defenceupdate

Publication for MDA National Members

Spring/Summer 2015

MDA National
Support Protect Promote

Celebrating 90 Years

Editor's Note

Revalidation, the process by which doctors have to regularly show they are up to date and fit to practise medicine, is under consideration for Australian doctors. The Medical Board of Australia commissioned a report which found positive evidence that revalidation is worthwhile in managing risk to patients.[1] In September 2015, the Board appointed an Expert Advisory Group which has been set a 12-month timeline to recommend one or more models for revalidation in Australia and to provide advice on how these can be piloted. Revalidation was introduced in 2012 for doctors in the UK, and a review of the impact and experience of revalidation in the UK is provided on pages 6–7.

In this edition of *Defence Update*, we continue our focus on the importance of doctors' health and wellbeing. On page 5, Georgie Harman, CEO of *beyondblue*, describes their Heads Up initiative which aims to improve mental health in the workplace.

On pages 11–14, one of our Medico-legal Advisers, Dr Julian Walter, provides practical advice on the assessment of a patient's decision-making capacity in relation to health care. Other articles in this edition include a detailed account of the Professional Services Review Scheme (pages 8–9) and medico-legal advice on what to do if you are asked to participate in a root cause analysis (page 18). Our regular CaseBook series features articles on whether you can ban animals from your surgery (page 15) and assessing a patient's fitness to drive (pages 16–17).

Also, a reminder that completing the *Defence Update* education activity (pages 19–22) enables you to obtain CPD points in the risk management area, at no cost to you.

This is our last edition of *Defence Update* for 2015. Thank you to our many Members and colleagues who have contributed their knowledge and shared their experiences in *Defence Update* this year. I look forward to continuing the discussions about medico-legal issues in 2016.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

1 Collaboration for the Advancement of Medical Education Research and Advancement (CAMERA) – The Evidence and Options for Medical Revalidation in the Australian Context. 15 September 2015. Available at: medicalboard.gov.au/Registration/Revalidation.aspx.

In This Issue

Doctors for Doctors

The modern medical profession is, in my view, overwhelmingly open minded, scientific and willing to embrace change, diversity and equality. It is a tradition we trace back to our Hippocratic roots, an ever evolving culture that needs to be honoured and protected.

Doctors should be free to use their unique skills without feeling they are at odds with the culture of the system, be it primary care or hospital based.

We seem to be in an unhealthy environment in some parts of health care. Adverse outcomes can lead to a bureaucratic response calling for discipline or more documentation and rules in the name of increased safety. Cost cutting can be applied with insufficient regard to clinical input. The short political cycle makes long-term projects hard to defend, when the payoff may be many years away.

People from other fields seem to have increasing confidence in telling us how to practise, or even in suggesting that alternative providers could suffice. If you tell a pilot or a lawyer that you know how to do their job after looking at some web pages, I am sure they will disagree with you.

Standards and guidelines, and even discipline and lawsuits, are tools for quality – but they need to be informed by clinicians in practice, and be authoritative and practical for just enforcement. In my opinion, the expert professor should be currently doing clinical work in order to authoritatively opine on their colleagues' standard of care.

I am a medical adviser on MDA National's Cases Committee, and many times I have seen the culture of our profession explained by senior doctors around that table. They have a keen understanding of the responsibilities we face, and they are motivated and eloquent in their teaching.

Along with Dr Rod Moore, I also represent our Members as a Director on our Insurance Board. Our non-doctor directors are impressive. With business, accounting, insurance, investment and complex project experience, they make a formidable team who focus on our purpose. And they understand the importance of culture.

We can learn from business successes such as the Wesfarmers[1] of the world about the principles of building enduring value and the emphasis on purpose and culture.

These are some headlines I find useful:

- **Focus on the organisation's singular purpose.** If a decision is hard, come back to this. Many failures come from crossed purposes, for example, when health bureaucrats have different priorities to clinicians. If your purpose is different to the people running the system, then something has to change – you or them.
- **Understand, live by and defend your values.** Champion the cause of transparent governance.
- **Foster a positive team culture and look after your people.** In the end, the organisation comes first, but if your team is unhappy you will fail to achieve your purpose.
- **Be scientific and measure the relevant outcomes ruthlessly.**
- **Understand your weak points and your strengths,** both internal and external to the organisation, and monitor them.
- **Direct pursuit of profit through revenue raising and cost cutting does not work.**[2]
- **Be sustainable** in the sense that short-term success should translate into something of value for the next generation.

Remember that in MDA National, you have a powerful doctor-owned ally whose only purpose is to "support and protect Members and promote good medical practice".

Dr Andrew Miller
Director, Mutual Board and Insurance Board

---

1 Thompson P. Wesfarmers 100: The People's Story 1914-2014. Nedlands, WA: UWA Publishing, 2014.

2 Kay, J. Obliquity: Why Our Goals Are Best Achieved Indirectly. New York: Penguin, 2010.

Celebrating 90 Years

Notice Board

Defence Update now on iTunes

Good news! You can now read *Defence Update* on your iPhone, iPad or Android device – and it's complimentary.

- Head over to the **iTunes App** or **Google Play** store.
- Type "Defence Update" in the search tool.
- You can then store and access *Defence Update* in a whole new way.

Stay Tuned on Social Media

Would you like more information on topical issues, articles of interest, or upcoming events and conferences? Then "like" us on **facebook.com/mdanational.com.au** or "follow" us on **Twitter @MDANational**.

MDA National **@MDANational**

AMA Strategic Alliances Benefit Our Members

MDA National now has strategic alliances with several of the country's state-based AMAs – the AMA Queensland, AMA Victoria and AMA (WA) – to deliver additional value to our Members in the medical profession via:

- promotion of doctors' health and wellbeing
- education, events and collaborative initiatives
- fundraising for the local medical community through alliances with our Corporate Social Responsibility Program.

Guiding You Through GP Supervision

GP Supervisors Australia (GPSA) has four new publications to help guide you through GP supervision:

- *Best Practice for Supervision in General Practice*
- *Team Leadership in General Practice*
- *The New Supervisor Guide*
- *Vertical and Horizontal Learning Integration in General Practice.*

Visit **gpsupervisorsaustralia.org.au/guides** to request a copy of the guides.

Reaching Out to Papua New Guinea

As part of our Corporate Social Responsibility Program, MDA National is supporting the Australian Orthopaedic Association (AOA) with medical procedures in Papua New Guinea (PNG) via Orthopaedic Outreach, the AOA's humanitarian arm.

