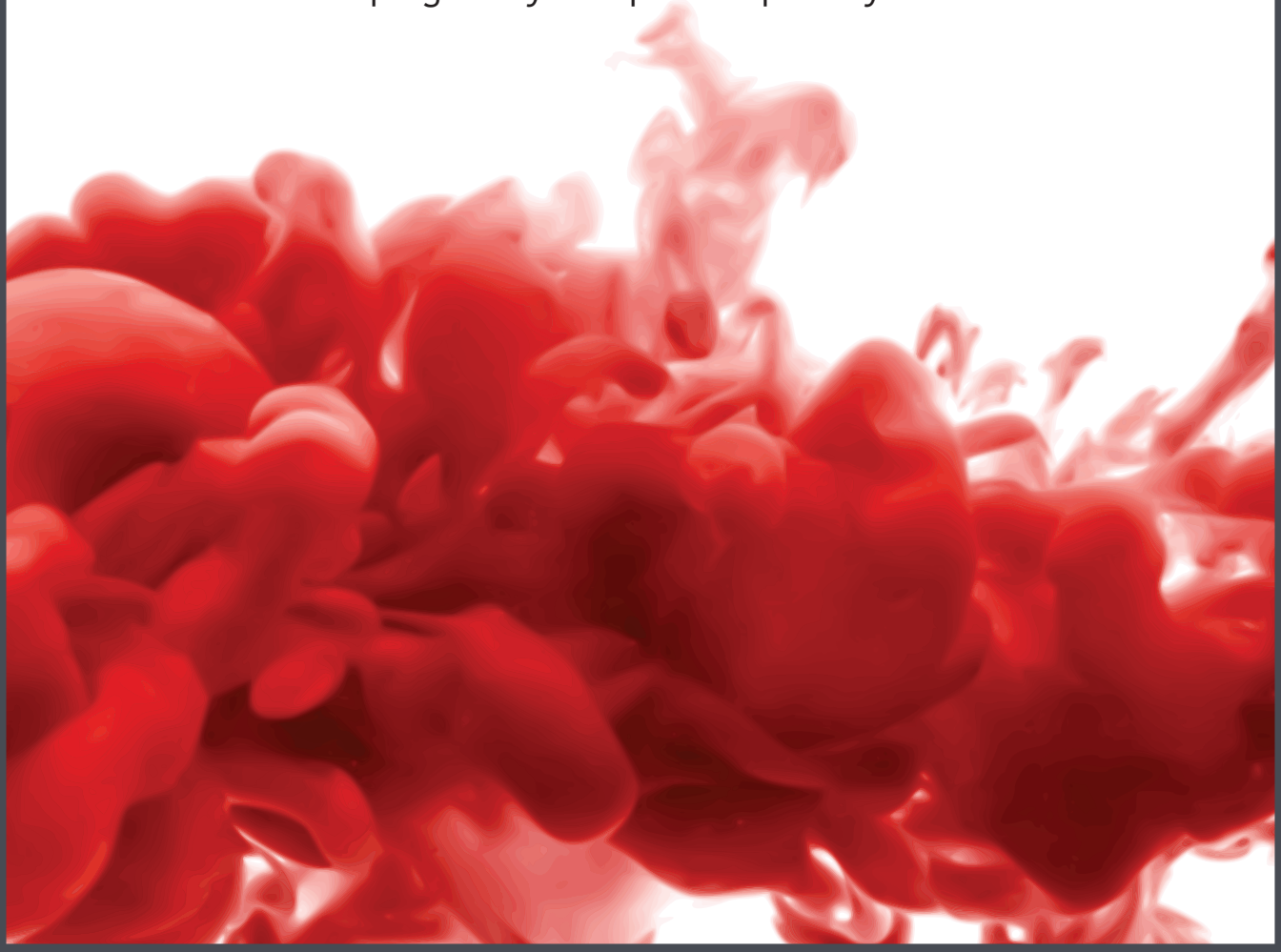
We advised him to decline the request for a medical certificate on the basis that he was unable to assess the child – and to do so without a clinical basis would interfere with existing court orders. He also requested a copy of the most up-to-date court orders to guide further decisions regarding the child.

Dr Wood referred the child to a psychologist, and advised dad to seek advice from the Family Court if he felt the current orders were inadequate. He also informed dad that he would not be issuing medical certificates unless he thought it was clinically appropriate to do so.

Family matters can become very complex and stressful, so feel free to contact our Medico-legal Advisory Service if you need advice or assistance.

