defenceupdate

Quarterly Magazine for MDA National Members

Summer 2011

MDA National
Support Protect Promote

Editor's Note

As the year comes to a close and many of us look to travel to visit family and friends, or simply to go on a well-deserved break, this issue explores the medico-legal ramifications of providing in-flight medical assistance and the challenges of medical tourism.

MDA National is committed to providing high quality and convenient education to suit Members' timetables and individual learning styles. As part of this commitment, *Defence Update* now has Continuing Professional Development (CPD) accreditation. Simply read and complete our questionnaire and evaluation form to be eligible for CPD points for your College program. Completion also contributes to MDA National's Premium Support Scheme Risk Management requirements for the 2011/12 premium period.

I will email you in the coming weeks with more detail. In the meantime, you can find out more at **http://www.mdanational.com.au/publications**. We trust this initiative will provide you with easily accessible CPD points in the topic area of risk management and medico-legal issues, at no cost to you.

As this is the final issue of *Defence Update* for 2011, I would like to take this opportunity to wish you and your family a safe and enjoyable festive season and New Year. Thank you to our many Members, staff and stakeholders who have contributed their knowledge and shared their experiences for the magazine this year.

On behalf of MDA National, we look forward to continuing to develop and improve *Defence Update* in 2012 to ensure it is an interesting and informative read for you.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In this Issue

Cover image: Dr Jill Maxwell OAM, MDA National President's Medical Liaison Council Member (SA), with SA/NT Relationship Manager, Megan Sheldon.

From the President

Is e-health riskier than we think?

The news that the £12.7 billion IT upgrade of the UK National Health Service has ended after years of rising costs and unmet expectations, will probably generate some anxiety amongst proponents of Australia's e-health initiatives.

Although all hospitals and GP surgeries in England and Wales were supposed to have been networked to a national patient records system by the end of 2006, it took a further five years and a change of government to realise that this ambitious and hideously expensive program simply could not deliver.[1] The blunt verdict of the UK Health Minister, Simon Burns, was that "the nationally imposed system is neither necessary nor appropriate to deliver this. We will allow hospitals to use and develop the IT (systems) that they already have."[2]

Unfortunately, IT fiascoes like this are neither rare nor limited to the public sector. For example, when the iconic jeans manufacturer, Levi Strauss embarked on a US$5m upgrade of its global computer system in 2003, few would have envisaged the ultimate US$192.5m charge against the company's earnings in 2008 to account for the botched project, along with the resignation of their Chief Information Officer.[3]

So major IT projects do pose a singular risk to governments and companies that embark upon them and by one estimate, almost one in six will have cost overruns of 200% or more! [4]

Therefore while the e-health initiatives of the Federal Department of Health and Ageing will hopefully improve information transparency and patient care, based on the UK experience, the risks of this project cannot be overstated. For example, the initial deployment of a personally controlled electronic health record (PCEHR) has sound and achievable objectives. Yet one suspects that even this relatively modest project will need to be broken down into smaller parts of more limited complexity.

Similarly, contingency plans are required to manage potentially unavoidable failures in such projects. Perhaps we should heed the advice of Professor Bent Flyvbjerg of Oxford University's Said Business School, who recommends a technique called "reference class forecasting". This analytic process was developed by Nobel Prize winners, Daniel Kahneman and Amos Tversky, who found that human judgment is generally optimistic due to overconfidence and insufficient consideration of possible outcomes.[5]

Therefore, people tend to underestimate the costs, completion times and risks of planned actions, whereas they tend to overestimate the benefits of those same measures. Such error is caused by a cognitive bias toward taking an "inside view," where focus is on the constituents of the planned action, instead of an "outside view" of the actual outcomes of similar ventures that have already been completed or obviously failed!

Certainly MDA National is very much aware of such thinking and considerations in relation to our own IT strategies. We also remain engaged with the National e-Health Transition Authority (NEHTA) to ensure that the medico-legal risks are understood and minimised in any new e-health system. We will remain advocates for our Members' needs to ensure your interests are protected and that satisfactory outcomes for patients are encouraged.

Finally, on behalf of MDA National, we wish you and your family an enjoyable and refreshing festive season and a successful 2012.

I also welcome John Trowbridge, our new Director to the MDA National Insurance Board commencing in January 2012. I extend my gratitude to our Insurance Board, Council, President's Medical Liaison Council (PMLC), and to our management team and staff, who have again enthusiastically contributed to the success of MDA National during 2011. We remain fortunate to have such a fine and dedicated team to support, protect and promote Members over and above medical indemnity.

A/Prof. Julian Rait
President, MDA National

References

1 Haughom JL. *Implementation of an electronic health record.* BMJ 2011:343:d5887

2 Campbell D. *NHS told to abandon delayed IT project.* The Guardian, 22 Sept 2011.

3, 4 Flyvbjerg B and Budzier A. *Why Your IT Project May Be Riskier Than You Think.* Harvard Business Review September 2011, pp 23-25.

5 Kahneman, D. and Tversky, A., 1979, *"Intuitive Prediction: Biases and Corrective Procedures."* In S. Makridakis and S. C. Wheelwright, Eds., Studies in the Management Sciences: Forecasting, 12 (Amsterdam: North Holland).

Notice Board

Business As Usual For Us Over the Festive Season

As always, MDA National is available to support, protect and promote Members 24 hours a day. Our Medico-legal Advisory Service will be operational throughout the festive season and can be contacted on 1800 011 255.

Our Member Services team will be available outside of public holidays:

Friday 23 December – 8:30am-3:00pm

Monday 26 December – Public holiday closure

Tuesday 27 December – Public holiday closure

Wednesday 28 December – 8:30am-5:00pm

Thursday 29 December – 8:30am-5:00pm

Friday 30 December – 8:30am-3:00pm

Monday 2 January 2012 – Public holiday closure

New Director joins MDA National Insurance Board

We welcome our new Director, John Trowbridge, as of January 2012 to the MDA National Insurance Board.

