SUMMER 2022

Defenceupdate

Using technology for patient care and communication

- Changing one person's world at a time
- Putting the heart back into health care
- Medico-legal Case Book
- First Defence for junior doctors

Medico-legal content

FOR MEDICAL PRACTITIONERS

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Welcome to our Summer 2022 edition of *Defence Update*.

If you need proof that the medical profession is in safe hands, you need look no further than Drs Daniel Nour and Ben Bravery. In this edition, we learn about Daniel's dedication to providing homeless health care through Street Side Medics, and Ben takes us on a personal journey to demonstrate the value of a meaningful therapeutic relationship.

Canberra GP Dr Gillian Riley provides advice on how to avoid iron staining claims (page 6), and we answer the age-old question, "Is it okay to say sorry?" (page 8).

Our Vice President discusses the rise of technology in a post-COVID world, and we deliver some top tips for using technology in patient communication (page 10).

Journey back in time to when premium pricing was simple, as the Underwriting team provides some valuable insight into the evolution of premium pricing and the benefits of aligning premium to risk (page 12).

We make the variations in mandatory reporting of child abuse legislation a bit easier to navigate in our medico-legal feature (page 13), while in our Case Book we look at patient complaints (page 18), managing dental damage (page 20) and the risks associated with inguinal hernia repairs (page 22).

Last, but not least, First Defence explores the importance of professionalism in medicine (page 24) and we learn about supporting the 'second victim' (page 25).

I would also like to take this opportunity to thank Dr Jane Deacon for her outstanding work as the editor of *Defence Update* for the past four years. I will certainly endeavour to keep up the excellent editorial standards that both Jane and her predecessor, Dr Sara Bird, have developed over many years.

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

Nerissa Ferrie
Medico-legal Adviser, MDA National

In this issue

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FROM THE VICE PRESIDENT
A message to our Members

Healthcare delivery has changed so much over the last few years. Clinicians have shifted and pivoted quickly throughout, driven by a need to protect our patients. We've been innovative in establishing virtual models of health service delivery that continue to offer the highest quality of clinical care.

As a doctor in clinical practice, I understand the increasing challenges of practice – from growing patient expectation to cost pressures, and a Medicare rebate that hasn't kept pace with inflation, let alone the cost of health service delivery.

It has been another tough year for us all, but it's with some relief that I note the World Health Organisation has announced the end is in sight for the COVID-19 pandemic. However, we'll still have to deal with acute infections and their sequelae.

Australia has a number of health system challenges, and technology will form the central plank of any solution. Telehealth has become ubiquitous, and a valuable tool to improve access, reduce healthcare costs, and address inequality. Systems that were once clunky have become more user-friendly. With patients increasingly looking for convenience, we need to carefully address how we balance quality care with ease of timely access. Online-only care has been on the rise – but it must be thorough, and with its limitations recognised.

Australia has state-of-the-art technology, but with reimbursement and regulation holding back further adaptation, we lag some way behind other developed nations. Governments need to participate and support interoperability standards desperately needed to support health information sharing. The wealth of this data, combined with analysis tools, will improve patient safety and support the development of preventative and predictive medicine.

Away from health – inflation is high, interest rates are rising, the investment environment is volatile, and we remain in an adverse claims environment. This necessitates difficult but necessary premium rises, but I can assure our Members that the Board takes these decisions seriously, taking care to minimise the effect on the membership while ensuring we're able to pay any claims that arise.

At MDA National, we keep on top of current trends and support our Members in delivering excellent medical care. Our medico-legal teams are an excellent resource for advice on any new models of care.

When potential issues arise in my own clinical practice as a GP, I reach out early and quickly for guidance. This has been invaluable in taking steps to minimise the likelihood of a complaint or claim. Importantly, reaching out for advice in this way doesn't affect your premium, and our team of advisers are always ready to support Members.

Thanks to all of you for your ongoing loyalty.

Dr Simon Benson
Vice President, MDA National

Changing one person's world at a time

Dr Daniel Nour, 2022 Young Australian of the Year, was a keynote speaker at the recent MEDCON22 conference in WA. This remarkable young man has proved inspirational to even the most seasoned doctors.

Street Side Medics, founded by Dr Daniel Nour, is a medical service dedicated to those experiencing homelessness. For more information, visit **streetsidemedics.com.au**.

Dr Daniel Nour
Registrar, Royal North Shore Hospital
Founder, Street Side Medics

Daniel's father, John, migrated from Egypt to provide a better future for the children he had yet to have – a lesson in hope that has not been lost on Daniel.

John eventually got married and had two children, Daniel and his brother Christopher. Christopher's early life was affected by medical concerns, and Daniel watched him go from the healthiest, most active person he knew, to someone riddled with pain in hospital.

Daniel noticed how his brother's condition would change and improve every time he went to the hospital. He also saw how his parents were overwhelmed by the anxiety surrounding his brother's illness – but observed how the doctors attended to his parents, just as they attended to his brother.

"Subconsciously, I realised the healthcare system was the fix for my family."

Far from being the exemplary child, including getting kicked out of school, Daniel was told by a high school career adviser that a job as a car salesman might be his best fit.

But the naivety and arrogance of youth – traits that have since served him well – propelled Daniel to turn his grades around enough to enter medical school. Daniel couldn't think of another career where he could contribute so positively to the community.

While in his final year of medical school and pursuing a career in cardiology, Daniel had the opportunity to attend the Imperial College of London.

"What happened in London changed the trajectory of my professional and personal life," he said.

Going home after a shift at the Hammersmith Hospital, he was at the Waterloo station when he saw a man clearly having a seizure, with a crowd around him. Although questioning whether he should respond – "Am I appropriate… should I be responding to this guy… I'm only a final year medical student… am I really trained…" – he did.

Afterwards, a group of bystanders told Daniel the man had been having seizures for months, but often in an alleyway where no one had really noticed. Daniel asked why he hadn't seen a doctor and was told, "The healthcare system barely cares about you, let alone us."

That event horrified Daniel for days and weeks to come. He returned to Australia, did some research, and discovered there were indeed barriers to health care – which included lack of access to transportation, cost, stigma, embarrassment, and the timing and location of appointments.

Knowing there were people in the streets suffering in silence prompted Daniel to do something about it. Hence the idea of Street Side Medics – healthcare for the homeless – was born, with one mobile healthcare van.

"I quickly realised I was a medical student about to become an intern, I wasn't even a doctor," Daniel said. Although fear kicked in, his mentors pushed him along.

He quotes actor Will Smith (whom he loves, despite the slap!): "On the other side of fear is greatness." This, along with a saying he saw engraved on a mirror in Mykonos that said, 'Don't forget that you are going to die', have deeply resonated with Daniel, fuelling him to overcome fear of failure, and arming him with a passion to deliver a service he truly believes in.

Today, Street Side Medics has grown to three vans servicing nine different areas in and around Sydney – with potential interstate expansion, and more than 1,200 volunteers providing health care and medicines free of charge; even helping those who don't have a Medicare card.

For Daniel, the goal was never to change the world – but to change one person's world at a time.

Edited from *Medicus* Aug 2022 with permission from the AMA (WA).

Iron staining – tips to avoid a claim

Nerissa Ferrie
Medico-legal Adviser, MDA National

While COVID-19 has been dominating the clinical landscape, iron staining[1] has quietly crept up to become the most common single cause of claims notified to MDA National in the past twelve months.

While iron staining claims[2] can be lower in value than other claims, the increasing volume is concerning – because many of the cases we review could have been avoided, or at least mitigated, by better processes.