In August 2015, the AOA sent a team of medical specialists to the PNG Highlands on a fact-finding/scouting introductory trip to assess the needs of people requiring their services. The AOA states that this visit would not have been possible without MDA National's support and generous donation. For more information on Orthopaedic Outreach, visit **orthoreach.org.au**.

Past President, Current Success

Congratulations to Dr John Blackwell who has been awarded a Medal of the Order of Australia in the Australian honours list for 2015.

As MDA National President from 1989-1997, John has played a vital role in the organisation's past and present.

Heads Up for Mental Health

Public debate on working conditions within the medical community has been highly publicised in the first half of 2015. Industrial issues, poor workplace culture and unbearably long working hours have been under the spotlight as members of the medical community highlighted workplace issues and the unreasonable expectations sometimes placed on them.

A landmark survey[1] in 2013, commissioned by *beyondblue*, found that one in five medical students and one in 10 doctors had suicidal thoughts in the past year. Young doctors are particularly at risk of poor mental health as they work longer hours, are far more psychologically distressed, think about suicide more, and are more burnt-out than their older colleagues. The findings sparked a national conversation on what needs to be done in the sector. Unfortunately, nearly two years on, we've heard that little has changed. So we have doubled our efforts, in partnership with the profession and others.

Heads Up: an Australian-first mental health workplace initiative

Together with the Mentally Healthy Workplace Alliance, *beyondblue* is encouraging organisational leaders to take action on mental health at work through the *Heads Up* initiative – **headsup.org.au** – launched in May 2014. Our resources are not just aimed at leaders in the medical profession. There is advice for everyone in the workforce about taking care of their own mental health and information on how to support their colleagues.

beyondblue has developed specific resources on the *Heads Up* webpage – **headsup.org.au/doctors** – which provides practical advice for organisational leaders and medical professionals to improve the mental health of their workforce.

- *Getting started*[2] – we encourage organisational leaders to view this as a first step. The kit includes everything required for strategy development and taking action. It has tools and resources to help structure a plan as well as a number of templates to make communicating with staff and stakeholders easier.
- *Create your action plan*[3] – a simple online tool that helps identify risk factors and determine any gaps in your current approach to workplace mental health.

Mental health action starts at the top

beyondblue encourages organisational leaders to speak openly and positively, but with authenticity, about mental health in the workplace, to raise awareness and reduce stigma.

Practical actions include providing:

- education and awareness training to all employees on mental health and wellbeing
- resources to help medical professionals look after their own mental health and wellbeing
- support to colleagues who may be struggling.

***beyondblue* encourages supervisors and leaders to provide training to help:**

- identify and manage the signs and symptoms of mental health issues
- identify and support employees at risk
- develop and implement processes to assist employees who have been unwell to return to work.

A compelling case for *Heads Up* strategies

A PwC report[4] revealed that Australian organisations receive an average return on investment of $2.30 for every $1 they spend on effective workplace mental health strategies. The research looked at the impact of employees' mental health on their productivity and the number of compensation claims lodged. Absenteeism, reduced worker productivity and claims resulting from employees' mental health conditions, such as depression and anxiety, cost Australian employers at least $10.9 billion a year.

The report, along with other research focusing on the attitudes of organisational leaders and employees, provides a compelling case for organisations to get involved and introduce *Heads Up* strategies in their workplaces. Since the launch of the initiative, more than 300,000 people have visited the *Heads Up* website and more than 7,500 people have registered to receive regular updates on how they can make their workplace more mentally healthy.

Georgie Harman
CEO, *beyondblue*

For a full list of references, visit
defenceupdate.mdanational.com.au/headsup-mental-health.

Proudly supporting beyondblue

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

UK Revalidation
A Valid Model for Australia?

Following the announcement in March 2015[2] that the Australian Health Practitioner Regulation Agency (AHPRA) has commissioned international research from CAMERA (a leading healthcare regulation research organisation in the UK) to develop revalidation in Australia – the question is no longer "if", but "when". With similar debates occurring in Australia, as previously seen in the UK prior to the implementation of revalidation in 2012, we look at the situation two years on and ask whether lessons can be learned from the UK's experience.

Implementation in the UK

After decades of debate and a series of medical scandals in the 1990s, the UK's medical regulator, General Medical Council (GMC), introduced revalidation in December 2012.[3] All registered medical practitioners with a licence to practise in the UK now have a statutory duty to demonstrate that they are up-to-date and fit to practise through a process of enhanced appraisal. With over 235,000 licensed doctors in the UK at the time of implementation, the national program was designed to be introduced over a number of years, ending in December 2016. Following initial revalidation, licensed doctors must revalidate every five years by demonstrating they continue to meet specified regulatory standards.

How do they do that?

The process focuses upon the annual appraisal and places reflective evidence at its core. In doing so, doctors are now required to produce a portfolio of six types of supporting evidence for discussion at their appraisal during each revalidation cycle. These are:

1. continuing professional development (CPD)
2. quality improvement activity
3. significant events
4. feedback from colleagues
5. feedback from patients
6. review of complaints and compliments.

The process is supported and managed by a national network of Responsible Officers (ROs) who are charged with making revalidation recommendations on behalf of each licensed doctor. Consequently, the GMC, NHS England, the Royal Colleges, the British Medical Association and other ancillary organisations have published reams of guidance to support doctors through the process. This massive undertaking has come at great expense – in England alone, the costs are estimated to reach £97 million a year until 2023.[4] Ultimately the scheme is predicted to generate net savings of between £50 million and £100 million a year from 2017 onwards as a result of improved quality of care, procedural efficiencies and reduced litigation costs.

Is it on track?

By January 2015, 45% of UK doctors subject to revalidation had reached their scheduled revalidation date, with over 98% either approved or deferred pending submission of additional evidence.[5] Thereafter, the majority of the remaining doctors are due to be processed by the end of 2016. But with the publication of the first reports into the impact of revalidation and scathing commentaries in the UK's medical media, the Australian authorities may be wondering whether UK's model is one to emulate.

What has been the impact?

As part of its ongoing commitment to monitor the implementation of revalidation, the GMC has published quarterly progress reports which have identified some revealing statistical trends. Firstly, there have been an unprecedented number of doctors relinquishing their licence to practise – some 18,655 since December 2012, as compared to only 2,230 in 2011.[6] Although the majority of these doctors cited "retirement" or "moving overseas" as their reason for relinquishing their licence, the temporal link with revalidation cannot be dismissed.