John completed a four year term as Executive Member of APRA (the Australian Prudential Regulation Authority) in 2010. He has spent the larger part of his career as a consultant, including founding Trowbridge Consulting in 1981 which became a leading actuarial and management consulting firm in Australia and Asia during the 80s and 90s. He has also held senior executive positions with two major Australian based insurers. He served as a Member of the Australian Treasurer's Financial Sector Advisory Council from 1998 to 2004.

In March 2011, John was appointed chairman of the Australian Government's Natural Disaster Insurance Review Panel, which completed its work in September 2011. He has now been appointed Interim Director of Australia's new Centre for International Finance and Regulation, a research and educational centre sponsored by the Australian and NSW Governments and operated by a consortium of universities led by UNSW.

John's experience complements our current Board Members, and will be invaluable in continuing the MDA National Group's financial stability and Membership growth.

Annual General Meeting

Our Annual General Meeting took place on Thursday 10 November 2011. Dr Reg Bullen, Dr Rod Moore and Associate Professor Julian Rait were re-elected unopposed to Council.

AHPRA Annual Report

Australian Health Practitioner Regulation Agency's (AHPRA) *2010-11 Annual Report* marks the first ever release of comprehensive national data on health practitioner regulation, as part of the National Registration and Accreditation Scheme. Of note:

- there are 530,115 registered health practitioners in Australia, including 88,293 medical practitioners and 16,839 medical students
- there were 8,139 notifications made under the National Law in 2010-11 across the 10 health professions registered under the National Registration and Accreditation Scheme, representing notifications involving 1.5% of all registered health practitioners
- the relevant National Board determined that no further action was required in 86% of notifications
- 4,122 (50.6%) of the notifications were in relation to medical practitioners, who represent 16.6% of all registered health practitioners
- in 2010-11, 4.6% of medical practitioners were the subject of a notification to AHPRA
- notifications against medical practitioners were most commonly about treatment (39%), professional conduct (25%) and communication and information (9%)
- there were 428 mandatory notifications received about health practitioners
- 144 (33.6%) of these mandatory notifications were in relation to medical practitioners
- 60% of mandatory notifications were made by employers and 40% by other providers
- 59.1% of mandatory notifications were about a departure from accepted professional standards, 29.9% related to impairment, 6.8% were about sexual misconduct and 4.2% about drug and alcohol issues
- of the mandatory notifications assessed in 2010-11, 57.7% were referred for investigation, 16.8% resulted in no further action and in 6% of mandatory notifications immediate action was initiated against the health practitioner.

In Focus

Is There a Doctor on Board this Flight?

Doctors are commonly asked by cabin staff to volunteer their services to assist passengers who are unwell whilst flying. It has been estimated that an in-flight emergency occurs in one in 10-40,000 passengers.[1] While approximately 70% of these incidents are managed by the cabin staff, in the remaining cases health professionals are asked to provide Good Samaritan assistance.

Causes of in-flight emergencies

Common causes of in-flight emergencies include collapse or syncope, gastrointestinal complaints, motion sickness, middle ear pain, allergic reactions, angina, myocardial infarction, transient ischaemic attacks, stroke, asthma, diabetic emergencies, trauma, seizures and panic attacks.[2, 3, 4] Cardiovascular events account for the majority of the medical diversions of flights.

Am I protected legally if I provide medical assistance during a flight?

Legal protection for doctors who provide assistance during in-flight emergencies is complex, and can be complicated further by issues of legal jurisdiction. The law governing events during a flight is usually the law of the country in which the aircraft is registered, except when the aircraft is on the ground or in sovereign airspace. However, the country of citizenship of both the passenger being assisted and the medical Good Samaritan can also have jurisdiction.

The United States *Aviation Medical Assistance Act* 1998 protects doctors who provide assistance while on aircraft registered in the US. Under this legislation individuals are not liable for damages in any action brought in a US federal or state court arising from acts or omissions of the individual providing assistance during an in-flight emergency, unless the individual is guilty of gross negligence or wilful misconduct. Individual airlines may also indemnify health professionals for in-flight Good Samaritan aid and, if required, doctors can seek written confirmation of indemnity from the aircraft captain.

In addition to the legislative protections outlined above, MDA National's Professional Indemnity Insurance Policy provides cover for any claims arising out of Good Samaritan acts regardless of the jurisdiction in which the claim is brought, including claims arising out of the US.

Good Samaritan acts are defined in the policy as the provision of emergency assistance by you, where you are in attendance as a bystander and where there is no expectation of payment or other reward. The cover only applies to acts necessary to stabilise the patient or to prepare the patient for transfer.

While the risk of a claim arising out of the provision of medical care during an in-flight emergency appears to be very low, Members are protected by a combination of legislation, indemnity by individual airlines and their MDA National policy for rendering Good Samaritan aid to a passenger during an in-flight emergency.

Dr Colleen Lau
Travel Medicine Alliance Australia

Dr Sara Bird
Manager, Medico-legal and Advisory Services

Share your in-flight and/or holiday medical emergency experiences with your colleagues by emailing **defenceupdate@mdanational.com.au**

1 Cocks R, Liew M. Commercial aviation in-flight emergencies and the physician. Emergency Medicine Australasia 2007;19:1-8.
2 Dowdall N. "Is there a doctor on the aircraft?" Top 10 in-flight medical emergencies. BMJ 2000;321(7272):1336-7.
3 Baltsezak S. Clinic in the air? A retrospective study of medical emergency calls from a major international airline. J Travel Med 2008;15(6):391-4.
4 Sand M, Bechara FG, Sand D, Mann B. Surgical and medical emergencies on board European aircraft: a retrospective study of 10189 cases. Crit Care 2009;13(1):R3.

Update

Anticoagulants and Surgery

The peri-operative management of anticoagulation can be complex. This article highlights some of the challenges of managing anticoagulated patients who are undergoing surgery from the perspective of a GP and a physician. Part two of this article which we will publish in the next edition of *Defence Update* will discuss the issue from a surgeon's and an anaesthetist's point of view.

