defenceupdate

Publication for MDA National Members

Summer 2014/15

MDA National
Support Protect Promote

Mental Health for Doctors - Time for Action

Bariatric Surgery - Perspectives from a Surgeon and an Anaesthetist

Medico-legal Feature: A Focus on Doctors' Wellbeing

When Mediation Meets Medicine

MDA National CaseBook

Editor's Note

Maintaining and monitoring your health and wellbeing is essential when dealing with a medico-legal matter. Our pull-out feature examines the impact of complaints and claims on medical practitioners, and outlines strategies on how to cope with these processes (pages 9-11).

Continuing the focus on health and wellbeing, Dr Steve Hambleton provides a personal reflection on the importance of looking after our own health (page 12).

The Action Plan developed by the AMA and *beyondblue* for better mental health and wellbeing for doctors and medical students at an individual, organisational and institutional level is outlined on page 5.

As part of MDA National's recognition of the importance of doctors' health, our Corporate Social Responsibility program continues to support the work of *beyondblue* as our Charity of Choice, and promotes the participation of our staff and Members in community sporting events, such as the City to Surf.

Other articles in this issue include the second part of our feature on bariatric surgery (pages 6-8), the role of mediation in resolving disputes (pages 13-14) and our regular CaseBook series (pages 15-18).

As always, we welcome your comments on these and other medico-legal topics.

Thank you to our many Members and colleagues who have contributed their knowledge and shared their experiences in *Defence Update* this year. Your input is invaluable.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

Doctors for Doctors

"Change is the law of life. And those who look only to the past or present are certain to miss the future." John F Kennedy

I'm delighted to address our Membership with the first article in this new "Doctors for Doctors" section of *Defence Update*. As a truly national organisation, we aim to keep you informed of pertinent medico-legal matters in your local state, from across the country and in our profession. I trust you'll find value in the upcoming editorial of this section in 2015 from various members of our Mutual and Insurance Boards.

For the past six years, A/Prof Julian Rait has provided compelling articles via his "President's Messages". As Julian stepped down from his role in October 2014, I would like to thank him on behalf of the Membership for his interesting and often thought provoking articles. Members who participated in our 2014 publication evaluation described *Defence Update* as "high quality", "relevant", "pertinent", "practical" and "informative" – and Julian's editorial flair has greatly contributed to these appraisals and, more broadly, Member engagement.

2014 is a milestone year for MDA National with:

- results from our 2014 Reputation Audit indicating that Members and stakeholders alike recognise MDA National's distinct character, Member service and on-the-ground support as key differentiators within the industry, of which we are very proud
- unprecedented financial performance as reported in our *2014 Annual Report* demonstrating long-term stability
- our Member vote against a proposed merger which we respect and interpret as support of our current business structure and offerings – scan the QR code below to watch our short video message
- changes in our leadership team including the imminent appointment of a new CEO, following the retirement of our longstanding CEO, Peter Forbes, on 31 December 2014.

As we plan ahead for the New Year, MDA National will continue to evolve to best meet our Members' needs. We are committed to upholding our "doctors for doctors" ethos by providing extensive professional indemnity coverage and quality support to Members.

On behalf of MDA National, I wish you and your family a safe and enjoyable festive season.

Dr Rod Moore
Acting Chairman, MDA National Mutual Board

Reputation Audit Research 2014

MDA National Members and stakeholders who participated in our research indicated the following:

MDA National stands out for its grass-roots initiatives and Member engagement, and for consistently delivering the service expectations of Members and other stakeholders.

MDA National's commitment to training, education and on-the-ground support is strongly acknowledged by all stakeholders.

The industry strongly associates MDA National with its value-added services over and above the core insurance products.

MDA National has a market leading level of awareness with customers and high visibility within the sector's content and conversation.

MDA National's commitment to our mutuality and to Members marks it out as being clearly different to the rest of the sector.

Hear from our leaders directly...

To view our video:

type ***http://youtu.be/PUl6C_hB6B0*** 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.

Notice Board

Supporting the Profession

MDA National prides itself on its mutually rewarding relationships and close associations with like-minded industry organisations to offer Members valued benefits and opportunities.

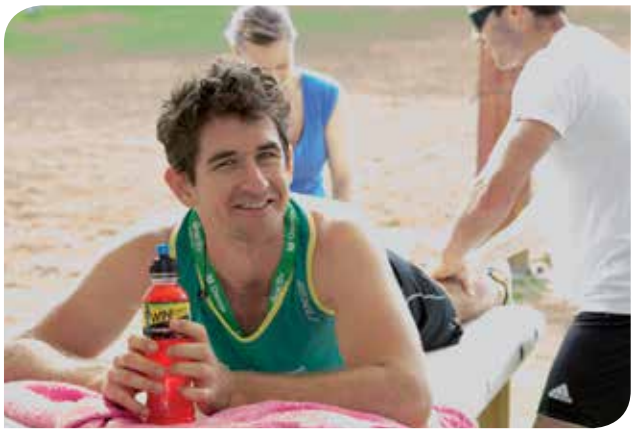
Our recent new strategic relationships include:

- Australian Orthopaedic Association (AOA)
- Rural Doctors Association of Australia (RDAA)

Stay tuned for more details of these relationships and how you can benefit.

A Run for Fitness and Fun

As part of MDA National's Corporate Social Responsibility program with a focus on Members' health and wellbeing, we hosted marquees at the Sydney and Perth City to Surf events in August. We had a great turnout at both locations. Over 130 Members and their families participated, and they all welcomed the refreshments and masseuses after their hard runs. It was a fulfilling day of fitness for a great cause.



PMLC Member, Dr Rob Henderson, enjoys a relaxing massage after the run.

Dr Anita Tandon and her family enjoy a day of fitness and fun.

Beware – Australasian Health Professionals Directory

MDA National has received enquiries from Members about correspondence from the Australasian Health Professionals Directory (AUAHP). The letter includes an invitation to medical practitioners to update and verify their details which have been listed in the directory.

Members need to be aware that the fine print in the contract from the AUAHP states that charges of $1,300 per year for a minimum of three years will apply if they complete and sign the contract.

More information is available from the AMA website: **ama.com.au/urgent-advice-members-australasian-health-professionals-directory.**

Criminal History Disclosure to AHPRA

Members are reminded that you have an obligation to provide written notice to the Medical Board within seven days if you are:

- charged with an offence punishable by 12 months imprisonment or more
- convicted or the subject of a finding of guilt for an offence punishable by imprisonment (Section 130 of the National Law).