Separately, the data shows a higher proportion of foreign qualified and ethnic minority doctors deferring their revalidation due to insufficient supportive evidence. This revalidation bias echoes concerns from those involved about the disproportionate burden placed on some sectors of the profession. The figures also show an age bias, with

Heralded as "the biggest change in medical regulation in more than 150 years",[1] is UK revalidation a suitable model for Australia?

a substantially higher deferral rate for women in their 30s and doctors over 65 years of age. While this higher rate for young female doctors may be a result of career breaks, the figures for the over-65s accord with wider concerns that revalidation favours the IT literate and junior doctors who are schooled in the requirements of modern regulation, as opposed to the more experienced practitioners.

Perhaps most interestingly, the GMC revealed that less than 1% of all UK doctors have been identified as requiring remediation,[7] leading to criticism by patient groups that the process is bureaucratic, ineffective and lacks credibility.[8] While these concerns have been dismissed by the GMC, they find some resonance in the impact reports published in 2014. The largest of these was from CAMERA,[9] the same group commissioned by AHPRA, which identified uncertainty as to whether revalidation would achieve its aims. It noted a lack of clarity surrounding the conflict between patient assurance and quality improvement, and recommended reconsideration of the peripheral role played by patients, a key driver.

Further questions have been raised as to whether revalidation is the correct tool to improve the quality of health care. Research suggests that revalidation may be profoundly altering the dynamic of the appraisal process, prioritising performance assessment over personal development. This perceived loss of traditional mentoring has led to a concern that doctors may be less willing to raise problems and will submit self-serving and potentially unrepresentative evidence to satisfy the new regulatory focus. Furthermore, with a fundamental reliance on the quality of individual appraisers, local inconsistency risks undermine the national process. With one survey[10] reporting that only 43% of appraisers agreed that revalidation had improved the appraisal process, there is clearly much more work to be done to convince the profession and garner the support necessary to make revalidation a driving force behind quality improvement.

Recent research has inevitably focused upon deficiencies in the process, but it is undoubtedly the case that revalidation has significantly improved rates of engagement in appraisal. These have risen from 63% in March 2011 to 76% by March 2013.[11] Whatever its deficiencies, revalidation has introduced a more systematic and quantitative approach to appraisal with a renewed focus on its importance. The GMC acknowledges that refinement of the UK system is required and fundamental questions about the impact of remediation remain. Only time will tell whether it is a model for Australia.

Adam Weston
Solicitor, BLM*

*BLM is UK and Ireland's leading risk and insurance law business.

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

Professional Services Review

The Professional Services Review (PSR) Scheme, formerly known as the Medical Services Committee, was established by the Australian Government in 1994. The PSR provides practitioners with a chance to explain their practice to the PSR or a committee of peers if the Director of the PSR considers the practitioner may have engaged in "inappropriate practice".

Inappropriate practice

Inappropriate practice is defined in the legislation as:

"... conduct by a practitioner in connection with rendering or initiating services that a practitioner's peers could reasonably conclude was unacceptable to the general body of their profession."

The two elements of the definition relate to practice or conduct when providing or initiating Medicare services, and/or conduct in prescribing or dispensing PBS medicines.

A practitioner will be deemed to have engaged in inappropriate practice if they provide 80 or more professional attendances on 20 or more days during a 12-month period, known as the 80/20 rule. A practitioner may still engage in inappropriate practice despite not breaching this rule.

A three-stage process

If the Department of Human Services (DHS) requests the Director of the PSR to undertake a review of a practitioner over a specified period, the practitioner reaches Stage 1 of the PSR process – ***Review by the Director.***

The Director must conduct a review if, after considering the request from the DHS, the Director forms the view that the practitioner may have engaged in inappropriate practice. On reviewing the DHS data, the Director may ask the practitioner to provide medical records for consideration or request a meeting with the practitioner. Once the Director's report is issued, the practitioner will be given an opportunity to make a submission.

The options open to the Director are to:

1. take no further action
2. negotiate an Agreement under s92 of the *Health Insurance Act 1973*
3. refer the practitioner to a peer review committee.

A Negotiated Agreement requires the practitioner to accept that he or she has engaged in inappropriate practice. The Director is not obliged to accept a Negotiated Agreement offered by the practitioner.

Stage 2 – ***Review by a Committee*** – begins if the Director believes the practitioner's conduct requires further investigation, if the practitioner declines to enter into a Negotiated Agreement, or if the PSR decides not to accept the practitioner's proposed Negotiated Agreement. A PSR Committee is established to determine whether the practitioner's conduct would be acceptable to the general body of the practitioner's peers.

If the committee forms a preliminary view that the practitioner may have engaged in inappropriate practice, based on the practitioner's records, the practitioner will be invited to attend a hearing. The practitioner can provide oral and written evidence at the hearing, and the committee will produce a Draft Report once all evidence has been considered.

If no evidence of inappropriate practice is found, the matter will be closed. If the committee finds that inappropriate practice has occurred, the practitioner will have an opportunity to provide submissions on the findings in the Draft Report. Once the submission has been considered, the committee will issue a Final Report to the practitioner and to the Determining Authority.

This brings us to Stage 3 – ***the Determining Authority*** – which has two main functions. This independent body will decide whether to ratify Negotiated Agreements reached between the Director and a practitioner, or determine the sanctions which should be applied if the committee finds the practitioner has engaged in inappropriate practice.

The Determining Authority must impose one or more of the following sanctions:

- a reprimand
- counselling
- partial disqualification from claiming a Medicare benefit for no more than three years
- full disqualification from claiming a Medicare benefit for no more than three years
- an order for repayment of any Medicare benefits for services provided in the review period that have been found as being provided inappropriately
- a full disqualification from the PBS for no more than three years.

The practitioner will have an opportunity to make submissions on the recommended penalty before a Final Determination is made. A Final Determination brings the PSR process to an end, so any appeals must be made to the Federal Court or Federal Magistrates Court.

Investigations into your practice should not be ignored or taken lightly, as the penalties for practitioners who are found to have engaged in inappropriate practice can be significant. If you receive correspondence or a request for information from Medicare, the DHS or the PSR, you should seek advice from MDA National immediately.

You can access more information from the PSR website: **psr.gov.au.**

Nerissa Ferrie
Medico-legal Adviser
MDA National

Legal Support for Professional Services Review Committees

In October 2011, the Senate Community Affairs Reference Committee's Review of the Professional Services Review (PSR) Scheme[1] was tabled in Parliament. The Senate Committee noted concerns expressed by MDA National that "consideration should be given to having the PSR Committees chaired by a legally qualified person with experience in administrative review proceedings."