MDA National frequently receives notifications from Members about complications involving patients taking anticoagulant drugs who undergo surgical procedures. Some recent incident reports include:

Case 1

A 58 year old patient underwent a total knee replacement. She was on warfarin because of an underlying thrombophilic disorder and a patent foramen ovale. The surgeon recommenced warfarin on the first post-operative day. The patient developed a large haemarthrosis which was managed conservatively with pressure bandaging. She subsequently developed a peroneal nerve palsy which was thought to be secondary to the pressure from the haematoma and bandaging.

Case 2

A 70 year old patient was booked for cataract surgery. She was on warfarin because of atrial fibrillation, which was then ceased pre-operatively. The cataract surgery was uneventful but the patient suffered a large stroke two days post-operatively.

Case 3

A 55 year old patient was commenced on clopidogrel following coronary stenting five years earlier. He was booked for elective surgery and stopped the clopidogrel 10 days pre-operatively. The patient suffered an intra-operative myocardial infarction and was unable to be resuscitated. Autopsy revealed blockage of his coronary stent.

Case 4

A 63 year old patient underwent a colonoscopy. His regular medications included aspirin and clopidogrel. A number of biopsies were performed during the colonoscopy. Nine days post-procedure the patient suffered a major gastrointestinal bleed.

A GP's perspective – A/Prof Moira Sim

Warfarin is highly effective in reducing morbidity and mortality relating to arterial and venous thrombosis.[1] Despite the risk of serious bleeding (between 1.2-8.1% of patients on long-term warfarin anticoagulation treatment) its use is common and increasing in the community.[2]

While patients on warfarin are often older, studies support the use of anticoagulation with increasing age.[1] With age comes increasing comorbidities including indications for surgery, for which warfarin is usually a contraindication.[3]

There is a need to make decisions on the cessation of warfarin prior to the surgery. As with all decisions there are benefits and risks. Who makes the decision on whether and when to stop warfarin? Should it be the GP, the surgeon, the anaesthetist or someone else?

Patients need advice which is consistent and this therefore means that decisions have to not only be well communicated to the patient, but they need to be communicated along the continuum of care. The patient needs to understand the plan early so uncertainty about anticoagulation does not become a reason for increased anxiety at the time of surgery, and the patient is not sent home after attending for admission because the INR is too high for surgery to be considered.

GPs are the coordinators of patient care and, in most cases, will have information about the rationale for the commencement of warfarin and understanding of the planned duration. Occasionally this information is not easily available to the GP, who may have recently taken over care, or may not have access to previous records. However, this is usually easily remedied as GPs can seek the information and review the rationale for the use of warfarin, including consultation with the physician who may have been involved in the decision to commence or continue warfarin. With this information GPs can assess the risk of cessation of warfarin.

However, surgical and anaesthetic methods have continued to change and most GPs are unlikely to know the contemporary surgical processes such as the surgical approach, the preferences of the surgeon, or whether reversal of warfarin or other strategies to manage bleeding are used by the anaesthetist. Without this understanding of the contemporary procedures in the operating room, GPs cannot necessarily assess the risk of continued warfarin or advise the patient on this risk. It would be useful for the GP to know the INR level above which the surgeon considers surgery to be too risky.

Patients need consistent advice which means decisions have to be well communicated throughout the continuum of care...

Ultimately this is an issue which requires good communication from:

- the GP who should inform the surgeon of the use and rationale of warfarin
- the surgeon who should inform the GP of the risks and requirements of surgery in relation to warfarin, and communicate with the anaesthetist who will need to be prepared for complications relating to coagulation
- all health professionals involved in the continuum of care, so that consistent advice is provided to the patient about warfarin.

Beyond warfarin there are now the new direct thrombin inhibitors such as dabigatran which, unlike warfarin, cannot be reversed with vitamin K. Patients may also be on the antiplatelet treatment, clopidogrel, premature cessation of which is associated with intracoronary stent thrombosis. Communication between treating doctors to assess the risks and benefits of surgery and cessation of anticoagulation is critical in providing optimal patient outcomes.

A physician's perspective – A/Prof David Watson

The management of anticoagulant and antiplatelet therapy is particularly the province of general practice. Usually, it is not the GP who initiates these therapies. In the context of a patient undergoing surgery or any other procedure it is usually the decision of the proceduralist, with the GP being advised sometime later. Herein lies one of the great problems of patient management and a potential source of difficulty.

Anticoagulants

For the most part this is warfarin.

In patients with atrial fibrillation, there's generally little difficulty. Warfarin can be withdrawn about five days ahead of the procedure and provided the INR is below 1.5, most would consider it safe to proceed.

Warfarin can be recommenced post-procedure at a suitable time that will depend on the nature of what has been done. Frequently, as there is no hurry to return the patient to a therapeutic INR, the warfarin re-start might be done without a loading dose. Where appropriate, the patient should be covered with a prophylactic dose of a heparin preparation.

Patients with prosthetic heart valves need additional consideration of how to protect the valve from thrombosis with the patient off warfarin. Patients with deep venous thrombosis and/or pulmonary embolism (VTE) require individual decisions about warfarin withdrawal and appropriate cover depending on:

- the nature of the VTE problem
- the procedure
- whether there is a recognised thrombophilic state (especially anti-thrombin factor III deficiency).

Rarely, there may be procedures where no withdrawal of warfarin is seen as necessary by the proceduralist.

It is good practice for the proceduralist to consult with the patient's GP and/or cardiologist or physician, so the decision on how to manage the process and anticoagulants is a joint one.

Antiplatelet drugs

Most frequently this issue crops up with coronary artery stents. Again management will be influenced by:

- the planned procedure
- the nature of the stents in situ
- when the stents were put in place.

Here, the proceduralist will have a view as to whether antiplatelet therapy needs to be withdrawn but in any event; best practice would suggest there is contact with the patient's cardiologist to establish the plan of management. Again, the patient's GP needs to be in the decision loop.

