SUMMER 2023

Defenceupdate

Responding to requests for unnecessary tests

Contracts: the basics every doctor should know

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Medico-legal content

FOR MEDICAL PRACTITIONERS

MDA National
Support Protect Promote

Nerissa Ferrie
Medico-legal Adviser, MDA National

Welcome to our Summer 2023 edition of *Defence Update*.

New and emerging technology has been a hot topic over the past six months. Our Vice President, Dr Simon Benson, talks about the benefits and challenges of embracing artificial intelligence and large language models in medical practice (page 3).

Many of our valued Members give back to the medical profession in any number of ways – and Dr Simon Torvaldsen provides an excellent example of the value of leadership and "making a difference" outside of direct patient care through his work with the AMA (page 4).

In this edition we also take a deep dive into contracts. We know this is becoming a minefield for doctors and practices alike, so Kym Gardner provides some much-needed advice in our medico-legal feature (page 11). What should you do if you are asked to attend a meeting at your hospital? Dr Julian Walter has the answers (page 14).

Death certification is a perennial challenge for doctors, and a reason for many of the calls to our urgent after-hours service. Daniel Spencer provides some excellent medico-legal guidance and advice on when you should say no to completing a death certificate (page 7).

Do you employ nurses in your practice? If so, Gae Nuttall from Support in Practice takes you through the information you need to know (page 8), and our Medicare Update contains some practical advice on billing urgent after-hours attendance items. We also invite you to catch our 'Practicalities of Medicare' video, a must-watch for all doctors in private practice.

We offer a wealth of useful advice in Case Book, where we look at responding to requests for unnecessary tests (page 16), the legal protections for good Samaritan acts (page 17), and Gillick competence and the mature minor (page 18). Dr Julian Walter tackles the tricky issue of discharge against medical advice (page 20) and Dr Jane Deacon gives some great advice on avoiding misunderstandings and complaints during physical examinations (page 22).

Guest author Dr Michelle Johnston is a shining example of how maintaining a healthy sense of humour can balance the unpredictability of a busy emergency department (page 24), and Dr Ryan Williams brings some festive cheer (nice photo Ryan!) as he describes the pleasure of raising money for charity with his like-minded musical colleagues in the Queensland Medical Orchestra (page 26).

That's it for another jam-packed edition of *Defence Update*. From all of us at MDA National, we wish you a safe and happy festive season.

In this issue

Membership queries?

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We thank all our in-house experts and guest authors for their valuable contributions to this edition.

FROM THE VICE PRESIDENT
A message to our Members

Dr Simon Benson
Vice President, MDA National

Dear Members,

As dedicated medical professionals, we are well aware of the unique challenges that come with providing health care in today's dynamic world.

Trust is paramount. Every decision we make impacts the lives of our patients, and with that responsibility comes the potential for unforeseen challenges. Your cover with us serves as a vital safety net, offering protection against financial and reputational risks stemming from medical malpractice claims. It reinforces the trust between you and your patients, assuring them that you are committed to providing the best care, even in the face of unexpected circumstances.

Unlike commercial insurers driven by profits, mutual insurers like MDA National operate with your best interests at heart. This translates into superior coverage, and a profound understanding of the unique needs of healthcare practitioners like you.

The field of health care is dynamic – constantly evolving with new treatments, technologies and regulations. As the practice of medicine changes, so do the risks associated with it. We are committed to staying at the forefront of these changes, ensuring your indemnity cover remains relevant and comprehensive. We are your steadfast partner in navigating this ever-evolving landscape.

ChatGPT and other large language models (LLMs) burst onto the scene earlier this year. Artificial Intelligence (AI) has the potential to revolutionise diagnostics and patient care. Tools are now on the market to improve back-office efficiency and act as medical scribes revolutionising the note-taking experience.

Keeping accurate and detailed patient records is the most valuable tool to enable us to defend claims on your behalf. As these technological advancements become available, we are here to provide guidance on how to harness the potential of AI, while maintaining the highest standards of patient care and professional responsibility.

In addition to indemnity insurance and case management support, our expert advisory team stands ready to provide guidance in the complex realm of medico-legal issues. Whether you need assistance with a patient query, regulatory compliance or patient consent, our advisers are always on hand to ensure you have the knowledge and resources you need to make informed decisions to protect your practice.

In these challenging times for healthcare professionals, having a stable professional indemnity insurer and reliable medico-legal assistance, coupled with expertise in new technology and evolving care models, is more critical than ever.

We encourage you to make the most of the benefits we offer, including our expert medico-legal guidance and broad range of complimentary education activities. Together, we can navigate the complexities of the medical profession – giving you peace of mind, and safeguarding both your reputation and your practice.

Beyond clinical practice

Dr Simon Torvaldsen (MDA National Member)
Vice President, AMA (WA)
Chair, AMA Council of General Practice

Niranjala Hillyard
Director, Inkpot & Pixel
Freelance Writer, Editor & Designer – *Defence Update*

There's no aspect of general practice that Dr Simon Torvaldsen doesn't love.

With his strong interest in health policy and strengthening the role of primary health care, it's no surprise that Simon is the Chair of the Australian Medical Association (AMA) Council of General Practice, working to improve our health system and promote the value of general practice. He was also recently appointed Vice President of the AMA (WA) where he plays an active role.

Simon has made significant contributions to the medical field, including founding Australia's first private Palliative Care Unit at Mount Lawley Private Hospital, and being a founding member of the Australian Motor Sports Medicine Association. He was instrumental in creating GP After Hours Mount Lawley at Mercy Hospital and later relocating it to Third Avenue Surgery.

Simon provides expert advice to a number of government committees, the Medical Board and the media. He finds satisfaction in making a difference for his patients and for the future of medicine in Australia. In this interview, Simon shares his reflections on doctors' roles beyond clinical practice.

> *"As doctors, we contribute in many ways to make Australia a better and healthier place – and the rewards can far outweigh the negatives. For me, being a doctor is a glass that's a lot more than half full. I hope it's the same for you too."*

What were your first thoughts when asked to contribute to this article?

Being asked to contribute to a publication by a medical defence organisation (MDO) raises some interesting questions. Most of us have benefited from the support and advice from our MDOs at various times. But, because they are the ones we turn to when 'disaster' strikes, they can also be a reminder of the hassles we encounter in medicine – the things we shouldn't do, or must do, to avoid problems – even when the outcome is sound advice and problems solved.

So I felt I should talk about the joys of medicine – the immense value we contribute to society, and everything we achieve beyond the doors of our consulting rooms.

What's your opinion on the role of doctors beyond clinical practice?

It's obvious that most of us contribute directly to patient care in some way, whether in general practice, diagnostics, or any other specialty; others contribute via research and teaching. And when I look around, there are many doctors who go above and beyond the traditional consulting role, using their wisdom and expertise to make Australia a better and healthier place. And, of course, many of us have talents outside the medical field – in arts, music, or other endeavours.

Medical training does emphasise leadership and decision-making, along with care and compassion. Many doctors end up in leadership positions. I believe this, in most cases, stems from a wish to make a difference and ensure better outcomes, rather than for glory. This may involve leadership in areas of health, such as hospitals, health departments and universities; or in other areas, such as politics or social advocacy.

Take MDA National President Dr Michael Gannon, for example, who also served as President of the AMA (WA) and the Federal AMA; and his numerous contributions through various boards and committees, far beyond his work as an obstetrician & gynaecologist. But we don't always have to be the high-profile leaders seen on television and social media to make a real difference. Much active leadership happens behind the scenes.

What does your role within the AMA typically involve?

The AMA is the most powerful medical lobby group, with onerous background work undertaken at all levels. I am part of this both in WA and nationally, including sitting on multiple committees and providing input into many facets of our health system.

On top of this is the formulation of AMA policy, strategy development, and the advocacy work itself. As a GP in an organisation representing the entire profession, my first task is to advocate for GPs within the AMA itself. How can I stand a chance with government if I can't convince my peers?

Then there's working with key stakeholders to ensure a united message; and pressing for key policies with government through logical and persuasive arguments. My Canberra meetings earlier this year involved pushing a lot of the agenda that emerged in the latest budget. Representing the AMA opened doors that would otherwise have been shut.

What motivates you in your active involvement within the AMA (WA)?

I continue to be active within the AMA (WA) because I want to make a positive difference to our health system and get better outcomes for patients, doctors, and our nation as a whole. Most doctors genuinely want to change things for the better. And while helping patients is clearly one way to do this, we often see that working towards making system improvements may achieve even more.

A lot of work goes on behind the scenes on behalf of the profession. General practice would be in an even more parlous position without the AMA, and with no way out. And our involvement at all levels also enables us to prevent many bad policy decisions before they even see the light of day.

A key lesson I've learnt from being with the AMA is that one person can indeed make a difference, and that goes for many of us who are active in roles outside the consultation room. As individuals, we may think we only make small differences here and there. But collectively, our nation is a better place for having the ethics and work of doctors contributing not simply to patient care, but in a much broader way. I feel extremely lucky to be in a position where I can exert my influence for the better.

Anything else you'd like to say to your fellow medical practitioners?

I think we should all be proud of the immense positive contribution our profession makes to society at so many levels. Even those of us who think we don't do much should stop and reflect – we are role models for so many; we are considered knowledgeable; our advice is listened to (perhaps not always as much as we would like!); and we are often able to advocate for those who have little voice.

I am no different to most of you, and we do tend to worry about the trials and tribulations of being a doctor. But we should also take a moment to consider the many ways in which we contribute to make Australia a better place – and that the rewards can far outweigh the negatives.