Another medical defence organisation, Avant, made a similar proposal. The Senate Committee was not persuaded, however, that chairpersons required legal qualifications, and strongly supported the concept that the PSR Committee members be peers of the practitioner under review, noting "that all submitters appear to support the PSR process: that it is a peer review scheme, not a court" (4.29).

Nevertheless, PSR has taken notice of this issue raised by MDA National, and is now providing PSR Committees with expert legal assistance throughout the process. PSR has engaged, on a full-time basis, both a General Counsel and a Corporate Solicitor. In addition, it uses the services of major law firms to engage other expert administrative lawyers to assist in its work and in training PSR Panel members.

PSR's General Counsel attends the committee hearings to help the committee understand the law and ensure that the practitioner under review gets a fair hearing. PSR is committed to ensuring that any concerns a committee might have regarding a practitioner's conduct are clearly raised in the hearing so that the practitioner has a real opportunity to give evidence and address those concerns.

PSR's Corporate Solicitor oversees the teams that manage the cases throughout the PSR process. By having PSR lawyers involved at all stages, the legal advisers who assist practitioners can more effectively engage with PSR to ensure the process runs efficiently and fairly.

It is pleasing to note that since PSR has implemented this enhanced level of legal assistance to committees, there have not been any Federal Court challenges to PSR processes or decisions. While legal challenges are unlikely to be eliminated, PSR is confident that practitioners who come before PSR should find the process fair and reasonable.

These enhancements have been made necessary in part by the growth in complexity of the Medicare Benefits Schedule (MBS) since the PSR Scheme was established in 1994. The MBS now includes Items for chronic disease management and health assessments. These Items provide scope for less scrupulous practitioners to populate the clinical record of an attendance with copious "generic" material often of little relevance to the particular patient. This process in turn has been facilitated by the widespread adoption of electronic health records. In the early days of PSR, peer-review committees often had to assess clinical records comprising scant, illegible scribble. Committees must now frequently assess copious, legible notes often of little relevance to the particular patient.

Dr Bill Coote
Director, Professional Services Review

1 Senate Community Affairs Reference Committee. Review of the Professional Services Review (PSR) Scheme. October 2011. Available at: aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2010-13/profservrev/report/index.

Outback Vision
A Compelling Mission for Eye Health

Photo courtesy of Alan McDonald, Fred Hollows Foundation.

MDA National Member, Dr Angus Turner, was named "First Amongst Equals" at the 2015 40Under40 Awards. He was recognised for his role in establishing Lions Outback Vision which takes specialist eye health services to regional and remote communities reaching nearly 5,000 people a year.

What drew you to a career in Ophthalmology?

I grew up in rural South Africa into a family of five generations of country doctors. It's genetic – medicine is in my blood! I watched my grandfather and father role-model the vocation of country medicine and was driven to follow in their footsteps.

I decided to become an Ophthalmologist when I was 15, during a high school science experiment at Guildford Grammar. I was enthralled dissecting an ox eyeball and somehow decided to email the Professor of Ophthalmology at Oxford University (UK) to ask for a job. He suggested that perhaps I should go to medical school first! As it turned out, I contacted him after completing my medical internship at Sir Charles Gairdner Hospital in 2001, and he gave me my first job.

What compelled you to make it your mission to improve eye health in remote communities?

My interest in remote eye health has evolved through many experiences into a passion. Saving or restoring someone's sight has a ripple effect, changing the life not just of one individual but also a community. The magnitude and impact of visual loss makes it a compelling area to work in. The rate of blindness among Indigenous Australians is 6.2 times higher than non-Indigenous Australians. Although 94% of vision loss is preventable or treatable, 35% of Indigenous adults have never had an eye examination.

My vision has been to bridge the traditional divides between professions and health services – bringing the three streams of eye health together to improve patient outcomes: optometry, ophthalmology and retinal screening. Establishing Lions Outback Vision five years ago has been a wonderful journey with a fantastic team – and there are constantly new dreams and improvements to be made.

What is your latest project?

The Lions Eye Institute is currently constructing a $2 million mobile eye health facility that will deliver the best available eye care to the bush. The Lions Outback Vision Van will have the capacity to treat 200 patients per week providing comprehensive optometry and ophthalmology care. It will travel over 24,000 kilometres a year on sealed roads throughout the state.

The most significant aspect of the Outback Vision Van is its unique service delivery model, working with the Aboriginal Health Council of WA to enhance our service delivery in Indigenous communities. It will be fully operational next year. It's very exciting to witness this project come to life and I'm grateful for the support of LotteryWest, the WA Department of Health, and the Commonwealth Government in helping me realise this dream.

Who are the "heroes" who inspired your work?

The gaps in visual care for remote patients have been recognised for a long time and many have tackled the problem over the last five decades in Australia. I see myself as accepting the baton from Indigenous eye health pioneers such as Father Frank Flynn and Prof Ida Mann who undertook the first survey of trachoma in the 1950s and 60s, and by the legendary Professor Fred Hollows, Hugh Taylor and WA ophthalmologists, Drs Phil House and Peter Graham.

In the words of Barack Obama: *"Focusing your life solely on making a buck shows a certain poverty of ambition. It asks too little of yourself… because it's only when you hitch your wagon to something larger than yourself that you realise your true potential".*

Dr Angus Turner was recently appointed inaugural McCusker Director, Lions Outback Vision. He heads Indigenous Eye Health at UWA's Centre of Ophthalmology and Visual Science, is a Consultant at Fremantle Hospital and teaches ophthalmology in the Rural Clinical School of WA.

Want more information on Lions Outback Vision?
Web: outbackvision.com.au
Email: info@outbackvision.com.au
Phone: (08) 9381 0802

Assessment of Capacity

We all make countless decisions each day, most of which have marginal impact on our lives. Butter or margarine? Walk or take the lift? Yet the issue of capacity underlies all these decisions, and a person's capacity is relevant to every situation that requires a decision. This article focuses on the assessment of a person's decision-making capacity in relation to health care.

Assessment of **Capacity**

What is capacity?