Newer anticoagulants

There has been much interest in the arrival of newer agents like dabigatran and rivaroxaban as replacements for warfarin. The biggest single problem that will emerge with these drugs centres on the reality that they are difficult to reverse. This will have an impact only in the emergency situation for procedures. There will routinely still need to be a conversation between proceduralist, the patient's GP and the individual who initiated the use of the drug to establish the plan of management around the procedure.

Summary

The issues are complex. There is an essential need for good communication between proceduralist, patient, the patient's GP and any specialist involved in the care around the indication for, and use of, anticoagulant or antiplatelet drugs to establish the safest environment around the proposed procedure.

1 Borosak M, Choo S, Street A. Warfarin: balancing the benefits and harms. Aust Prescr 2004;27(4):88-92.

2 Baker R, Coughlin PB, Gallus AS, Harper PL, Salem HH, Wood EM, the Warfarin Reversal Consensus Group. Warfarin reversal: consensus guidelines, on behalf of the Australasian Society of Thrombosis and Haemostasis. Med J Aust 2004;181(9):492-7.

3 Campbell P, Roberts G, Park D, Eaton V, Coghlan D, Gallus A. Managing warfarin therapy in the community. Aust Prescr 2001;24:86-9.

The Hidden Dangers of Medical Tourism

We have seen a lot of press recently about the increase in medical tourism, and the potential danger it poses for patients seeking a nip, tuck and a holiday for far less than they would pay for the same surgical procedure in Australia. The lure of a post-operative recovery in a 5 star resort is not always as luxurious as it sounds.

We have all heard the horror stories about what can go wrong for the patient, but are there increased risks for Australian doctors treating these patients post-operatively?

Plastic surgeons frequently treat patients that require or request corrective surgery, following off-shore plastic surgery that has produced a less-than-ideal result. There is a slightly increased risk for doctors that agree to provide corrective surgery for patients that have returned from overseas surgery, for two main reasons:

- patient selection – the end result may still not live up to the patient's expectation
- the doctor is likely dealing with an already disgruntled patient who is understandably angry at being asked to pay much more for the correction than they did for the original surgery.

There is an even greater risk, however, which affects a larger number of specialties, particularly GPs. This was evidenced recently in a case where a GP Member was accused of negligence after seeing a patient on two occasions following her return from overseas where she had recently undergone breast augmentation surgery.

The patient suffered necrosis, infection and subsequent scarring as a result of the surgery and it was clear that the GP would not ordinarily have been included in the action had the patient's lawyers been able to sue the overseas surgeon. The legal system was quite different in the country where the procedure was performed, and any opportunity to seek recovery from the surgeon had long since passed.

Through expert evidence and expertise, MDA National and our legal representatives convinced the patient's solicitors to release our GP Member from the action; however this did not reduce the emotional stress placed on the doctor while we worked towards this result.

MDA National Members should bear this case in the mind when presented with a post-op complication arising from surgery performed overseas. If you have any concerns about the presentation, referral of the patient to the nearest hospital, and/or an urgent specialist review should be considered. By the time the patient presents to you, the damage may have already been done, but you raise your potential liability simply because the legal system in Australia is more accessible than it is in the countries specialising in cheap cosmetic procedures.

It is not clear whether medical tourism has reached saturation point, or whether more infrastructure and aggressive marketing will increase the popularity of cut-price cosmetic surgery on foreign shores. We encourage our Members to be vigilant when dealing with these post-operative patients; in the absence of anyone else to sue for their damage, the patient may well turn their attention to you.

Nerissa Ferrie
Medico-legal Adviser

If you have any concerns about the presentation of a post-op complication from off-shore surgery, consider referring the patient to the nearest hospital.

What is privacy?

The concept of privacy in the context of health care can be difficult to define. From a medico-legal point of view, privacy refers to the rights of an individual to access and control the use and disclosure of information held about them.

Privacy

What is the difference between privacy and confidentiality?

The term confidentiality refers to the duty not to disclose information that has been provided in confidence. Privacy covers a broader range of issues, including restrictions on the disclosure of personal information but also the right of an individual to access information held about them.

What privacy legislation is there in Australia?

There is no general protection of privacy under Australian law. The *Privacy Act 1988* (Cth) (Privacy Act) was amended on 21 December 2001 to cover health service providers in the private sector. The Privacy Act does not cover most Commonwealth, state and territory public sector health service providers, such as public hospitals.

There is also legislation in ACT, NSW and Victoria which covers health information held in the private sector. This legislation generally mirrors that of the Privacy Act, but in the ACT and Victoria there are additional principles covering the transfer of records, closing a practice and making information available to another doctor.

What are the obligations of medical practitioners under the privacy legislation?

The provisions in the Privacy Act are based around 10 National Privacy Principles which represent the minimum privacy standards for handling health information. Health information includes any information collected by a health service provider during the course of providing treatment and care to an individual, including:

- medical information held in any form, such as paper, electronic, audio and visual records (e.g. x-rays and photos)
- personal details, such as name, address, billing information, Medicare and other identification numbers
- information generated by a health service provider, such as notes and opinions about an individual and their health
- information about physical or biological samples
- genetic information.

The 10 National Privacy Principles are outlined below, including some guidance for medical practitioners on compliance with these principles in medical practice:

1. Collection

Medical practitioners should only collect health information necessary for their functions or activities. Health information should be collected directly from an individual if it is reasonable and practicable to do so. At the time of collecting health information, or as soon as practicable afterwards, medical practitioners should take steps to make a patient aware of:

- why information is being collected
- who else the information may be given to.

If information is collected about a patient from someone else, reasonable steps should be taken to ensure the patient is aware of the above points. Consent should be obtained to collect health information, unless an exemption applies.