CASE BOOK

- Don’t let a black mark stain your reputation
- Keeping an eye on patient privacy



Don’t let a black mark stain your reputation

Dr Sara Bird
Executive Manager, Professional Services
MDA National

Case history

A Practice Manager received an email from a 26-year-old patient:

I attended your practice for an iron infusion three weeks ago. During the infusion, I voiced concern on a couple of occasions about swelling and discomfort around the IV site. The nurse checked and said it was OK. I now have a large, unsightly black mark on my forearm.

I am waiting to see a dermatologist, but my online research suggests the stain will be permanent. I was not warned of the risk of skin staining. I am getting married in three months and I want you to pay for the costs of the dermatology treatment. I also want compensation for my pain and suffering.

The Practice Manager sent the email to MDA National. On review of the patient’s claim, it became apparent that the GP had not warned the patient about the possibility of skin staining – and the nurse was not aware that extravasation could lead to a permanent skin stain. There was also no documentation in the medical records about the infusion, including no notation about the patient’s complaints of swelling and discomfort around the IV site.

Based on this information, MDA National liaised directly with the patient and promptly resolved her claim by paying for the costs of laser treatment of the skin staining by the dermatologist.

Iron infusions

The use of iron infusions has increased over the past decade with estimates that intravenous iron was dispensed to one in 50 Australian women of reproductive age in 2017.

MDA National continues to receive numerous notifications from GPs and practices arising from the administration of intravenous iron. A review of our data reveals that some of the claims associated with iron infusions have settled for amounts in excess of $100,000.

The Medical Board of Australia and the Medical Council of NSW have also raised concerns about an increasing number of complaints associated with skin staining following iron infusions.

Common themes in these claims and complaints are:

- failure to obtain informed consent
- inadequate practice protocols and staff training
- failure to appropriately monitor the infusion.

Have you obtained informed consent?

This involves a discussion with the patient about the benefits and risks of the intravenous iron, so that the patient can decide whether to proceed with the treatment.

A key issue is to ensure there are appropriate indications for the intravenous iron, i.e. that the potential benefits will outweigh the risks. Treatment alternatives should be discussed, such as oral iron, and the patient given an opportunity to ask questions about the proposed treatment. The risk of skin staining is an important adverse event to discuss and a vital part of the consent process.

Consider the individual patient's circumstances. The timing of the treatment may be relevant to a patient's decision. In the case above, the patient may have delayed the treatment until after her wedding. For some patients, a permanent skin stain may have a significant impact on their work, e.g. a professional dancer or model.

The provision of written information to the patient may be useful, including de-identified photos of skin staining. Ensure the consent process is documented in the patient's medical records.

Reducing the risk of skin staining

It is recommended that in order to minimise the risk of injection-site leakage or extravasation, the IV cannula should be flushed with 0.9% saline before and after the administration of the iron.

Ask patients to notify staff if there is any pain, discomfort or swelling during the infusion.

Staff should be trained in the administration and monitoring of iron infusions. If the patient complains of any symptoms during the infusion, careful clinical assessment should be undertaken and documented in the medical records.