Capacity is the ability to make and understand information relevant to a decision, and the ability to appreciate the reasonably foreseeable consequences of a decision (or lack of a decision).[1]

Presumption of capacity

The law helpfully tells us there is an automatic presumption that an adult has capacity to make decisions, but that this presumption can be rebutted where the need (and evidence) arises. The reverse presumption applies to a child, i.e. they are presumed not to have capacity, but this position may be rebutted.[3]

A conclusion that a patient lacks capacity should be supported by facts which should establish why it is more likely (than not) that the patient lacks capacity.

Capacity is elastic and decision specific

The capacity to weigh up a complex decision as to what medical treatment to adopt will usually be greater than the capacity required for simple tasks, such as ordering lunch. Capacity can vary over time, so your findings regarding a patient's capacity and their relevance today may not be the same as tomorrow. Consider the separate issues that may be interfering with your assessment, e.g. language, cultural, knowledge and hearing issues.

There are also different areas of capacity that may not be affected equally – such as testamentary capacity for making a will, criminal capacity enabling a person to stand trial, and financial capacity.[4] Specific testing may be required. In terms of medical care, patient autonomy and their right to self-determination is predicated on the ability to weigh up options and ascertain risk.

A patient's capacity may vary where there is fluctuating impairment to their mental processes, whether through fatigue, effects of drugs or other substances, mental illness or other physiological conditions. Where a patient is deemed to lack capacity, consider how the patient's capacity might be improved, e.g. discussing issues early in the day to assist with fatigue or before certain medications are administered, or delaying decision-making until intercurrent illnesses are managed.

Refusal to be assessed

In most situations, a sensitive explanation of the possible consequences of refusal – e.g. that the patient's decisions may later be challenged or invalidated – will be enough to resolve the issue. A second opinion may be helpful.

In the event of continued refusal, there are very few circumstances where a patient can be forced to undergo capacity assessment[6] and a legal dilemma may arise if detention is required.[7] A refusal may also be relevant to the objective findings a clinician relied on to make a decision about the patient's capacity. Collateral history may be relevant, as are indirect observations regarding demeanour and medical history.

Ensure that the patient is free from undue influence. The patient's decisions must be made freely and voluntarily and not pressured by others. An interpreter, rather than a family member, will be an important consideration if language issues are present.

Generally a person with capacity will be able to:

- understand the facts of the situation
- understand the main choices available
- weigh up those choices, including benefits and risks
- make and communicate the decision[2]
- understand the ramifications of the decision.

It is the ability to go through the process itself that is important, not the decision that is made. We may disagree with the final decision, but this does not equate to a lack of capacity.

Assessment of capacity to make health decisions

The patient needs to understand the nature and effect of the proposed treatment at the point of consent. Although each situation will vary, some general principles apply. Allow for the possibility that this assessment will take some time. Assessment of cognition is different to an assessment of capacity. So just performing a limited cognitive screen, such as a mini-mental state examination or orientation to time/place/person, is generally not sufficient evidence of capacity. Impaired cognition is a "red flag".

Inform the patient that you are assessing their ability to make a healthcare decision (or a specific decision) and what this will involve. Remember you are not assessing whether you agree or disagree with the patient's decision. You are assessing the patient's ability to weigh up the relevant information and make their decision. There is a risk of patients coming to harm if their decision-making is impaired.

The patient should understand their own circumstances, why treatment options are being considered and the range of options available. They should understand what the options involve (including doing nothing) and the impact, benefits and risks. The patient must be able to indicate they want a particular option and articulate why they have chosen this over the other options.

Assessment of capacity to make decisions in other areas

Great care needs to be taken if you are asked to assess a patient's decision-making capacity in areas other than health, e.g. to make a will; or to sign a power of attorney or enduring guardian document.

There may be specific issues or legal tests to consider (which should be provided by the person requiring the assessment).[8,9]

- You may need to assess and record whether the patient understands specific issues in relation to that legal test.
- If you don't understand what the patient is contemplating on doing, you may not be able to determine whether the patient is able to consider the relevant issues.
- You need the ability to objectively assess the validity of the patient's understanding. For example, in assessing testamentary capacity, an objective assessment of the patient's understanding cannot occur without knowing the actual assets held by a patient or their potential benefactors.

Red flag events

Knowing when to assess capacity can be challenging. Certain "red flag" events are worth considering as a possible indication of capacity impairment and a need for further assessment.[5]

Examples of red flags include:

- hasty high-risk decisions
- decisions that place a person at unexpected risk of harm
- decisions out of character for the person
- cognitive decline and abrupt change in mental state
- serious mental health illness, particularly psychosis.

A conclusion to hand over decision-making power – e.g. Advance Care Directive, Power of Attorney or Enduring Guardian – may also require assessment before the relevant documents are completed.

Some procedures cannot be consented to by a substitute decision maker except by way of court or tribunal. These will vary by jurisdiction, but may include live donation of organs, permanent rendering of infertility and neuro-psychosurgery.

Document your findings

This will include your conclusion, reasons and supporting facts, and ideally some record of what the assessment process included. This will help support your reasoning if your decision is later challenged, regardless of your conclusion as to the presence or absence of capacity.

What if you are unsure?

Sometimes the decision as to a patient's capacity will be uncertain. Can you form a reasonable belief (more likely than not) based on objective reasons? Because there is a (rebuttable) presumption that a patient has capacity, marginal cases may require a conclusion in favour of capacity. You should consider a second opinion.[10] Collateral history may be relevant, if privacy or confidentiality concerns can be addressed.

Capacity assessment in relation to healthcare choices

This assessment will typically occur after the patient has been provided with relevant information, whether by you or another health practitioner in the past. There is no "magical formula" to determine capacity, but the following examples may assist in starting the appropriate discussions.

Can the patient:

understand the facts of the situation

- "Tell me about what is going on"
- "Is someone else helping you to decide?"

understand the main choices available (what, where, when, how)

- "Can you tell me about what your options are?"
- "Is doing nothing an option?"
- "What would these treatments involve?"

weigh up those choices, including benefits and risks

- "What are the benefits and risks for these options?"
- "What would be the benefits and risks of doing nothing?"
- "Which option is best for you?"

make a decision and be able to communicate this

- "So what are you doing to do?"

understand the ramifications of the decision

- "What was important to you in making that decision?"
- "How did you balance the other choices and come to this decision?"

Remember you can usually decline to perform an elective assessment. Where additional information is required before you can begin an assessment, communicate this by contacting the person requesting the assessment, particularly in non-health decision-making.

Although less common in Australia, consider the use of a capacity assessment tool. Various commercial[11] and free[12,13] options are available, but you should take care that the tool used is appropriate to the task at hand.