I spoke to ACT General Practitioner Dr Gillian Riley for some practical advice on what doctors can do to avoid an adverse event while performing iron infusions.

Q 1.

How important is patient selection, and what clinical indications should you consider before proceeding with an iron infusion?

Ferinject (ferric carboxymaltose) is a suitable and effective preparation for patients with iron-deficiency anaemia who haven't had any improvement with, or haven't been able to tolerate, oral iron preparations.

At present, it's PBS listed for this indication.[3]

Q 2.

How, and when, should you decline if a patient insists on an infusion against your clinical judgement?

It's really important not to proceed unless you're comfortable there will be clinical benefit, and that the patient is aware of (and comfortable with) the potential risks.

In this context particularly, there's a lot of talk on social media that an iron infusion will be a panacea for fatigue, but unfortunately this is not always the case.

While an iron infusion is a low-risk procedure, it's not a *no-risk* procedure. Judicious clinical judgement should always apply.

Q 3.

How do you manage patient consent, and what level of detail do you provide in relation to the potential for staining?

As part of my consent process, I inform patients that the risk of staining is somewhere around 1 per cent. Some data suggests that staining may fade, but it must be considered permanent and irreversible. Like tattoo removal, cosmetic recourse has its own uncertainty.

I tell my patients we will monitor for issues carefully, but we can make no guarantees with respect to staining. I then show my patients some photos sourced from a reputable online site. I find the use of images to be the most important step in the process. Most patients who are very concerned will decline at this point.

I spend quite a bit of time on the staining aspect, because I know this is the issue where a complaint is most likely to arise. I do this for every patient. In my experience, the patient you least expect is the one most likely to complain, so I feel everyone should have a clear, complete, and well-documented consent.

Q 4.

How important is the technique of cannulation?

There is a small amount of evidence that extravasation is reduced if using a vein not in a flexural site, so stay away from the wrist or antecubital fossa. I usually use the large veins in the forearm.

There is also evidence that the less vessel trauma, the better. We use a giving set and secure the cannula very well, infusing slowly – generally over 15-20 minutes. We use the smallest suitable cannula size (mostly a 20G; but a 22G is sometimes needed, in which case the infusion rate is slower).

The vessel should flush easily with 10 ml of saline, and flush easily again with 10 ml following. If a patient is hard to cannulate, I would usually abandon the attempt that day, as the chance of the iron leaking out due to vessel trauma may increase if you've put multiple holes into a venous system.

Q 5.

What warning signs should patients and medical staff be aware of as a sign of extravasation?

There isn't an enormous amount of evidence, but there is one study where patients reported pain, swelling, and prickly and odd feelings at the cannulation site prior to extravasation. It's important for patients to let you know if they feel anything like that. I also tell my patients to let me know if the cannula feels weird at all, and we will stop. Extravasation can also be painless.

Q 6.

Iron staining is one of the most common claims arising from infusions, but are there other risks doctors should be aware of?

The biggest risk is nausea at about 3 per cent, followed by hyperphosphatemia at around 2 per cent. There is around a 1 per cent risk of headache, hypertension, injection site reactions and dizziness; and a small, but possible, risk of anaphylaxis.

Pregnant women in the second and third trimester face a very small risk of foetal bradycardia and hypoxia, which is what occurs when mum experiences bradycardia. Pregnant women MUST be taken through the consent process very carefully for this and monitored closely.

We have a nurse monitoring our patients during the infusion, with the doctor in the room next door. We check and document BP, HR and O2 saturation at the commencement, during, and at the end of the infusion. If the patient is pregnant, we also check foetal HR.

Q 7.

What would be your number one tip for doctors doing iron infusions?

Make sure you're doing it for the right reasons – and make sure you communicate really clearly with your patients!

View the references online at mdanational.com.au/iron-staining-avoiding-claims

Is it okay to say sorry?

Janet Harry
Medico-legal Adviser, MDA National

There is a common myth within the medical profession that says you can't apologise to a patient in case it's seen as an admission of liability.

Treat your patients how you would wish to be treated if you or one of your loved ones suffered an unexpected complication or adverse outcome. If a claim arises due to the adverse event, the medical evidence will generally speak for itself. If you've clearly made an error, then an early and sincere apology will benefit you and the patient.

DO

- Contact MDA National for advice.
- Offer an apology, if it's genuine. You don't always need to be at fault to show empathy to a patient who has suffered an adverse outcome. You can be sorry the patient has suffered a setback, even if you have done nothing wrong.
- Prioritise any follow-up treatment and be sure to follow through. Failure to do so can undermine any trust you have built.

DON'T

- Speculate or fall on your sword before you know the cause of an adverse event.

Adverse outcomes and unexpected complications are not good for anyone, but a timely and genuine apology is often a very powerful first step to rebuilding a patient's trust in you and the profession. Poor communication, unmet expectations, and disappointment in the level of care are often at the root of patient complaints.

So how should you manage an adverse event?

Acknowledge the patient's concern in a timely way – and be present.

When a patient feels ignored, matters can escalate unnecessarily. Hospitals often have staff experienced in patient liaison, so the hospital's legal personnel should be consulted at an early stage. Doctors in private practice should ensure they have developed a good response strategy. Notify MDA National early and facilitate any follow-up investigations or treatment as a priority.

Investigate the facts as soon as possible.

Policies should be followed, and incident reports completed where necessary. The extent of an investigation will depend on the nature of the complaint or complication. Remember to ensure that patient confidentiality is maintained, or authority sought when needed.

Respond in writing or in person, depending on the situation.

Some matters are so serious they warrant a formal open disclosure process and a face-to-face discussion with the patient and/or their family members. Others may be dealt with by a phone call or in writing.

In nearly all situations, the worst thing you can do is to ignore the situation entirely. It's important to be open and transparent, but this does not mean attributing blame, criticising a colleague, or disparaging the workplace – particularly if the matter has not yet been investigated.

A well-crafted response ensures the patient feels heard, and it gives them reassurance that steps will be taken to minimise the chance of the same thing happening to someone else.

Medicare update – prescribed patterns of service

Dr Kiely Kim
Medico-legal Adviser,
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Gae Nuttall
Risk Adviser, MDA National

Recent changes have been made to the existing prescribed pattern (80/20) rule, and a new 30/20 rule has been introduced.

Changes to the 80/20 rule

Many GPs are aware of the 80/20 rule in which a medical practitioner is considered to have 'engaged in inappropriate practice if they have rendered or initiated 80 or more relevant professional attendance services on each of 20 or more days in a 12-month period'. Practitioners who breach the 80/20 rule are referred to the Professional Services Review (PSR), which may take into account some exceptional circumstances.[1]

From 1 July 2022, telehealth services including telephone and video consultations are now also included in the 80/20 rule.

The 80/20 rule is based on the number of **services** per day, which may exceed the number of patients seen. Relevant services generally include Group A GP and OMP attendances, but do not include A44 COVID-19 vaccine suitability assessments or A46 COVID-19 management support service items. Group A13 and Group A21 public health and emergency physician attendances are also included.

See the Department of Health and Aged Care (DHAC) factsheet for more information: **health.gov.au/resources/publications/prescribed-pattern-of-service-what-you-need-to-know**

The new 30/20 rule

A new prescribed pattern of service, the 30/20 rule, came into effect on 1 October 2022. It applies to telephone attendances provided by **consultant physicians** and **GPs**. A medical practitioner who renders or initiates 30 or more **relevant phone services** on each of 20 or more days in a 12-month period will be referred to the PSR. Of note, phone item 91836 (equivalent to face-to-face item 119 consultant physician, minor attendance) is included in this rule.

