defenceupdate

Publication for MDA National Members

Autumn 2015

MDA National
Support Protect Promote

Celebrating 90 Years

Editor's Note

Welcome to the first issue of *Defence Update* for 2015.

One of the aims of *Defence Update* is to update you on medico-legal developments that will impact on contemporary clinical practice. The recent Western Australian Court of Appeal decision regarding a medical practitioner's duty to provide Good Samaritan assistance is discussed on page 15.

Some Members are not aware of the breadth of the assistance, advice and support MDA National can provide. On pages 6 and 7, Dr Jane Deacon, Medico-legal Adviser, outlines the role of our Medico-legal Advisory Services team, including some of the common reasons why Members contact us for advice.

We also have a number of practical articles to assist you to navigate medico-legal processes, including receipt of a notification from the Australian Health Practitioner Regulation Agency (page 5) and an employer's request for you to attend a meeting (pages 8 and 9).

A reminder that you can receive continuing professional development (CPD) recognition for every issue of *Defence Update* by completing a questionnaire after reading the magazine. MDA National is committed to providing you with high quality and convenient education. The *Defence Update* education activity enables you to obtain CPD points in the risk management area, at no cost to you. You can now complete the activity online (and instantly receive your participation certificate) or fill out the form included in this issue and send it to us by email, fax or post. See page 19 for more information.

I hope you find this issue of *Defence Update* informative, relevant and interesting. Your comments and contributions are warmly encouraged. Please feel free to contact me at **sbird@mdanational.com.au**.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

Doctors for Doctors

At MDA National, we have many reasons to celebrate. This year, we celebrate a milestone anniversary, our 90th, and the appointment of Ian Anderson as our new Chief Executive Officer.

This year we're celebrating 90 years of supporting, protecting and promoting Members. MDA National was established in 1925 as a "doctors for doctors" mutual, and has continued to build on this time-honoured culture.

Today, Members and stakeholders alike tell us that MDA National is the most trusted medical defence organisation in Australia.* MDA National has had a successful past and we look forward to an exciting future.

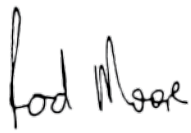
We are pleased to announce a new milestone in our development with the appointment of Ian Anderson as our new Chief Executive Officer. A comprehensive national search was conducted to find the individual with the right qualities and experience to lead MDA National forward.

Ian has significant leadership experience, an impressive depth of knowledge and experience in both health care and financial services, and a personal approach that makes him an ideal fit for the role. Ian was previously CEO of St John of God Midland Hospitals and SKG Radiology, Director of Capital Management at the North Metropolitan Health Service, and General Manager of HBF Health Fund.

Ian commenced with MDA National on 9 February 2015, succeeding Peter Forbes who retired on 31 December 2014 after 39 years of committed service. Peter has left MDA National in a very strong position, both financially and competitively.

Ian will ensure the organisation continues to provide quality professional indemnity cover and services that Members value and need in this exciting new phase in our development.

Thank you to all our Members, stakeholders and employees for making MDA National the organisation it is today. We have a strong and exciting future ahead.



Dr Rod Moore
Acting Chairman, MDA National Mutual Board

*MDA National's Reputation Audit Research 2014

MDA National's New CEO

– Ian Anderson

Celebrating 90 Years

Notice Board

Celebrating our History

MDA National, Our History, Our MDO is an exciting new video that showcases our development and some key highlights over 90 years. It provides a unique oral history which is as much about the people as it is about medical indemnity.

Celebrating 90 Years

To view our video:

type ***http://www.youtube.com/watch?v=18udiAn06hQ*** into your browser

or scan the code with a ***QR code app*** on your smartphone.

Search for ***"QR Code"*** in your phone's ***app store*** to download a free QR Code app.

Have You Ever Been the Subject of a Complaint?

The University of Sydney is conducting an interview study aimed at preparing junior doctors for the possibility of a complaint against them, and to better support all doctors in the event of a complaint.

The University is seeking participants who are currently registered, practising or recently retired, and have had at least one formal (finalised) complaint. The study will analyse the different ways in which doctors respond to complaints in order to understand the reason why some doctors undergo significant changes in mood, behaviour or attitudes during the complaints process. The study is interested in whether doctors seek support and their perception of the complaints process.

Interested participants will be asked to participate in a 60-minute interview at a convenient time and location with Elizabeth van Ekert, who has a long history of working with doctors and is undertaking this study as part of her PhD.

If you wish to participate or want more information, please contact Elizabeth van Ekert on **0401 997 537** or send an email to **elizabeth.vanekert@sydney.edu.au**.

Your 2015 Renewal Invitation

You will soon receive your 2015 Membership and policy renewal invitation. Please check your Renewal Notice carefully to ensure you have the most appropriate level of cover heading into the new policy period.

If you require any changes or have queries about your Membership and policy, please contact our Member Services team on **1800 011 255** or email **peaceofmind@mdanational.com.au**.

Our team is available from 8:30am to 8:00pm (AEST) Monday to Friday to assist with your enquiries. You can also log in to Member Online Services via **mdanational.com.au** to renew at a time that best suits you.

Clinical Images and the Use of Personal Mobile Devices

On 21 November 2014, ***Clinical Images and the Use of Personal Mobile Devices: A Guide for Medical Students and Doctors*** was released by the Medical Indemnity Industry Association of Australia and the Australian Medical Association. MDA National provided legal and medico-legal input for this publication.

The guide outlines the key ethical and legal issues that doctors and medical students need to be aware of before using a personal mobile device to take or transmit clinical images for the purpose of providing clinical care.

Key topics discussed in the guide include:

- the process for obtaining consent to collect, use and disclose clinical images
- privacy and confidentiality
- storage and security
- access to clinical images.

The guide is available at:

ama.com.au/article/clinical-images-and-use-personal-mobile-devices.

I've Received a Letter from AHPRA

Members who receive a notification from the Australian Health Practitioner Regulation Agency (AHPRA), regardless of its nature, are encouraged to immediately contact our Medico-legal Advisory Services team so we can assist you in preparing an appropriate response.

What is a notification?

A notification is a complaint or concern about a medical practitioner that is lodged with AHPRA or the Medical Board.

Note: NSW and Queensland manage notifications differently. In NSW, the Health Care Complaints Commission receives complaints about medical practitioners. In Queensland, such complaints are received by the Office of the Health Ombudsman.

Who can make a notification?

Anyone can make a notification about a medical practitioner to AHPRA, which receives it on behalf of the Medical Board. The majority of notifications are made by patients or their families. While health practitioners, employers and education providers have mandatory reporting obligations imposed by the National Law,[1] the majority of notifications are voluntary.