When renewing your registration, you also have an obligation to provide a number of mandatory disclosures, including the following:

- During your preceding period of registration, has there been any change to your criminal history that you have not declared to AHPRA?
- Do you have any criminal history that you have not disclosed to AHPRA (other than that disclosed in the question above)?

Criminal history is defined in the National Law as:

- every conviction of a person for an offence
- every plea of guilty or finding of guilt by a court of the person for an offence
- every charge made against the person for an offence

whether before or after the commencement of the National Law. This includes traffic offences.

AHPRA is currently undertaking random audits of practitioners' compliance with these requirements by obtaining criminal history checks.

We encourage you to contact our Medico-legal Advisory Services team if you have any questions.

For more information, visit:

- **defenceupdate.mdanational.com.au/the-mandatory-requirement-to-disclose-under-the-national-law/**
- **medicalboard.gov.au/Registration-Standards.aspx**
- **medicalboard.gov.au/Registration/Audit.aspx.**

Mental Health for Doctors – Time for Action

The *beyondblue* National Mental Health Survey of Doctors and Medical Students in October 2013 highlighted significant issues relating to the mental health of medical professionals. In response to this, the Mental Health of Doctors and Medical Students Roundtable (the Roundtable) – a joint initiative of the Australian Medical Association and *beyondblue* – was held in Melbourne on 6 June 2014.

The following is a summary of the outcomes statement[1] resulting from the Roundtable.

The Roundtable

The Roundtable acknowledged that many of the issues brought to light by the *beyondblue* survey stem from organisational and institutional pressures. It also highlighted that while legislation and regulation provide a necessary framework for the medical sector to support practitioners and their employers, they can also act as barriers to seeking help.

The Roundtable recommended a range of workplace strategies including:

- building a team and workplace culture that makes people want to come to work
- creating a culture of mindfulness and willingness to support colleagues
- providing a range of accessible touch points for debriefing and support
- promoting access to prevention and early intervention services
- having well-defined systems in place to support doctors returning to work after a mental illness.

Developing a nationally consistent and comprehensive suite of services for doctors and medical students via Doctors' Health Advisory Services was seen as one of the most practical strategies to improve access to resources. This should be accompanied by strategies to debunk the myths surrounding mental illness and the requirements for mandatory reporting, which significantly deter medical practitioners from seeking assistance with their own mental health. Developing better communication systems to reduce fragmentation and strengthen information sharing was also considered as central to improving access to services.

The Action Plan

The Roundtable discussions resulted in a number of priority projects being identified for initial action. These will form the basis of a Mental Health Action Plan for doctors and medical students. It is now up to key groups within the medical profession to commit to taking a lead role in advancing each of these.

Continued leadership, advocacy and support from within the profession is essential to develop policies and initiatives and a professional culture that empowers better mental health and wellbeing for doctors and medical students at an individual, organisational and institutional level.

Actions from the Roundtable

Increase personal awareness, knowledge and skills regarding mental health issues for self and others

Enablers

- Education regarding effective personal wellbeing practices and coping strategies.
- Awareness of (atypical) signs of doctors' mental illness.
- Appropriate care practices for health of self and colleagues.
- Prioritisation of, and self-responsibility for, own health.

Create a mentally healthy workplace

Enablers

- Building positive work environments.
- Access to support systems in the workplace.
- Access to support to stay at, or return to, work.

Create regulatory and cultural environments that support mental health and wellbeing

Enablers

- Mechanisms to address the source and effects of stigma towards mental health conditions.
- Enablers and barriers to care for doctors with mental health conditions.
- Access to mental health services and programs (independent of workplace).
- Supportive regulatory frameworks.
- Other impacts of the professional culture of medicine.

Supporting, **protecting** & **promoting** doctors' mental health

1 AMA and *beyondblue*. Developing an Action Plan to Support the Mental Health of Doctors and Medical Students – Summary and Outcomes Statement. The Mental Health of Doctors and Medical Students Roundtable. Melbourne, 6 June 2014.

Bariatric Surgery

Our Claims and Advisory Services team continues to deal with a number of patient claims and complaints related to bariatric surgery. In the first part of this series (published in *Defence Update* Winter 2014), a GP and a Physician provided their perspectives on bariatric surgery. In this final part, we have asked a Bariatric Surgeon and an Anaesthetist to discuss their views on this topic.

A Surgeon's Perspective: Bariatric Surgery

The judgment in the NSW Supreme Court of *Almario v Varipatis*,[1] which was thankfully overturned, raised the prospect that a clinician may be found liable for failing to recommend appropriate treatment for a severely obese patient. This judgment would have created difficulty for clinicians, as real barriers exist in obtaining treatment for patients with obesity-related medical conditions. Despite the evident need, Australia lacks a framework within which obesity treatment can easily be offered. Obese patients visit their GPs frequently,[2] consume health resources frequently[3] and are over-represented in the ranks of patients with chronic disease.[4] Despite this, their treatment is predominantly managed by the dieting industry which offers treatments without clear benefits.[5]

Obesity is a chronic disease, but its management is not supported by Medicare. Also, while primary care streams for psychiatric, women's health, paediatric and other common health conditions exist in General Practice, no such stream exists for obesity. Many National Health and Medical Research Council (NHMRC) recommendations such as those for asthma, diabetes and immunisations are routinely adhered to, but no discernible uptake of obesity management guidelines has occurred since NHMRC first published on the subject in 2004. Patients admitted into hospital with obesity-related diseases will be unlikely to receive inpatient or post-discharge treatments for their obesity condition. While bariatric surgery for public patients is provided in some Australian states, the services are poorly funded and oversubscribed or, as is the case in NSW and QLD, almost completely absent.

Bariatric surgery is a topic that generates conflicting emotions in clinicians, the media and the community. This is probably due to the dissonance experienced at the prospect of the broader community paying for what is, in its simplest consideration, a disease caused by overconsumption. This is reflected in the negative way in which both medical practitioners[6] and the community[7] can regard the obese person. Creating a framework for effectively treating obesity while managing valid concerns about the ethics of "rewarding" patients for poor health choices can occur in the Australian context – but firstly, the reasons for treatment need to be clearly articulated, and treatment needs to be managed in a way that is valid ethically[8] and economically.