For more information, visit the Federal Register of Legislation at: **legislation.gov.au/details/f2022l00348**

Consultant Physicians: do you know what MBS items 132 and 133 require?

Is a 132 a long consult, with the 133 being a subsequent consult? Unfortunately not, and many doctors have recently received a voluntary compliance letter from the DHAC. Voluntary compliance (aka Review and Act Now) is the least serious form of a Medicare/DHAC review, but it needs to be taken seriously – as this is your first opportunity to review and (possibly) repay items billed in error. Audits further along the system are more onerous with increased penalties.

What are the 'rules' for a 132?

An **MBS item 132**[2] is more than an assessment and consultation. It's designed to produce a 'consultant physician treatment and management plan of significant complexity … and provided to the referring practitioner' and has a significant amount of detail required to meet the item descriptor – including that the patient must have a minimum of two morbidities, and a minimum attendance of 45 minutes.

Associated **Note AN 0.23**[3] provides comprehensive information regarding the compliance requirements for items 132 and 133.

The explanatory note refers to 'longer term management' which is part of the requirements for these plans to 'provide a longer-term consultant physician treatment and management plan, listing alternative measures that might be taken in the future…'.

View the references online: **mdanational.com.au/medicare-update-prescribed-patterns**

Using technology for patient care and communication

Karen Stephens
Risk Adviser, MDA National

Can I use SMS to communicate with a patient?

Yes – provided you have the patient's consent. We recommend you:

- use this type of communication for administrative rather than clinical matters, remembering that an SMS may be seen by someone else
- send the SMS from a practice-dedicated phone or web subscription rather than your personal number
- consider any workplace protocols about the use of SMS and related consent and privacy issues
- save the message to the medical record.

Can I use SMS or apps such as WhatsApp to communicate with colleagues about patients?

Yes, but use with caution. There's a high risk of a privacy breach because:

- SMS is not encrypted and could be intercepted
- messages on the device may be seen or accessed by someone outside the group
- WhatsApp is encrypted during transmission, but once decrypted on your device the messages may be stored in the cloud on a server overseas
- ex-employees may still have access to group chats.

If your organisation allows it, and you decide the benefits outweigh the risks:

- avoid identifying the patient in the message
- save each message to the patient's record
- keep your phone secure via settings and strong passwords.

Some healthcare organisations are now using secure clinical communication platforms which allow messaging, group chats and sending images.

Can I use email to communicate with patients?

Yes, if:

- patients consent to it and understand that email isn't necessarily secure
- there are reasonable IT security measures in place
- you follow workplace protocols
- consent and privacy issues are managed.

Communicating from your personal email address is not recommended.

Emails should be saved in the patient record.

Can I use email to communicate with colleagues about patients?

Yes, if:

- patients consent to it, and understand what information is being sent and that email is not necessarily secure
- you follow workplace protocols
- you manage consent and privacy issues
- there are reasonable IT security measures in place.

Strengthen security by:

- **using secure messaging or encrypted email instead of standard unencrypted email**
- **sending clinical information as a password-protected PDF and sending the password by another means.**

Can I use my mobile phone to take clinical photos of patients?

Yes, if the patient consents to it and understands:

- the purpose of taking the photo/s
- who will see the photo/s
- what will be in the photo/s and whether the patient will be identifiable
- how photos will be stored and kept secure, and for how long.

Images where the patient can be identified are subject to the *Privacy Act 1988*. It's important to:

- keep your phone as secure as possible via settings and strong passwords
- upload the image to the medical record
- securely delete the image from your phone when it's no longer needed
- not post images to social media.

Can a consultation be recorded?

Yes, if the patient consents to it and the recording is kept secure. The consent should be written or oral as part of the recording, and the patient should understand:

- what will be recorded and whether they'll be identifiable
- who will hear the recording
- how it will be stored and for how long
- how they can withdraw their consent.

The laws on getting consent for audio and video recordings vary across states and territories. In the Northern Territory, Queensland and Victoria, a patient could legally record and share the recording, including telehealth consultations, without asking you.

What do I do if a patient asks to record the consultation?

- Ask the patient why.
  - If it's for a good reason and you're comfortable with being recorded, you can agree to it.
  - If you don't feel comfortable or don't think it's a good idea (e.g. the patient's condition is sensitive) you can decline. If you decline, you should explain why and offer alternatives such as giving them a written summary or having a family member present during the consultation.
- You may:
  - choose to make a recording yourself and keep a copy
  - express that you don't want the recording posted on the internet (including social media) and you could get agreement on this in writing.
- Consider having a practice-wide policy on this issue.

Need more specific advice?

- Call **1800 011 255** – available 24 hours a day in an emergency.
- Complete our **Contact us** form.
- Don't hesitate to ask us your question, we're here to support our Members.

View the references and recommended reading online: **mdanational.com.au/using-tech-for-patient-communication**

The evolution of premium pricing

A message from Underwriting

Luke Thomson
Manager, Underwriting & Insurance Risk Services
MDA National

When I started at MDA National in 2003, I inherited a collection of membership manuals, documents, and a folder of old membership subscription schedules. Having responsibility for pricing, I was delighted to find the subscription rates schedule for 1994/95. It was a single-page document, with subscription rates on one side and a description of our risk categories on the reverse. The application form was similarly succinct, with basic questions padded out on a double-sided A4 page.

For renewal that year, Members were asked to select one of the seven risk categories, based on specialty, and to select one of our income bands (gross fees per annum). These were:

- less than $20,000
- $20,000 to $40,000
- $40,000 to $60,000
- $60,000+

Twenty-nine years later, there has been a great deal of change – as our current 46-page risk category guide bears testament.

Back then, Members with the same billings in the same specialty would pay the same premium, irrespective of their specific risks. These days, premium is affected by the style and nature of the Member's practice, their claims history, and level of specialisation.

Each year the actuaries analyse the most recent cut of data, showing movements in the claims cost reserves of previously notified matters, as well as changes in frequency and severity of claims. The ever-growing claims database is bittersweet, of course. While our data is richer for the experience, each passing year confirms that claims aren't going away.

But this analysis enables important insights, such as those specialties seeing an increase or decrease in claims. While not unexpected, there are sometimes significant differences between the states and territories (given tort law is state-based). Our understanding of risk factors continues to grow. Some of these are useful for pricing, while others assist in education or risk assessment.

But one thing is for sure. The pursuit of insights from our data is incredibly important, not only for MDA National, but in providing Members with relevant information about their craft group and practice, enabling them to be risk aware in their day-to-day management of patients.

There are benefits to our deep understanding of medico-legal risks and continuing claims data analysis. At the micro level, we're able to help Members understand and manage risks better. More broadly, we hope the insights will help improve the quality and safety of healthcare outcomes in Australia, which of course is in keeping with MDA National's purpose – to support and protect Members, and to promote good medical practice.

From a pricing perspective, the premium setting is far more complex than ever – but it means our premiums are better aligned to risk which is fairer to all Members. So perhaps the golden days of mutuality are now!

MANDATORY REPORTING OF CHILD ABUSE

There is limited uniformity among states and territories in legislating mandatory reporting of child abuse by medical practitioners. This has the potential to lead to doctors not reporting when they should, and to generate confusion about the limits of their mandatory obligations.