The notifications process [2]

After AHPRA receives a notification, a preliminary assessment is conducted. Grounds for a notification include:

- the practitioner's professional conduct is, or may be, of a lesser standard than that expected by the public or the practitioner's peers
- the knowledge, skill or judgement possessed, or care exercised by the practitioner is, or may be, below the standard reasonably expected
- the practitioner is not, or may not be, a suitable person to hold registration
- the practitioner has, or may have, an impairment
- the practitioner has, or may have, contravened the National Law
- the practitioner has, or may have, contravened a condition of his or her registration or an undertaking given to the Board
- the practitioner's registration was, or may have been, obtained improperly.

If the preliminary assessment suggests there may be grounds for notification, the medical practitioner is usually sent a copy of the notification and invited to provide a written response. The notification and the practitioner's response are then sent to the Medical Board for assessment.

The Medical Board's decisions are focused on keeping the public safe. In the majority of cases, the Medical Board makes a decision to take no further action and the matter is closed. However, if the notification raises concerns that the practitioner's conduct or the way in which they practise is unsatisfactory, or they are impaired, the Board may decide to investigate the matter or require the medical practitioner to undergo a performance or health assessment.

The Medical Board has the power to take a range of actions at any time after an assessment or investigation, including:

- take no further action
- refer the practitioner for a health assessment
- refer the practitioner for a performance assessment
- refer the matter to a health panel
- refer the matter to a performance and professional standards panel
- impose conditions on, or accept an undertaking from, the practitioner
- caution the practitioner
- take immediate action
- refer the matter to a tribunal
- refer the matter to another entity, e.g. a health complaints authority.

AHPRA and the Medical Board: Facts and Figures [3]

- There was a **19% increase** in notifications about medical practitioners in 2013/14 – compared with a **16% increase** across all registered health professions.
- **4.9%** of medical practitioners were the subject of a notification in 2013/14.
- **85% of notifications** closed in 2013/14 resulted in no further action.
- There was a slight **decrease in the number of medical practitioners subject to mandatory notifications**, from 28.9/10,000 in 2012/13 to 27.2/10,000 medical practitioners in 2013/14.
- There was wide variation in mandatory reporting across states and territories, with a **79% increase in Queensland, a 13% decrease in NSW and a 5% decrease in Victoria**.
- The Medical Boards took **"immediate action" 246 times – up 67% from 2012/13**. The biggest increase was in WA, where the WA Medical Board took immediate action 38 times, up from 11 in 2012/13.
- **69% of "immediate actions" led to regulatory action** – such as conditions, undertakings or suspension of registration.

Dr Sara Bird
Manager, Medico-legal and Advisory Services
MDA National

For a full list of references, visit **defenceupdate.mdanational.com.au/ahpraletter.**

A Call a Day **Keeps the Lawyers Away**

A core component of MDA National's service to Members is access to immediate support, expert guidance and personalised medico-legal advice. This article provides a snapshot of calls received by our Medico-legal Advisory Services team in a day, highlighting some of the medico-legal issues which are of frequent concern to our Members.

8:30am: Dr A calls to say she has received a letter from the son of a former patient, requesting a copy of his deceased father's medical file.

ACCESS TO DECEASED PATIENTS' RECORDS. *A complex area which depends on several factors, including the reason for the request. Specific advice is given to Dr A, with suggested wording for a letter to be sent to the deceased patient's son.*

9:30am: Dr B, a junior doctor, has been asked to complete a police report for a patient he saw in ED earlier in the year. He calls seeking advice on how to write the report.

MEDICO-LEGAL REPORTS. *Dr B is given general advice on how to complete a police report, and a brochure with further information is emailed to him. Dr B is also invited to send his report to us for review if he would like further assistance.*

10:30am: A very distressed call from Dr C. He has just been informed by AHPRA that they have received a serious notification alleging that his surgical complication rate is so high he must cease operating. AHPRA is about to fax a letter to him about the notification.

AHPRA NOTIFICATION – NEW FILE. *A claims manager is assigned to the matter immediately. The claims manager will start liaising with AHPRA today, and will meet with Dr C as soon as possible.*

11:30am: Time to "log off' the phones for now, and attend to some paperwork and emails. Dr B's draft police report has been received; this is now reviewed and sent back to Dr B with some suggested changes included.

2:00pm: Dr D rings to say one of his patients has sent him a very suggestive card, inviting him out for a drink. He is worried about this and not sure how to handle the situation.

TERMINATING THE DOCTOR-PATIENT RELATIONSHIP. *After some discussion, Dr D decides it will be best to terminate the doctor-patient relationship. A suitable letter is drafted for Dr D to send to the patient, and he is advised to contact us if there are any developments.*

3:00pm: Dr E is very upset as she has damaged a patient's ureter during surgery this morning. The damage was noted and repaired while the patient was anaesthetised. She is now going to make her post-op rounds and wants advice on what to say to the patient.

OPEN DISCLOSURE. *Dr E is given advice on how to handle this difficult conversation. She rings back afterwards to say that the patient and family seem to have taken the news of the complication quite well, but she will keep us updated of the patient's progress.*

4:00pm: Dr F, a GP, rings to say that one of his colleague's nursing home patients has died. His colleague is overseas and Dr F has never seen the patient. The nursing home has just phoned to ask him to complete the death certificate – can he do this?

COMPLETING A DEATH CERTIFICATE. *Advice is given about when a death certificate can be completed, and specific advice is provided to cover this situation.*

5:00pm: Dr G phones for advice on responding to a complaint letter from a patient stating that he was rude and did not order the appropriate tests leading to a delay in diagnosis.

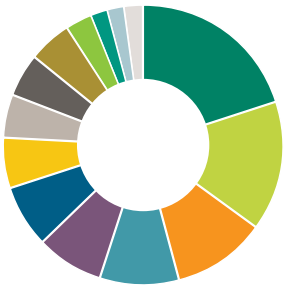
PATIENT COMPLAINT – NEW FILE. *However trivial the complaint, we would like to be involved right from the outset. Dr G is asked to send us a copy of the patient's medical record, the complaint letter and his draft response. A claims manager will be assigned to review the letter and manage the file.*

Dr Jane Deacon
Medico-legal Adviser
MDA National

DID YOU KNOW...

- Any communication to and from MDA National – such as file notes of discussions, emails and correspondence – should not be recorded in a patient's medical record.
- Our Medico-legal Advisory Service can be contacted on **1800 011 255**. It operates on weekdays from 8:30am to 8:00pm (AEST), with access to emergency advice 24 hours a day. Members can also use our dedicated email portal: **advice@mdanational.com.au**.
- The Medico-legal Advisory Services team receives approximately 350 calls every month from Members. Almost 50% of calls involve notification of an adverse event, a complaint, a coronial or other investigation, a claim or another matter covered under their policy. The remaining calls are requests for general medico-legal advice, as shown in the graph below.