When considering treatment for obesity, the risks versus benefits of treatment need to be considered. Surgery in morbidly obese patients is known to improve health, quality of life and length of life.[9,10,11] However, it has also been shown to increase hospital costs[12,13] even while it decreases medication[14] and probably food costs to the individual. Surgery creates abnormal anatomy and physiology in patients and creates a situation whereby illness can result from the procedure at any time from the early to late post-operative period.[15,16,17] In many chronic disease states, interventions are offered when the benefits are believed to outweigh risks, e.g. transplantation, dialysis, coronary revascularisation, major joint arthroplasty. However patients may seek obesity surgery before medical morbidities have occurred, or delay treatment until after organ injury has been sustained.

BMI is a crude determinant of the medical risk associated with obesity. Rating obesity according to its severity and making decisions to treat according to severity, rather than BMI, can make decisions easier for referring clinicians and alleviate concerns about resources and equity.

Proposed simple rating score for obesity

Stage I: Obesity without discernible medical or physical disability.

Stage II: Obesity with medical or physical conditions/ disabilities for which non-surgical treatments are available.

Stage III: Obesity with medical or physical conditions for which treatment is unlikely to result in return to reasonable health or where treatment slows but does not prevent further decline in health.

Stage IV: Obesity with permanent organ dysfunction/failure where treatment may delay life or organ threatening disease, but return to normal health is not possible.

Perhaps we should target patients who are already active users of healthcare resources with an aim to returning them to a state of reduced healthcare consumption. This would have real potential to improve their health and also reduce their community-funded medical costs.

Selecting patients who have previously received and failed appropriate alternate treatments for their underlying conditions – e.g. a tablet-controlled diabetic in whom insulin treatment is now required – will improve the "bang-for-buck" of obesity surgery and improve the likelihood of health improvement. Surgery in inappropriately selected patients has the possibility of converting patients from "well but overweight" to "slim but unwell". Stage III patients would be ideal candidates, and most appropriate in a public hospital setting, if public services were available. However some stage II and IV patients will also likely benefit from surgery if the risks were acceptable. Stage I patients may seek surgery as a "simple" treatment but are more likely to suffer harm than benefit from surgical therapies.

Obesity is a chronic disease, so chronic care is required. There are significant differences in outcomes between monitored[18] and unmonitored[19] patients after bariatric surgery. This means effort needs to be put in to preserve the investment made in performing the surgery in the first place. Long term follow-up is of paramount importance, not just in effectiveness but in safety. Providing chronic care is a major stumbling block for surgery in many situations. Some clinics and clinicians may presume that patients may be okay to be discharged to their GP without long-term supervision, but this will likely lead to poor outcomes for many patients.

The data supporting obesity surgery in obese patients with medical morbidities is overwhelming. This is despite its controversy and barriers to providing long-term care to post-operative patients. Should the courts ever have cause to examine the reasons for patients being denied treatment in our public hospitals,[20] the outcomes could prove interesting.

Dr Michael Talbot, Bariatric Surgeon
MDA National Member

For a full list of references, visit **defenceupdate.mdanational.com.au/bariatricsurgery-surgeon.**

An Anaesthetist's Perspective:

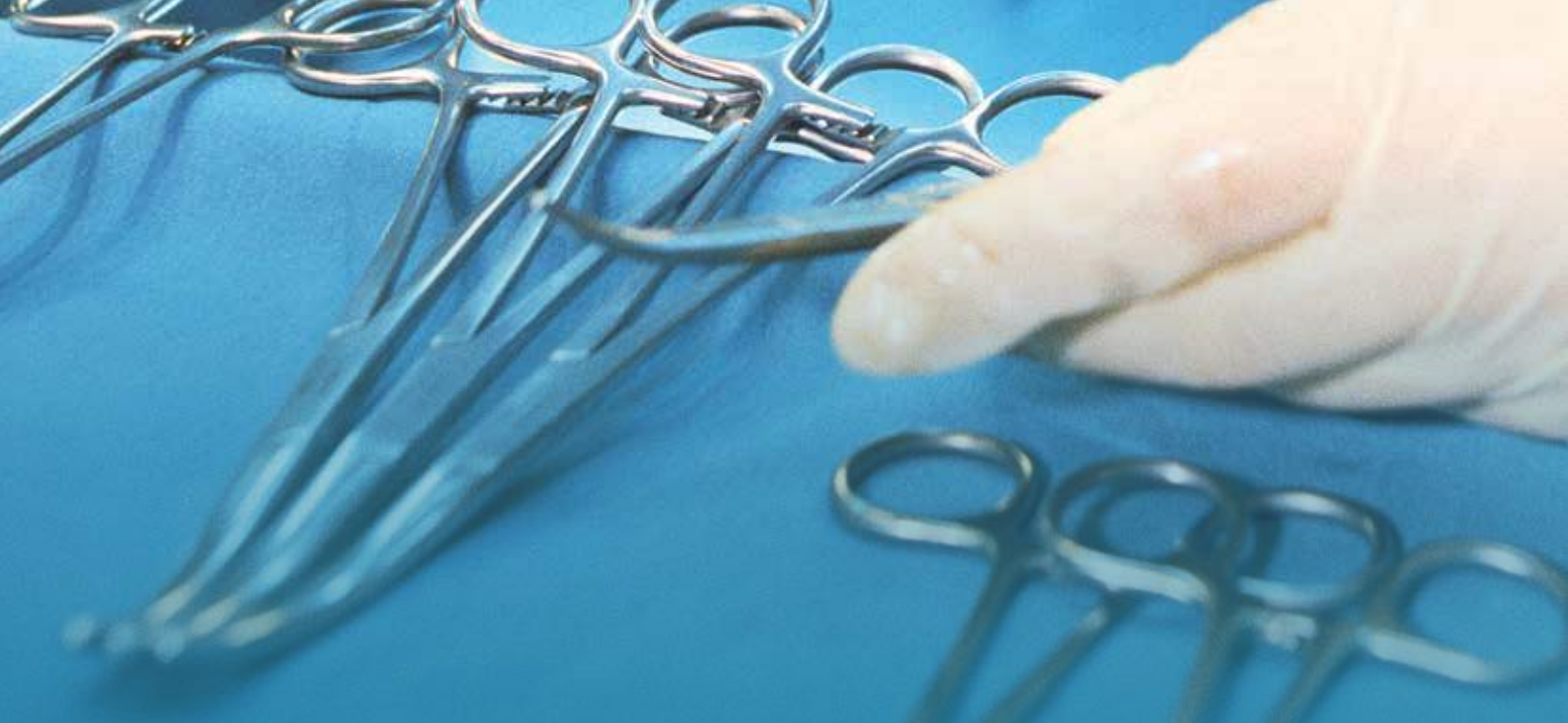
Bariatric Surgery– Where Are We Now?