2. Use and disclosure

Medical practitioners should only use or disclose health information for the primary purpose of collection (that is, for the provision of heath care to that patient) and directly related secondary purposes within the patient's reasonable expectations. Secondary purposes include:

- billing or debt recovery
- disclosure to a medical defence organisation or lawyer for the purpose of addressing liability indemnity arrangements, e.g. reporting an adverse event
- an organisation's quality assurance or clinical audit activities
- disclosure to a clinical supervisor.

A medical practitioner can also use or disclose health information for almost any purpose if they have the consent of the patient to do so.

Other circumstances where use and disclosure are permitted include:

- to lessen or prevent a serious and imminent threat to an individual's life, health or safety; or a serious threat to public health or public safety
- to investigate and report suspected unlawful activity
- where required or authorised by law.

3. **Data quality**

   Medical practitioners must take reasonable steps to ensure that the health information they collect, use or disclose is accurate, complete and up-to-date.

4. **Data security**

   This principle requires that a medical practitioner take reasonable steps to:

   - protect the health information it holds from misuse and loss, as well as from unauthorised access, modification or disclosure
   - destroy or permanently de-identify health information that is no longer needed.

5. **Openness**

   Medical practitioners should have a document ('Privacy Policy') that sets out the practice's policies on how the practice manages health information which can be made available to anyone who asks for it.

6. **Access and correction**

   Access involves a medical practitioner giving a patient information about themselves and applies to records created on or after 21 December 2001 and also to information collected before this time if it has been referred to or in use after 21 December 2001. Access may involve the inspection of the medical records or obtaining a copy of the records, unless certain prescribed exceptions apply. These exceptions include:

   - access would pose a serious threat to the life or health of any individual
   - privacy of others may be affected
   - the request is frivolous or vexatious
   - information relates to existing or anticipated legal proceedings
   - access would be unlawful
   - denying access is required or authorised by or under law
   - law enforcement and national security
   - commercially sensitive evaluative information.

It is not legally necessary for a patient to request access to their medical records in writing. However, a note should be made in the records that access has been provided and, in some situations, it may be preferable to obtain the patient's request in writing. The Privacy Commissioner recommends that when a written request for access is received, an acknowledgement should be sent within 14 days. The acknowledgement should include an indication of the costs (if any) involved in processing the request. As a guide, the Privacy Commissioner recommends that the total time for processing a request for access should be no more than 30 days.

7. **Identifiers**

   This principle prohibits the use or disclosure of Commonwealth identifiers except where these uses or disclosures are necessary to fulfil obligations to Commonwealth agencies, or where certain other provisions apply.

8. **Anonymity**

   This principle sets out a medical practitioner's obligations to make available to individuals the option of not identifying themselves wherever this is lawful and practicable.

9. **Transborder data flows**

   This sets out a medical practitioner's obligations when transferring health information outside Australia.

10. **Sensitive information**

    This includes all health information about an individual.

Conclusion

If you have any questions about your obligations with respect to compliance with the privacy legislation and, in particular, requests for access to medical records or preparation of a Privacy Policy in your practice, please contact our Medico-legal Advisory Service on 1800 011 255 or email us at **advice@mdanational.com.au**.

For urgent medico-legal advice, Members can contact MDA National 24 hours a day, 7 days a week on 1800 011 255 and speak to an experienced medico-legal adviser.

Further information

Privacy Commissioner. Guidelines on Privacy in the Private Health Sector. 8 November 2001. Available from: **www.privacy.gov.au/materials/types/guidelines/view/6517**

AMA. Privacy Resource Handbook. July 2010. Available from: **http://ama.com.au/node/5974**

Office of the Australian Information Commissioner **www.oaic.gov.au/privacy-portal**

Privacy – A General Practitioner's Perspective

Dr Jill Maxwell OAM (pictured on front cover)
SA GP and Member of MDA National's President's Medical Liaison Council (SA)

Every day in general practice we face decisions that involve patient privacy. From the time patients give their personal information to practice staff to the time they tell the doctor all the confidential details of their medical and personal problems, they are potentially exposing themselves to breaches of their privacy. Patients place enormous trust in doctors and our staff, and it is up to us to ensure that we are worthy of their trust.

There are many situations where we need to stop and think about whether something we or our staff do (or don't do) could, even in an extreme situation, lead to a breach of the patient's privacy.

Think, for example, of the many situations in which we are asked to transfer information about a patient to another person: referral letters; transfer of patient records to another doctor; innocent information requested by a third party etc.

Should we ask the patient's permission to transfer each particular piece of information? What should we do when a patient requests that select pieces of information be kept from other providers? Is it part of our job to warn them of the risks of disclosing and not disclosing every piece of information that is normally contained in the referral letter?

E-health brings many advantages, including vast improvements in communication between healthcare providers, but improved communication brings new privacy risks. The Personally Controlled Electronic Health Record (PCEHR), to be introduced Australia-wide in July 2012, will have many more attendant risks of privacy breaches.

The following are some situations that I have encountered in my general practice over recent months:

A physiotherapist or her receptionist rings to ask for a patient's telephone number or new address, do you provide the details?

Arguably this would be permissible if it is within the patient's reasonable expectations that his or her healthcare providers (including physiotherapist) would share such private information.

This can easily be ascertained by:

- asking the patient
- asking patients to review and sign a *Practice Privacy Policy* which expressly states that patients' private information will be shared with other health professionals who are managing their care.

In the absence of the patient's specific consent, the reason for the request from the physiotherapist will be of relevance. If the details were required to follow up care, it would be appropriate to release the information. If the details were required for research or marketing purposes, additional and specific consent from the patient would be required to release the information.

The father of a five year old patient rings and asks for a copy of his son's medical records. The patient attends the practice with his mother and the parents are separated. Should you give the records to the father?

In general terms, either parent of a young child is able to obtain information about the medical management of their child. In the case of children who are not capable of giving consent, you can disclose health information to a "person who is responsible" for the child, including a parent. The Privacy Act does not specify that a parent must be a "custodial parent."

However, exceptions may apply when there is a court order that grants sole responsibility for the medical care of the child to one parent, or where the medical practitioner believes disclosure of the information may pose a serious threat to the life or health of any individual.