General medico-legal advice by subject
2013/14



20%	Advice/ethical dilemma
15%	Other
11%	Medical records
9%	Medico-legal report
8%	Subpoena/appearance in court
7%	Confidentiality/privacy
6%	Ending doctor-patient relationship
5%	Legislation/legal issues
5%	Clinical incident (no file)
5%	Practice management
3%	Employment issues
2%	Mandatory reporting of colleagues
2%	Consent
2%	Professional interaction issues

I've Been Asked to Attend a Meeting

The first inkling of a dispute or serious investigation may arise when you are called in for a meeting with your employer. Alternatively, you may already be well aware of the matter by the time you are asked to attend the meeting. It is important to appreciate that not all such meetings are as serious as may first appear. The fear of the unknown and loss of control, coupled with anxiety over your future employment prospects, can make this period a terribly stressful time.

As noted by Benjamin Franklin, "By failing to prepare, you are preparing to fail".

The information below aims to provide you with a better understanding of what processes you might face and what preparations may assist you in beginning to deal with, and take control of, the challenges ahead.

Call MDA National

Our Professional Indemnity Insurance Policy includes cover for employment disputes and investigations relating to the provision of health care, as per the terms and conditions listed under the policy.

Once you have a reasonable understanding of the situation (consider jotting down a brief chronology to aid your understanding), consideration of all the issues below should include a discussion with our Medico-legal Advisory Services team on 1800 011 255. The earlier these discussions occur, the sooner we can assist you.

Obtain the relevant workplace policy

If the meeting relates to a complaint, investigation or disciplinary process, it is likely that the process itself is governed by a policy document. You should request, in advance of the meeting, a copy of the policy document(s) so you can understand the upcoming steps in the process. You should forward a copy to your MDA National adviser.

Know the agenda

There are a number of important logistical matters you should attend to before the meeting. Know when the meeting will be, where it will be held and who is attending. Ensure you are able to attend the meeting and that your usual work role will be covered by someone else so you can give the matter your full attention. You should be provided with sufficient time to prepare if you are expected to present information at the meeting, otherwise explore whether the meeting can be reasonably deferred.

It is essential that you know the purpose of the meeting. Clarify this in advance – this may include what will be discussed at the meeting. In some cases, you will not know the nature and substance of the complaint, investigation or disciplinary procedure including what allegations are being made against you, prior to attending the meeting. If so, consider advising the meeting organisers that you will only attend on the basis that you will be provided with this necessary information during the meeting, but you will not be responding to this information until a later date (in person, by discussion or in writing). This enables you to properly consider the issues, allegations and evidence, and then obtain advice before responding.

Explore what options you have for responding – formal meeting, informal meeting, written response and other alternatives to face-to-face communications. Written responses allow for careful deliberation; however, a written response may not be necessary or appropriate in all circumstances.

Support person

The right to be accompanied by a support person at a meeting will be inherent in many workplace policies and is a requirement under the *Fair Work Act 2009* (Cth) if the discussions relate to dismissal.

A support person will generally not be able to advocate on your behalf, but can offer physical and emotional assistance. The support person can call "time out" during the meeting if they perceive this may be of benefit to you. This can be a useful strategy to give you time to gather your thoughts or obtain advice.

The choice of support person is an important consideration. Whether it is a colleague, a medico-legal adviser from MDA National or a lawyer, each will send a different kind of message. The early attendance of lawyers may be necessary; however you should consider carefully what sort of adverse inference or impact this might have on negotiations. You may need to discuss this with your adviser.

Procedural fairness

Procedural fairness[1] (or "natural justice") is a legal principle that refers to the procedures adopted by decision makers in reaching an outcome, rather than the actual outcome reached. Procedural fairness will generally apply to any decision that negatively affects the rights or interests of an individual subject to an adverse decision, unless there is a clearly expressed contrary intent under law or policy. Breach of procedural fairness can enable a decision to be reviewed.

There are three main obligations:

Hearing rule

The right to present your case at a fair hearing after being informed of the case against you.

Rule against bias

The decision maker must be impartial and not have a personal interest in the outcome.

No evidence rule

The decision must be based not on speculation, but on logically probative evidence, i.e. evidence that has a factual basis relevant to the matter.

The meeting itself

Plan to meet with your support person before the meeting to discuss any last minute issues or tactics. Ensure the support person is prepared to take notes.

As outlined above, consider whether the initial meeting with the employer can be restricted to an information gathering exercise, enabling you to respond later after appropriate consideration of the issues. This helps to prevent you from being "ambushed" during the meeting and having to respond to questions you are not prepared for.

Conclusion

With proper planning and advice, a meeting may be a much less daunting experience. You may be able to significantly improve your position and the way in which the matter proceeds. You are also likely to benefit from having a greater understanding of both the process and issues involved.

Ensure you have appropriate professional and medico-legal assistance and personal succour. Seek early support for any health issues that may arise.

Dr Julian Walter
Medico-legal Adviser
MDA National

1 Australian Health Practitioner Regulation Agency. Legal Practice Note: Procedural Fairness/Natural Justice. 31 January 2013. LPN 17. Available at: ahpra.gov.au/documents/default.aspx?record=WD13%2F12365&dbid=AP&chksum=VxsDx6Y8IlFBOoAYkNBx%2BA%3D%3D.

Shared Access to Medical Records

In hospitals, all treating health professionals share the patient's medical record. But in private practice, allied health professionals and doctors have often shared patient information by mail, fax or phone. Electronic medical records make it easier for doctors to allow allied health professionals – e.g. Physiotherapists, Audiologists, Podiatrists, Social Workers, Psychologists, Speech Pathologists and Occupational Therapists – to access and contribute to patient files.

Benefits

Multidisciplinary access to medical records can improve continuity of care and patient safety, and reduce the time spent communicating. The Speech Pathologist who is treating a five-year-old can see a delay in developmental milestones which may be related to current speech patterns. A doctor may see that a Physiotherapist has recorded deterioration of a patient's range of motion over several consultations. This may prompt the doctor to review the patient and consider imaging and/or referral to a specialist.

As Surgeon Atul Gawande put it:

> *The public's experience is that we have amazing clinicians and technologies but little consistent sense that they come together to provide an actual system of care, from start to finish for people. We train, hire and pay doctors to be cowboys. But it's pit crews that people need.*[1]

Managing the risks

Informing patients

Disclosing patient information to an allied health professional may be interpreted as a "secondary" purpose under Australian privacy law. This disclosure is acceptable if:

- the patient consented to the secondary use or disclosure, or
- the patient would reasonably expect the secondary use or disclosure, and that is directly related to the primary purpose of collection.

The practice's privacy policy should include details about access by allied health professionals.