What if your assessment demonstrates a lack of capacity?

A substitute decision maker will be required.[14] Each state and territory has specific laws regarding the type and hierarchy of decision makers and what must be considered. You may need to obtain advice from our Medico-legal Advisory Service, or bodies such as the Guardianship services available in each state and territory.

Try to determine if the patient has already left some form of guidance, e.g. Advance Care Directive or other decision-making document. Treatment can generally be provided in emergency circumstances and to relieve pain and suffering, although a record should be made of why the treatment was provided without consent and the efforts made to contact a substitute decision maker. Decisions may also need to be made under a general duty of care.[15]

Summary points[16]

- Always presume an adult patient has capacity.
- Capacity is decision specific.
- Don't base your decision on appearances.
- Assess the decision-making ability, not the decision.
- Emergency or substitute decision-making is a last resort.

Dr Julian Walter
Medico-legal Adviser
MDA National

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

CaseBook

Dog Discrimination

Case history

The doctor was concerned about a patient who attended the practice with a large dog, which the patient described as an "assistance animal". The doctor thought the dog might frighten other patients in the waiting room. He was unsure if he was able to advise the patient that he could no longer bring the dog to the practice.

Medico-legal issues

Discrimination legislation across Australia makes it unlawful to discriminate against a person with a disability because they are accompanied by an assistance animal in certain circumstances.[1] This situation may arise in practice for doctors when a patient seeks to be accompanied by an assistance animal while attending the doctor's surgery, and perhaps also during a consultation.

Although an assistance animal includes a guide dog for the vision and hearing impaired, the definition of assistance animals covered by legislation is broader than this.

Under the *Disability Discrimination Act 1992* (Cth), an assistance animal includes a dog or other animal trained to assist a person with a disability to alleviate the effect of their disability and to meet standards of hygiene and behaviour that are appropriate for an animal in a public place.[2] An animal may qualify as an assistance animal by reason of being accredited under state or territory law, or accredited by an animal training organisation prescribed by the regulations.[3]

This recognises that there are currently a wide range of assistance dogs helping people with disabilities, e.g. alert and response dogs for conditions such as epilepsy and diabetes; dogs that assist physically disabled persons to perform specified tasks, and psychiatric service dogs.

An animal does not qualify as an assistance animal merely by reason of providing companionship. It is not always clear whether an animal is an assistance animal so that the provisions of the Act apply.[4] The Act provides that it is not unlawful to request the person with the disability to produce evidence that the animal is appropriately trained as an assistance animal.[5]

It is also not unlawful to require that the assistance animal remain under the control of the person with the disability or another person on their behalf, although this may not require direct physical control.[6] Further, the Act provides that it is not unlawful to discriminate when reasonably necessary, if it is suspected that the assistance animal has an infectious disease, or if it is otherwise necessary to protect public health.[7] This may arise, for example, if the animal is displaying aggressive behaviour which threatens other patients at the practice.

Failure to comply with the legislation may result in the disabled person making a discrimination complaint against the practitioner to the Human Rights and Equal Opportunity Commission, and court proceedings against the practitioner which may include a claim for compensation.

Summary points

- Practitioners should be aware of their obligations under the discrimination legislation so as to not unlawfully refuse access to assistance animals.
- If there is uncertainty, it is appropriate for a practitioner to ask the person accompanying the animal whether it is an assistance animal and for evidence in support of this.
- If you are uncertain as to how to proceed, we encourage you to contact our Medico-legal Advisory Service for advice and information about how the legislation applies to your particular situation.

Karen McMahon
Medico-legal Adviser (Solicitor)
MDA National

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

CaseBook

Fitness to Drive

Case history

Mr B suffered from epilepsy following a head injury in 1979 when he was 20 years of age.

October 2001: Mr B's neurologist wrote to his GP stating that he thought Mr B could return to "very limited" driving, given it had been over three years since Mr B's last seizure. Some handwritten notes were made on this letter in Mr B's records at the general practice, referring to a discussion with Mr B's wife. The notes stated that his wife had phoned the practice and reported that Mr B was still having seizures.

August 2002: The neurologist reported that Mr B had experienced a recent seizure. Mr B had asked whether he could return to driving, but the neurologist advised Mr B that he needed to be seizure-free for at least 12 months.

17 May 2005: Mr B saw a GP in the practice, Dr A, and informed him that he had been involved in a motor vehicle accident (MVA).

12 July 2005: Mr B consulted Dr A again, reporting he had been involved in another MVA. At this consultation, Mr B brought a letter from the Driver Licensing Authority (DLA) stating he was required to provide a medical certificate before 22 July 2005 that he was fit to drive, or his licence would be revoked. Dr A issued a certificate stating Mr B did have a medical condition but was medically fit to drive, subject to the restriction: "contingent upon authorisation by neurologist".

Following this consultation, Dr A wrote to the DLA advising that an appointment had been arranged for Mr B to see his neurologist, and referred to having provided a certificate to Mr B contingent on the neurologist's report being favourable.

August 2005: The neurologist sent a report to Dr A stating: "I have told Mr B that he was observed to have two fits recently and he must not drive, and indeed it is illegal for him to do so until two years have elapsed since his last seizure."

On 26 August 2005, Mr B saw Dr A and requested a referral to another neurologist for a second opinion. On 29 August 2005, Mr B phoned Dr A requesting a certificate to facilitate a driver's licence. The GP informed Mr B that he could not provide certification due to the neurologist reporting he was not fit to drive.

Mr B was seen by the second neurologist on two occasions. Based on collateral history obtained from the other neurologist, the ambulance officers who attended the MVAs and the local hospital, the second neurologist reported:

"Advised him that I would not be prepared to write a medical certificate for him now or in the future. As difficult as it seems to be for Mr B, I think it is important that he accepts he will not be able to drive a motor vehicle and arrange his life accordingly."

2 June 2006: At a consultation with Mr B, Dr A certified Mr B as fit to drive.

2 November 2009: Mr B saw Dr A seeking a new medical certificate to have his driver's licence re-issued. Dr A provided the certificate noting in his medical records: "No seizure for many years on record".

26 November 2009: Mr B was driving a motor vehicle which struck and killed a pedestrian.

Legislative Requirements - Fitness to Drive

Patients - all states and territories

- Legislation requires a driver to advise the DLA of any long-term or permanent injury or illness that may affect their safe driving ability.