After a patient dies, to what extent is it appropriate to discuss their medical history with their family members?

The Privacy Act does not apply to deceased persons. In this situation, each case should be considered on an individual basis. It may be appropriate to discuss a deceased patient's medical history with their family for compassionate reasons, but information should not be disclosed if it is contrary to the known wishes of the deceased patient. In other situations, it may be necessary to obtain the written authority from the executor or administrator of the patient's estate before releasing any information. This is especially important when there is a dispute about the patient's will or estate.

A patient asks for a copy of the specialist's letter about her. The letter contains nothing that you are unhappy to share with the patient. Do you give it to her?

The specialist's letter should be given to the patient. Under the Privacy Act, patients have a right to access their medical records, including reports to and from specialists. This is regardless of whether or not the specialist's letter states that it is not to be released to a third party without the permission of the specialist.

You refer a patient to a specialist and the patient asks that you do not include in the letter the fact that he/she is taking medication for genital herpes. What is the most appropriate response?

It is incumbent on the medical practitioner to discuss and impress upon the patient that the specialist needs to be aware of the full range of medications, and their relevant past medical history, in order to make an accurate assessment of the patient. This is especially the case if the information will be of direct relevance to the referral; for example, obstetric care where a past history of genital herpes may be of significance.

In some circumstances, particular information may not be relevant to the referral, and by agreement can be omitted from the letter to the specialist.

Legal

Sexual Boundaries and the Doctor-Patient Relationship

A number of recent Medical Board decisions have highlighted the importance of maintaining clear professional boundaries in medicine.

In one recent case, a GP who engaged in a sexual relationship with one of his patients 26 years ago was suspended after the patient's former husband reported him to the Medical Board.[1] The GP started the affair with the patient less than 12 months after delivering the woman's second child, while he was still treating the patient and her children occasionally.

In another case, a female GP was cautioned, reprimanded and ordered to undergo counselling as to the importance of a medical practitioner maintaining the professional boundary between her and her patients.[2] The inappropriate personal relationship had ostensibly grown out of a workplace relationship – the patient was also the part-time (week-end) cleaner at the medical clinic. After engaging in conversation over a cup of tea in the tearoom, gradually a situation developed wherein the pair would "make out" when the clinic was closed. A sexual relationship developed.

In another case, disciplinary proceedings were commenced against a psychiatrist following his sexual relationship with a female patient whom he was treating for bipolar affective disorder.[3] The psychiatrist's registration was suspended for two years.

Background

The Good Medical Practice: A Code of Conduct for Doctors in Australia provides some guidance for doctors about sexual boundaries.

Section 1.4 of Good Medical Practice states:

Doctors have a duty to make the care of patients their first concern and to practice medicine safely and effectively. They must be ethical and trustworthy.

Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.

Section 8.2 of Good Medical Practice states:

Professional boundaries are integral to a good doctor-patient relationship. They promote good care for patients and protect both parties. Good medical practice involves:

- *maintaining professional boundaries*
- *never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient.*
- *avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.*

That maintaining a sexual relationship with a patient is professional misconduct by a doctor is very well established by the case law.[4] All of the decisions emphasise that the doctor-patient relationship is one that puts the doctor in "a position of special trust towards, and power over a patient."[5]

The potential to cause harm to the patient and loss of objectivity in the doctor is particularly relevant. For example, to quote the judgment of Kirby P (as he then was) in *Stewart v Secretary, Department of Health*: [6]

... it is unacceptable for advantage to be taken of a position of trust, particularly to do harm to the patient, including emotional harm whilst the patient remains in the care of the medical practitioner. Equally unacceptable is it to deprive the patient of the advantage of dispassionate diagnosis and treatment because the relationship between the medical practitioner and the patient has become charged with emotion (whether sexually based or not) which prevents the practitioner from offering objective professional judgment and skill, or the patient from receiving it, to the patient's best advantage.

On 28 October 2011, the Medical Board of Australia published guidelines for doctors to complement *Good Medical Practice: A Code of Conduct for Doctors in Australia* and provide more detail about maintaining and understanding sexual boundaries in the doctor-patient relationship[7] (the Medical Board's guidelines).

Maintaining sexual boundaries

The Medical Board's guidelines make clear that doctors are responsible for establishing and maintaining boundaries with their patients. It always unethical and unprofessional for a doctor to enter into a sexual relationship with a patient, even if the patient has provided his or her consent. It may also be unethical and unprofessional to begin a sexual relationship with a former patient, an existing patient's carer or an existing patient's close relative.

These guidelines indicate that a doctor should:

- explain to the patient what is to occur in a medical examination and provide an opportunity for the patient to ask questions
- gain patient consent to conduct an examination, and do not proceed with an examination if consent is uncertain, has been refused or has been withdrawn
- allow a patient to undress for an examination in private and provide suitable covering during the examination
- use gloves when examining genitals or conducting internal examinations
- not allow the patient to remain undressed for any longer than is needed for the examination
- ask for the patient's permission if anyone else, including medical students, are to be present during an examination or consultation
- discuss with the patient the value of a chaperone being present during physical examinations or allow the patient to bring a support person if this would make the patient feel more comfortable
- if a chaperone is not available, or the patient is uncomfortable with the choice of chaperone, offer to postpone the examination until an appropriate chaperone is available, if this does not impact on the patient's health care.

A doctor should not:

- discuss his or her own sexual problems or fantasies
- make unnecessary comments about a patient's body or clothing or make other sexually suggestive comments
- ask questions or make comments about a patient's sexual history or preferences unless this is relevant to the patient's problem or the doctor has explained why it is necessary to discuss the matter.

Former patients

Whilst cases demonstrate that a sexual relationship between a doctor and an existing patient will never be countenanced, the position is less absolute regarding a sexual relationship with a former patient. The guidelines indicate it may be unprofessional, depending on the particular circumstances. The Medical Board will consider each case individually, including:

- the duration of care provided by the doctor, for example, if there was long-term emotional or psychological treatment provided
- the level of vulnerability of the patient
- the time elapsed since the end of the professional relationship
- the manner in which and reason why the professional relationship was terminated
- the degree of dependence in the doctor-patient relationship
- the context in which the sexual relationship was established.