Practice tips

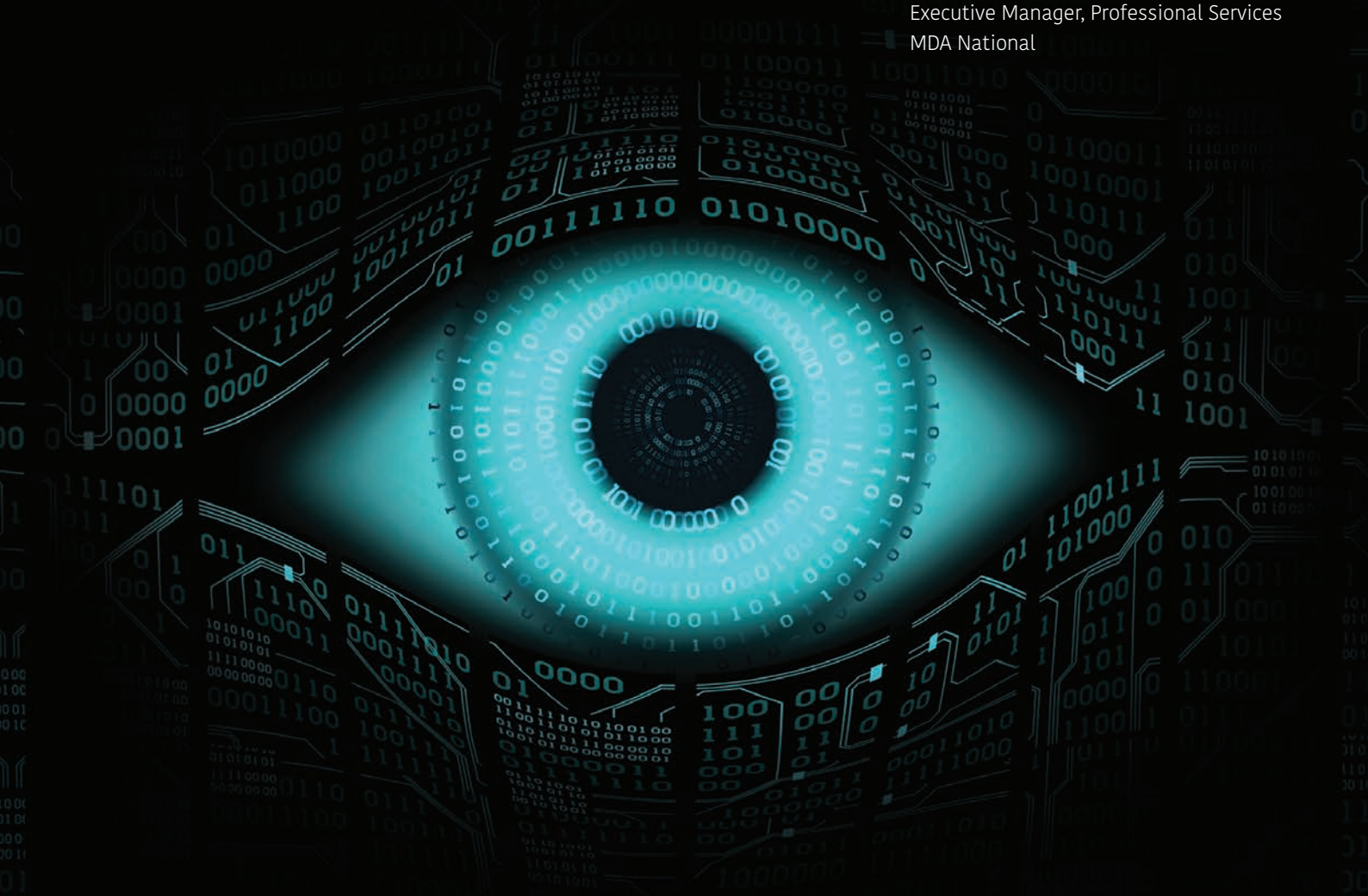
- Ensure you have obtained informed consent – including warning patients about the risk of permanent skin staining.
- Advise patients to immediately report any symptoms during the infusion, such as pain or swelling.
- Have practice protocols in place for the administration and supervision of intravenous iron.
- Trained staff should monitor patients during the infusion.
- Ensure all practice staff have appropriate professional indemnity insurance.

More information

BloodSafe – *IV Iron Tools*
bloodsafelearning.org.au/iv-iron-tools

Keeping an eye on patient privacy

Dr Sara Bird
Executive Manager, Professional Services
MDA National



One of our ophthalmologist Members recently contacted us about an unusual request from the police to breach patient confidentiality and privacy.

Case history

In January 2021, police sought information from optometrists and ophthalmologists about a fugitive who had failed to attend court in 2010 in relation to charges of conspiracy to murder. He had a prior conviction for murder. Interestingly, the police also offered a $100,000 reward to the optometrists and ophthalmologists for information leading to the fugitive's capture.

The police asked the practitioners to search their records for a client with a date of birth of 17 October 1957 and listed several of his known aliases. They also provided details of a prescription (R -1.75 -0.75 x5, L -1.75 -0.50 x147) obtained from an optometrist in Queensland in 2010 for a pair of glasses that were ordered, but never collected by the patient/fugitive.

Would it be reasonable in this situation for you to provide information to the police?

Duty of confidentiality

Doctors have an ethical, professional and legal duty to protect the confidentiality of information obtained as a result of their management of patients. This duty forms the basis of trust and honesty in the doctor–patient relationship.

The obligation of medical confidentiality is long established. The Hippocratic Oath states:

What I see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

However, the duty of confidentiality is not absolute. The Medical Board of Australia's Code of Conduct confirms that patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required or permitted by law.

Exceptions to the duty of confidentiality and privacy

Under the Commonwealth *Privacy Act 1988* (Privacy Act), there are limited and specific circumstances where health information can be disclosed to a third party, such as the police, without the patient's consent to do so.