For me, being a doctor is a glass that's a lot more than half full. I hope it's the same for you too.

You can contact Dr Simon Torvaldsen with any questions or comments via email at **simon.torvaldsen@amawa.com.au**.

Do GPs need a Working with Children Check?

Kym Gardner
Medico-legal Adviser, MDA National

Every jurisdiction has a responsibility to ensure the safety of its children by implementing checks to avoid obvious dangers, and to prevent known offenders working in positions of trust. However, like many laws in Australia, each state and territory does it a little differently to the next. Information about this isn't always easy to find, so we've done the hard work for you!

Let's take a look around the country and answer the question:

Do GPs in private practice need to obtain a Working with Children Check (WWCC) or the equivalent?

Australian Capital Territory

Called a 'Working with Vulnerable People' (WWVP) Check – it is specifically not required if you are a health practitioner registered with Ahpra.

New South Wales

A GP seeing an adolescent without an adult present, regardless of the frequency of doing so, would be considered 'ordinary' in the course of being a GP. However, a GP who does not have a WWCC, when seeing an adolescent who has presented without an adult, should ask a member of staff to sit in on the consultation (with patient consent) in a chaperone-type situation.

Northern Territory

Called an 'Ochre Card' – essentially if your work duties include, or may include, contact with children, then you are required to have a clearance.

Queensland

Called a 'Blue Card' – a health practitioner registered with Ahpra is exempt from obtaining one when employed or carrying on a business as part of their functions as a registered health practitioner. However, this exemption does not apply to medical students.

South Australia

General practitioners should obtain a WWCC, as a person must not work with children (i.e. undertake 'child-related work') unless they have a WWCC. The SA legislation defines what is considered to be child-related work, which generally involves regular contact with children while providing specified services or activities, including health services, for children.

Tasmania

Called 'Working with Vulnerable People' (WWVP), GPs in private practice are required to have a WWVP, as would anyone who provides care or services to children.

Victoria

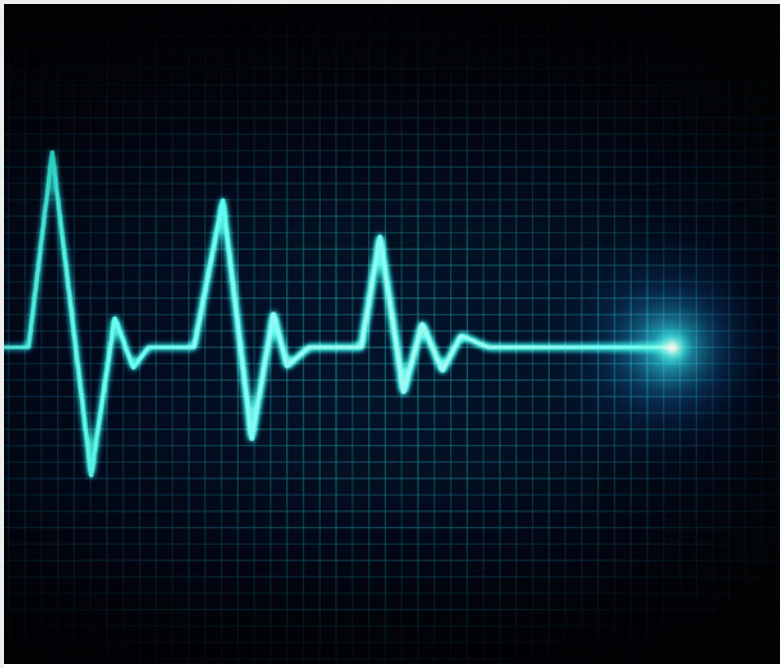
Generally needed only if the employer or practice owner requires it, or if you work in a paediatric ward of a public or private hospital. However, if the GP is involved in counselling or other support services for children, then they would be best placed to obtain one, as they would technically meet the criteria. Organisations are free to implement their own policies that may go beyond the legislative requirements.

Western Australia

There is no category of 'child-related work' specifically for general health practitioners in private practice. So they are not required to have a WWCC, unless they also carry out child-related work in connection with another category.

Death certificates
and when to say no

Daniel Spencer
Medico-legal Adviser, MDA National



Medico-legal enquiries relating to the completion of death certificates are common, and the questions vary:

- *The police called and asked me to write a death certificate for my colleague's patient who died in her sleep last night. My colleague is overseas, and I've never seen the patient. Should I complete the death certificate?*
- *I am not 100 per cent sure what caused their death, but I'm quite confident. Is that enough for me to complete the certificate?*
- *I won't get a chance to see the body before completing the certificate. Is that ok?*

You will generally be responsible for completing a death certificate where you were caring for the patient immediately before the death or after you examined the body. The death certificate needs to be completed within 48 hours (unless the death is a 'reportable death'[1] and has been reported to the Coroner).

The general position is that you will be able to complete a death certificate if:

- the death does not need to be reported to the Coroner; and
- you are 'comfortably satisfied' as to the cause of death.

While 'comfortably satisfied' is difficult to define, it essentially means more likely than not. It is not the case that a doctor must be *certain* of the cause of death to be able to complete the certificate.

If you are not 'comfortably satisfied' as to the cause of death, you should not complete the certificate, and the death should be reported to the Coroner.

The Coroner's office in each state can assist you in reaching a conclusion about the probable cause of death. In some reportable deaths, the forensic pathologist will determine the most likely cause of death, and the Coroner's office will then direct you to complete the certificate.

Doctors have an obligation under the Medical Board's Code of Conduct to not sign a report or certificate they do not believe to be accurate. It is therefore important that doctors comply with the requirements for completing a death certificate in their jurisdiction.

There is no requirement to sight the body prior to issuing a death certificate in most states, provided the doctor was responsible for medical care of the deceased immediately before death. A doctor affiliated with the treating team who has access to relevant records, but who was not directly responsible for medical care immediately prior to death, should examine the body before completing the certificate.

In the ACT and Queensland, a doctor not responsible for the medical care of the deceased, and who has not examined the body, may examine the deceased's records, speak to another doctor regarding the deceased, or consider information from someone who was with the deceased when they died, to enable them to complete the certificate.

If you believe an error has been made on a death certificate, please contact our Medico-legal Advisory Services team for advice.

View the references online: **mdanational.com.au/death-certificates-when-to-say-no**

Do you employ nurses in your practice?

Gae Nuttall
Risk Adviser, MDA National

Nurses are an incredibly important addition to any medical practice, but scope of practice and supervision requirements can vary depending on a range of factors.

Registration and indemnity

There are four main 'types' of nurses registered with the Nursing and Midwifery Board of Australia (NMBA) – Registered Nurse; Enrolled Nurse; Nurse Practitioner; and Midwife.

Each type has their own professional standards and registration requirements. Ahpra has a public register of practitioners which includes nurses. Check the register prior to employing a nurse (and annually) for valid registration, also noting any conditions that may have been imposed by the NMBA. Renewal of NMBA registration is due 31 May each year.

One of the requirements for registration is professional indemnity insurance (PII) – ask for evidence that all nurses in your practice have PII (including contractors). Nurses coming from a hospital role, in which insurance is usually provided, may have little experience with insurance in the private sector.

PII for nurses is available from various insurers, including MDA National via our Practice Indemnity Policy (PIP).

Scope of practice

Nurses must only deliver care within their individual scope of practice. An individual nurse's scope of practice will vary depending on their education, clinical experience, context of practice, relevant legislation, and the employment setting. A guide on scope of practice is available at **nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx**. Employers should also be aware of nurses' requirements in this regard.

What's the difference between an Enrolled Nurse (EN) and a Registered Nurse (RN)?

From an education perspective, ENs will usually have a diploma and RNs will generally have a degree.

ENs must work under the supervision of an RN. This supervision can be indirect (if the RN agrees that the EN is experienced), but the RN should be available or contactable whenever the EN is working.

ENs cannot be supervised by doctors. See **nursingmidwiferyboard.gov.au/codes-guidelines-statements/faq/enrolled-nurse-standards-for-practice.aspx**.

You can have more than one RN being the supervisor (to cover leave or days off, etc), but there needs to be agreement between all, and the RNs are responsible for assessing that the EN can work under 'indirect' supervision (i.e. RN is available to contact, but is not on site at all times).

A doctor can 'request' or 'direct' a nurse to provide patient care, but cannot be the formal supervisor.

Administration of medications and immunisations

Generally, nurses require a written medication order from the treating doctor to proceed with administration of medications.

The main exception in most states is vaccines administered for the National Immunisation Schedule, on the proviso that the nurse has an approved immunisation certificate. If a nurse is not experienced within the area of immunisation, then they should consider completing a formal immunisation course.

Regulations are state-specific, so nurses should be aware of the regulations applicable to the state in which they are working.

We recommend that a second practitioner double-checks the medication being administered, and nurses need to be up to date with anaphylaxis management.

Medicare items cannot be billed for immunisations if there is no doctor present (except for COVID-19 vaccine items which still require a doctor to be on site).

Cosmetics

The NMBA has published a position statement on nurses and cosmetic medical procedures that states:

The main focus of this position statement is ***minor (non-surgical) cosmetic medical procedures ('cosmetic medical procedures')****. Nurses practising in the area of major cosmetic medical and surgical procedures ('cosmetic surgery') work with a medical practitioner.*

The Medical Board of Australia's guidelines for registered medical practitioners who perform cosmetic surgery and procedures note that the medical practitioner who prescribes a cosmetic injectable is responsible for the management of the patient (including appropriate post-procedure care) and is also responsible for ensuring the nurse has appropriate qualifications, etc.