Access controls

Consider whether the patient would reasonably expect that their records would be available in totality to allied health professionals. For example, are they happy that the Podiatrist who is fitting orthotics can see their sexual health history? Can the software restrict access to only the relevant parts of the record?

Informing allied health professionals

Allied health professionals have the same obligations as doctors regarding privacy and confidentiality. Having them sign a confidentiality agreement may protect you in the event that they breach confidentiality using information from your notes. Allied health professionals could be included in staff training about privacy requirements.

Communication

Have clear guidelines for when specific communication other than writing in the notes should be made. Do not assume that urgent or important matters will be picked up in the notes.

Abbreviations that can't be understood across professions may cause problems and should be clarified. For example, a Physiotherapist may add "cervical spine mobilisations" before recording the symbols for types of spinal mobilisations that are unique to their profession.

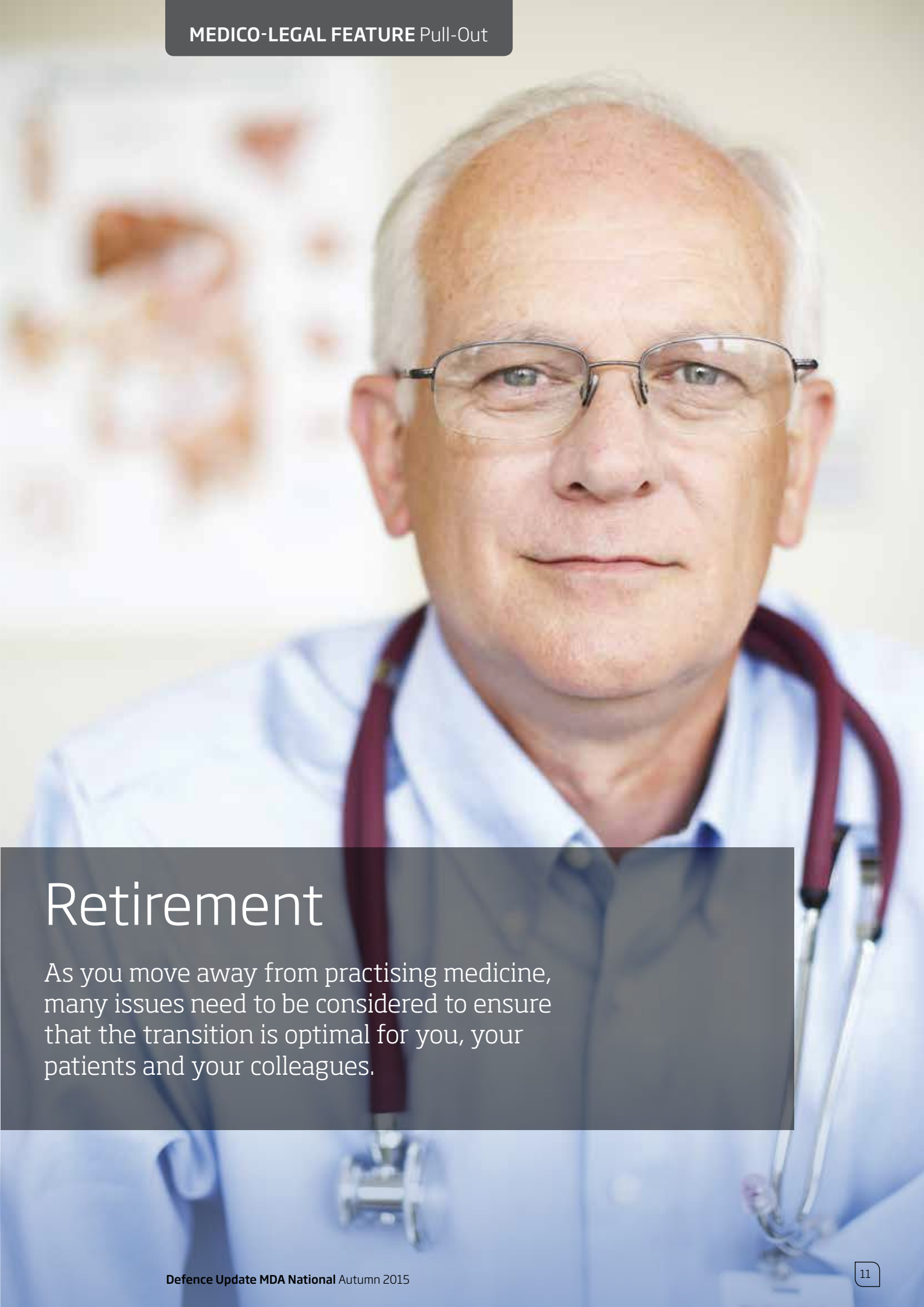
Data security

Privacy law also requires protecting the security of personal information. Reasonable steps may include:

- robust IT systems – firewalls, virus protection, frequent password updates, backups, maintenance of hardware and software
- procedures – appropriate staff access levels, safe and proper use of internet and email, signed confidentiality agreements from staff
- building security and alarms.

Karen Stephens
Risk Adviser, MDA National

1 Gawande A. Cowboys and Pit Crews. *The New Yorker*. May 26 2011.



Retirement

As you move away from practising medicine, many issues need to be considered to ensure that the transition is optimal for you, your patients and your colleagues.

Retiring from Medical Practice

Retirement from medical practice requires careful planning and execution, particularly for doctors who wish to continue to contribute to the profession after they cease clinical practice.

"Challenges when retiring... the psychological effect of loss of collegiality with peers and the profession in general, with the extended family of patients and professional status." Professor John Murtagh, Victoria

For many doctors, there is a sense of excitement and opportunity associated with retirement. For some, the thought of leaving clinical practice fills them with dread. If this is the case, the practical and emotional fallout can be overwhelming if proper consideration is not given to the transition process.

It is important to recognise that a lifetime of dedication to patient care may not be easy to walk away from "cold turkey". Consider reducing your hours gradually, or seek out a non-clinical role that will allow you to use your expert knowledge to give back to the profession and/or the community, such as teaching or volunteer work.

Below we address some of the practical considerations you should be aware of when planning your retirement.

First steps

How you will manage the practical aspects of your retirement will depend upon the current status of your medical practice. Are you a sole practitioner or a sub-contractor in a large medical practice? Do you have a formal contract, or are you the employer of staff? Do you supervise other practitioners and need to make arrangements to pass this task to someone else? These are things you need to think about when you first start the process.

Informing patients

Unless your retirement is imminent or unplanned, you should provide your patients with sufficient time to find a new doctor, and arrange the transfer of their medical records.

You can notify patients by signage in the practice, by post or during consultations. It is a legal requirement to publish a formal notice of your practice closure in the local newspaper if you practice in the ACT or Victoria, but we would also recommend this for doctors in other states.