These include the following:

- **Required or authorised by law:** For example, mandatory reporting of child abuse, or mandatory reporting of notifiable conduct by a health practitioner, or a valid subpoena or search warrant.
- **Serious threat:** You can disclose health information where it is unreasonable or impracticable to obtain consent to the disclosure, and you reasonably believe the disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety (in the ACT and NSW, the legislation states a "serious and imminent" risk or threat). You must have a reasonable basis for your belief and be able to justify it. The test is what a reasonable person, who is properly informed, would believe in the circumstances.
- **Enforcement related activities:** You can disclose health information where you reasonably believe it is reasonably necessary for enforcement-related activities conducted by, or on behalf of, an enforcement body. If you do so, you must make a written note of the disclosure.

  Enforcement bodies include Commonwealth, state and territory bodies responsible for policing, criminal investigations, and administering laws to protect public revenue or to impose penalties or sanctions. Enforcement-related activities include the prevention, detection, investigation and prosecution or punishment of criminal offences, and intelligence gathering and monitoring activities.

  Importantly, while the Privacy Act *allows* disclosure in this situation, it does not *require* disclosure. Other obligations, such as your duty of confidentiality, may affect whether you can disclose information to enforcement bodies.

"Public interest" disclosure

There are limited circumstances where confidentiality can be breached in the "public interest". For example, if a patient continues to drive despite advice that they are unfit to do so, and the doctor believes the patient is endangering the public, it is appropriate to report concerns directly to the Driver Licensing Authority (DLA).

This "public interest" disclosure is reflected in the legislation which states that health practitioners who make a report to the DLA about a patient who is unfit to drive, without the patient's consent but in good faith, are protected from civil and criminal liability. In the NT and SA, legislation imposes on health practitioners a positive duty to notify the DLA in writing of their belief that a patient is physically or mentally unfit to drive.

What would you do in this fugitive case?

Based on the limited information provided by the police, it is not clear that there is a valid exception to the duty of confidentiality and privacy in this situation. In particular, concern would arise about the offer of a reward which may, of course, influence a practitioner's decision to disclose information to the police without a clear legal or professional basis to do so.

More information

Office of the Australian Information Commissioner
Guide to health privacy, Sept 2019
oaic.gov.au/privacy/guidance-and-advice/guide-to-health-privacy

Firstdefence

FOR DOCTORS IN TRAINING

- The angry patient
- Q&A: Medico-legal advice
- Empowering the medical leaders of tomorrow
- Feeling like an imposter?

The angry patient

Karen Stephens
Risk Adviser, MDA National

An angry patient can be confronting. The way you approach them can either ease or escalate the situation.

Be aware that behind a patient's anger, there may be other emotions such as pain, fear or worry. They may be feeling neglected or unfairly treated, or believe they've not been respected or listened to. There could also be other reasons – such as a prolonged waiting time in crowded or uncomfortable conditions; or an underlying medical or psychiatric condition.

You can try to ease the angry patient's distress with these strategies:[1-4]

- Appear calm, respectful, self-controlled and confident. Don't take the patient's comments personally.
- Approach in a warm, friendly manner. Avoid confrontational body language (e.g. crossed arms, standing too close).
- Be careful with the use of touch – it may be interpreted as a threatening gesture.
- Find out what the problem is from the patient's point of view.
- Use active listening, and show you are listening, e.g. by nodding. Don't interrupt, and give the patient time to clarify their thoughts.
- Ask reflective questions, putting their statements in your own words to clarify your understanding – e.g. *You need to see a GP as soon as possible, is that correct?* Use a series of 'yes' questions – it's hard to remain angry with someone who keeps agreeing with you.
- Speak softly and clearly, using simple language without 'talking down' to the patient.
- Give clear messages showing that you want to help and you understand their point of view.
- Don't try to provide solutions until the patient has calmed down, so they can listen and be more rational.
- Give control to the patient, e.g. *What I would like to do/ discuss/consider now is XYZ, is that alright with you?* Ask the patient to list possible solutions.
- Don't promise what you can't deliver.
- Be considerate, e.g. offer them a glass of water.

Be aware that behind a patient's anger, there may be other emotions such as pain, fear or worry...

Staff safety

The above strategies don't always work, and anger may escalate to violence. Staff safety should be a priority, not least because of Work Health and Safety laws. Practice or hospital-wide systems should apply in these circumstances, and practical solutions might include:

- the use of duress alarms and optimising the physical layout of the workplace
- training staff in dealing with difficult patients and situations, ideally at new staff inductions and as refreshers for all staff.