Nurses working in the area of cosmetic medical procedures must know and comply with organisational requirements and the relevant state, territory and Commonwealth requirements, as jurisdictional differences are common.

It is not within a midwife's therapeutic model of care to work in the area of cosmetic medical procedures.

Ear syringing

Some insurers have withdrawn cover for nurses conducting ear syringing, and we have received many enquiries about this. Our current advice to holders of an MDA National PIP is:

We will cover nurse employees on the proviso the ear syringe procedure is within the nurse's scope of practice, they have undertaken appropriate training, have been assessed as competent, are confident to conduct this procedure, and the Practice has agreed documented policies and procedures. The nurses must be added to the Practice Indemnity Policy if not done previously.

It is acceptable for a senior RN who has appropriate training and experience to train or upskill other nurses, provide supervision, and sign them off as competent.

More resources

Royal Australian College of General Practitioners – *Ear wax management*
racgp.org.au/afp/2015/october/ear-wax-management

MDA National – *Minimising vaccination errors*
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2020/12/minimising-vaccination-errors

Department of Health and Aged Care – *About nurses and midwives*
health.gov.au/health-topics/nurses-and-midwives/about

Nursing and Midwifery Board – *Position statement on nurses and cosmetic medical procedures*
nursingmidwiferyboard.gov.au/codes-guidelines-statements/position-statements/nurses-and-cosmetic-procedures.aspx

Medical Board of Australia – *Guidelines for registered medical practitioners who perform cosmetic surgery and procedures*
medicalboard.gov.au/codes-guidelines-policies/cosmetic-medical-and-surgical-procedures-guidelines.aspx

Medicare news for Members

Gae Nuttall
Risk Adviser, MDA National

Nerissa Ferrie
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Urgent after-hours attendance items

The Department of Health and Aged Care (DHAC) is conducting an early intervention compliance activity ('targeted compliance') focused on MBS urgent after-hours attendance items **585**, **588**, **591**, **599** and **600**.

This activity includes a checklist provided by DHAC which explains the following criteria (emphasis added):

The MBS urgent after-hours items may be used when the medical practitioner determines, from the information available, that the patient's medical condition requires urgent assessment during the unbroken after-hours period. Specifically, the practitioner must form an opinion that the assessment cannot be delayed until the start of the next in-hours period.

- The attendance must be requested by the patient or a responsible person.
- The request must occur during the same unbroken urgent after-hours period in which the medical service is provided.
- Prior to the consultation, the practitioner has formed an opinion that the patient's medical condition requires urgent assessment during the unbroken after-hours period, and cannot be delayed until the start of the next in-hours period.
- You attend the patient at the patient's location or reopen the practice rooms for the attendance.
- A record of the assessment has been included in the patient's medical record.

For more information on MBS after-hours attendance items, see the MBS Online Note AN.0.19: **tinyurl.com/MBS-Note-AN019**.

Medicare compliance video

On 5 September 2023, we launched a new video resource for MDA National Members on Medicare compliance – ***The practicalities of Medicare*** – accessible to Members at **https://members.mdanational.com.au/member/learning-and-development/webinars/practicalities-of-medicare.**

This video has been produced by the MDA National Medicare Committee (Nerissa Ferrie, Nicole Golding, Dr Elizabeth Harris, Gae Nuttall and Daniel Spencer) and addresses some of the most commonly asked questions around Medicare compliance.

In the video, we take you through chronic disease management, the audit process, the rules around bulk billing, the principles that guide co-claiming of MBS items, telehealth (including the 30/20 rule), what can't be billed to Medicare, and monitoring what is billed to your provider number.

We're not Medicare, and we can't provide a formal legal interpretation of the MBS, but we can share the knowledge we gain through roundtable meetings with the regulators and key stakeholders, and the feedback other Members receive when they are the subject of a Medicare audit.

Many compliance audits relate to GP items – particularly chronic disease management – but co-claiming and the audit process applies to all medical specialties.

We urge everyone to watch the video, and please remember to contact MDA National if you receive any audit correspondence from DHAC, the Practitioner Review Program, or Professional Services Review.

DHAC's Online Compliance Program

If you receive a call from DHAC about an OCP audit, it's not an audit of your oral contraceptive prescribing!

The OCP is a new, user-friendly, online audit platform which is being trialled by DHAC in a recent targeted compliance exercise relating to the billing of MBS items 31206 and 31356 to 31376 (inclusive).

We've seen the new platform in action and can help you conduct your self-audit. So please contact us on **1800 011 255** or **advice@mdanational.com.au**, if you receive notice of this audit.

CONTRACTS

Although many doctors have either signed an independent contractor agreement or asked others to sign an agreement in their capacity as a practice owner, the wording and legal jargon can be quite confusing. The good news is that most agreements and contracts are not as overwhelming as they seem at first glance.

The basics every doctor should know about contracts

Kym Gardner
Medico-legal Adviser, MDA National

Doctors study medicine, not contract or employment law. So it isn't surprising that contracts appear to be written in a whole different language.

You should never sign a contract before you have read it, understood it, and asked questions about anything you don't understand. Remember, the main objective is for both parties to reach an agreement as to the terms of the arrangement to avoid disputes down the track.

For those practitioners entering contracts or agreements as independent contractors with the practice entity providing support services to them, there are some key aspects to consider and look for in the written agreement.

The following information will hopefully take some of the confusion out of the contract process, but if you are concerned about any aspects of the agreement or the arrangement overall, we recommend you seek advice from a lawyer and/or a tax accountant.

Parties to the contract should be clearly identified

The practice corporate entity should be clearly identified. This is not usually the name the practice is known by in the community, but a Pty Ltd that owns the business and has an ABN. Similarly, if you have your own service entity under which you work, then it too should be clearly identified, and the ABN noted.

Term or duration of the contract

Is the commencement and end date clearly identified, or is there no set end date? Many contracts are intended to be ongoing, with reasonable options for either party to terminate the contract according to the terms agreed. Other contracts may identify a period of time over which they run, or a maximum timeframe before review, but still allow for termination. In some instances, we see fixed-term contracts with a set period of time, but no option for early termination. This isn't generally ideal, as it doesn't allow for unforeseen life events that might require flexibility.

The practitioner's obligations

Most contracts document what's expected of the practitioner – and most of these expectations mirror aspects of the Medical Board's Code of Conduct – but keep an eye out for any unreasonable expectations that may require further negotiation.

The practice's obligations

The contract should clearly list the range of services the practice will provide. Think about the things that allow you to practise safely on a day-to-day basis – including administrative support, reliable software, a suitable consulting room, and nursing services. It's also important that you're able to request regular billing summaries, to allow you to review what has been billed under your provider number.

Payment arrangements under the contract

Where the income from your billings is paid – the practice account, your own account or a trust account – should be clearly set out in the written agreement. The transaction cycle should also be clearly stated, i.e. every 7 days, 14 days, etc.

Hours of work and periods of leave

If you're independent and not an employee, you should have the freedom to decide what hours you work and when you take leave. However, it's a reasonable request that there be an agreement upfront regarding the working hours and planned leave timeframes, to enable the practice to run efficiently. Think about your objectives and needs. Ideally, there should be room to change hours by mutual agreement if it becomes necessary in the future.

Medical records, storage and ownership

The contract should specify who owns the medical records. This is important, not only for the management and upkeep of the medical records during your time at the practice, but to ensure the exit arrangements are clear going forward. It's often presumed the records belong to the practice, unless otherwise specified.

Confidentiality

Most contracts include reference to current privacy laws, but often go further to protect any operational or trade secrets. As you would expect, it's reasonable to be asked not to divulge any confidential corporate information that's not publicly available.

Taxation elements

An independent contractor is responsible for their own tax as a starting point. As with many things, the taxation aspects of a contract have become more complicated as the years have gone by. We recommend you discuss the taxation clauses with your accountant, particularly with respect to superannuation, GST, and (depending on the state you work in) any potential payroll issues.

Insurances required

Contracts often refer to the insurances that each of the parties are required to hold. This may include professional indemnity (which both parties should hold) and public liability insurance. While you're not legally obliged to hold public liability insurance as a contractor, if you sign a contract agreeing to do so, you should ensure you meet this obligation.

Restraints or restrictions

Restraints of trade are becoming less common due to their effect on certain taxation elements. However, if the contract you're considering signing includes a restriction on your activities, either during or after termination of the contract, then you need to read it carefully and ensure you understand the potential consequences. If the clause is reasonable, it's likely to be enforceable – but the parties should discuss this and agree on a position before the agreement is signed.

Termination clauses

Unless the contract is for a fixed term without an early termination option, it should clearly set out the rights of the parties to terminate. Most often, in the first instance, there should be a mutual right to terminate without cause (in other words, without needing to identify a reason) by way of a minimum timeframe in which written notice must be provided. This can range from anywhere between four weeks to six months. Think about what works for you and the practice. There will also usually be a list of events that, if they occur, will result in immediate termination. The right to immediate termination is generally limited, but this should be clearly set out in the agreement.

I've been asked to attend a meeting

You receive an email out of the blue:

"You are required to attend a meeting with the head of department and the head of human resources at 9.00am next Monday."

Dr Julian Walter
National Manager, Advisory Services,
MDA National

Being called to a meeting is often the precursor to an investigative or disciplinary process. Loss of control, fear of the unknown, and the risk to your employment prospects can lead to significant anxiety. Before you even set foot into the room, preparation is key.

Is this an investigation?