Retirement can be a stressful time for doctors and patients alike. To ensure patients can transition as smoothly as possible, you should communicate:

- the date you will cease practice
- whether you intend to sell or close your practice
- options for ongoing care
- how to arrange transfer of records to another practice.

Storage of medical records

If you are simply leaving a practice, and your patients are being managed by other doctors within the practice, there is no need to make specific arrangements regarding the medical records.

If you transfer ownership of the practice to another doctor/entity, the new owner will likely take ownership of the medical records as part of the contract of sale. If this is the case, the new practice should seek the consent of each patient for the "transfer" of records to occur. You should also negotiate appropriate access to the records in the event of a claim or investigation down the track.

If you are a sole practitioner, you are required to keep the records safely and securely for the legislated time period or as recommended by MDA National. If your practice is closing, records should be securely stored where they are protected from damage, loss or theft and can be easily retrieved. If you use a commercial company specialising in storage and disposal of records, we recommend you request a written record of certification.

For storage of electronic health records, you may need to liaise with the software company regarding the need to maintain your software licence for future access to records as required. Although you may have legal custody of the records, you still need the means to access them.

And finally, cull any records which are no longer required to be kept and arrange for them to be securely destroyed. For adult patients, the minimum statutory period is seven years from the date of the last entry. For patients who were under 18 years of age at the date of the last entry, the records should be kept until the patient turns 25 years of age.

Advise your MDO

You should contact your MDO to discuss your retirement plans. This will ensure you maintain appropriate cover, particularly if you intend to continue your medical career in another capacity such as teaching or medico-legal reporting.

"Discuss the medico-legal aspects of your indemnity with your insurers and reflect on any possible potential liability issues that could surface post-retirement." Professor John Murtagh, Victoria

Advising others

You may wish to notify colleagues; local hospitals and healthcare centres; and pathology, radiology and outpatient services of your plans to ensure continuity of care for your patients.

You should also advise Medicare, AHPRA and your College to ensure all regulatory and professional requirements are being met. If you wish to maintain your registration with AHPRA, you will need to be aware of the registration standards required, such as continuous professional development.

If you decide to maintain non-practising registration with AHPRA, you can continue to use the title "medical practitioner" and be subject to professional conduct requirements, but you MUST NOT provide medical treatment or opinion to an individual (including yourself), prescribe medication or issue referrals to other health professionals.

A registered business

If you have a registered business, we strongly recommend you discuss your plans with a financial adviser or taxation accountant, as you will have obligations to meet in relation to ASIC and the Australian Tax Office.

Other considerations

If you are an employer, you will also have additional obligations.

You should:

- keep staff informed of your plans
- be aware of your statutory and contractual obligations regarding staff entitlements – the *Fair Work Act 2009* (Cth) outlines the amount of notice required for termination of employment, based on the employee's period of continuous service
- ensure all tax, superannuation, FBT reporting, leave and termination payments are made, and provide employees with a group certificate payment summary prior to 14 July in the year following cessation of employment
- retain employee records securely for seven years
- review leasing agreements, other insurance policies, debtors and creditors, and utilities and mail arrangements
- consider the need to retain one staff member in the immediate post-retirement period to assist you with administrative tasks.

ARE YOU PREPARED?

Review any current contracts, including leasing and equipment hire.

Engage with your MDO regarding your ongoing insurance needs.

Timing is everything. Decide when you will actually cease clinical practice and work to those timeframes.

Inform your patients of your decision to allow them time to find a new doctor.

Respectfully decline to take on any new patients in the lead up to retirement, unless it is a one-off emergency situation.

Ensure your professional bodies (AHPRA, Medicare, and Colleges) are advised of your plans, and inform colleagues and health services to ensure continuity of care for your patients.

Nerissa Ferrie
Medico-legal Adviser
MDA National

Retirement

To Do or Not To Do That is the Question

A/Prof David Watson provides a personal perspective on the issue of retirement.

All of us lead busy professional lives and that means planning for one of the most important decisions of our lives can be put off for long periods. Retirement is challenging, and it needs thought and planning. In my own family, my late father was a third generation Dentist and a founding Fellow of the Royal Australasian College of Dental Surgeons (RACDS). Although a golfer and keen photographer with intentions to utilise a technique developed by his father to cast Australian flora in gold and silver, he was retired from his practice with little warning by his partners and did not have time to develop a retirement plan. I do not think he and my mother ever adjusted to that.

Some people do plan and take up alternative work after retirement. So Primo Levi,[1] having survived Auschwitz after his capture whilst fighting with the Resistance in Italy, went back to work as an industrial chemist for 35 years rising to the director of his factory before retiring and devoting the rest of his life to writing. He died in 1987. James Leavesley,[2] well known to many of us in WA, also made a successful career as an author. In "Changing Jobs at Forty: Lights, Camera, Wheelchair", he makes a number of points around this subject. Richard Asher,[3] an eminent Physician and Psychiatrist pre- and post-WW II cautioned not to rush into writing too eagerly.

Without getting into the hunting joke involving a Surgeon, a Physician, a Pathologist and a Psychiatrist, there is no doubt that different disciplines shape, or are shaped by, our personalities. This means issues around retirement are inevitably different for each of us. For those in procedural disciplines, the physical demands not infrequently dictate retirement deadlines that are at variance from non-procedural disciplines.

We do learn useful skills during our careers. They include leadership, tenacity, clear thinking and, for many of us, compromise. We are for the most part eloquent and capable of running meetings. We may develop hobbies that metamorphose into subsequent careers – photography, grape growing, pottery or testing new motor cars, to name a few. Adverse events such as marriage breakdown, bereavement or career changes for partners can also influence these decisions.

It has been a dream of mine for almost the entire time I have been involved with MDA National to find ways of assisting Member colleagues with their retirement plans. My interest stems from the reality that for a colleague to continue in practice beyond when the time has come to retire is to increase the risk of mistake and late-in-life litigation or a Board enquiry. These events have a bi-modal distribution: early and late in professional life. Not all who wish to be out of practice come to that late in life.

To end on a historical note from a former British Prime Minister: "Don't be afraid to take a big step if one is indicated. You can't cross a chasm in two small jumps."[4]

A/Prof David Watson
MDA National Member

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1 Levi P. *The Truce*. London: The Folio Society, 2002.