A review of the legislation

Daniel Spencer
Medico-legal Adviser,
MDA National

If you are a medical practitioner touring around outback Australia in your caravan, combining leisure with some occasional locum work, then re-learning mandatory reporting of child abuse as you cross each state border probably isn't at the top of your to-do list. But it does deserve some attention.

There are some immediate thoughts that may spring to mind for a doctor when a child abuse disclosure is made:

- Does this trigger my mandatory reporting obligations?
- Am I breaching doctor–patient confidentiality by reporting?
- Will the patient and their family become aware that I've made the report (and does that even matter)?
- What if I get it wrong?

There are differences in the legislation in both thresholds and definitions which impact on when a report must be made. This was summarised by Mathews et al (2020)[1] who noted:

'… the laws are not uniform across jurisdictions, and there are broader and narrower models.

The first main dimension of difference is in which types of abuse and neglect must be reported … three of the eight jurisdictions – Victoria, Queensland, and the Australian Capital Territory – require reports of sexual abuse and physical abuse, but not of the other three kinds of maltreatment (emotional abuse, neglect, and exposure to domestic violence).

Other Australian jurisdictions require reports of only sexual abuse (Western Australia), or of all five types (for example, New South Wales).'

What a minefield!

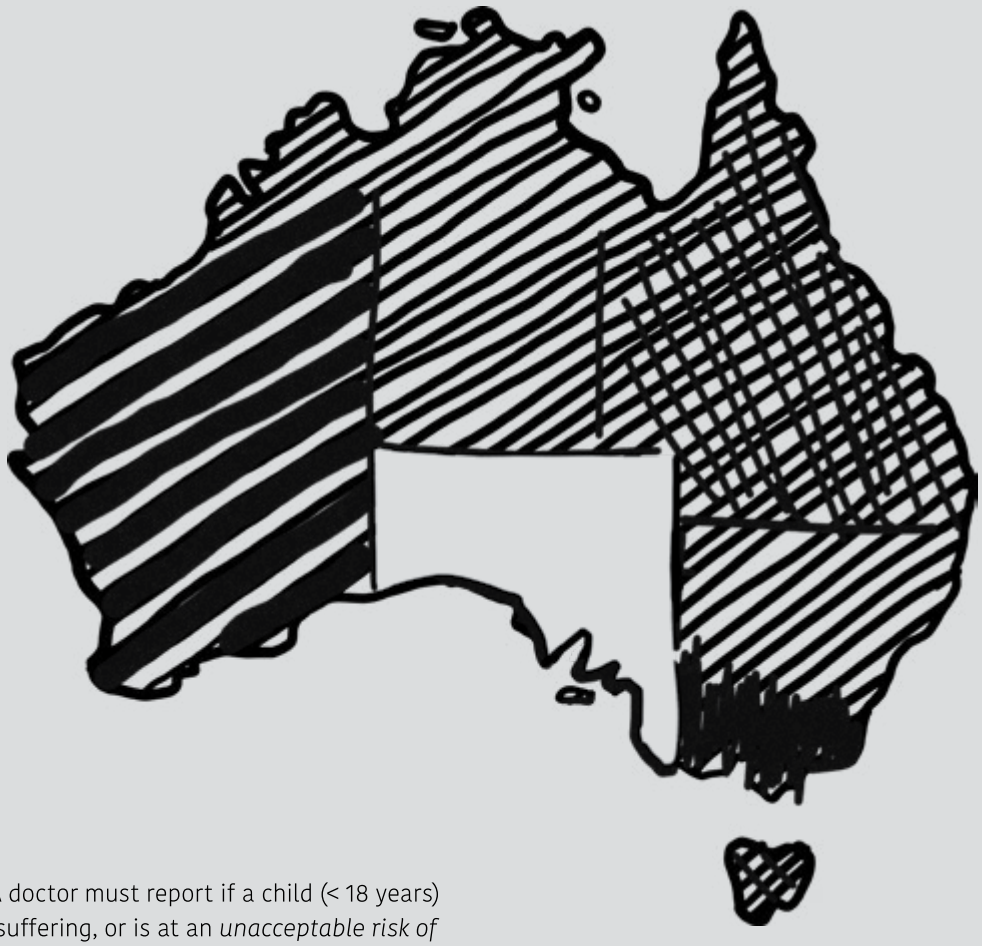
Perhaps it's useful to compare some of the key areas of difference among states.

In the NSW legislation, provided the doctor's view is that there are no current concerns for the safety, welfare or wellbeing of a child – despite having knowledge of previous abuse – they are not required to report. The WA legislation, by contrast, requires a report of child sexual abuse irrespective of whether the child remains at risk.

Let's look at the reporting thresholds in each jurisdiction.

What must be reported by doctors?[2]

- **ACT** – A doctor must report if a child or young person (< 18 years) *has* experienced or *is* experiencing, sexual abuse, or non-accidental physical injury.
- **NSW** – A doctor must report if a child (< 16 years) is at risk of significant harm. This is defined broadly and is not limited to sexual abuse.
- **NT** – All persons must report if a child (< 14 years) *has been* or *is likely to be* a victim of a sexual offence; and all persons must report a child (< 18 years) who *has* suffered or *is likely* to suffer harm or exploitation, or *has been* or *is likely to be* a victim of an offence under s128 of the NT Criminal Code (children > 16 under special care). Additionally, a doctor must report if a child (aged 14 to < 16 years) *has been* or *is likely to be* a victim of a sexual offence, and the difference in age between the child and alleged sexual offender is more than two years.



- **Queensland**[3] – A doctor must report if a child (< 18 years) *has* suffered, *is* suffering, or is at an *unacceptable risk of* suffering, significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect them from harm. All persons must report a child sexual offence in relation to a child (< 16 years; or a child 16-17 with an impairment of the mind) by another adult.
- **SA** – A doctor must report if a child or young person (< 18 years) *is*, or *may be*, at risk, which is defined very broadly.
- **Tasmania** – A doctor must report if a child (< 18 years) *has been* or *is* being abused or neglected, or there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides. There are also reporting obligations for unborn children who are at risk after birth.
- **Victoria** – A doctor must report if a child (< 17 years) is in need of protection because the child *has* suffered, or is *likely* to suffer, significant harm as a result of physical injury or sexual abuse, and the child's parents have not protected them or are unlikely to do so.
- **WA** – A doctor must report if a child (< 18 years) *has been* the subject of sexual abuse or *is* the subject of ongoing sexual abuse.

There are reporting requirements across the jurisdictions with respect to potential abuse or neglect that may be suffered by an unborn baby.

It's important to note that, while mandatory reporting obligations arise as a result of a person being a doctor, some states have similar obligations for other health practitioners and persons generally.

Exceptions and penalties

There are limited exceptions to mandatory reporting in some jurisdictions' legislation.

Penalties for a failure to report range from no penalty (NSW) through to imprisonment and substantial fines in other jurisdictions. Failure to report can also be the subject of health regulatory action.

Other considerations

The reassuring part for doctors is that 'getting it wrong' by reporting when the criteria for a mandatory report are not met doesn't generally result in dire consequences, due to the protection from liability afforded by each jurisdiction's legislation when mandatory and voluntary reports are made in good faith (subject to limited exceptions).

The identity of the reporter is generally protected from disclosure, although circumstances may lead to the alleged victim or their family being able to establish who the reporter is. You may be required to give evidence if the matter proceeds to court and you are subpoenaed as a witness.

If you're unsure of your mandatory reporting obligations in any particular circumstance, you should contact our Medico-legal Advisory Services team for advice and assistance.