Preventing boundary violations

An improper emotional or sexual relationship between a doctor and a patient can start very easily. In many instances, violation of professional boundaries is not a consciously predatory action, but develops from a more benign boundary crossing of a non-sexual nature; this is often referred to as the 'slippery slope'.[8] Therefore, attention to non-sexual boundary issues may be an effective way to prevent sexual boundary violations.

Warning signs that indicate that professional boundaries are threatened include:

- patients requesting or receiving appointments at unusual hours, especially when other staff are not there
- giving or accepting expensive gifts or social invitations from a patient
- a doctor revealing intimate details about his or her life to a patient during a professional consultation, especially personal crises, sexual desires or practices
- patients asking personal questions, using sexually explicit language or being overly affectionate.

If you recognise your own behaviour in any of the above points or you feel attracted to a patient, consider whether this is interfering with the patient's care. It might be helpful to confidentially discuss how to manage the situation with MDA National's Medico-legal Advisory Services.

If you believe you cannot remain objective and professional, it is important to transfer the patient's care to another doctor. However, this does not mean that you can begin a sexual relationship with the patient.

Your duty to notify

If you form a reasonable belief that another doctor may have breached sexual boundaries with a patient, you have a legal responsibility to report this to the Australian Health Practitioner Regulation Agency (AHPRA). Healthcare professionals have a legal responsibility to report all "notifiable conduct", which includes a practitioner who has engaged in sexual misconduct in connection with their practice. The report must be made even if the patient does not wish to complain to a regulatory body.

The Medical Board's guidelines are available on AHPRA's website **http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx**.

Enore Panetta
Director, Panetta McGrath Lawyers

1 *Medical Board of Australia v Erhardt* [2011] VCAT 1702
2 *Medical Board of Australia v Petrovic* [2011] VCAT 795
3 *Medical Board of Australia v Yasin* [2011] QCAT 300
4 See, for example, *Re a Medical Practitioner* [1995] 2 Qd R 154
5 Dowsett J inRe *a Medical Practitioner* [1995] 2 Qd R 154 at 163
6 *Stewart v Secretary, Department of Health*, New South Wales Court of Appeal, 6 August 1986
7 *Sexual Boundaries: Guidelines for doctors,* 28 October 2011.
8 Galletly C. *Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation.* Med J Aust 2004; 181:380-383.

MDA National

CaseBook

Refunding Fees: An Admission of Liability?

Case history

The 34 year old patient underwent a breast augmentation. Her post-operative course was uneventful but at a six month review, the patient expresses dissatisfaction with the cosmetic outcome, complaining that her breasts are asymmetrical. The patient requests a refund of the fees she paid for the procedure as she plans to have corrective surgery performed by another surgeon and further costs will be incurred.

Medico-legal issues

Members should contact MDA National for advice as soon as possible if faced with a patient who is requesting a refund of fees. If the request is made by a patient during a consultation, it may be appropriate to either ask the patient to put their request in writing to you, or to advise them that you need to seek advice before providing any response to their request. If you receive a written request for a refund of fees, this should immediately be forwarded to MDA National.

Should I agree to the patient's request to refund the costs of their treatment?

There is no "correct" way of managing this situation and each case needs to be considered on its own merits. The request for a refund from the patient may be made when:

- there has been an error associated with an adverse outcome e.g. wrong site surgery
- there has been a complication of treatment and an adverse outcome but not necessarily negligence e.g. keloid scar following a skin cancer excision
- the patient is dissatisfied with the outcome of treatment but has not experienced any complication or adverse outcome e.g. dissatisfaction with the outcome of a cosmetic procedure when objective review reveals a satisfactory outcome.

In general terms, the advice given by MDA National in each of these three situations will differ:

1. There has been an error and negligence

You should send an incident report to MDA National as soon as possible. After you have discussed the case with the Claims Manager at MDA National, it is appropriate for either you or MDA National to refund the costs of treatment. Ideally, this should be done on the basis of a Deed of Release, although in some circumstances it may not be possible to complete a Deed; e.g. if the patient's condition has not stabilised. These matters will generally be dealt with by MDA National on your behalf as a 'Claim' under your Professional Indemnity Insurance Policy.

2. There has been a complication of treatment and an adverse outcome but not necessarily negligence

Again, an incident report should be sent to MDA National. In these cases, following your discussion with the Claims Manager, a decision will be made as to whether or not to agree to the patient's request for a refund. If the patient's medical condition is stable, it may be appropriate for the refund to be provided to the patient on the basis of a Deed of Release.

3. The patient is dissatisfied with the outcome of treatment but has not experienced any complication or adverse outcome

MDA National strongly recommends that if a refund is considered in this situation it should only be made on the basis of a Deed of Release and advice should be sought from MDA National.

If a Deed of Release is required, MDA National will prepare the document for you. It is essential when forwarding a Deed of Release to a patient that the covering letter advises the patient that they should seek independent legal advice before signing the Deed. Most Australian states provide review of 'unjust' contracts and an essential consideration when reviewing the enforceability of a contract (Deed) is any inequality in bargaining power between the parties to the contract. Ensuring that the patient is advised to seek independent legal advice will mitigate the possibility of the patient successfully challenging the Deed of Release.

Is it an admission of liability to refund fees?

No, refunding fees per se is not an admission of liability, but care needs to be taken in this situation, and expressions to use may include:

"As a gesture of goodwill, I am refunding my fees for the procedure."

"I regret that my treatment has not met your expectations and so I have agreed to refund my fees for your procedure, but please note that this offer should not be construed as an admission of any liability on my part."