2 Leavesley JH. *A Mixed Medical Bag*. Sydney: ABC Books, 1985:111-116.

3 Sir Francis Avery Jones (Ed). *Richard Asher Talking Sense*. Bath: Pitman Medical, 1972:96-101.

4 Hayward S. *You Have a Purpose: Begin It Now*. Sydney: In-Tune Books, 1987.

CaseBook

Court of Appeal Decision:
Dekker v Medical Board of Australia

The Western Australian Court of Appeal was recently required to decide in the case of *Dekker v Medical Board of Australia*[1] whether there is a specific professional duty for medical practitioners to attend and provide medical assistance to a person who is not a patient in circumstances where the medical practitioner is:

- aware that a motor vehicle accident has, or may have, occurred in their vicinity
- aware that anyone involved in the accident has suffered, or may have suffered, any injury
- "physically able" to render assistance.

Case history

The incident occurred one evening in 2002. Dr Dekker was in a stationary position on a dirt road waiting to turn right at a T-intersection. Another vehicle travelling along the road into which she was preparing to turn suddenly veered towards her. Dr Dekker took evasive action by moving her car across the road. The other vehicle passed behind her, crossed an embankment and ended up in a ditch. Dr Dekker did not see the other vehicle crash, but did hear the noise of impact. Dr Dekker immediately drove to a nearby police station to report the incident. She was said to be in a "state of shock", "petrified" and "freaked out" by the "near miss".

Medico-legal issues

In 2013, the State Administrative Tribunal ("Tribunal") found that Dr Dekker had been guilty of "improper conduct in a professional respect" for failing to stop and render assistance in a "near miss" incident involving her motor vehicle and a second motor vehicle.[2]

The Court of Appeal set aside the Tribunal's improper conduct finding. It found that a medical practitioner does not owe a professional duty to assist, as formulated by the Tribunal.

The Court of Appeal observed that the duty, as formulated by the Tribunal, would have applied:

- without regard to the mental state of the doctor, to the circumstances in which the doctor is, or may be, aware that a motor vehicle accident has occurred in his or her vicinity, and the circumstances of the accident
- to a doctor who lacked mental capacity or was affected by alcohol
- even if there were other emergency services on their way or already in attendance
- irrespective of whether the doctor has other medical or non-medical commitments
- equally in a remote location in the bush where there is no town and no ready access to police or other emergency services, as in a city where the occupants of the vehicle or passers-by may be readily in a position to contact police or ambulance services.

The Court of Appeal found there was no evidence of any such specific professional duty that was generally accepted by members of the medical profession in 2002.

The Court of Appeal allowed Dr Dekker's appeal and dismissed the Medical Board's application for want of evidence.

Conclusion

This decision should provide reassurance to medical practitioners that their professional duty to render assistance in an emergency situation will depend on consideration of a range of issues, and the particular facts and circumstances existing at the time.

Professionally, the conduct of doctors practising in Australia is assessed in accordance with the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*.[3] Section 2.5 of the Code 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.

Enore Panetta
Director at Panetta McGrath Lawyers, Perth

1 *Dekker v Medical Board of Australia* [2014] WASCA 216.

2 *Medical Board of Australia and Dekker* [2013] WASAT 182. A detailed discussed of this case is provided in the article "Duty to Offer Emergency Assistance" published in *Defence Update* Autumn 2014. Available at: defenceupdate.mdanational.com.au/duty-to-offer-emergency-assistance/.

3 Medical Board of Australia. *Good Medical Practice: A Code of Conduct for Doctors in Australia*. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

CaseBook

Duty of Care to Third Parties

A recent High Court judgment, *Hunter and New England Local Health District v Sheila Mary Simon & Anor*[1] considered the duty of care of hospitals and medical practitioners to protect third parties who may be harmed by a patient on discharge from hospital.

Case history

The claim arose from the discharge of a psychiatric patient, Phillip Pettigrove, from the Manning Base Hospital at Taree in NSW.

Mr Pettigrove had a long history of chronic paranoid schizophrenia and was being treated for his illness in Echuca, Victoria. While in NSW with a friend, Mr Stephen Rose, in July 2004 Mr Pettigrove was involuntarily admitted to, and detained in, the Manning Base Hospital under the *Mental Health Act 1990*.

Following admission, Mr Pettigrove's medical records from the Echuca Community Health Service were obtained and he was reviewed by a Psychiatrist, Dr Warwick Coombs. Dr Coombs spoke with Mr Rose as well as Mr Pettrigrove's mother in Victoria over the phone. All agreed that Mr Pettigrove would be kept in hospital overnight and that Mr Rose would then drive Mr Pettigrove to his mother's home in Echuca, where he would receive continuing medical treatment.

Mr Pettigrove was discharged from the hospital the following day and he set off with Mr Rose to travel by car to Echuca. In the course of that journey at about 8:30pm, while parked alongside the highway south of Dubbo, Mr Pettrigrove attacked and killed Mr Rose. He later told the police that he acted on impulse, believing that Mr Rose had killed him in a past life. Mr Pettigrove later committed suicide.

Mr Rose's mother and his two sisters commenced proceedings against the Local Health District and the Psychiatrist alleging negligence and seeking damages for psychiatric injury.

Medico-legal issues

District Court

At first instance in the District Court, the trial judge found in favour of the Local Health District and Dr Coombs. His decision focused on whether there was a breach of duty of care.[2] The trial judge was not satisfied that the risk of Mr Pettigrove attacking Mr Rose was sufficiently foreseeable, taking into account there was no history of violence towards others in Mr Pettrigrove's 20-year history of schizophrenia. The trial judge also accepted peer expert evidence that the treatment accorded with widely accepted peer practice.[3] On causation, the trial judge was not satisfied that the incident was triggered by the road trip in itself or the lack of additional medication.

Court of Appeal

The relatives appealed the decision of the trial judge. The Court of Appeal overturned the District Court's decision and ordered judgments totalling $251,424, together with interest and costs in favour of the relatives.

While the main focus of the trial judge's decision was breach of duty, the Court of Appeal addressed in more detail the question of whether a duty of care was owed to the relatives. The Court was satisfied that a duty of care was owed in view of the degree of control the hospital and Dr Coombs had over the risk that arose to Mr Rose and the extent of their dealings with him.

The Court of Appeal disagreed with the trial judge's approach to breach of duty holding that the relevant risk to be assessed was not the risk that Mr Pettigrove would intentionally kill Mr Rose, but the risk of physical harm to him; and that the car trip enabled the attack to occur in isolated circumstances where no one was able to come to Mr Rose's assistance. The Court of Appeal also held that the trial judge was in error with regard to the treatment being in accordance with peer practice, as no relevant practice had been sufficiently identified.

The High Court decision provides guidance to practitioners treating involuntary patients and is an endorsement of the importance of the principle of least restrictive care.

High Court

The Local Health District and Dr Coombs obtained special leave to appeal to the High Court against the Court of Appeal decision. On 12 November 2014, the High Court unanimously allowed the appeal.

The focus of the High Court's reasoning was whether imposing a duty of care would be inconsistent with a practitioner's obligations under the *Mental Health Act 1990* (the Act).