When I started in consultant practice in the mid-1990s, I was involved in some of the early cases of adjustable gastric banding (AGB) in both public and private settings. As the idea was unheralded in our facilities, the first few cases (in the 200kg plus range) got sent back from the pre-anaesthesia clinic to the Endocrinologist with my suggestion that the patient lose some weight before the procedure was re-booked. Since then, we have all seen many great successes and some prolonged ICU stays, and sadly even some mortality. Many practices have sprung up with very well-trained surgeons and back-up teams along with sophisticated marketing online.

Like all Anaesthetists, I now commonly see post-bariatric surgery patients coming in for other procedures. Recently I saw a patient who was around 75kg who had an AGB in place. When I asked her how much weight she had lost in the two years since the band, she told me she had been 87kg before the band, but "I had to eat to get there". She had been denied surgery at 83kg because that surgeon had a minimum 85kg rule. This type of patient will be recognised by clinicians who are used to dealing with human motivations for "lifestyle" procedures – not everyone acts reasonably all the time.

As an Anaesthetist you may ask, so what? We don't select the patients, and there should be a GP and perhaps also a Physician and others involved in a multidisciplinary team. It is a relevant issue for us because these patients have an increased risk of Anaesthetic mortality and morbidity compared to the general population, and the surgery is elective. We are part of a team and equally responsible for the wellbeing of this vulnerable group of people. The patients have high expectations and there are often also high costs because access to public treatment options can be difficult, further increasing the medico-legal risk.[1]

Cont. overleaf



An Anaesthetist's Perspective:
Bariatric Surgery – Where Are We Now? *Cont.*

General anaesthetic concerns are well known and well managed by Anaesthetists who deal with these patients frequently. Obesity creates extra challenges including:[2]

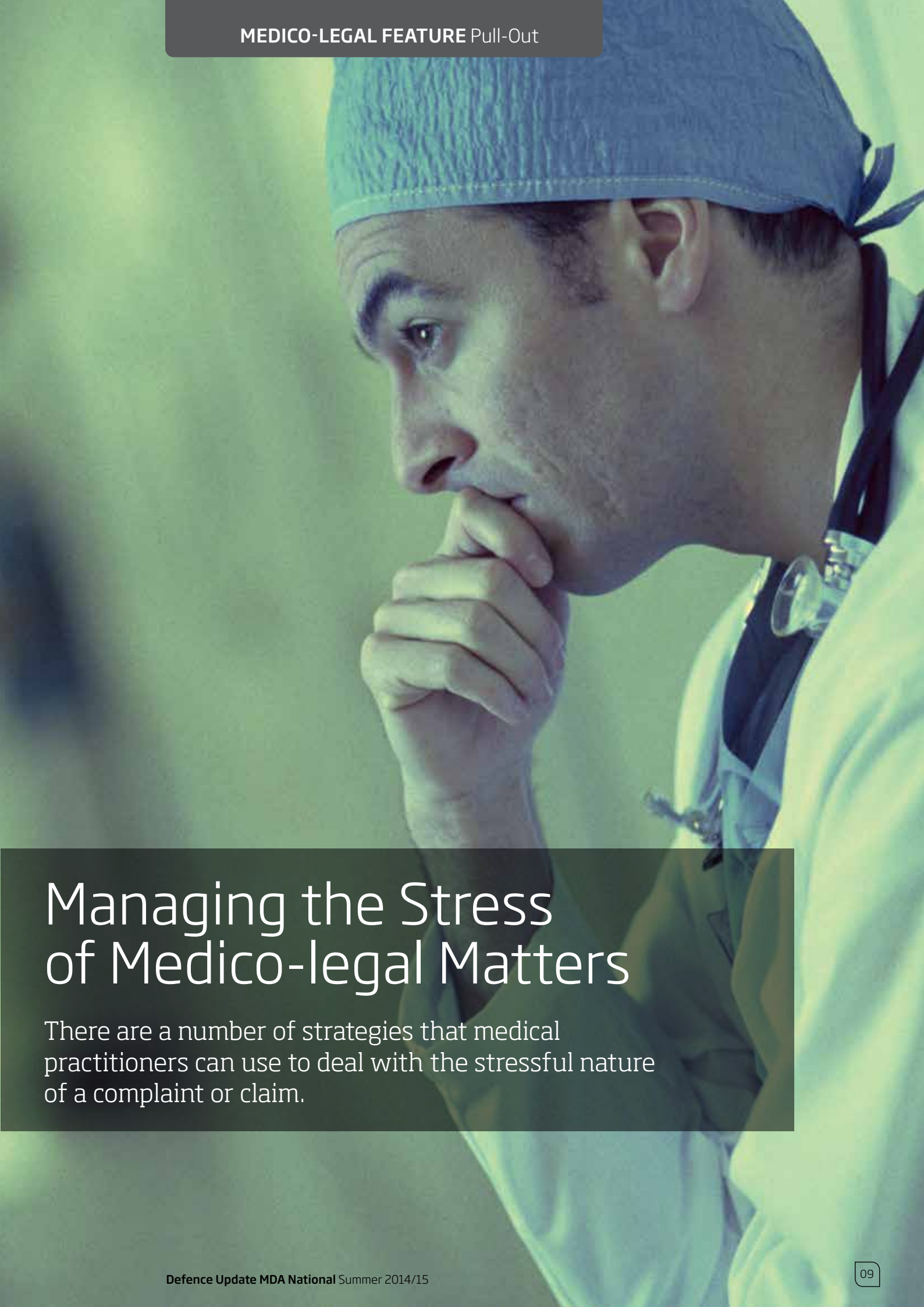
- moving and positioning patients
- intravenous and arterial line access
- weight-based drug dosage
- airway management[3] – ventilation, intubation and dental damage
- fluid balance
- high intra-abdominal pressures with laparoscopic surgery
- management of major haemorrhage or other critical events such as anaphylaxis that require resuscitation
- comorbidities including sleep apnoea, complicated by opiate pain relief and compromised ventilation
- post-operative atelectasis and venous thromboembolism

I would like to highlight other very specific risks from my MDA National experience and the anecdotal claims of others:

- Anaesthetist participation in the surgery by way of introduction of large bougies into the oesophagus and stomach to facilitate surgery.[4] Though rare, cases of perforation are potentially catastrophic, and proper training should be undertaken before the Anaesthetist is expected to agree to participate – if he or she agrees at all. In my opinion, the Anaesthetist must remain protective of the patient and should also be comfortable that this approach will not put their employment at risk, as professional autonomy is also important.
- The "occasional" bariatric list where someone who is not familiar with the Surgeon and their work is thrust into what can be a very complex case on a very challenging patient.