It's also useful to establish a practice policy which covers:

- what to do if anger escalates into violence
- how to set boundaries and prevent future episodes from the same patient
- how to end the relationship with the patient if necessary
- post-incident response, including debriefing and support for staff.

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

Q&A
Medico-legal advice

Nerissa Ferrie
Medico-legal Adviser, MDA National

Do you have a burning medico-legal question, but don't have time to pick up the phone? Below we answer some common questions we receive from our junior doctors.

Police statements

When I was working as an intern in ED a couple of years ago, I treated the victim of a serious assault. I've received an email from the hospital asking me to provide a statement to the police because the matter is proceeding to court. I have no recollection of the patient – what should I do?

Provided you (or your hospital) have received authority from the patient, you can ask the hospital for a copy of the notes relating to the admission so you can draft a factual statement based on those notes. Our handy guide on writing police statements is an excellent starting point, and one of our medico-legal advisers will be happy to review your statement before you finalise it.

Have more questions?

Call our Medico-legal Advisory Service on 1800 011 255.

Medicare billing

I've recently started a new placement as a GP Registrar, and I'm concerned about my billing. If I bill an Item 23, the practice changes it to an Item 36. I've also been told that I can only spend 10 minutes with a patient, when the MBS descriptor clearly states a minimum of 20 minutes. What should I do? I'm worried that my supervisor will write a negative report if I make a fuss – but I don't want to end up on the wrong side of Medicare.

Regardless of whether you're a GP registrar or a GP reaching retirement age, you're responsible for the services billed under your provider number. Upcoding item numbers can lead to a finding of inappropriate practice, and you'll be held personally responsible for any debt incurred through an audit of your billings. Your concerns are valid, and you should seek advice from our Medico-legal Advisory Service and/or your training provider before you take any action.

If you're concerned, you can ask the practice manager to provide you with a list of your billings on a weekly or monthly basis, so you can check what's being billed to your provider number. If you see any discrepancies you should request a correction, in writing, and ask for confirmation that the corrections have been made. For more guidance and information, check out our webinar: *Protecting Your Provider Number.*

Prescribing for family

I was at a family BBQ on the weekend, and my sister asked me to write a script for the oral contraceptive pill (OCP). I wrote the script on a hospital script pad, but now one of my colleagues says I've done the wrong thing. I am an intern and a qualified doctor, so who is right – me or my colleague?

Did you take a full medical history? Did you explain the risks of taking the OCP? What did you write in your notes?

There are a number of good reasons why doctors shouldn't prescribe for family and friends, themselves or the family dog – but this is even more problematic for an intern.

According to Ahpra: *Interns are only permitted to work in accredited intern positions. They are not permitted to carry out any clinical work outside of their allocated intern position.*

In addition to your registration obligations, the hospital may also investigate if the script was written on a hospital script pad. You're also putting your family at risk, because if something goes wrong as a result of your prescribing, you could leave your family member without financial recourse – there is an exclusion in the Professional Indemnity Insurance Policy for any claim against you which arises out of the provision of elective medical treatment by you to a member of your immediate family. This means your current or former spouse, de facto or domestic partner; your children; the children of your current or former spouse, de facto or domestic partner; and your brothers, your sisters or your parents.

Patient confidentiality

I've been asked to attend a meeting with the Head of Department at my hospital. My boyfriend asked me to look at his mother's medical notes, because she was unhappy with the care she received when she attended the ED at the hospital where I work. My boyfriend's mum made a formal complaint and referenced my involvement. Am I in trouble?

It's not appropriate to access a patient's clinical notes, unless it is for the purposes of providing treatment. We have seen a number of junior (and senior) doctors investigated for accessing a patient's notes out of curiosity or misguided loyalty.

Most hospitals will have their own policies in relation to accessing notes, but there is an overarching principle relevant to all doctors in *Good medical practice: a code of conduct for doctors in Australia* which includes "accessing an individual's medical record only when there is a legitimate need".

If you are subject to a hospital investigation, you should contact our Medico-legal Advisory Service for advice and assistance.

Empowering the medical leaders of tomorrow

Dr Mellissa Naidoo
MDA National Vice President
Chair, MDAN State Advisory Committee, QLD

Dr Hashim Abdeen (MDAN Member)
Junior Doctor Advisory Committee, QLD
Advanced Trainee, Rheumatology & General Medicine

Medical leaders throughout the pandemic, with their increased visibility and diversity in leadership styles, have been important role models for aspiring clinical leaders.