Prior to attending the meeting, seek written confirmation about whether the meeting is disciplinary or investigative in nature. Understand who will be in attendance (noting any potential conflicts of interest), and what their roles are. Confirm whether the meeting is being conducted under a workplace policy, and seek a copy prior to the meeting to ensure you're familiar with the process.

The art of listening

If you're expected to respond to allegations at the meeting, these should have been provided to you in advance, and in writing. You should have access to necessary documents (e.g. patient records) and time to seek advice. It may be appropriate to have a chronology prepared.

Often, no information of significance will be provided to you before the meeting, so it may be an exercise in listening. You can agree to attend in order to understand the issues at hand – but be clear that you will respond at a later date once you've given the matter due consideration. This enables you to properly consider any allegations, and obtain advice, before responding.

At the meeting, listen carefully and document the discussion (via your support person). Ask for any allegations to be provided in writing, avoid becoming defensive, and don't be tempted to provide information on the fly – as you may provide an inaccurate, poorly considered or emotional response.

Support persons

For most investigative or disciplinary meetings, you will have a right to request that a support person accompany you (the workplace doesn't necessarily have a positive obligation to offer a support person, although this is built into many workplace policies). Unreasonable refusal to allow a support person may undermine dismissal.

While a support person will generally not be able to advocate on your behalf, they can provide emotional support and call 'time out' for breaks where necessary. Your support person should take notes during (or immediately after) the meeting, including who was in attendance, the timing, what was discussed, etc.

Choice of support person is important, as who you choose might send different kinds of messages. Legal representation may be indicated; however you should consider carefully whether this might set an adversarial (rather than insightful or reflective) tone with little practical benefit.

Day of the meeting

Know when and where the meeting will be, and consider options such as phone and video attendance. Will your usual work role be covered, and will you have sufficient time to prepare?

Meet with your support person before the meeting and ensure they are prepared to take notes and know when to call a break. Be prepared to just attend and listen, if that's the plan. If presenting information, ensure you have this in an easily presentable format.

Seek advice from MDA National

With proper planning, attending a meeting may be less daunting and result in a better outcome. Contact our Medico-legal Advisory Service on **1800 011 255** for advice. The earlier these discussions can occur, the sooner we can prepare you for what lies ahead.

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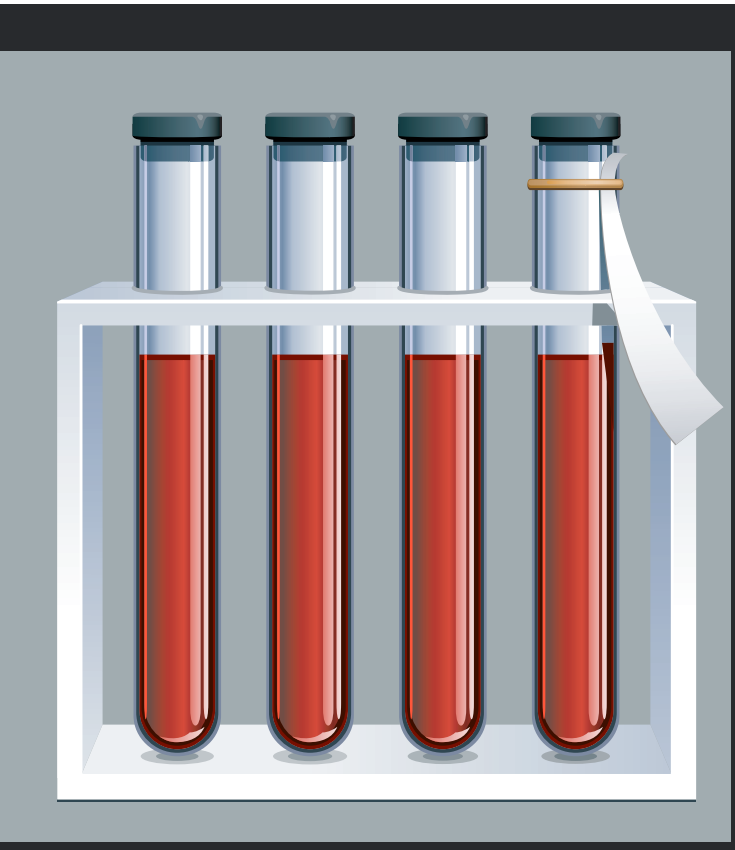
Responding to requests for unnecessary tests

Nerissa Ferrie
Medico-legal Adviser, MDA National



Most patients come to see you for the benefit of your clinical expertise – but what happens when a patient comes in with a shopping list of referrals, or perhaps asks you to provide clinical care that may be unsafe?

Case study

Jenny is a new patient. She has booked a double appointment, which leaves time to discuss her past medical history and address her presenting problems. Jenny is polite, on time, and hands you a piece of paper as she sits down.

"Hi doctor – I know you'll want a full medical history, but it's a waste of your time and mine. My friend is a naturopath, and she understands my symptoms. I need you to order the tests because I can't pay for them privately."

You glance down the long list of obscure tests – most of which you've never ordered before. You try and elicit more information, but Jenny is having none of it.

"Look, I just want the tests. And while I'm here, can you cannulate me and administer this," she says, pulling out a bag of orange fluid with foreign writing on the side.

You ask what it is, with some trepidation.

"It's a special vitamin mix I ordered online from Europe."

Discussion

There is a good reason why you will often see the word "necessary" when it comes to the provision and funding of medical services. *Good medical practice: a code of conduct for doctors in Australia* encourages doctors to ensure "the services you provide are necessary and likely to benefit the patient" as noted under Section 7.2: Wise use of healthcare resources.

This in turn references Choosing Wisely Australia – an initiative of NPS Medicinewise hosted by the Australian Commission on Safety and Quality in Health Care, which aims to reduce unnecessary tests, treatments and procedures through better education.

Doctors should exercise clinical judgement when it comes to requesting tests under the MBS. Explanatory note PN.0.2 of the MBS defines an "Excessive Pathology Service" as "a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned." Pathology referrals are monitored by Medicare and, if pathology ordering is found to be excessive, you could be referred to Professional Services Review.

Follow-up can also be problematic. If a patient is reluctant to engage with you clinically, how can you adequately follow up any abnormal results? It is also inappropriate for a patient to add their own tests to your pathology form.

And, as for administering an unknown orange substance, we recommend you only ever administer medications that you would prescribe.

If in doubt, contact our Medico-legal Advisory Services team for advice. The RACGP also has some excellent resources on responding to patient requests for clinically inappropriate tests.

Is there a doctor in the house?

Dr Sarah Taylor
Medico-legal Adviser, MDA National

You're enjoying a relaxing dinner at a restaurant when you suddenly hear, "Help! Is there a doctor in the house?" Your heart sinks...

Case study

In the restaurant, there are four doctors – you (an experienced GP), an emergency physician eating alone with two small children, a medical registrar who has just finished a bottle of champagne, and a recently retired psychiatrist.

You, the ED physician and the psychiatrist make yourselves known, and ensure that an ambulance has been called. The registrar feels he is not safe to provide any medical care and correctly stays out of the situation. The ED physician cannot leave his children to assist, but he has let the staff know he's available if necessary.

Along with the psychiatrist and a nurse, you start CPR on the collapsed patient, and a defibrillator is brought from the sporting complex across the road. The ambulance arrives as the patient regains consciousness, and care is handed over. You contemporaneously document the situation and contact your MDO the next day.

Discussion

Medical practitioners in Australia have an ethical and professional obligation to respond in an emergency situation.

Doctors providing emergency medical care as good Samaritans are protected from liability in each state and territory in Australia – with some jurisdictional differences in the protections offered. The purpose of this legislation is to encourage people to assist strangers in need of emergency treatment, without fear of legal repercussions.

Generally, a 'good Samaritan' is defined as a person who, in good faith and without expectation of payment or reward, comes to the aid of an injured person, or person at risk of injury.

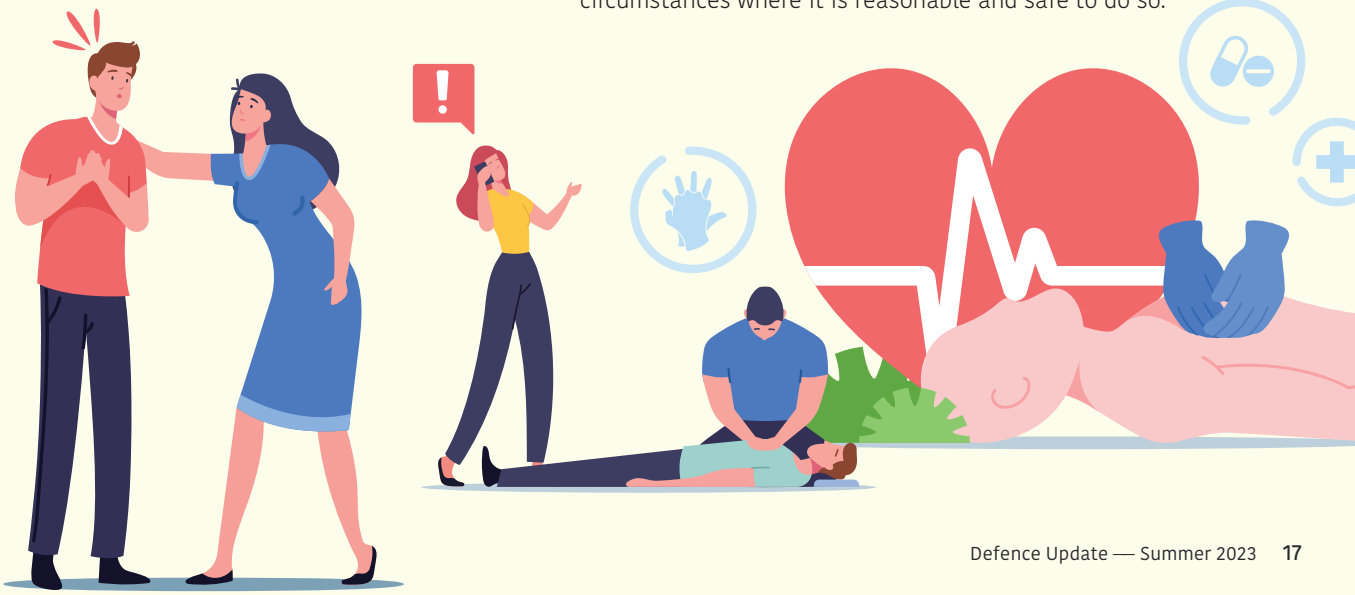
To be protected, the good Samaritan must act 'in good faith', 'honestly', 'without recklessness' and 'with reasonable care and skill'. A good Samaritan who is significantly impaired by alcohol or another drug is excluded from legislative protection in all states, except Queensland and Victoria.