Dr Andrew Miller, Anaesthetist
MDA National Mutual Board Member

For a full list of references, visit **defenceupdate.mdanational.com.au/bariatricsurgery-anaesthetist.**



Managing the Stress of Medico-legal Matters

There are a number of strategies that medical practitioners can use to deal with the stressful nature of a complaint or claim.

Managing the Stress of Medico-legal Matters

Impact of a complaint or claim

A complaint or claim against a medical practitioner causes emotional and physical stress, regardless of the outcome. It is not uncommon for medical practitioners to experience a range of differing emotions as a medico-legal matter proceeds. Symptoms may last for only a short period, recur with each step in the process or persist throughout the entire medico-legal process.

Reactions after an adverse event, complaint or claim include:

- distress
- anger
- fear
- guilt
- depressed mood
- loss of confidence
- feeling ashamed
- insomnia and nightmares
- loss of reputation
- wanting to give up medicine.[1,2]

An Australian study found that GPs with a current medico-legal matter reported increased levels of disability in work, social or family life, as well as higher prevalence of psychiatric morbidity, compared to those GPs with no current matter.[3] GPs with a history of past medico-legal matters reported increased levels of disability and depression sub-scores. Male GPs with a current or past medico-legal matter had significantly higher levels of alcohol use than GPs with no experience of medico-legal matters.

Further research has shown that medical practitioners who were the subject of a medical negligence claim described the following reactions:

- 96% acknowledged an emotional reaction for at least a limited period of time
- 39% experienced depression, including symptoms such as depressed mood, insomnia, loss of appetite and loss of energy
- 20% experienced anger, accompanied by feelings such as frustration, inability to concentrate, irritability and insomnia
- 16% described the onset or exacerbation of a previously diagnosed physical illness
- 2% engaged in excessive alcohol consumption
- 2% experienced feelings of suicidal ideation.[4]

Coping strategies

The ability to cope with stress is highly individual and medical practitioners need to reflect on their own means of coping. There are a number of strategies medical practitioners can use to deal with the stressful nature of a complaint or claim. Effective coping responses include both problem solving and emotionally-focused coping. Practitioners need to learn to switch, when appropriate, between coping responses. Difficulty can arise if medical practitioners try to apply the wrong response in a given situation, for example, trying to solve an unsolvable problem.

One of the first steps in coping is to obtain sufficient information about the process in which the medical practitioner is now a participant, albeit an unwilling one. MDA National's Claims and Advisory Services team can provide detailed information about the particular medico-legal process in which a Member is involved.

Additionally, medical practitioners need to understand what can be expected psychologically and also observe their emotional and physical reactions throughout the process. Members should consult their GP if any symptoms develop, e.g. depression, physical illness or substance abuse. Self-medication should be avoided, even if faced with the common symptom of insomnia.

For most medical practitioners, a feeling of being "out of control" pervades the onset of a complaint or claim process. Medical practitioners may feel like they are on a rollercoaster ride, with alternating feelings of confidence and loss of self-esteem, of assurance and self-doubt. Regaining a sense of mastery and control is important.

Medical practitioners often have difficulty identifying their strengths, but are well practised in identifying their weaknesses. By identifying strengths, medical practitioners are in a position to develop them, and to look at shaping their life and working to feed those strengths. Engaging in activities that make the practitioner feel in better control of their personal and professional lives will assist in restoring a sense of balance (see Table 1).

Table 1 – Strategies for coping with complaints and claims[5]

Social support

- Discuss your feelings with a trusted person – a colleague, family member, friend, GP and/or your claims manager.

Restore mastery and self-esteem

- Ask your claims manager to describe each step of the medico-legal process.
- Clarify the anticipated length of time required to conclude the matter.
- Take an active role in the preparation of the case, including participating in the choice of any medical experts.
- Put aside the necessary time to deal with the case.
- Prepare yourself for the unpredictability of the process.
- Identify areas of your practice that cause anxiety or feelings of "loss of control" and find ways to diminish them.
- Engage in activities that increase your sense of competence, e.g. teaching, CPD activities.
- Review the amount of time spent on professional and family activities, and make appropriate changes.
- Participate regularly in physical and other leisure activities.

Change the meaning of the event

- Review your career objectively and reinforce your sense of competence.
- Seek the advice of trusted family members, colleagues, friends and professionals about your feelings and the progress of the case.

Barriers to seeking support

Medical practitioners describe a number of barriers to seeking help:

- lack of time (89%)
- uncertainty or difficulty with access (69%)
- concerns about lack of confidentiality (68%)
- negative impact on career (68%)
- stigma (62%).[6]

How we can help

When dealing with a medico-legal issue, MDA National's aim is to obtain the best possible outcome for our Member. Unless the Member is well and able to cope with the process, the best result for that Member cannot be achieved. Therefore, providing support is an integral part of MDA National's role. Our Claims and Advisory Services staff have extensive experience in supporting Members throughout the course of a complaint, claim or other medico-legal process.

Every Member has individual needs, depending on their personality and the nature of the matter they are dealing with. Some Members find it relatively easy to implement strategies to cope with the stressful nature of the process, while others may be reluctant or unable to obtain the support they need.

To ensure that our Members are provided with an appropriate level of support when dealing with a medico-legal issue, we have two additional support programs:

- Doctors for Doctors Program
  - This program aims to provide understanding and support by enabling the Member to share their experience with another doctor during the course of a medico-legal matter.
  - The claims manager will discuss the program with the Member and provide a prompt referral if the Member would like to use this service at any stage during the case.
  - The program complements the role of the claims manager and offers the Member additional support from a colleague throughout a medico-legal matter.
- Professional Support Service
  - This service aims to provide a Member with direct access to an independent psychiatrist who can provide professional support during the course of a medico-legal matter.
  - The service is completely confidential and details of any discussions between the psychiatrist and Member will not be disclosed to MDA National.
  - MDA National covers the cost of up to 10 consultations per Membership year.

If you are faced with a complaint or claim, please take the opportunity to discuss these additional support programs with your claims manager. We are here to assist, advise and support you throughout the process, to ensure that the best possible result is achieved for you.