Health professionals - NT and SA

- Legislation imposes on health professionals a positive duty to notify the DLA in writing of their belief that a patient is physically or mentally unfit to drive.

Health professionals - ACT, NSW, Queensland, Tasmania, Victoria and WA

- Legislation provides that health professionals who make a report to the DLA that a patient is unfit to drive, without the patient's consent but in good faith, are protected from civil and criminal liability.

Doctors have an obligation to give clear advice to a patient in cases where an illness or injury may affect their safe driving ability, and this advice should be documented in the patient's medical record.

Medico-legal issues

A complaint was subsequently made about the GP's conduct in issuing certificates to Mr B (on 2 June 2006 and 2 November 2009) that he was medically fit to drive without conditions or restrictions.

The matter proceeded to a Tribunal hearing and the findings were handed down on 23 March 2015.[1]

The Tribunal found that Dr A's conduct fell substantially below the standard reasonably expected of a registered health practitioner of his level of experience (he had been a GP for almost 20 years).

The Tribunal concluded that the sanctions imposed in this case should act "to deter other medical practitioners who may feel prevailed upon by patients to certify them as being fit to drive even when the practitioner considers them not to be, from doing so… Medical practitioners should be aware that acting contrary to their professional judgement in such circumstances will, in all likelihood, result in a significant sanction".

The Tribunal found Dr A guilty of professional misconduct. He was fined $10,000 and ordered to pay the Board's costs. Dr A was also prohibited from issuing certificates of fitness to drive and ordered to undertake a course on managing interactions with difficult patients.

Discussion

The roles and responsibilities of health professionals in assessing patients regarding fitness to drive for licensing purposes are outlined in Austroad's guidelines: Assessing Fitness to Drive.[2]

Ultimately, the responsibility for issuing, renewing, suspending, refusing or cancelling a person's driver's licence lies with the DLA. In making a decision, the DLA will seek input regarding a person's medical fitness to drive from the driver and/or from a health professional.

Doctors have an obligation to give clear advice to a patient in cases where an illness or injury may affect their safe driving ability, and this advice should be documented in the patient's medical record.

On occasion, it may be appropriate for doctors to report concerns directly to the DLA about a patient's fitness to drive, where the patient:

- is unable to appreciate the impact of their condition, or
- is unable to take notice of the health professional's recommendations due to cognitive impairment, or
- continues driving despite appropriate advice and is likely to endanger the public.

It is preferable that any action in the interests of public safety should be taken with the consent of the patient, wherever possible, and should be undertaken with the patient's knowledge of the intended action. However, there may be an occasion where the health professional feels that informing the patient of the disclosure may place them at risk of harm.

In deciding whether to report directly to the DLA, a health professional should consider:

- the seriousness of the situation, i.e. the immediate risk to public safety
- the risks associated with disclosure without the individual's consent or knowledge, balanced against the implications of non-disclosure
- whether the circumstances indicate a serious and imminent threat to the health, life or safety of any person.

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

1 *Medical Board of Australia v Andrew* [2015] QCAT 94. Available at: sclqld.org.au/caselaw/search/all/QCAT/24.

2 Austroads. Assessing Fitness to Drive for Commercial and Private Vehicle Drivers: Medical Standards for Licensing and Clinical Management Guidelines. March 2012 as amended up to 30 June 2014. Available at: onlinepublications.austroads.com.au/items/AP-G56-13.

Root Cause Analysis

Consider this scenario: The Director of Medical Services contacts you to advise that a Root Cause Analysis (RCA) will be conducted into the unexpected death of a patient, and that you are required to attend an interview with the RCA team.

This article discusses:

- the nature and purpose of RCAs
- how to proceed if you are involved in a RCA.

What is Root Cause Analysis?

RCA is a systematic and comprehensive methodology to analyse systems and processes of care. The aim of a RCA is to identify areas of concern that may not be immediately apparent and which may have contributed to the occurrence of an incident. It focuses on the organisation of health care, rather than the assignment of individual blame.

The goal of a RCA is to find out:

- what happened
- why it happened
- what can be done to prevent it from happening again.

RCAs have the following characteristics:

- The review is interdisciplinary in nature.
- The review is undertaken by a small team (three to five people) who are familiar with the area in which the incident occurred, but not directly involved in the incident.
- The analysis focuses primarily on systems and processes rather than individual performance.
- The analysis identifies changes that could be made in systems and processes, through either redesign or development of new processes or systems that would improve performance and reduce the risk of recurrence.

The RCA team is required to determine the facts of what happened. In order to do so, information is gathered from a variety of sources, including interviewing and/or obtaining statements from those practitioners involved in the patient's care and any witnesses to the incident. The RCA team is not permitted to investigate the competence of an individual doctor or other health practitioner.

At the conclusion of the RCA process, the RCA team must provide a written report describing the incident, the reasons they think it occurred and any recommendations for change to practice or procedures. The final RCA Report is made available to a range of parties, including the patient and/or their family and the hospital administration.

When is a RCA conducted?

Generally, a RCA is performed on serious adverse clinical events. RCAs may be mandated in certain circumstances – such as patient incidents with a severity assessment rating of one (serious events which are likely to recur) and sentinel or reportable events, e.g. maternal deaths or wrong site procedures.

What should you do if you are asked to participate in a RCA?

You should initially review the relevant medical records and consider your direct involvement in the patient's care.

If you are asked to attend an interview with the RCA team, it may be useful to prepare some notes to assist you during this discussion. Any notes should be marked as being "prepared for the purpose of a RCA". You can bring a support person to the interview, if you wish to do so.

If you are asked to prepare a report for the RCA team, again, this report should be clearly marked as being prepared for that purpose.

If asked to participate in a RCA, Members are encouraged to contact our Medico-legal Advisory Services team for advice and support.

Summary points

- RCA is a process analysis method used to identify the factors that cause adverse events.
- The focus of RCA is on system change, not the assignment of individual blame.
- If you are asked to participate in a RCA, contact our Medico-legal Advisory Services on **1800 011 255** for advice.

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

Education Activity
– Spring/Summer 2015

MDA National
Support Protect Promote

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 how to establish a patient's capacity to make health decisions
- plan to contribute to a healthcare workplace having a system that supports practitioners to appropriately document each capacity assessment
- explain necessary considerations when a patient exerts pressure for certification of being fit to drive.