View the references online: **mdanational.com.au/mandatory-reporting-child-abuse-legislation**

Case study

Daphne, a 16-year-old female who was six weeks pregnant to her 17-year-old boyfriend, attended with her mother to see Dr Flynn. He had never seen Daphne before, but she had seen other doctors at the same Victorian medical practice.

Upon review of Daphne's clinical records, Dr Flynn noted a reference to recent trauma with domestic violence and depression. It wasn't clear whether the domestic violence related to her current intimate relationship, or exposure more generally.

Dr Flynn questioned Daphne about her relationship to try to elicit any specific safety concerns. She denied any coercion, saying the relationship was consensual. When Dr Flynn enquired about how the relationship began, she said they had met through mutual friends.

Daphne stated she was considering going ahead with the pregnancy, but Dr Flynn was not entirely convinced of her competence. While Daphne's mother was supportive and understanding, her view was that the pregnancy should be terminated.

Unsure of his obligations, Dr Flynn telephoned our Medico-legal Advisory Service for immediate advice.

The relevant Victorian legislation – *Children, Youth and Families Act 2005* (Vic) – requires a report to be made in circumstances where a child is in need of protection because they have suffered, or are likely to suffer, significant harm as a result of physical injury or sexual abuse, and the child's parents have not protected them or are unlikely to do so.

While this was not a 'black and white' case, given the reference to domestic violence in the records and further information being obtained by the doctor, it was significant that Daphne denied coercion, reported a consensual relationship, and had a supportive mother. Further, it was noted that the relationship had not commenced in circumstances where there was a power imbalance between the two, such as in a teaching or coaching arrangement.

After talking it through, Dr Flynn formed the view that Daphne's circumstances would not trigger a mandatory report. He concluded that Daphne wasn't in need of protection as she had not suffered (or was not likely to suffer) significant harm from physical injury or sexual abuse and, significantly, it appeared her mother was taking all reasonable steps to protect her and would continue to do so.

Dr Flynn was advised to confer with the patient's regular GP at the practice to seek their views, including obtaining further information regarding the domestic violence referenced in the medical records.

As a follow-up, Dr Flynn enquired about his duty of confidentiality to a young person if, in another circumstance, he believed his mandatory reporting obligation *did* arise. We advised that, while it would depend on the specific circumstances, his duty of confidentiality would be overridden by his duty to report, and he would be protected from liability in this respect. In the interests of preserving the therapeutic relationship, he was advised that it may be prudent to inform the young person and/or their guardian about his obligations.

EDUCATION FOR SENIOR DOCTORS

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Are you ready for the new CPD registration standard coming into effect from 1 January 2023? And do you understand the requirements to meet your obligations?

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Scan the QR code to find out more.

We provide a diverse suite of education activities, complimentary for MDA National Members.

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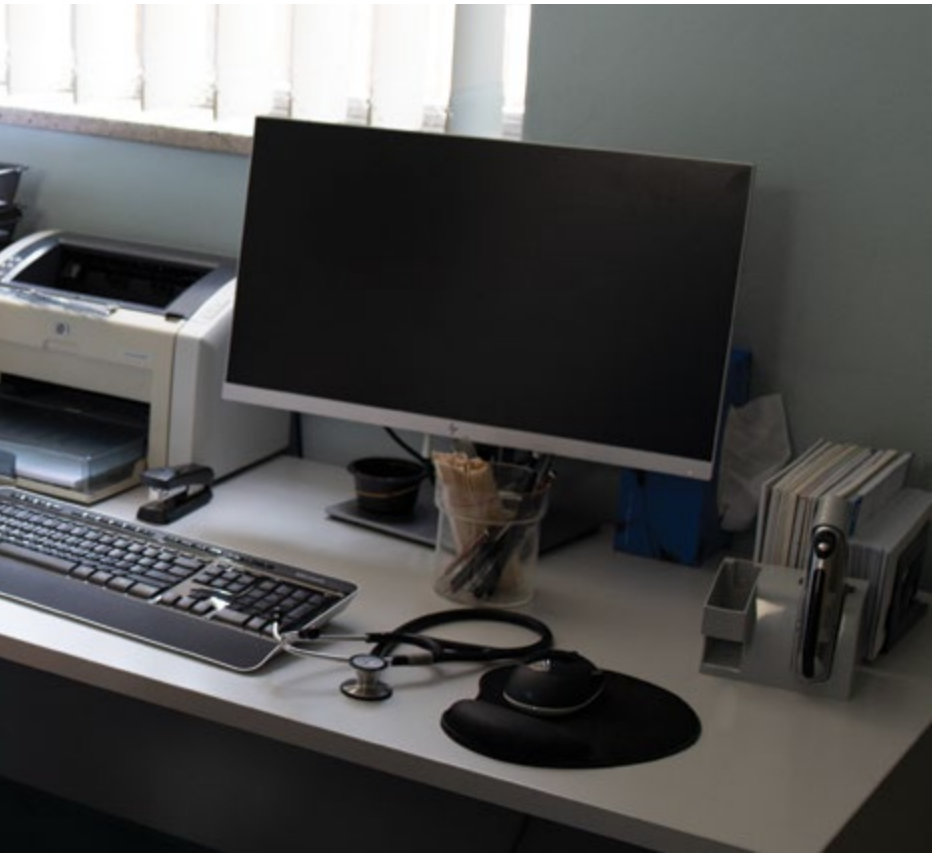
The doctor or the practice?

Nerissa Ferrie
Medico-legal Adviser, MDA National



When a patient writes a complaint to a medical practice, the lines can be blurred when it comes to who should provide a response.

Sometimes the complaint is like a hot potato, and no one wants to take responsibility for it. At other times, the practice provides a substantive response when it may not be appropriate to do so.

Below we discuss ways to best manage these common dilemmas.

The complaint is solely about the clinical care

If you're a practice owner or practice manager, you may feel the need to respond and protect the reputation of the practice. But a complaint about a doctor's clinical care should be addressed by the doctor involved, for a number of reasons including:

- prompting the doctor to contact their MDO for advice
- reflecting on the care provided
- providing a considered response, which may form part of an investigation if the complaint is escalated.

This doesn't mean the practice should ignore the complaint entirely, but we recommend a holding response along the following lines.

Dear Mr Jones

Thank you for your email/letter/phone call dated 30 May.

We take all patient feedback seriously, and we appreciate you taking the time to contact us.

As your concerns relate to the clinical care you received at the practice, your comments have been forwarded to Dr Smith for response.

We hope to see you at the practice again soon.

Yours sincerely

Does the advice change if the doctor is a registrar?

No. A registrar should treat a complaint as a learning opportunity, and a chance to engage with their own MDO. The best thing the practice can do is support the registrar through the process.

The practice can send a holding response, but it should avoid offering to 'investigate' the complaint or provide details of any findings to the patient. This can be unhelpful to the registrar, particularly if the matter goes further.

If part of the complaint relates to supervision – for example, the registrar checked something with the supervisor and received incorrect advice – it may be appropriate for both the registrar and the supervisor to provide a joint response with input from their individual MDOs.

The complaint is about the practice and clinical care

This may require a joint response, or two separate responses, depending on which allegation is more significant. If the patient complains about everything – from the booking system, wait times, the receptionist – adding a throwaway line about the doctor being disinterested, a single line response from the doctor could be incorporated into the overall practice response.

If, however, there are legitimate concerns raised about both the practice and clinical care, the practice could adapt the holding letter to incorporate a response to any issues raised about the practice. The complaint should then be referred to the doctor for a separate response with the assistance of the doctor's MDO.