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

Sources of further assistance

- **Doctors' Health Advisory Service** (DHAS):
  - **ACT** 0407 265 414
  - **NSW** 02 9437 6552
  - **NT** call the NSW DHAS hotline
  - **QLD** 07 3833 4352
  - **SA** 08 8366 0250
  - **VIC** 03 9495 6011
  - **WA** 08 9321 3098
- **Australian Medical Association Peer Support Service:** TAS and VIC call 1300 853 338
- **Employee assistance programs** (hospital based employees)
- **MDA National Doctors for Doctors Program:** 1800 011 255
- ***beyondblue:*** call 1300 224 636 or visit beyondblue.org.au/get-support.

For a full list of references, visit **defenceupdate.mdanational.com.au/medicolegal-stress.**

Looking After Our Own Health

Dr Steve Hambleton

The common belief is: "We don't get sick, we treat sick people – and besides, we are too busy to go to a doctor." Attitudes are changing and we are all off to a good start, but there is more to do.

It is vital that doctors and other health professionals look after their health and have their own GP. We need to be healthy to offer the best care to our patients, and to experience rewarding and satisfying careers.

Sharing stories

Our own health issues were once taboo, but that is now changing. It is good for us to get together in the light – in the open – to share stories and to learn from each other's experiences.

I have two short stories. One is about a highly respected colleague who developed chest pain in the middle of the night. He was an ex-smoker, morbidly obese, and with many other risk factors.

He woke up with central chest pain feeling sweaty and clammy – what did he do? He concluded he was suffering from indigestion and did not want to bother the ambulance or look foolish in front of his colleagues. So he waited until morning before he sought attention for what turned out to be a coronary occlusion.

The next is my story. Given that my major exercise is punching the keys on a computer, it is important for me to take my own advice about staying fit and getting regular exercise.

So I took a holiday recently and realised that fitness and I were not on the same page.

Upon walking up a "very steep hill" on Lord Howe Island, I took my pulse and found it was 192. If you take the standard formula for maximum heart rate of 220 – minus your age – mine is 168.

Was that a vague chest pain I was feeling? Then and there, I promised my wife that I would see my GP. I realised it was time for a check-up and time to restart the exercise program.

Staying well is not just about physical health

The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity".

Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients.

"Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients."

Work-life balance is important. It could be music; it could be writing; it could be bushwalking; it could be spending time with your family – but it's not all about work.

I also find voluntary work very empowering and that is why I find the time to be the President of the AMA Queensland Foundation which has financially supported many worthwhile causes, including the Doctors' Health Advisory Service. I should also pay tribute to the emerging medical profession for really highlighting these issues within the AMA.

Adopting a multidisciplinary approach

It is important that we adopt a multidisciplinary approach, especially in areas where stressors and barriers to health care are similar.

A good example of this is bullying and harassment in the workplace, where health professionals may witness events but don't feel empowered to intervene.

The evidence is clear that workplace bullying contributes to poor employee health, including the physical and psychological manifestations of stress and depression.

However simple resilience programs can teach us effortless strategies to reduce and manage workplace bullying and harassment.

Overall, it is vital that healthcare professionals help one another to stay healthy, and offer support, encouragement and advice.

Dr Steve Hambleton
AMA Queensland Foundation President and former Federal AMA President

For more information on the work of the AMA Queensland Foundation, visit: **amaqfoundation.com.au.**

When Mediation **Meets Medicine**

In this article, experienced mediators, Steve Lancken and Elizabeth Rosa, debunk the myths and discuss the realities of mediations involving medical professionals.

It is not just doctors who hate being involved in conflict and dispute. Only a few perverse individuals thrive on the adrenaline of a claim being made by or against them, and the ongoing conflict.

In our careers as mediators, and before that as lawyers, we have seen the full range of personal conflict and legal disputes – from partnership disputes, familial separations, employment claims, allegations of professional negligence, and even allegations of criminal misbehaviour. Almost everyone who faces such problems feels a knot in the stomach and a fear of the unknown.

People dislike conflict because autonomy is lost, creating an uncomfortable loss of control. The choice at first blush is between giving in or fighting. Even in Australian courts where the forum for determination is clean and impartial, the truth is that disputants lose control. Even good and diligent lawyers describe the "litigation lotto" of the uncertainty of judges deciding who is right or wrong.

The courts are the best option offered by the "state" to decide disputes. Courts offer a fair process, but for at least one half of their "clients" (the losers), the outcome is not seen as fair.

So what can mediation and mediators offer when conflicts occur in the medical environment? How can MDA National support you to sort out conflict in a way that addresses your professional and personal goals without resorting to the "litigation lotto"?

Here are some thoughts about mediation that will help MDA National Members get the most out of mediation.

Mediation as a decision-making tool

Sometimes mediation is marketed as solving all problems. It does not. What it does offer is the chance to make good and informed decisions about whether you are better off continuing with the dispute, i.e. continue to litigate, or to take some alternative course.

Mediation is NOT about giving in. What mediation offers, however, is the benefit of certainty. A negotiation can result in a decision that is certain and final. During the process of the negotiation there are decisions and trade-offs to be made, and they can be made in an environment where information can be exchanged openly, without the fear of it being used against you.

Agreeing to mediation is not a sign of weakness. In addition, in many cases, court orders are imposed which make mediation compulsory.

The information exchanged during mediation assists in making decisions. Parties or their representatives share information to enable good decision making – and the mediator, who is trained in communication skills, assists with this process.

Settlement at mediation is voluntary

No one is obliged to make an offer or even to stay at a mediation session after information is exchanged. Dr Helen Havryk, Claims Manager at MDA National, has told us there are many instances where MDA National will attend mediation on behalf of a Member and make no offer of monetary compensation. This is likely to occur

when a case has no prospect of success. On the other hand, if MDA National foresees a risk, they might seek to settle on a commercial basis that reflects the seriousness of that risk. In some cases, mediation is welcomed as an opportunity to attempt settlement of a matter where this is clearly the correct decision.

Mediation has no downside

The worst thing that can happen at mediation is that there is no resolution and everyone has to continue on with the litigation. There is a small cost of the mediator's fees and the time spent by claims people on behalf of a Member.

According to Dr Havryk, "It is very rare that we would require a Member to attend mediation. Of course if our Member wants to attend, we will discuss with them their role, preparation and what they want to achieve."

Members are not required to attend mediation unless there is a good reason. You might want to attend for one of the following reasons:

- to understand more about the dispute
- to engage and speak directly with the other party, be they a patient, employee, business partner or colleague – good mediators manage such communications in a way that helps you achieve what you seek from these conversations
- to understand the decision-making process and its impact on you, and this includes the financial, professional and reputational impact
- to discuss the issues with your claims staff and lawyers.

We think that if the mediation is about any ongoing relationships such as employment or partnership, you should attend and participate in creating options for the future.