The laws protecting individuals from liability vary from country to country, and it can be complex to determine the responsible jurisdiction for an inflight emergency. It is reassuring to note that some airlines have insurance policies covering doctors who assist in emergencies, and the *US Aviation Medical Assistance Act 1998* also provides protection.

The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* states:

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

Under the Code of Conduct, medical practitioners may be subject to disciplinary action if they don't provide assistance in circumstances where it is reasonable and safe to do so.



Gillick competence
and the mature minor

Daniel Spencer
Medico-legal Adviser, MDA National

Three teenagers walk into a practice...

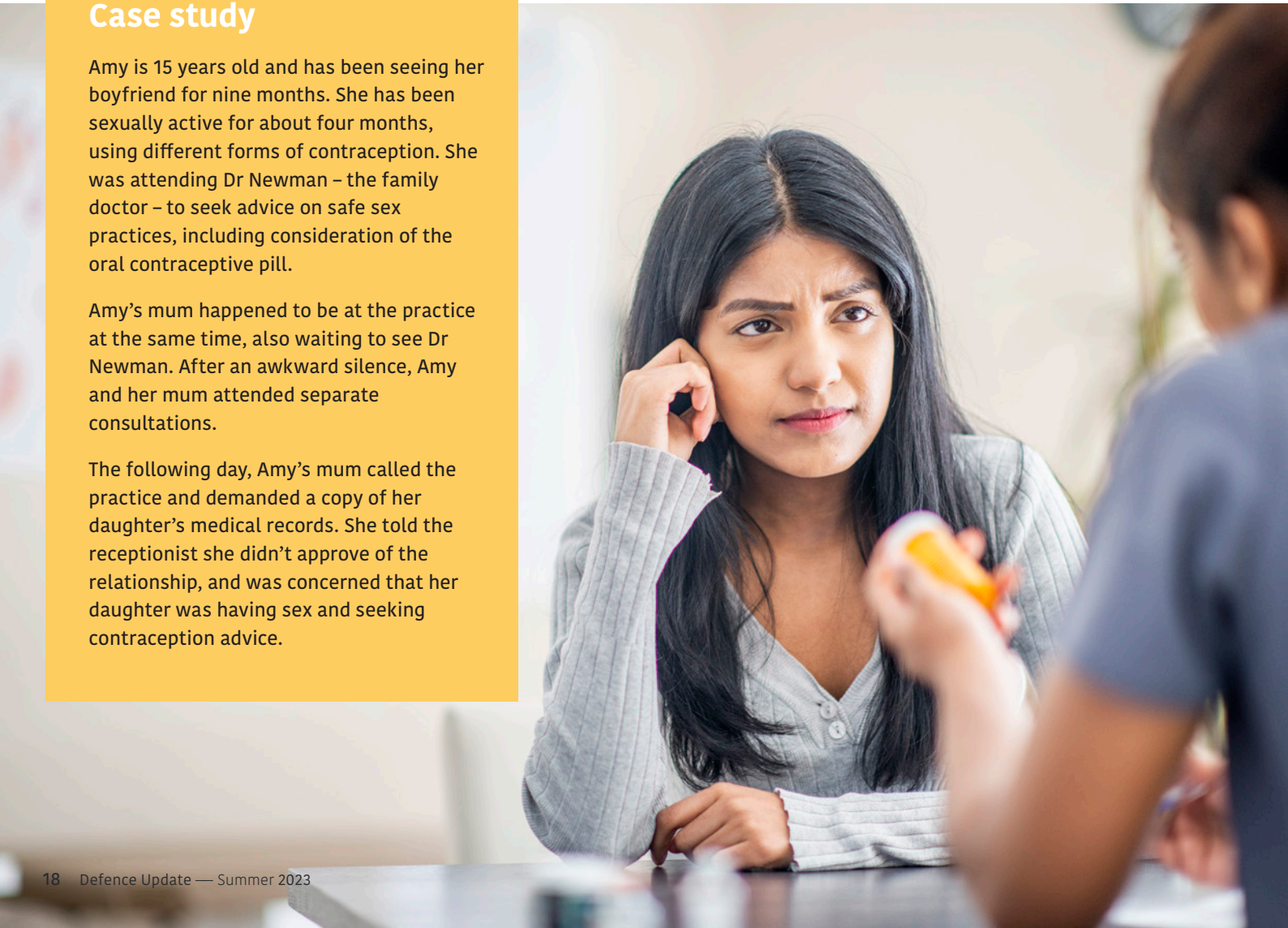
There's no punchline here, but a regular challenge faced by GPs who are trying to determine who is and isn't a mature minor, for the purpose of medical treatment. The clinical management of young people can be difficult. There are subtle nuances, and each case requires its own careful assessment.

Case study

Amy is 15 years old and has been seeing her boyfriend for nine months. She has been sexually active for about four months, using different forms of contraception. She was attending Dr Newman – the family doctor – to seek advice on safe sex practices, including consideration of the oral contraceptive pill.

Amy's mum happened to be at the practice at the same time, also waiting to see Dr Newman. After an awkward silence, Amy and her mum attended separate consultations.

The following day, Amy's mum called the practice and demanded a copy of her daughter's medical records. She told the receptionist she didn't approve of the relationship, and was concerned that her daughter was having sex and seeking contraception advice.



Discussion

Put simply, if a child is a mature minor (or 'Gillick competent'), they're entitled to the same confidentiality about their health information as an adult patient.

A child can consent to their own treatment if they "achieve a sufficient understanding and intelligence to enable [them] to understand fully what is proposed".[1]

While a minor may be considered Gillick competent for one procedure, this assessment cannot be similarly applied to all episodes of treatment. Each presentation must be assessed individually.

There are some circumstances that require specific consent, such as in NSW where the consent of the Guardianship Tribunal is required for 'special medical treatment' in someone aged under 16 years.

While those under 18 years require an assessment of capacity to consent, it's generally accepted that those aged 16 or older do have the capacity to consent. In some jurisdictions, laws allow for those 14 years and over (NSW) and 16 years and over (SA) to consent to their own treatment.

The Office of the Australian Information Commissioner allows a presumption[2] that an individual aged 15 and over has capacity to control who accesses their health record.[3,4]

Consent to provide treatment is not required in emergency situations, if it is impractical to obtain.

While queries in this space often relate to a young person's capacity to consent to treatment, they also arise where parents seek access to their children's medical records. A common example is where a parent wants to know whether their daughter is taking the oral contraceptive pill.

If the patient is considered Gillick competent, a parent or guardian will not have the right to access the health information of the mature minor, unless consent has been obtained. In the absence of consent, the request for access should be politely declined, subject to the exceptions under the Australian Privacy Principles, such as a serious risk to health or safety.

One practical option is to encourage the patient to discuss their treatment with their parent(s) if it is in the patient's best interests to do so. You might also suggest to an enquiring parent to discuss their concerns directly with their child. It's not ideal for you to be stuck in the middle of a family dispute – particularly when you treat all members of the family.

Checklist for doctors

Here is a non-exhaustive list of factors to be considered when determining whether a child is a mature minor:

- age and maturity
- circumstances of presentation
- medical and social history
- the nature, consequences and implications of the proposed treatment, and the patient's ability to understand this
- degree of independence
- family or other social dynamics
- the type and sensitivity of the information to be disclosed
- the complexity and nature of the treatment (e.g. elective, therapeutic or emergency, minor or major).

While some parents feel they have a right to be made aware of any treatment their child is receiving, mature minors may be discouraged from seeking help if they think their privacy will be undermined. Preserving a young person's right to privacy, to the extent that it's safe and lawful to do so, can help a doctor to build trust and allow the patient to disclose personal matters that may otherwise remain unspoken.

It's important to explain your confidentiality obligations to a mature minor, including the limited circumstances that might override their right to privacy, such as mandatory reporting.

When documenting a mature minor's capacity, it's important to include details of how you assessed that the patient is able to understand the information given, and the broader consequences of the decisions they are making. Providing specific examples in your notes might be helpful in supporting your opinion, and it may assist other health practitioners involved in the patient's care.

"It is that parental right yields to the child's right to make (their) own decisions when (they reach) a sufficient understanding and intelligence to be capable of making up (their) own mind on the matter requiring decision."