The complaint entirely relates to the practice

If the complaint does not involve clinical care, the practice should contact their practice insurer for advice on how to respond.

What if we don't want the patient to come back to the practice?

If the patient has been rude or abusive, and the therapeutic relationship is irretrievable, the practice or the doctor can incorporate a termination letter[1] into the response.

Case study

John had been a patient of the practice for years, but he took a dislike to Carli, a female registrar. When he couldn't see his usual doctor, he reluctantly agreed to see Carli for an urgent appointment.

Despite John being belligerent throughout the consultation, Carli did her best to examine him and provide clinical advice. John was annoyed that he couldn't see his usual doctor, and he wasn't happy with Carli's advice, so he made a complaint to the practice.

Carli's supervisor and practice owner, Dr James, didn't want to undermine Carli's confidence, so he decided to respond to John himself:

Dear John

I'm sorry I wasn't available to see you for an urgent appointment last week, but I had a commitment that could not be moved.

You indicated you were unhappy with Carli's treatment plan. She recommended rest and fluids, but otherwise suggested you take a "wait and see" approach with regards to your chesty cough.

I would have commenced antibiotics immediately, but we need to make allowances for young doctors who are still training and have limited practical experience.

Carli will be moving on soon, so I trust I will see you next month for review of your chronic disease management plan.

Kind regards

Dr James completed a very positive assessment and Carli moved on to another practice. She was shocked to receive a complaint from Ahpra a few months later. It included Dr James' response, which John had used as proof of her "complete and utter negligence".

The matter was ultimately dismissed. But Carli felt completely blindsided by Dr James' failure to advise her of the concerns raised, and his unhelpful response which she believed prompted John's notification to Ahpra.

View the references online: **mdanational.com.au/the-doctor-or-the-practice**

A practical guide to managing dental damage

Nicole Golding
Medico-legal Case Manager (Solicitor)
MDA National

Dental damage is the leading cause of complaints and claims against anaesthetists. We examine the importance of consent, your duty to warn, and the steps you can take if damage occurs.

Case study

Dr Singh, an anaesthetist, consulted with a patient in hospital the morning of her parotidectomy procedure. During the consultation, Dr Singh took a detailed medical history from the patient. No questions were asked regarding dentition, and the patient did not volunteer details of previous restoration. Dr Singh didn't discuss the potential risk of dental damage as part of his general consent process.

The parotidectomy was uneventful, and Dr Singh didn't encounter any difficulties with intubation. No dental damage was noted prior to the procedure, and although Dr Singh heard a cracking noise on extubation, he didn't check her teeth for damage.

The day after surgery, the patient reported to the surgeon that her left upper bridge was cracked. The surgeon recommended she seek urgent dental review. The patient consulted her usual dentist and subsequently advised Dr Singh that she had sustained a porcelain fracture on tooth 11, which had a full coverage crown.

The patient was unhappy that the damage had not been reported to her by Dr Singh immediately after her surgery, and that she had not been warned of the possibility of dental damage during her pre-operative consultation.

The patient requested Dr Singh to cover the costs of having her crown replaced.

Duty to warn

Dental damage is a well-recognised complication of anaesthesia, and there is a positive obligation to warn patients about this risk prior to a procedure. It's not appropriate that you rely on the surgeon to provide these warnings to the patient.

During your pre-operative consultation with the patient, it's important to take a detailed medical history, including details of any pre-existing dental conditions. In the event the patient has had restorative dental work, an examination may be needed to enable you to consider the most appropriate airway management to minimise any potential risk during the procedure.

Informed consent must be obtained from all patients, and the general risk of dental damage should be discussed with every patient, regardless of their dentition. If you identify a patient as having a higher risk for dental damage, you should discuss ways in which you may be able to minimise the risk of damage.

Some anaesthetists provide patients with an information sheet outlining the risks of anaesthesia. While this can be a useful tool to guide your discussion with the patient regarding risks, it should not be used in place of a discussion.

Documenting consent

It's important to document consent, because it provides a potential defence in the event of a claim. Contemporaneous records outlining all pre-existing dental conditions identified during the consultation should be documented clearly in the clinical records, together with a detailed account of your discussions regarding the risk of dental damage. If the patient is high risk, your clinical records should reflect a more extensive discussion. You should also document the patient's understanding of the risks and their willingness to proceed.

Our Support in Practice team can assist you in developing an appropriate consent form or reviewing your existing consent process.

If damage occurs

In the unfortunate event that your patient experiences dental damage, and this is identified during or after the procedure, it should be clearly documented in the notes.

Talk to the patient as soon as practicable so they are aware of the damage. Open disclosure is encouraged, and while you can say you're sorry the patient has suffered damage, it's important you do not admit liability until you have sought advice. In the meantime, you can recommend that the patient seek an urgent review from their dentist.

If the patient asks you to pay for the cost of any necessary dental treatment, you can suggest they put their request in writing and provide copies of any treatment quotes or invoices for you to consider. Do not agree to pay the costs of dental treatment without first seeking advice from MDA National. If the patient was appropriately warned, and there's no evidence that you've departed from accepted standards, there may not be any basis on which the patient can recover these costs.

On occasion, the damage may occur while the patient is in recovery. In this situation, we encourage you to speak to your private hospital regarding indemnity.

Checklist

- ☐ Take a detailed medical history from the patient, including any dental issues.
- ☐ Warn every patient about the risk of dental damage during anaesthesia.
- ☐ Obtain the patient's informed consent.
- ☐ Carefully document your discussion around risks and consent in the clinical records.
- ☐ If dental damage occurs during the procedure, engage in open disclosure with the patient as soon as practicable.
- ☐ Contact MDA National for advice.

Cutting the risks in hernia repairs

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

A/Prof Michael Hollands
MDA National Mutual Board member
Chair, Eastern Cases Committee

Case history

Mr Black consulted Dr Cut in June 2011. Dr Cut obtained the history that Mr Black had been troubled by left groin pain for the past year, and an ultrasound ordered by his GP revealed an uncomplicated reducible indirect left inguinal hernia.

On examination, Dr Cut elicited a positive cough impulse in Mr Black's left groin, but she was unable to palpate a hernia. Mr Black also complained of testicular pain, which Dr Cut believed could be due to spermatic cord compression at the deep inguinal ring.

Dr Cut explained to Mr Black that although the ultrasound confirmed the presence of a hernia, she could not be certain this was the cause of his left groin pain. However, Dr Cut advised she was reasonably sure that repairing the hernia would fix Mr Black's groin pain, although there was no guarantee of success.

Dr Cut discussed the risks associated with laparoscopic hernia repair which she listed as wound and mesh infection, nerve injury, and recurrence. Mr Black confirmed that he understood the risks and provided his consent for surgery.

At the surgery performed a couple of weeks later, a hernia of extraperitoneal fat was revealed coming through the deep inguinal ring and accompanying the spermatic cord. Dr Cut used mesh which she fixed in place with staples, and the peritoneum was closed over the mesh with staples.

Three weeks later, Mr Black was reviewed by Dr Cut and advised he was still experiencing left groin pain following the surgery. There was no sign of any recurrence of the left inguinal hernia. Dr Cut referred Mr Black for an ultrasound of his left groin, and no abnormalities were identified in the report.

Mr Black then saw a sports physician and physiotherapist. He was advised to work on his core strength in the hope that his symptoms would settle with the strengthening of his gluteal muscles.