Mediation can be about personal issues as well as "the case"

In mediation, the private concerns of parties such as reputation, future goals and aspirations can be addressed. Also, the question of what is going to happen in the future as a result of learning from the past can be dealt with. These issues do not exercise the minds of judges.

Mediation is private

The deliberations of courts and tribunals are public. Not so in mediation, where the usual practice is for the outcome to remain confidential. In almost all cases, if the matter is not resolved at mediation, the court will not learn what was said or what "offers" were made.

Mediation is about the future, not the past

Mediation is not all about fault or responsibility. While lawyers at a mediation might discuss the events that led to the dispute so they can understand the risks going forward, the outcomes in mediation are forward focused – about what is best for tomorrow, not who is to blame for the past.

For that reason mediation is not the forum for personal or professional criticism, especially that of the medical professional. In that respect, mediation is not at all like a trial where attribution of fault is often the main issue.

"In a medical negligence case, our Members will know in advance what view MDA National and its lawyers take about liability issues, and there is opportunity for discussion," says Dr Havryk.

A good approach to mediation

Mediation is best approached with an understanding of what it is and what it is not. Being successful in negotiating at mediation warrants a great deal of preparation, not about who is right or wrong – as the lawyers will do this for the trial – but about issues such as:

- how and what to communicate
- whether it is appropriate to offer an expression of regret or condolences or understanding for another's suffering
- what might be an appropriate trade-off for the avoidance of risk, if any
- what is important to you and your family, your insurer and others affected by the result.

Professional mediators assist with the conversations needed to find outcomes that make sense to all parties.

Some myths about mediation

Myth	Reality
The mediator will tell the other side (or you) that you are wrong.	This is NOT what a mediator does.
You must settle.	Settling should NEVER be a requirement of attending.
What you say will be used against you.	Almost all mediations occur in situations where there is a legal privilege protecting communications from being used against the participants.
Cross examination or questioning takes place.	This occurs in court, NOT in a mediation.
Agreeing to mediate is a sign of weakness.	Trying to find an outcome that is better for all concerned should never be seen as a sign of weakness. "I want to talk" does not mean "I want to give in".

Steve Lancken, Mediator, Negocio Resolutions and Elizabeth Rosa, Mediator

Duty to Warn Patients of Surgical Track Record

In a recent case, the UK High Court[1] was asked to consider the nature of a doctor's duty to warn patients of risks affecting their surgical track record. While the "risk" under review had been eradicated, the Court's observations provide interesting reading.

Case history

In 2009 Mr Lu, a Cardiac Surgeon, was identified as the source of infection which caused a cluster of Prosthetic Valve Endocarditis (PVE). A strain of antibiotic-resistant bacteria had embedded itself in Mr Lu's skin and transferred to 11 patients undergoing heart valve surgery. Five of the patients died and it was said to be the worst reported outbreak of PVE. The transfer was thought to have occurred via micro perforations in Mr Lu's surgical gloves. It was accepted that Mr Lu's infection control techniques were "robust" and the transfer did not occur through any breach of duty.

Mr Lu immediately ceased performing heart valve surgery and subsequently ceased all surgery. During this period of self-enforced "suspension" he underwent microbiological testing. In 2010, it was confirmed that he had been eradicated of the bacteria.

Medico-legal issues

In 2012 the Trust Board, as part of its investigations, sought expert opinion from three microbiologists who agreed that the risk to patients of Mr Lu returning to cardiac surgery, including heart valve surgery, was minimal, provided he adhered to practical measures recommended by them, e.g. further microbiological testing and "double gloving" during procedures. As he no longer carried the bacteria, he did not pose a greater risk than any other Cardiac Surgeon.

At the time this case was heard, Mr Lu had still not returned to surgical practice due to a number of issues regarding the Trust's proposed re-training program for him. One particular issue was patient consent.

Issue of patient consent

It is well established that a doctor owes a duty of care to warn a patient of the risks of a procedure which a reasonable person would consider to be material. This duty extends to risks a particular patient would attach significance to.[2]

However, in addition to Mr Lu informing his patients that PVE was a material risk of heart valve surgery, the Trust Board sought a condition that Mr Lu would need to advise his patients about his previous involvement in the PVE outbreak. This condition extended to the patients of the surgeons under whom Mr Lu was re-training as part of his re-entry program.

Mr Lu claimed that such requirements were unjustified and not required by law, given that he did not pose any greater risk of infection than his colleagues. The Trust argued that there was a moral duty for them to provide the information.

Outcome

The court held that:

- there was no requirement for any Surgeon under whom Mr Lu was re-training to provide additional information over and above that which the clinician considered adequate to obtain informed consent
- Mr Lu was not required, on his return to independent practice, to tell his patients of his involvement in the PVE outbreak.

However, the court made it very clear that this ruling was not intended to influence the exercise of clinical judgement, and that it was a matter for the individual Surgeons whom Mr Lu was assisting to decide what information should be provided to their patients to obtain informed consent.

Had Mr Lu continued to carry the bacteria and/or there was a negligent cause contributing to the PVE, there is no doubt the court would have decided differently. However, the case does seem to indicate that if the risk of undergoing the procedure at the hand of a particular Surgeon remained higher than the Surgeon's colleagues, the Surgeon may have an obligation to inform the patient of that risk.

Amy Rogerson, Associate
and Kerrie Chambers, Partner
HWL Ebsworth Lawyers

1 Mr John Lu v Nottingham University Trust Hospitals NHS Trust [2014] EWHC 690 QB.

2 *Rogers v Whitaker* (1992) 175 CLR 479 AT 490.

CaseBook

Maintaining Physical Contact Boundaries

Touch can be therapeutic and comforting and is often essential in medical care, but it can also be misconstrued. Following protocols and communicating clearly will ensure patients remain comfortable with physical contact at all times.

Case history

A 23-year-old female patient presented with a sore throat. On examination, the doctor noted the patient was afebrile and had a slightly inflamed throat. There were no palpable cervical lymph nodes. The doctor performed a brief respiratory examination, pulling up the patient's top, and examined the lung fields anteriorly and posteriorly. No abnormality was found. The doctor advised the patient that he thought she had a viral throat infection. He recommended that she return for review if her symptoms worsened or did not improve within the next few days.

Two months later, the doctor received a letter from AHPRA stating that he was being investigated in relation to an allegation of sexual misconduct. The patient had complained that she had attended for treatment of a sore throat and the doctor had inappropriately touched her breasts during the consultation. The doctor was shocked to receive the complaint. He had no specific recollection of the consultation with the patient.