Few of us receive formal leadership preparation as part of our medical training. Yet, many doctors will findthemselves in clinical leadership roles as they progress through their careers.

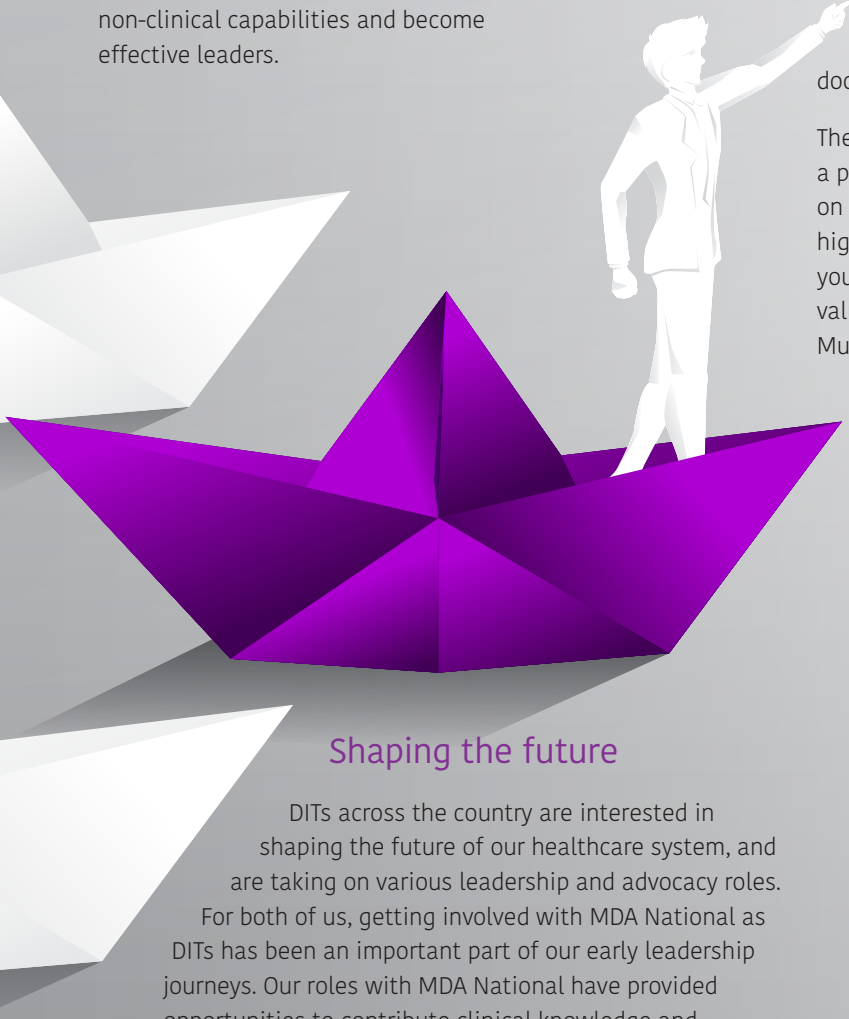
The value of medical leadership

The past 18 months have seen rapid changes as the healthcare system continued to adapt to the evolving threats of COVID-19. Doctors hold a trusted role in the community; and throughout the pandemic, the public have looked to our profession for reassurance, credible advice and reliable information.

Strong medical leadership has been a critical component of our pandemic response – and it's apparent that we need clinical leaders to help address the wider issues within the Australian healthcare system and ensure the best possible outcomes for our patients.

The value of medical leadership is becoming increasingly recognised and was highlighted further through the COVID-19 crisis. Medical leadership across the health sector at all levels – from frontline clinical care to health policy and systems – is more important than ever.

However, while leadership is a concept taught to us in medical school, few of us receive formal leadership preparation as part of our medical training. Yet, many doctors will find themselves in clinical leadership roles as they progress through their careers. It's therefore important that we empower our future medical leaders by arming them with the skills, experience and opportunities necessary to develop their non-clinical capabilities and become effective leaders.



Shaping the future

DITs across the country are interested in shaping the future of our healthcare system, and are taking on various leadership and advocacy roles. For both of us, getting involved with MDA National as DITs has been an important part of our early leadership journeys. Our roles with MDA National have provided opportunities to contribute clinical knowledge and further develop essential non-clinical skills.

Doctors for doctors

Clinical thought leadership is essential to MDA National. As such, practising doctors are embedded throughout the organisation from those on staff to those on the Boards, committees and working groups. MDA National also engages with doctors through their local State Advisory Committees (SACs) to better understand the current challenges facing the profession and the local issues affecting Members across specialties. The SACs give Members the opportunity to get involved with the organisation in a thought leadership and advocacy role.