Four months post-surgery, Mr Black was still complaining of diffused pain in the left groin area. He was referred for a CT scan and an MRI. The imaging showed 'no cause for presentation'.

A year later, Mr Black's groin pain was still present, and he underwent two further surgeries with a different surgeon.

Mr Black commenced proceedings against Dr Cut, alleging her management was negligent in that Dr Cut had failed to obtain informed consent. It was alleged that it was inappropriate for Dr Cut to recommend surgery, and that a conservative approach should have been taken. There were also allegations about the surgical technique used, with staples or clips placed in an area of risk of damage to nerves.

Discussion

Up to 10 per cent of men will develop an inguinal hernia. Many are asymptomatic, and many do not require repair. The risk of bowel obstruction, which forms the basis of most surgeons' advice to recommend repair, is probably overstated. Two longitudinal studies of patients who were not operated upon showed that most patients eventually elect to have their hernia repaired because of ongoing discomfort, but obstruction was rare.

With the substantial decrease in hernia recurrence rates over the last two decades, the focus on surgical outcomes has shifted from recurrence rates to chronic pain and testicular injury. This case highlights the former.

The guidelines for the management of groin hernia published by the HerniaSurge group[1] report an incidence of 10-12 per cent clinically significant chronic pain decreasing over time. Debilitating chronic pain severe enough to affect daily activity and work has an incidence of 0.5-6 per cent.

In this case, the patient was in pain before his surgery and remained in pain after it. We do not know the patient's expectations, but his surgeon told him she was confident his pain would be alleviated. Pre-operative risk factors for pain include young age, female gender, pain elsewhere or in the groin, and mental status. Peri-operative risk factors include inexperienced surgeon, open technique, as well as mesh type and fixation. Post-operative factors include increased pain in the immediate post-operative period, post-operative complications, and sensory dysfunction.

The key message is beware the patient presenting with pain as the dominant symptom. Their expectations concerning pain relief are likely to be unrealistic.

Medico-legal issues

As for all surgical procedures, patients undergoing elective hernia repair should be advised about the risks, including chronic post-operative pain.

Good documentation of the consent discussion is vital in the event of a claim or complaint. You cannot rely on your recall of events to defend yourself. Some discussion of chronic pain, perhaps reflecting that the patient understands its consequences, must be documented.

Better still, be very cautious about recommending a hernia repair in a patient with an incidental hernia. You will successfully treat the hernia, but may be left with a very dissatisfied patient.

View the references online: **mdanational.com.au/cutting-risks-in-hernia repairs**

The journey through medical professionalism

Dr Hashim Abdeen
Advanced Trainee, Rheumatology
Chair, Junior Doctor Advisory Committee (Qld)

Professionalism for doctors in training (DiTs) is something not entirely embedded within us during our earlier medical school education or junior training. It does, however, become more well developed as our careers progress, and the journey throughout medicine teaches us some important life lessons. Unfortunately, it's the issues related to professionalism that usually end up getting us doctors into sticky situations.

Professionalism, for many, starts during that first year as a doctor on the wards. However, it's often hard to define what medical professionalism really looks like. It's the first time you develop this sense of responsibility and the realisation that the decisions you make as an individual have the potential to significantly impact someone else's life – either positively or negatively.

As we progress through medical training to become registrars, our sense of responsibility increases. As we approach the glorified years of becoming a consultant, we begin to realise we're now almost entirely responsible for our patients' outcomes.

I have the privilege of serving as Chair of MDA National's Junior Doctor Advisory Committee (JDAC) – an important platform to help us understand the issues relevant to DiTs. The Committee has been discussing how we can best support our DiT members on their own journey of developing professional skills and identity. We have also contributed to MDA National's professional development education series.

We hope to contribute to this growing field of embedding professionalism more consistently and thoroughly within our medical education and training systems. We welcome any feedback on this topic.

You can contact your local JDAC member through your state office: **mdanational.com.au/contact-us**.

Professionalism engenders the ability and willingness to ensure the best possible patient outcomes.

- It's about realising the great privilege we have to be truly involved in the most sensitive parts of an individual's life and respecting that privilege.
- It means doing your best to put yourself in someone else's shoes, communicating with them, and facilitating their health care in the safest and most culturally-aware way possible.
- It means looking after yourself to ensure you're best able to look after the patients you care for.
- It's about recognising our own differences and biases, and ensuring these don't inadvertently interfere with the care we provide.
- It's working in a collaborative team-based manner that supports a positive culture, which is ultimately better for patient safety and quality of care, while also protecting the wellbeing of other healthcare professionals.
- It's the times where we identify issues or problems within our healthcare system, and take leadership to contribute to the solutions.

The second victim

Supporting junior doctors through medical errors

Dr Sarah Newman
Assistant Director, Doctors' Health Advisory Service WA

The term 'second victim', coined by Wu in 2000, encapsulates the impact of medical error on clinicians. Despite public perception, and what hard-line medical culture would have us believe, medical error is inevitable as we are all fallibly human.

We accept the patient as the first victim, and our critical incident review process naturally focuses on their outcomes. But the health professionals who feel responsible can often be neglected.

Although linear root cause analyses attempt to appreciate the multifactorial reasons behind incidents where the individual is only one 'hole' in the 'Swiss Cheese' model, the emotional impact of errors may be overlooked. Doctors who are second victims may experience psychological distress, burnout, post-traumatic stress, risk-averse practice, and maladaptive behaviours including drug and alcohol abuse, leaving the profession and, in the worst case, suicide.

Junior doctors and trainees (JMOs) are particularly vulnerable to the effects of medical errors. Inexperience, high workload, increased fatigue, burnout, and feelings of inadequate clinical supervision are important contributors. Senior guidance is critical in shifting the perceptive from trauma to growth. Medical errors can be re-envisioned as formative learning experiences – for the second victim, their colleagues and the organisation.

Medical leadership sets the culture for how medical errors are viewed, processed and managed.

The work environment must be a safe place to discuss mistakes. Water-cooler gossip is harmful and should be actively discouraged. JMOs require support when providing open disclosure to the patient, and it helps to understand that admission and apology do not imply legal liability. They should be encouraged to have early discussions with their MDO to address medico-legal consequences.

1. Assess any acute needs.

Second victims are often distressed immediately after the incident comes to light, needing a safe space for a sounding board and psychological first aid, while steering away from clinical scrutiny. The JMO may need a break or to go home. Disclosing one's own inevitable experience of medical errors normalises and validates their experience.

2. Facilitate reflection to enable clinical growth.

Have regular check-ins with the JMO and make sure they know the existing hospital and external support available for further assistance.

The DRS4DRS website **drs4drs.com.au** has many health resources. In times of crisis or distress, this website directs viewers or callers to the state-based doctors' health organisations which provide 24/7 advice lines manned by medical practitioners experienced in doctors' health. These organisations can support doctors acutely, anonymously, and with confidentiality.

Systemic change is needed when approaching medical error. When the second victim is blamed, the healthcare organisation and patients suffer. Consider what simple interventions in everyday practices could prevent future second victims, and integrate early and ongoing support for second victims into the workplace.

Open discussion of medical errors during college education, peer groups and supervision will help dispel the stigma of mistakes. At the end of the day, we are all only human. A human response of empathetic support helps JMOs become better clinicians, moving forward from 'victim' to formulating meaning and experience after medical error.

References available on request.