Discussion

What you, as a doctor, think of as "intimate touch" may not align with your patients' thoughts, so always imagine how they may view the situation. Also always consider the intent behind any touch – it must serve the patient's best interests. Check if your workplace has relevant policies.

Talk to patients about their preferences

Maintaining a professional doctor-patient relationship does not mean you need to be cold, unsympathetic or distant. Culturally appropriate physical contact, such as handshakes and hugging children, may be expected in many social groups. It is important to know patients' customs and beliefs. Whether a doctor is female or male may be critical in certain circumstances, as may be the need for a chaperone. These matters should always be discussed with patients.[1]

Strategies to avoid misunderstandings around physical examinations

- During the examination, explain what is going to happen next at each step and why it is necessary. If you need to depart from what you have previously outlined, explain why and seek permission.
- Explain the clinical need to touch each body area before starting any examination and ensure that the person understands the reason for conducting the examination.
    - Giving comprehensive information about what will happen in an intimate examination is crucial, especially in obstetrics and gynaecology. Consider having information brochures in the waiting room and consider those with poor literacy. For example, provide DVD or cartoon versions of information.[2]
- Before undertaking an intimate examination, consider whether the information is necessary for your clinical management of the patient.
- Make only the minimum required physical contact and use gloves for genital and internal examinations.[3]
- Be aware of the person's responses during the examination – they may give signs that they no longer consent or are unsure. If this happens, stop the examination.[3]

What you, as a doctor, think of as "intimate touch" may not align with your patients' thoughts, so always imagine how they may view the situation.

- Always enable people to undress and dress in privacy, and allow them to dress as soon as possible after the examination.
  - Do not assist patients to remove their clothes without clarifying with them that your help is required.
- Provide appropriate cover during the examination such as modesty gowns or sheets. There needs to be as little physical exposure as possible during an exam and staged exposure whenever possible, i.e. re-cover an exposed area before uncovering the next area to be examined.
- Do not ask personal questions that are not directly related to the exam while a patient is undressed, or during an intimate examination.[2]
- Consider using a chaperone.
  - This could be a trained chaperone or a personal support person. Exploring the need for a chaperone with a patient is part of good medical practice.[3]
- Have more than one team member present in the workplace at all times.
- Consult within delineated service hours.
- If workplace policies cannot be fulfilled in a particular situation, the reason(s) for the exception need to be documented.
- If a patient refuses to respect the doctor-patient relationship, they should be referred to another doctor.
- Seek assistance from MDA National's Medico-legal Advisory Services team if a patient behaves inappropriately.

Always value and maintain people's dignity

Communicate with patients respectfully and professionally at all times. Personal comments – for example about a patient's body or clothing – or sexually based jokes may seem harmless, but they are easily misconstrued[4] and are generally unacceptable. Think carefully about using terms of address that may be nonsexual to some people but not to others – for example, "my dear", "honey" or "love".[1]

Intimate examinations, and physical touch in general, can be embarrassing or distressing for patients and it is particularly important to maintain professional boundaries. Knowing that clear protocols exist can help a patient feel more comfortable when disclosing very personal information.

Summary points

- Touch has an important role – use it mindfully.
- Do not let a fear of performing intimate examinations deter you from providing good medical care.
- Ensure that your patients are fully informed at all steps during a physical examination.

Professional Services, MDA National

For a full list of references, visit **defenceupdate.mdanational.com.au/boundaries-physical-contact.**

CaseBook

Medicare Audits: Wound Repairs

Benefits paid under MBS items involving wound repairs have recently been scrutinised by the Department of Human Services (the Department) for compliance with item descriptors.

Case history

The GP received a letter from Medicare notifying her of an audit of possible up-coding of wound repair MBS items. Enclosed with the letter was an audit schedule which included a list of patients, the dates of service and the MBS item numbers claimed. The letter asked the GP to confirm that she had met the descriptors for the MBS Items claimed. The GP contacted our Medico-legal Advisory Service for assistance.

Discussion

Practitioners claiming MBS items need to be prepared to show substantiating documentation if asked to participate in a Medicare compliance audit. Where there is a reasonable concern that the Medicare benefit paid exceeds the amount that should have been paid, the Department can issue a notice requiring a health professional to produce documents to substantiate their services.

Document what you are repairing

In a recent Medicare audit, practitioners were asked to answer the following questions in relation to services rendered under wound repair (MBS items 30026 to 30049):

- Did the wound involve deeper tissue?
- Was the wound more than 7cm long?
- Was the wound on the face or neck?

The terms "superficial" and "deeper tissue" have specific definitions under the MBS for the purpose of claiming under the wound repair Items:

- superficial – "affecting skin and subcutaneous tissue including fat"
- deeper tissue – "all tissues deep to but not including subcutaneous tissue such as fascia and muscle".

When claiming benefits for the repair of deeper tissue, practitioners should ensure that they are repairing fascia and muscle. Recording the layers involved in a repair as well as the location and length of the wound will be of invaluable support should you be required to substantiate those services to the Department.

Repair of multiple lacerations on the one occasion

It is not uncommon for patients to present with multiple lacerations requiring repair. In certain circumstances, the multiple services rule applies allowing fees to be charged for two or more operations performed on the patient on the one occasion.

The Schedule fee for billing under Medicare is derived from calculating the aggregate of fees, based on a formula set out under the rule. Further information on how the fees are calculated can be obtained from Medicare or MDA National.

Summary points

- For wound repair items, record information that sufficiently explains the nature of the repair so that you can confidently respond to audit questions.
- If you are unable to substantiate that the wound repair was performed or that the correct Medicare benefit was paid – e.g. where the descriptor for repair to "deeper tissue" is not met – you are encouraged to voluntarily notify the Department of any incorrect payments.
- Early notification of incorrect payments can avoid the imposition of an administrative penalty.

Alice Cran, Claims Manager (Solicitor)
MDA National

Education activities available wherever you are!

Each issue of *Defence Update* comes with a questionnaire that prompts closer reflection on the medico-legal issues covered in the publication. These education activities are currently accredited for professional development recognition with a number of medical colleges for all of the 2014 editions. You just read *Defence Update*, download and complete the questionnaire, and send the form in.

For more information, visit **mdanational.com.au/publications/defence-update.aspx** and click on the latest edition.

Keep an eye on our **What's On** page at mdanational.com.au for regular updates on state-based and national education events.

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 we can continue to contact you with important information about your medical indemnity.

Season's greetings

from all of us at

MDA National