Source: Per Scarman LJ at [186] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112

View the references online: **mdanational.com.au/gillick-competence-mature-minors**

Discharge against medical advice

Dr Julian Walter
National Manager, Advisory Services
MDA National

Mr Stewart's pneumonia is responding well after two days of intravenous antibiotics – but he's now yelling at the nurses and demanding to be discharged home, or else "the police will be called". With a sinking feeling, you step into the room and introduce yourself.

Understanding the history

If possible, read the notes before you engage the patient so that you have a good understanding of the clinical background.

- Are there concerns about cognition, insight or capacity?
- Does the patient have any physical, mental health, or drug and alcohol issues which might impair judgement?
- How premature is the patient's request for discharge?
- Who is the next of kin?

Introduce yourself and explain that your role is to understand the patient's plan, and to make their discharge as safe and simple as possible. Let the patient know you want to understand what they're trying to achieve.

It may be that a particular concern can be addressed that will enable the patient to stay, or some form of compromise or practical arrangement can be negotiated. The patient may be their spouse's carer, or they might have a family pet that needs to be cared for.

While you're talking with the patient, you will need to address two key assessments that are required to discharge a patient against medical advice (these are often performed together):

1. Is the patient competent (do they have the capacity to make the decision)?
2. Has the patient provided informed consent regarding their decision to self-discharge?

Competence (Capacity)

Under the law, adults are presumed to be competent unless proven otherwise. A person is competent to make decisions if they are able to:[1]

- understand the nature of their condition
- understand the nature and consequences of the treatment options (including the consequences of having no treatment)
- retain and weigh up the information
- communicate their decision.

While you should be able to understand the reasoning, it's important to note that capacity is not contingent on a patient's decision being:

- rational or wise
- consistent with a belief shared by the treating team or the population at large.

The patient without capacity

Does the patient have an acutely altered mental state?

In the acute care setting, this may be due to many causes (e.g. delirium, the effects of medication, drugs or alcohol). Document your findings, ideally with a cognitive screening assessment such as a mini mental state examination and consider a focused mental state examination. If the patient lacks capacity, they may need to be managed under the emergency provisions of the relevant guardianship legislation (with a view to involving a substitute decision-maker as soon as possible) until such time as capacity is regained. Consider getting a second opinion.

Mental health issues

Where the patient has a likely mental illness or disorder and poses a risk of harm to themselves or others, consideration should be given to managing care under the relevant mental health legislation (including involuntary detention, admission and treatment). This is beyond the scope of this article.

The patient who refuses assessment can be particularly challenging. You should be upfront about the purpose of the assessment and note that your findings will potentially form the basis of any treatment that might be required in an emergency, if capacity cannot be established.

Informed consent

Ensure the patient has sufficient information about the risks of discharging against medical advice, and any steps required to minimise risk.

A practical test of the patient's understanding, capacity and retention is to ask them to paraphrase their reasons for leaving, and the risks this might pose.

Allowing discharge against medical advice

If the patient is competent and has been informed of the risks, they should be allowed to depart. Careful documentation is key.

1. Ask the patient to sign and date a statement declaring they are leaving the hospital against medical advice. The declaration should state they have been advised of the risks to their health and safety, and that they understand and accept the risks. Most hospitals have a pre-printed form for this purpose. If the patient refuses to sign a form, document the circumstances carefully.
2. The patient should be given a clear contingency plan – signs of deterioration, any ongoing treatment, and when to return to the hospital.
3. If the patient provides consent, the patient's family or carer(s) should be contacted and made aware of the patient's imminent self-discharge and the circumstances surrounding it. This might involve a discussion of the patient's condition and any potential risks.
4. The patient's care providers in the community (GP, specialists, case workers) should be contacted, and a discharge summary should be sent as soon as possible, to ensure continuity of care and follow-up.

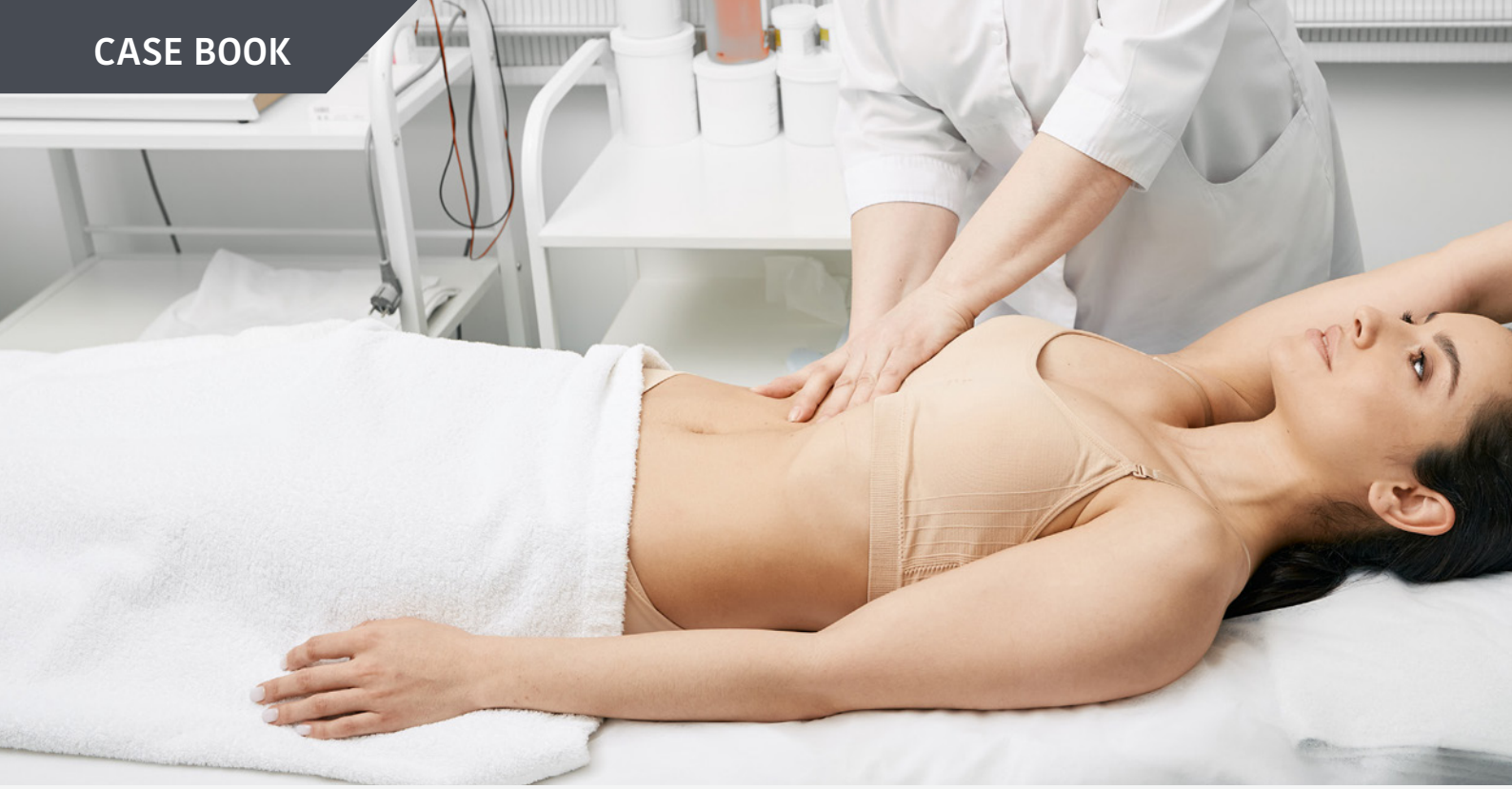
Dealing with a patient who requests discharge against medical advice can be a daunting experience, due to the significant risk of clinical deterioration.

On one hand, the doctor who permits (or makes inadequate efforts to prevent) inappropriate self-discharge may be the subject of a claim, investigation (including the coronial process) or complaint arising from subsequent harm to the patient.

On the other hand, detaining and treating a competent patient against their wishes may have serious legal (including criminal) consequences.

It may be prudent to seek advice or obtain a second clinical opinion where possible. Contact our Medico-legal Advisory Services on **1800 011 255**, where urgent advice can be obtained 24 hours a day.

View the references online: **mdanational.com.au/discharge-against-advice**



Physical examinations

How to avoid misunderstandings

Dr Jane Deacon
Medico-legal Adviser, MDA National

Case study

Dr Tan was shocked when his practice manager told him that a complaint had been made about him.

Dr Tan was initially outraged. He considered that he had given Anne excellent care, as he was aware she was well overdue for her first cervical screening test (CST). He recalled she had been a bit reluctant, but he was always keen to ensure patients were participating in appropriate screening programs.

Dr Tan contacted MDA National for advice before replying to Anne. It was suggested that he review the Medical Board of Australia document, *Guidelines: Sexual Boundaries in the Doctor–Patient Relationship.*

Dr Tan was aware of this document, but thought it was about doctors wanting to have a relationship with patients and therefore didn't apply to him.

Dear practice manager

I am writing to tell you about an awful experience I had when I saw Dr Tan recently.

I came for a repeat script of the pill, and Dr Tan bullied me into having a cervical screening test. I had never had one before, and I knew I needed to have one, but I was not feeling ready or prepared for it that day.

He made me get on the bed, did not explain to me what was happening, and really hurt me with the thing that he used. I begged him to stop, but he said he was nearly finished and kept going. Then he stared at me as I got dressed.

I didn't even need the test, as the result was normal.

I felt humiliated and very uncomfortable, and I don't know if I will ever be able to have another.