Member insights through the SACs and Mutual Board leadership have led to advocacy on various important issues over the past 12 months – including coronavirus FAQs, COVID-19 indemnity, doctors' wellbeing, healthcare worker safety, support for GP registrars and those experiencing training disruptions, as well as diversity and inclusion.

Empowering emerging leaders

MDA National is committed to giving a voice to doctors in training (DITs). While there is DIT representation on each of the SACs, the impact of COVID-19 on junior doctors and the specific challenges they face prompted MDA National to form a Junior Doctor Advisory Committee (JDAC). As a national committee of like-minded DIT leaders, they represent junior doctors' perspective on medical indemnity and practice issues.

The JDAC provides an important conduit for DIT voices and a platform to provide advice and insights to MDA National on key advocacy issues and initiatives relating to DITs – highlighting to the organisation what is truly important to you, as a DIT member of MDA, and how they can increase the value of your membership. With links back to the SACs and Mutual Board, this is a powerful mechanism for better understanding and responding to the unique needs of Members in the early stages of their careers.

Do you have a topic you'd like to raise for discussion at a JDAC or SAC meeting?

Are you interested in being involved with an MDA National committee?

Contact your local SAC or JDAC member through your state office:
mdanational.com.au/contact-us

Feeling like an imposter?

Gemma Brudenell
Education Writer & Content Editor, MDA National

Chris Martin, Dr Margaret Chan and Maya Angelou – what do they all have in common? They, among many others, have admitted to feeling like a fraud.[1]

Imposter phenomenon (IP) mainly afflicts high achievers and people with perfectionist tendencies.[2]

It's most common at early career stages or at times of transition, and in careers that have high levels of expectation and a high cost of mistakes.[3]

More than low self-confidence, IP involves a pattern of thinking where success is attributed to factors beyond our control, and a constant fear of exposure, isolation and rejection.[4] These thoughts can be overwhelming, affecting mental health and causing people to change careers or decide to not go on with their training.[5]

Syndrome or phenomenon?

Although imposter syndrome is the term commonly used, it was actually first (and more accurately) documented as imposter phenomenon[6] – because IP is not a diagnosable condition as the term 'syndrome' suggests.

Think you might be experiencing IP? Reflect on these questions to find out.

	Never	Sometimes	Often	Always
I am quick to find fault in my work.	○	○	○	○
I am overly critical of my mistakes.	○	○	○	○
I feel all my colleagues are more competent than me.	○	○	○	○
I feel I don't deserve my achievements, I just got lucky.	○	○	○	○
Others think I'm more intelligent than I am.	○	○	○	○
I fear that people will find out I don't know what I'm doing.	○	○	○	○

If you answered 'often' or 'always' to most of these questions, you may be experiencing IP. Please note these results are not an official diagnosis – if you have concerns, talk to your GP or mental health provider.

It can help to:

- talk about what you're going through with someone else[3,5]
- focus on what you're doing well and acknowledge your success[2,3]
- pay attention to situations where you feel like an imposter and challenge these thoughts with evidence.[2]

Stay tuned for our podcasts on this topic to learn more about IP and strategies to manage IP feelings. These podcasts are tailored for doctors in early stages of their career and will be available soon at **mdanational.com.au/advice-and-support/library/podcasts**

View the references online: **mdanational.com.au/imposter-syndrome**

Keep on learning...

Webinars

National opioid regulatory reforms

NEW

Systematic efforts to reduce harms due to prescribed opioids – understand and apply recent changes to opioid indications and PBS listings

45

- Recorded live 11 March, with experts from the Australian Government's Department of Health.
- Check that your opioid prescribing aligns with current national requirements.
- Hear about common difficult circumstances related to prescribing opioids that prompt Members to call us.
- Access links to useful resources.