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
If I was to appear before the Professional Services Review (PSR) I would be confident that the process is fair and reasonable.	☐	☐	☐	☐	☐
If an assistance animal was acting aggressively towards other people in a healthcare workplace, I would ask the person who required the assistance animal to control their animal or leave.	☐	☐	☐	☐	☐
The outcome of the fitness to drive Tribunal case discussed in this *Defence Update* issue is significant motivation for doctors to resist patients who push heavily to be certified as fit to drive when the doctor's professional judgement is that they are not fit.	☐	☐	☐	☐	☐
The aim of a Root Cause Analysis (RCA) is to identify areas of concern in the organisation of health care which may not be immediately apparent and may have contributed to an adverse event occurring – it does not focus on assigning individual blame.	☐	☐	☐	☐	☐

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

	True	False
Doctors who receive correspondence or a request for information from Medicare, the Department of Human Services or the PSR need to contact their medical indemnity insurer for advice immediately.	☐	☐
Professional Services Review's General Counsel attends hearings to ensure the practitioner being reviewed gets a fair hearing.	☐	☐
Since the PSR implemented enhanced legal assistance to committees, the number of Federal Court challenges to their processes or decisions has increased.	☐	☐
When assessing a patient's capacity to make healthcare choices, you need to assess their decision-making ability rather than the decision they made.	☐	☐
A patient either has capacity to make all healthcare decisions or none.	☐	☐
Not all procedures can be consented to by a substitute decision maker.	☐	☐
Assessment of cognition is different to an assessment of capacity.	☐	☐
Great care needs to be taken if you are asked to assess a patient's decision-making capacity in areas other than health, e.g. to make a will, sign a power of attorney or enduring guardian document.	☐	☐
It is unlawful to request a person with a disability who has an assistance animal to produce evidence that the animal is appropriately trained as an assistance animal.	☐	☐
An RCA team is not permitted to investigate the competence of an individual health practitioner.	☐	☐

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

What do you think is a particular strength or weakness of the United Kingdom's revalidation process?

What do you look for when assessing whether a person has capacity to make a decision?

How could a patient demonstrate that they have understood their options and retained the information discussed?

List at least five "red flags" which indicate potential capacity impairment that warrants further assessment.

What elements need to be recorded when documenting a capacity assessment?

Are you confident that you currently document all necessary information related to a capacity assessment? Is there anything you or your workplace could do differently to ensure comprehensive records are made each time?

What would you consider when deciding whether to report concerns about a patient's fitness to drive directly to the Driver Licensing Authority?

Activity evaluation

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

	Not met	Partially met	Entirely met
Describe how to establish a patient's capacity to make health decisions.	☐	☐	☐
Plan to contribute to a healthcare workplace having a system that supports practitioners to appropriately document each capacity assessment.	☐	☐	☐
Explain necessary considerations when a patient exerts pressure for certification of being fit to drive.	☐	☐	☐

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* Spring/Summer 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 **How likely is it that you would recommend this activity to a friend or colleague?**

✗ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ ✓

6 **Please rate the quality of the following in relation to *Defence Update* Spring/Summer 2015.**

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

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 Member 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* Spring/Summer 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 **mdanational.com.au**.
    - Log on to Member Online Services.
    - Click on the "Education" tab.
    - Select "Online Education Activities".
    - Select "*Defence Update*", then "*Defence Update* Spring/Summer 2015".
  - › Submit a handwritten 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/defence-update-springsummer-2015** 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 Educational Events for Members

October 2015

8	Online Communication for Medical Professionals **Sydney, NSW**
10	Bunbury Education Day • Enhancing Patient Understanding – Health Literacy and Communication • Maintaining Boundaries: The Risk of Dual Relationships • Complexities of Informed Consent Conversations **Bunbury, WA**
29	Enhancing Patient Understanding – Health Literacy and Communication **Brisbane, QLD**

November 2015

14	Practical Solutions to Patient Boundaries **Coffs Harbour, NSW**
14	Practical Solutions to Patient Boundaries **Perth, WA**
21	Adelaide Education Day • Challenging Emotions of Difficult News • Avoiding Misunderstandings around Physical Contact and Intimate Examinations **Adelaide, SA**
28	Practical Solutions to Patient Boundaries **Melbourne, VIC**

Event Snapshot

Complexities of Informed Consent Conversations

In June 2015, we delivered a series of education events on Complexities of Informed Consent Conversations to over 300 participants across the country. Members who attended these sessions were able to strengthen their knowledge and skills in facilitating optimal patient understanding and consent processes.

Across the sessions, an average of:

- **92% of evaluation form respondents agreed that the activity met their expectations**
- **76% indicated the activity was "entirely relevant" to their medical work**
- **71% reported they were considering doing something differently as a result of attending the session.**

Many thanks to facilitator Prof Stephen Trumble and panellists Julie Brooke-Cowden, Victoria Astill Smith, Allyson Alker and patient representative, Clare Fountain for their excellent delivery.

We continually add educational sessions to our events calendar – so to avoid missing out on upcoming activities, keep an eye on our What's On page at mdanational.com.au.

To register for any of the MDA National events, visit **mdanational.com.au** or contact us on **1800 011 255**.

Celebrating 90 Years

MDA National
Support Protect Promote

It's my mda national

Wherever you practise in Australia, you can be assured that MDA National will be there to support you. A dedicated team of professionals continue to provide expert medico-legal advice. The commitment to deliver the very best value to Members remains true.

Strong. Secure. Trusted. As always.
It's my MDA National.

Dr Georgie Stilwell
MDA National Member

Freecall: 1800 011 255 Member Services fax: 1300 011 244
Email: peaceofmind@mdanational.com.au Web: mdanational.com.au

YouTube

Adelaide
Unit 7
161 Ward Street
North Adelaide SA 5006
Ph: (08) 7129 4500
Fax: (08) 7129 4520

Brisbane
Level 8
87 Wickham Terrace
Spring Hill QLD 4000
Ph: (07) 3120 1800
Fax: (07) 3839 7822

Hobart
Level 1, ABC Centre
1-7 Liverpool Street
Hobart TAS 7001
Ph: (03) 6231 6235
Fax: (03) 6234 2344

Melbourne
Level 3
100 Dorcas Street
Southbank VIC 3006
Ph: (03) 9915 1700
Fax: (03) 9690 6272

Perth
Level 3
88 Colin Street
West Perth WA 6005
Ph: (08) 6461 3400
Fax: (08) 9415 1492

Sydney
Level 5, AMA House
69 Christie Street
St Leonards NSW 2065
Ph: (02) 9023 3300
Fax: (02) 9460 8344