Yours sincerely

Anne

Key points

- Sexual misconduct is an abuse of the doctor–patient relationship and can cause significant and lasting harm to patients.
- It is never appropriate for a doctor to engage in a sexual relationship with a current patient.
- A doctor must only conduct a physical examination of a patient when it is clinically indicated, and with the patient's informed consent.
- Good, clear communication is the most effective way to avoid misunderstandings in the doctor–patient relationship.
- Doctors are responsible for maintaining professional boundaries in the doctor–patient relationship.

Discussion

As in many aspects of medical care, clear communication is key. Before conducting a physical examination, it should be explained to the patient why the examination is recommended, what information will be obtained, and how the examination will be conducted.

For example, presentation of a female patient with a lump in the axilla would suggest that a breast examination is indicated. This may not be obvious to the patient, and the breast examination may be misinterpreted unless the doctor has explained the reason for the examination.

The patient should be given an opportunity to ask questions about the proposed examination, and the patient can refuse to have the examination.

In this case, Anne felt she was not given the opportunity to refuse the CST. Some patients may need to be emotionally prepared for this examination, and some may not be comfortable with a vaginal examination at all. There is now the option of a self-collected swab for the CST, and this was not discussed with the patient.

During the examination, the doctor should observe the patient and be aware of any verbal or non-verbal signs indicating the patient has withdrawn consent. The doctor should not continue with the examination when consent is uncertain, has been refused, or withdrawn at any time.

The patient should be allowed to undress and dress in private. A suitable covering 'modesty sheet' should be provided so that the patient is covered as much as possible, to maintain their dignity. Gloves should be worn when examining genitals or internal examinations.

Guidelines: Sexual Boundaries in the Doctor–Patient Relationship is a very valuable resource, and all doctors should familiarise themselves with the contents. Section 7 contains detailed information regarding conducting a physical examination. Use of observers or chaperones is also discussed.

There is also information regarding maintaining appropriate boundaries with patients. The start of an inappropriate relationship between a doctor and a patient may not always be immediately obvious to either the doctor or patient. Doctors need to be alert to warnings that might indicate boundaries are being, or about to be, crossed.

There are a wide range of behaviours that breach sexual boundaries – from making unnecessary comments about a patient's body or clothing, to criminal behaviour such as sexual assault.

Dr Tan – Postscript

After reviewing the guidelines, Dr Tan felt there were some aspects of his usual practice that could be improved.

The medical practice where he worked conducted regular small group meetings as part of their continuing professional development; and at the next meeting all members of the group reviewed and discussed the document, considered their usual practice, and made some improvements.

MDA National assisted Dr Tan with responding to Anne, and he heard nothing further from her.

Reflections of an ED clinician

Dr Michelle Johnston (MDA National Member)
Emergency Medicine Clinician

I've been doing this job for a while now, and I'd like to share with you some of the wisdom I've attained over the years. I believe I may have something to offer – the wealth from my experience. We are now all schooled in wellness and life-balance, and I have taken this gentle, lapping mindfulness to heart.

Once in a while, we don't have to be epic. We can be a plain worker bee – low ranking, mission brown, a serf. We are permitted to hitch up our strides like peasants, and get on with the business of hoeing through the garden of the unwell.

Such freedom, you say. None of the high-level responsibility of being in charge of the department. No duty phone. No behaving like a desperado when asked to go to a flow meeting. Just good, honest toil.

I usually start rostered days by rising at 5.00am, meditating for 20 minutes, then fixing an oaty berry bowl of deliciousness, after which I write down a list of things that I craft into an acrostic poem. Things about gratitude, goals for the day, things I can teach my juniors, things, other things, aphorisms. And I absolutely would do these things, except that I don't. Ever.

Most days I drive in, late and flustered, already slightly rageful at the insolence of traffic cones; un-breakfasted; in mismatched scrubs; and the most mindful thing I do is try and compose a humorous but slightly pathetic tweet whilst stuck at traffic lights... so that by the time I get into the heaving department, this place bursting at the seams with Very Unhappy People, I will have two, maybe three replies by kind people saying, "There, there, it will all be alright." I hope to God they mean it.

I stride in, fortified. I have four likes and a retweet. A record. Somebody cares for me.

Faced with a handover, and a to-do list that would make a self-help author blanch (shock this person, drain the CSF from another, placate this patient, find out what's wrong with this one – please – and maybe this one too), I focus on the main apothegm that will get me through the day. Smile, be kind, and work on being only a minor train wreck. It mostly works.

I fire up the plough. I dive into the innards of people. On the whole, my job consists of figuring out what's not wrong with people. I have become an expert in recognising the dark matter of the emergency pathology universe – once I know 'what is not', I can work out how to deal with 'what is'. This should be simple, except my day is now less ploughing, more running in a blindfolded steeplechase... and not on horses, but cows with a particularly dementing strain of bovine spongiform encephalitis. There are barriers, pitfalls, lava pits and sinkholes. It is not pretty.

I am very keen to teach the interns something. Five-minute teaching, bedside pearls, teaching on the run... that sort of thing. But thus far, the potential clinical encounters have been a large-bodied nudist who is currently in dispute with God, several patients with hazy chest pain, a scandal involving a nursing home where one resident swallowed another one's tablets, and an extremely briefly run cardiac arrest.

I offer nothing. When I do haul an intern aside, sternly demanding this be a teachable moment, he presents his latest patient to me. I go in to see the patient. This is not the same patient he presented. Different story, different examination features, perhaps even different gender. I kindly confront him about this. He assures me it is the same patient. We sigh.

I, in the meantime, have a patient load of my own. Decisions, decisions. Much of my time is spent trying to work out which specialty team to speak to. I see more patients. I listen to the shadows and the echoes of the stories in these brushes with humanity. I pull my notebook from my scrubs pocket and jot things down. After all, I like to write, and these details are the lifeblood of novels. Unfortunately, when I take my notebook out on wash day, I realise I cannot read a single word of what I've written. Not one.

I also have, on rotation, a set of books that I keep in the other pocket. Virginia Woolf, Keats, other small anthologies of poems. Like my extreme commitment to mindfulness, I read and reflect on these often – which, actually, is also an Instagram-grade falsehood. Mostly, they simply offer succour by being close to me throughout the long day, even if I never read them. I am a poor excuse for a novelist, I realise, and go back to focusing on being a doctor.

For an hour, I look after the unbuckled body of a boy in a motorbike crash. I think he might die, and for the duration I have a nameless ache in my entrails, part nausea, part fear, that despite all I know and all I can do, it might not be enough. I might not be enough. He hangs on long enough to get to ICU. A minor success. Cases like this, however, feed on your adrenaline, leaving you tired and depleted. I wish, for the millionth time, that we had little rest pods – white, comfortable, softly lit refuges – where nobody could reach you for 20 minutes. We don't. Instead, I buy another coffee.

I return to it. The training registrars with whom I work are quite brilliant. I learn bucketloads from them, and I am sustained by their commitment and energy. We have this quaint setup where they assure me they are learning from me, and are grateful for the teaching, on and off floor. They say this sincerely, and we all smile.

Emergency medicine evolves faster than Monsanto canola. It's hard to keep up with all the latest and greatest. But, funnily enough, it's the doing of the basics well that seems to be the most effective tool for the best patient outcomes. Perhaps there's something to be said for us plodders, turning up again and again, year after year, just trying to do the best for the single patient in front of us.

No system or institution is perfect. Ours certainly isn't. But I honestly believe we do a very good job for most of the people who have the misfortune to hurtle through our doors on their bad days. Their days are our days. We're in it together. We, the proletariat of medicine.

I clock off, joining the queue shuffling out the doors in our overalls.

> *"I have become an expert in recognising the dark matter of the emergency pathology universe – once I know 'what is not', I can work out how to deal with 'what is'."*

Dr Ryan Williams conducting the 2022 QMO Christmas Concert.

Music has always been a constant in the life of Dr Ryan Williams. He actively prescribes himself a daily dose of music to benefit from its uplifting and restorative powers.

Ryan started off with an Arts & Education degree and a four-year stint as a German language and science teacher. In his mid-20s, he felt ready to take the leap into medicine.

Today, as a general practitioner, and the Artistic Director for the Queensland Medical Orchestra (QMO), one could say Ryan has truly found his niche – bringing together his love for music, passion for medicine, and his desire to alleviate suffering and make the world a better place.

Having 'resuscitated' the QMO from hibernation 13 years ago, Ryan still has his hand firm on the baton. And the QMO stands strong, raising vital funds for many charities.

It was a pleasure interviewing Ryan who responded very openly to my umpteen questions, with patience.

Finding the rhythm in music & medicine

Niranjala Hillyard
Director, Inkpot & Pixel
Freelance Writer, Editor & Designer – *Defence Update*

Q1. When did you first realise you wanted to become a doctor?

> Right from my high school days. For me, it was a combination of wanting to help people and an utter fascination with the workings of the human body. Using scientific knowledge to alleviate suffering and make the world better for individuals and communities seemed (and still seems) very meaningful. And at times rockstar-esque!

Q2. What made you choose general practice, and what do you love about it?

> I'm a generalist by nature. I learnt to play multiple instruments, rather than just one instrument exceptionally well. I speak German, Russian, French, Indonesian, and can count in a dozen more languages, instead of being a near native speaker in just one language. The thought of only focusing on one organ or area of medicine seemed limiting, just not the right fit for me.

Q3. Has music always played an important role in your life?