Putting the heart back into health care

Niranjala Hillyard
Creative & Editorial Director,
Inkpot & Pixel

Dr Ben Bravery's journey has been anything but smooth sailing. In 2011, Ben was growing his science communication business in Beijing and had just found his life partner. Things were going well for the 28-year-old, until his life was rocked by a diagnosis of colorectal cancer. After 18 months of treatment in Australia, Ben took on a complete career change. Today, he is a psychiatry registrar with a mission to put patients at the heart of health care.

I interviewed Ben about his journey, and he responded to my questions with candour.

Ben launched his memoir, *The Patient Doctor*, in June 2022.

Q1. You were 32 years old when you started studying medicine – what drew you to this?

I decided to become a doctor while undergoing treatment for colorectal cancer. I thought it would be a good way to give back. I had a sense of my own mortality, so I went to med school to learn what had happened to my body. I had also noticed the health system makes it very hard to be flexible, and it's not always in the best interests of patients. If I wanted to make a difference in health care, I felt I would have to enter it.

Q2. Was medical school everything you expected? Did anything surprise you?

Firstly, the medical curriculum is overflowing because medical knowledge continues to increase at a rapid rate. Topics compete for attention in this busy space, and one of the casualties is cancer. Cancer affects one in two people by the age of eighty-five, and every doctor needs a broad understanding of it.

Secondly, we should be training doctors who reflect the cultural and socioeconomic backgrounds of patients. Admission shouldn't only be about exam performance. The current system favours people graduating from private or selective schools who live in healthy parts of the country.

Yes, grades are important – but so is a person's lived experience, their commitment to compassion, or their ability to connect with people.

Thirdly, our exams measure our factual knowledge. This is important, but it shouldn't be the only measure of what makes a 'good' doctor. As the medical curriculum has swelled, the things that perhaps doctors understood in the past – the value of conversation, how to best put a patient at ease – have been lost.

Q3. What made you choose psychiatry as your specialty?

Psychiatry struck me as the branch of medicine that has best held on to the notion of the patient–doctor relationship, and that the patient is a person. Psychiatrists also tend to think about systems and how people function (or not) in those systems. It isn't perfect, and it's under the same pressures as the rest of medicine – but it feels like the space where I have the best shot at being the kind of doctor I think patients deserve.

Q4. From your experience as an inpatient, what are some of the things you feel need to change in our healthcare system?

More staff. More beds. Better food and uninterrupted lunch breaks. Name badges for staff. Second ward rounds or, even better, thorough and unrushed ward rounds. Medical students learning directly from patients – this type of patient contact is known to help medical students develop skills, knowledge and empathy. And what students learn at medical school forms the basis of their knowledge for the rest of their careers. Cultivate empathy. We need to fix the system one patient and one doctor at a time.

Q5. As a patient, what's your message to doctors?

It's not necessary for a doctor to be sick to understand sickness. We can show them what it's like to be sick through sharing the lived experiences of others; and teach them empathy, compassion and how to listen. Patients and doctors are interdependent, so it helps if they can better understand each other. But differences between patients and doctors will always exist, which is why doctors must compensate for these by making sure their patients are heard.

> *"Cancer changed me forever. I feel neither well nor unwell…*

> *Not fully a doctor, nor fully a patient. My book is about my place in these two worlds and the things I've learnt. My hope is to empower both patients and doctors, to better understand each other and to demand a better kind of medicine."*

Q6. As a doctor, what's your message to patients?

It's good to read about your symptoms online, but you should discuss what you read with your doctor, and take printouts if that's easier. Take a notebook where you've written questions before the appointment, and you can also record any test results and what the doctor tells you. If a friend or family member is free, take them along – an extra pair of ears can be important, and having someone familiar and supportive can help you feel more confident in expressing yourself to the doctor.

Q7. You've recently released your book, *The Patient Doctor*. What inspired you to write it?

Instead of running away from the health system after cancer treatment, I ran towards it and re-trained as a doctor. As a patient, I had often been frustrated with the health system, and now even more so as a doctor. I realised patients and doctors were hurting, so my mission to improve things got even bigger. My scans tell me there are no tumours now, but cancer changed me forever. I feel neither well nor unwell. Not fully a doctor, nor fully a patient. My book is about my place in these two worlds and the things I've learnt. My hope is to empower both patients *and* doctors — to better understand each other and to demand a better kind of medicine.

Q8. What advice would you give an aspiring medical student or junior doctor?

Protect your humanity, it's something your patients will care about.

Education programs tailored to your needs and career stage, so you can keep on progressing with confidence

MDA National Junior Doctor Members have access to educational resources on professional development and career progression to support their medical career journey.

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 which areas of medicine they enjoy, and to assist participants in identifying the medical specialty that suits them best.

Topics include:
Aiming for the Stars
From uncertainty to clarity – A practical session

Member feedback:

"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."

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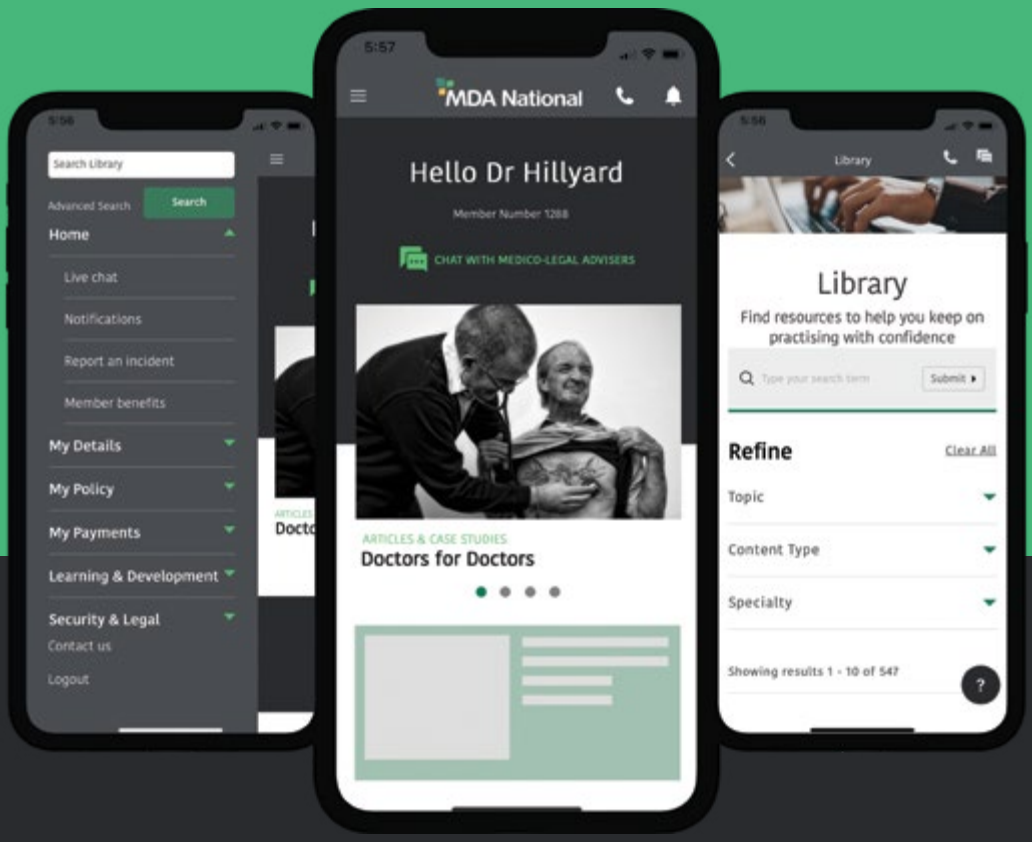

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