The High Court noted that the Act should be applied such that the interference with the rights, dignity and self-respect of mentally ill patients is kept to the minimum necessary in the circumstances.[4]

Consistent with this is Section 20 of the Act which states:

"A person must not be admitted to, or detained in or continue to be detained in, a hospital under this Part unless the medical superintendent is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available to the person."

The High Court considered that this section was particularly relevant and held that the performance of this obligation could give rise to inconsistent obligations if hospitals and practitioners also owed a common law duty of care to those whom a mentally ill person may come into contact with after being discharged.

The High Court indicated classes of cases in which difficulty can arise in determining the existence and scope of a duty of care – such as when the defendant exercises a statutory power or discretion; the direct cause of the harm suffered is criminal conduct of a third party; or there is difficulty confining the duty within reasonable limits.[5] In this case, the determining factor was the nature of the statutory power being exercised by the hospital and Psychiatrist.

The High Court commented that if, as the relatives submitted, the hospital and Dr Coombs owed Mr Rose and his relatives a duty of care, then it was not easy to see why that duty did not extend to any and every person with whom Mr Pettigrove would come in contact with after his release from the hospital and who might foreseeably suffer harm if Mr Pettigrove acted irrationally or violently. The potential liability could be extensive.

Conclusion

The decision provides guidance to practitioners treating involuntary patients and is an endorsement of the importance of the principle of least restrictive care. While the Act has been amended in NSW, similar provisions are contained in the new legislation[6] and are also contained in the mental health legislation in other states and territories. Claims arising from the discharge of involuntary patients are likely to be significantly curtailed by the decision.

Karen McMahon
Medico-legal Adviser
MDA National

1 *Hunter and New England Local Health District v Sheila Mary Simon & Anor* [2014] HCA 44.
2 Section 5B of the *Civil Liability Act 2001* (NSW).
3 Section 50 of the *Civil Liability Act 2001* (NSW).
4 Section 4(2)(b) of the *Mental Health Act 1990* (NSW).
5 Relying on the earlier High Court decision of *Sullivan v Moody (*2001) 207 CLR 562.
6 Sections 12(1)(b) and s68(f) of the *Mental Health Act 2007* (NSW).

CaseBook

Providing Expert Evidence

Providing a report as an independent expert is different to providing a report as a treating doctor.

Case history

You receive a letter from a solicitor asking if you will provide an expert report in a case in which a patient experienced a post-operative infection.

Discussion

Requests for an expert report may come from a variety of sources including:

- solicitors seeking a report for use in litigation
- coronial matters, either by the coroner or an involved party
- AHPRA, regarding the conduct or treatment provided by another doctor
- courts and tribunals such as Guardianship, Workers' Compensation and Probate.

You are not obliged to act as an expert. You should only accept if you consider that you have the requisite expertise and experience, and understand your obligations in accepting the request. You will be asked to provide information in your report as to your expertise and you can expect to be questioned on this if giving evidence in court.

The expert is an independent witness whose role is to assist the court (or tribunal) to evaluate the medical issues involved in reaching its conclusion. The expert is not an advocate for a party. Your role is to remain objective and independent from any bias. It is the role of the court or tribunal to determine the outcome. Your role is to apply your expert knowledge in examining the facts and circumstances.

All states and territories have a code of conduct for expert witnesses and it is important to familiarise yourself with this. Generally, the code of conduct will require you to include in your report:

- your qualifications and experience
- the assumptions made in providing the report
- any tests or investigations relied upon
- a summary of your opinion and your reasoning
- a summary of the instructions, facts, literature and documents you considered when reaching your opinion
- any unknown matters or further investigations which you consider are needed to avoid incompleteness or inaccuracy
- if applicable, that a particular question or issue falls outside your expertise
- an acknowledgement that you have read and complied with the code of conduct.

When preparing your report, you should try and use clear language and explain any technical terms so that non-medical people can understand them.

You should respond to the questions asked of you, not what you think should be asked – but you can raise any omissions which need to be examined.

It is not unusual for the same set of facts or assumptions to be interpreted differently by different experts, and you should not allow your professional opinion to be swayed just because you differ from another expert. As part of the process of narrowing the issues, you may be asked to identify the areas of agreement and disagreement. This may involve meeting with the other expert(s), but you can still provide your own independent opinion on areas of difference. If you change your opinion at any stage before you give evidence, you should inform the party who instructed you.

If the matter proceeds to a hearing, then it is very likely you will be asked to give evidence and also be cross-examined in relation to your report. Accordingly, you will need to be familiar and comfortable with the process, and willing to attend court if required.

You may be asked by the lawyer acting for the opposite party to meet to discuss your conclusions or to provide a supplementary report. This can be done, but it raises issues regarding legal professional privilege and not revealing any confidential information you have received as part of your instructions. Also, if you have had a consultation with a patient as part of your opinion, then you will need to consider your duty of confidentiality to the patient within the context of your duty as an expert. These can be very complex issues and you should consult MDA National for advice.

Although Australian expert witnesses currently have legal immunity, there have been cases where complaints have been made to the Medical Board about doctors who have provided incorrect advice in expert reports and when giving evidence.

Janet Harry
Medico-legal Adviser
MDA National

MDA National
Support Protect Promote

Education Activity – **Autumn 2015**

You can receive professional development (PD) recognition for this *Defence Update* issue by answering a questionnaire online or using the hard copy form below.

Only MDA National Members can access the activity online. Log on to Member Online Services and enter the "Education" section.

See page 22 for more information.

Activity learning outcomes

By the end of this activity participants should be able to:

- Describe information that needs to be communicated to patients before their doctor's retirement.
- Identify workplace procedures necessary to fulfil privacy requirements for medical records.
- Discuss aspects of writing a report as an independent medical expert that need to be considered before agreeing to such a role.

Questionnaire

1 **Rate the extent to which you agree with the following statements (this is a personal reflection exercise):**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel reassured by the Western Australian Court of Appeal's decision in the case of *Dekker v Medical Board of Australia* [2014] WASCA 216 that doctors' professional duty to assist in an emergency situation depends on consideration of a range of issues and the particular facts and circumstances existing at the time.	☐	☐	☐	☐	☐
I feel reassured by the High Court's decision in Dr Coombs' case that the principle of least restrictive care when treating involuntary patients was endorsed.	☐	☐	☐	☐	☐
It is not unusual for the same set of facts or assumptions to be interpreted differently by different experts.	☐	☐	☐	☐	☐

2 **Respond true or false to the following statements**.