Other webinar videos

- *Avoiding medical marketing mistakes*
- *Diplomacy in a hierarchy: tips for approaching a difficult conversation with a senior colleague*
- *DNA deliberations: tips for talking about direct-to-consumer tests*
- *Intimate examinations: respect and responsibility*
- *Loss leading to learning: strengthening teamwork in response to Jack and Dr Bawa-Garba's case*
- *Privacy and information security in private practice*
- *Privacy Q&A: practical, proactive advice and answers to your information security questions*
- *Protecting your practice from cyber strike*
- *Protecting your provider number: when Medicare comes knocking*
- *Risk hotspots for hospital specialists and how to respond when things go wrong*

Access recordings online at:
bit.ly/WebinarVideos

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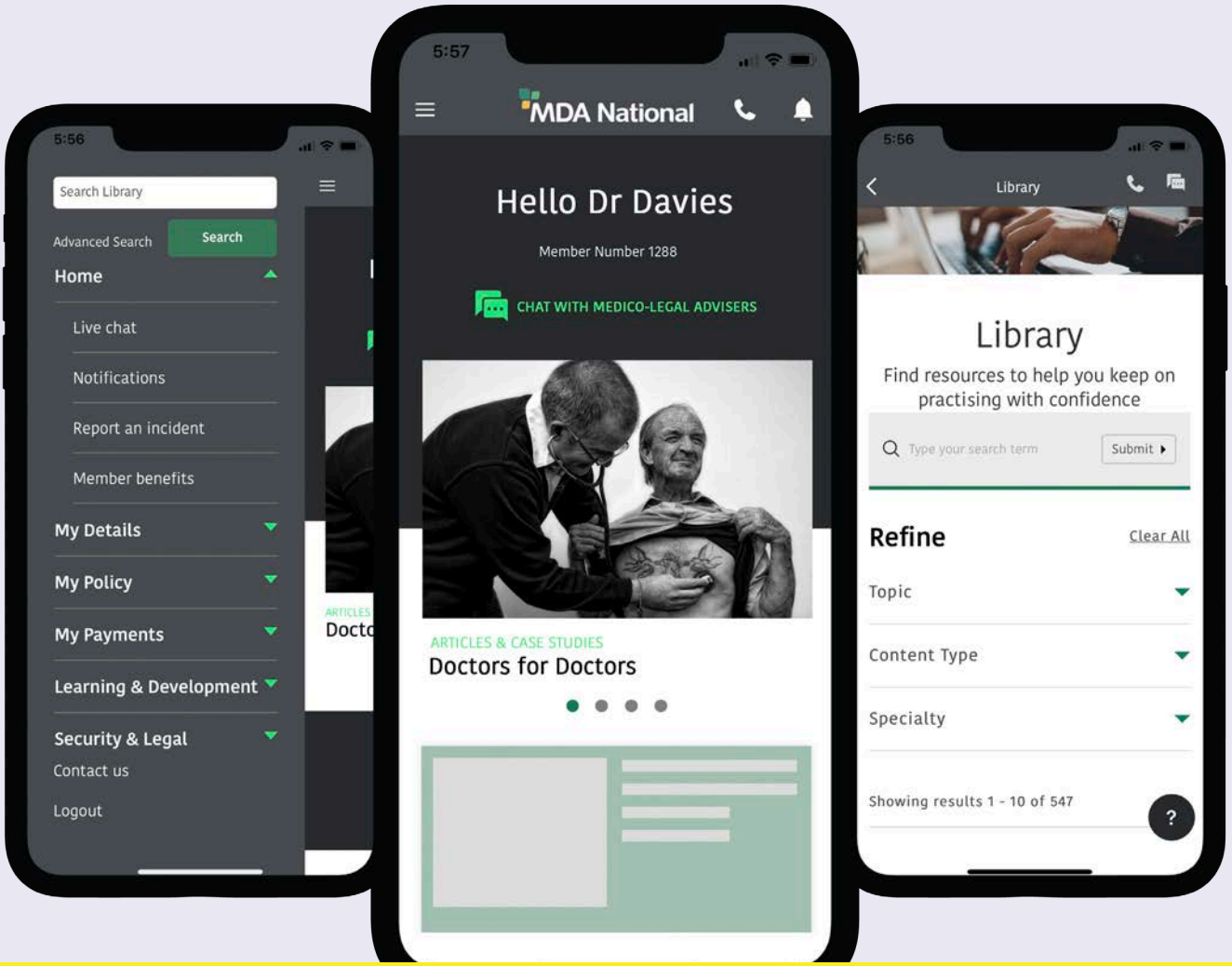
Topics include:	Survey respondents planning to change their work due to the activity:
• *Noteworthy: the how, what, where & why of medical documentation*	93%
• *Prescribing opioids*	98%
• *Medico-legal CPD quiz 1*	79%
• *Informed consent challenges*	87%

Access e-learning activities at:
bit.ly/2qLMnv8

- Let us know your education preferences. When works best for you? What format?
- Take a one-minute survey at **surveymonkey.com/r/MDANeducation**.
- Your feedback truly matters.

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 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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