Music has been a constant in my life. I started learning the piano with private lessons in grade 3, and at the same time began the viola at school. I started the flute in grade 5, the bassoon in grade 9, percussion in grade 10, and then just played anything I could get my hands on. My school let me run amok with instruments in different ensembles. As a nerdy gay kid in high school, I was bullied mercilessly. So immersing myself in music was my absolute oasis.

Through university and my years as a high-school teacher, music was a fun thing to do on the side. Since becoming a doctor, music has actually become even more important. Cherishing the uplifting and restorative powers of music, especially after a difficult or draining day or week at work, can be almost therapeutic. I try to actively prescribe myself some music at least once a day to maintain good work-life balance and mental health.

Q4. Can you tell us a bit about the QMO?

QMO is an ensemble of doctors, medical students, healthcare professionals and friends who are passionate about music and its importance in living a joyous and happy life. We come together four times a year to perform concerts that raise funds for charity. We've raised more than $150K over the last 12 years for various charities.

QMO was founded as the University of Queensland Medical Society Orchestra by Dr Nick Brown in 2004, but it went into hibernation when he moved away for work. I was asked to 'resuscitate' it in 2010, and the rest is history. They haven't taken the baton from me yet!

Q5. Would you recommend the QMO to other doctors?

Yes, I would. Our jobs as doctors can be rewarding; but often draining and stressful, if not outright distressing. Coming together with like-minded healthcare professionals to make wonderful music together in a supportive and lighthearted environment, can be the difference between a weekend that lifts you up and a weekend that you just survive.

It's great seeing first-year medical students sitting next to senior consultant specialists without any sense of hierarchy, with just music uniting them. It's a good networking opportunity too. We've had residents make connections that helped them find jobs, advice, and even applications for specialist training programs.

Q6. Any tips for your peers on work-life balance?

Learn to say 'NO'. I'm still working on this one. It's so much harder than it sounds. Fit in activities that are fun and relaxing, and protect these as fiercely as you would any other appointment in your diary. Use your weekends wisely and plan regular holidays, including long weekends and/or four-day weeks when you can get them.

Q7. Have you travelled much, and what have you learnt from those experiences?

I've been VERY fortunate here. I've travelled extensively in Europe, North America, and parts of Asia. I've lived and studied in Germany and Russia. I've practised medicine in Germany and in the Democratic of Congo (DRC) where I took part in two medical aid trips teaching medical students and junior doctors. My biggest lesson from DRC was realising how fantastic our healthcare system in Australia is, when considered on a global scale. Sure, our systems and rules are frustrating, but at least we can provide and access health care. Lots of places in the world have neither, so I try to be mindful of this before I become too critical of 'how bad' we have it here in Australia.

Q8. Any words of advice for young doctors interested in pursuing general practice?

Make sure the specialty you choose is the right fit for your values, your passion, the way you want to make a living, and the contribution you want to make to the world. General practice can deliver all those things, but it isn't perfect. No specialty is. So talk to GPs to find out what they love about general practice, and see if that's what you're looking for. Choose well, and you can have an incredibly rewarding career.

Q9. How important do you think medical indemnity insurance is for junior doctors?

Absolutely! In the first few years as a doctor, questions about 'am I doing the right thing?' are so common, and impostor syndrome is prominent. It's incredibly important to know you're protected if a disaster strikes; also if you're worried that a situation could deteriorate, or you just need some advice. It's good to have that safety net in place. I've had MDA National as my MDO since my first year of medical school in 2008, and I call them a few times every year when I want advice around any situation.

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Elevate your career with industry-leading education programs tailored to your needs and career stage

As junior doctor Members of MDA National, you have access to complimentary educational resources on interview preparation and career planning to help you progress through your early career with confidence.

Need help with your medical officer interviews?

Presented by Medical Interview Coach Dr Brooke Bullock, the Interview Preparation workshop series provides education on interview techniques, and training on how to tackle both standard and unexpected interview questions.

Topics include:
Interviewing for Doctors: How would you respond to the following scenario?
Interviewing for Doctors: What are your thoughts on XX?
Interviewing for Doctors: What are your best cards?
Interviewing for Doctors: Tell me about a time when?

Stay tuned to your inbox for forthcoming updates from us, including event dates, times and registration information.

Unsure about your career path?

Presented by Medical Career Counsellor Dr Ashe Coxon, the Career Planning series provides practical guidance and personality-based insights to help junior doctors identify the areas of medicine they most enjoy, and assists participants in identifying the medical specialty that suits them best.

Topics include:
Your medical career: What to do when you don't know what to do!
Understanding individual personality traits and how these impact work satisfaction and career choices
Skills and Strengths: The importance of identifying yours in your career planning, and when applying for your desired role

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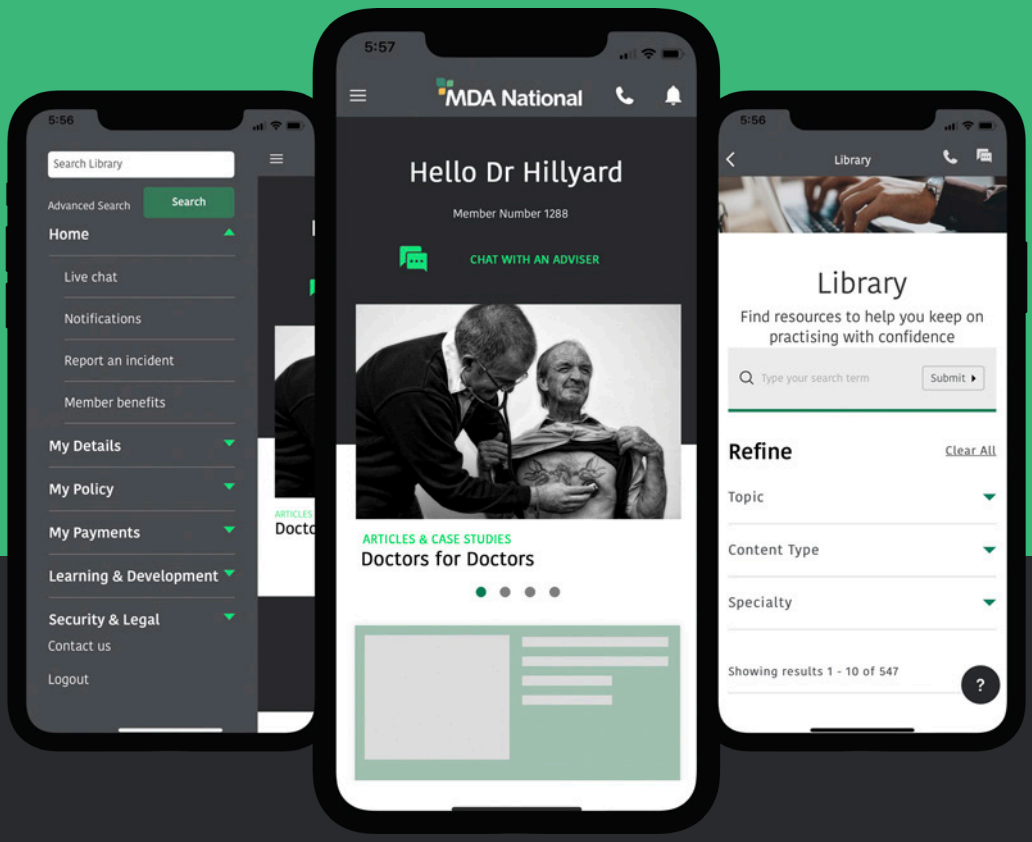
"*This is extremely helpful. I feel thrilled. This is the last missing piece of the puzzle.*"

"*Thank you for your help. I have been telling everyone to consider doing this – it is so good to feel confident in what I am doing and why.*"

Manage your membership and stay connected to our support services at your convenience.



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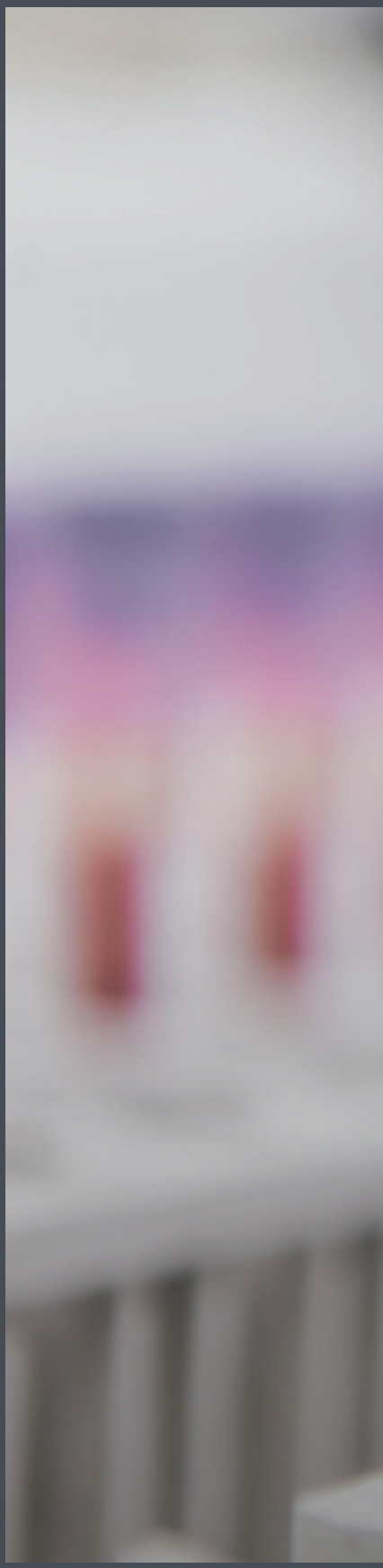

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