	True	False
Allied health professionals have the same obligations as doctors regarding patient privacy and confidentiality.	☐	☐
It is a legal requirement in Victoria and the Australian Capital Territory to publish a formal notice in the local newspaper advising that a medical practice is closing.	☐	☐
If ownership of a medical practice is transferred to another doctor or entity, then the medical records automatically transfer across and there is no need to seek patients' consent for this records transfer.	☐	☐
When a retiring doctor's patients are being taken on by other doctors within the same practice, it is necessary to ask in advance for patients to consent to their records being accessed by the new doctors.	☐	☐
Medical records for adult patients need to be kept for a minimum of five years from the date of the last entry.	☐	☐
Medical records for people who were under 18 years of age at the last consultation need to be kept until the patient turns 25 years of age.	☐	☐
There is no need to contact your medical defence organisation (MDO) if you receive a complaint letter that is clearly trivial in nature.	☐	☐
All communication from your MDO relating to a patient complaint should be kept in that patient's medical record.	☐	☐

Respond true or false to the following statements.

	True	False
One in 50 medical practitioners were the subject of notification to the Australian Health Practitioner Regulation Agency (AHPRA) in 2013/14.	☐	☐
Doctors who receive a notification from AHPRA should consult with their senior colleagues about the nature of the notification to determine if they should contact their MDO.	☐	☐
If an expert report writer believes an element that needs to be examined has been omitted from the list of questions to be addressed in the report, then the expert can raise those omissions.	☐	☐
The Medical Board has not received complaints about doctors giving incorrect advice in expert reports.	☐	☐

3 **Write short notes to answer the following questions.**

What circumstances make disclosing patient information to an allied health professional acceptable?

Note at least two data security measures which need procedures to be explicitly established, documented, communicated and implemented to protect the security of personal patient information, e.g. appropriate internet use.

What should be communicated to patients before their doctor's retirement?

What factors would you consider if deciding whether you will give a report as an independent medical expert?

Imagine that you are called in for a meeting with your employer. You believe the meeting is related to a serious matter but you will not find out the nature and substance of the complaint, investigation or disciplinary procedure until the meeting. Make brief notes on key things you would you do in advance of the meeting.

Activity evaluation

1 **Please rate to what degree the activity learning outcomes were met.**

	Not met	Partially met	Entirely met
Describe information that needs to be communicated to patients before their doctor's retirement.	☐	☐	☐
Identify workplace procedures necessary to fulfil privacy requirements for medical records.	☐	☐	☐
Discuss aspects of writing a report as an independent medical expert that need to be considered before agreeing to such a role.	☐	☐	☐

2 **Rate to what degree your personal learning needs were met.**

☐ Not met ☐ Partially met ☐ Entirely met

3 **Rate to what degree this activity was relevant to your practice.**

☐ Not relevant ☐ Partially relevant ☐ Entirely relevant

4a **Has the content in *Defence Update* Autumn 2015 caused you to consider making any change(s) to your practice?** ☐ Yes ☐ No

4b **If you answered "yes" to question 4a, what change(s) do you envisage making?**

5 **Please rate the quality of the following in relation to *Defence Update* Autumn 2015.**

	Very poor	Poor	Neutral	Good	Very good
Magazine content	☐	☐	☐	☐	☐
Magazine presentation (hard copy)	☐	☐	☐	☐	☐
Questionnaire content	☐	☐	☐	☐	☐
Questionnaire presentation (hard copy)	☐	☐	☐	☐	☐

6 **Would you recommend this activity to colleagues?**

☐ Definitely not ☐ Probably not ☐ Unsure ☐ Probably ☐ Definitely

7 **What could be done to improve this activity?**

8 **What future educational resources would you like MDA National to produce? Feel free to nominate any topics and any delivery formats, e.g. "responding to errors, online presentation", "cross-cultural communication, face-to-face workshop", "managing staff, *Defence Update* article".**

9 **Please indicate your career stage:**

☐ Prevocational ☐ Vocational trainee ☐ Early career ☐ Mid-career ☐ Late career ☐ Retired

10 **If chosen, please indicate your specialty:**

Your details

Name	
Email	Phone
Address	
Name of college PD program in which you participate	
RACGP/ACRRM identification number (if applicable)	MDA National number

Please sign and date here

Signed **Date (DD/MM/YYYY)** / /

☐ Tick here if you do not wish to receive your completion certificate by email.

In completing this form you consent to your comments being used for promotional purposes by the MDA National Group.

☐ Tick here if do not consent to your evaluation comments being used anonymously by the MDA National Group for promotional purposes.

Activity directions

- Read *Defence Update* Autumn 2015.
- Complete the education activity questionnaire in hard copy or online. Fill out the activity evaluation and provide your details.
  - MDA National Members can access the questionnaire online:
    - Go to **www.mdanational.com.au**.
    - Log on to Member Online Services.
    - Click "Education".
    - Select "Online Education Activities".
    - Select "*Defence Update*", then "*Defence Update* Autumn 2015".
  - Submit a hand written activity by:
    - **email** peaceofmind@mdanational.com.au
    - **fax** 1300 011 244
    - **post** Level 3, 100 Dorcas Street, SOUTHBANK, VIC 3006
- Receive your completion certificate.
- Report to your college's PD program if it is a self-reporting program.
- MDA National will report relevant points for the following programs on your behalf:
  - Royal Australian College of General Practitioners (RACGP) Quality Improvement and Continuing Professional Development (QI&CPD) Program
  - Royal Australian and New Zealand College of Ophthalmologists (RANZCO) CPD Program
  - Australian College of Rural and Remote Medicine (ACRRM) Professional Development Program (PDP).

Accreditation details

Visit **mdanational.com.au/publications/defence-update/defenceupdateautumn2015.aspx** for this activity's PD recognition details.

This activity is usually accredited with colleges for General Practice, Emergency Medicine, Ophthalmology, Obstetrics and Gynaecology, and Radiology. Other specialists can receive PD recognition too.

What's On?

MDA National continues to support your professionalism in 2015 with a number of educational sessions.

March 2015

7	Practical Solutions to Patient Boundaries **Sydney, NSW**
21	Cairns Education Day **Cairns, QLD**
28	Practical Solutions to Patient Boundaries **Melbourne, VIC**

May 2015

16	Practical Solutions to Patient Boundaries **Perth, WA**

June 2015

3	Avoiding Misunderstandings Around Physical Contact and Intimate Examinations **Sydney, NSW**

Keep an eye on our What's On page at **mdanational.com.au** for regular updates on state-based and national events that MDA National will have involvement with.

Interested in consent?

Keep an eye on your inbox and our website for an invite to attend one of our large group education activities on the topic of consent which will be run across the country in June.

Have you moved? Have your details changed?

If so, please take a moment to notify us of your new information. To update your details, please call Member Services on **1800 011 255** or email **peaceofmind@mdanational.com.au**.

It's important that you notify us of your updated information to ensure you maintain continuous cover and to make sure that we can continue to contact you with important information about your medical indemnity.