Dr Sara Bird
Manager, Medico-legal and Advisory Services

Open Access Endoscopy Claim

Case history

In 2002 Ms M, aged 23 years, presented to the local GP for the first time. Ms M described some obsessive compulsive characteristics and, following a few consultations, the GP prescribed antidepressants. Ms M also had a history of Coeliac Disease which had been diagnosed at age 16 and was managed by diet.

On 29 January 2004 Ms M experienced persistent episodes of severe stomach cramps, vomiting and weight loss and she attended another GP. Ms M was referred to a private specialist for "urgent" endoscopy but did not attend because of financial difficulty.

Ms M continued to experience symptoms of abdominal pain, vomiting and weight loss. After contacting her local GP, an "open access" endoscopy was organised at the Endoscopy Centre, where it was agreed Ms M would be bulk-billed.

On 9 February 2004 Ms M saw the local GP, who completed the standard *Gastroenterology Request Form* for the Endoscopy Centre. The GP marked the square next to "Upper endoscopy" and under the heading "Clinical Notes" the GP recorded the following:

"Known Coeliac after endoscopy 7 years ago. Over 4kg weight loss, vomiting and abdo pain and some diarrhoea for many weeks."

The patient was given a document headed "Information Concerning Panendoscopy" and on 13 February 2004 an endoscopy was performed by a gastroenterologist who worked at the Endoscopy Centre one day a week.

At the conclusion of the procedure the gastroenterologist wrote to the local GP and reported that the pharynx, oesophagus and stomach appeared to be "normal", but the "duodenum still appears abnormal consistent with ongoing villous atrophy". Under the heading "Summary" the gastroenterologist wrote "persisting villous atrophy".

Ms M fell pregnant despite persistent symptoms of abdominal pain, vomiting, diarrhoea and weight loss, and successfully delivered a child in January 2005.

By May 2005 Ms M weighed 38 kg and had lost 12 kg. Another gastroenterologist performed a further endoscopy which revealed a small bowel carcinoma.

Medico-legal issues

Ms M claimed damages against both the local GP and the first gastroenterologist.[1] The claim against the GP did not proceed to trial.

The case against the gastroenterologist was essentially comprised of two parts. The precise location of the tumour was in issue. According to some evidence the tumour was located in the third part of the duodenum and according to other evidence it was located at the junction of the duodenum and the jejunum.

In issue was the distance to which the endoscope should be passed to adequately assess the upper gastrointestinal tract. Evidence obtained from two expert witnesses indicated that at the time it was accepted by peer professional opinion that the usual practice was to pass the endoscope only as far as the second part of the duodenum, unless an attempt to go further was warranted by particular symptoms or signs. The Court held that the gastroenterologist was not presented with a set of symptoms strongly indicating the presence of tumour and he had exercised reasonable care and skill in the performance of the endoscopy.

The second issue was the gastroenterologist's written report which communicated his findings to the local GP. The Court held that the duty which the law imposes on a medical practitioner is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement".[2]

Although the open access request required the gastroenterologist to perform an investigatory procedure and did not require him to treat Ms M, the Court held that it was incumbent upon the gastroenterologist to reveal the limitations of his investigations, in case the treating doctor or the patient believed no further investigations were warranted.

The Court found that the gastroenterologist's written report implied that all of Ms M's symptoms were explained by villous atrophy. The report did not give the GP an indication that some of Ms M's symptoms were not explained by untreated Coeliac Disease. The Court held that there was a foreseeable risk that in Ms M's case a serious condition such as a tumour may exist and despite the "open access" basis for the procedure, the gastroenterologist was obliged to exercise reasonable care and skill to avoid that risk.

The gastroenterologist was found to be negligent for not adequately and fully reporting or advising Ms M and the GP that further investigations and treatment were urgently indicated in this case. The Court held that more probably than not the gastroenterologist's negligence was causative of Ms M not undergoing further investigations and her tumour being undetected until her second endoscopy in 2005. Damages were awarded.

Discussion and risk management strategies

Open access endoscopy is a widely used and accepted practice. Study results are mixed with respect to reports of potential problems and patient satisfaction. The common problems identified include inappropriate referral and poorly informed less satisfied patients. Many patients prefer to be seen at a specialty clinic before their endoscopy and a British study has shown that additional diagnoses not made by open access endoscopy were made at the clinic visit.[3]

In Ms M's case the procedural skill of the gastroenterologist was held to be of a reasonable standard but the quality of the gastroenterologist's written report was found to be negligent because the gastroenterologist had not adequately communicated the significance of his findings to the treating doctor.

It is important to establish procedures to make open access endoscopy an efficient, safe and reasonable practice. Detailed information about the indications and contraindications of endoscopy should be available to both patients and primary care providers. Mechanisms should be in place to facilitate the endoscopist to receive the patient's pre-endoscopic information.[4]

A detailed mechanism for reporting results and establishing proper follow-up is essential. Ms M's case clearly demonstrates the essential requirement of communication and transfer of information between medical practitioners as the crux of optimum patient management.

Dr Benvinda Xabregas
Medico-legal Adviser

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1 *Mazza v Webb* [2011] QSC 163

2 *Sidaway v Board of Governors of Bethlehem Royal Hospital Board* [1985] UKHL; [1985] per Lord Diplock at 893, cited with approval in *Rogers v Whitaker* [1992] HCA 58; (1992) 175 CLR 479 at 483.

3 Saunders BP, Trewby PN. Open access endoscopy: is the lost outpatient clinic of value? Postgrad Med J 1993;69:787-90.

4 Sheperd HA, Bowman D, Hancock B, et al. Postal consent for upper gastrointestinal endoscopy. Gut 2000;46:37-9.

The Gift of Giving

At MDA National, we believe that our responsibility as a successful organisation extends beyond our own business – it's a commitment to the community in which we operate. To demonstrate this commitment and ongoing focus, we officially launched the MDA National Corporate Social Responsibility (CSR) Program in May 2011 which has three key components:

1. The MDA National Community Fund

Our community fund enables us to engage in activities focussed on making a difference in the communities in which we operate.

Support through our Community Fund to date:

- Queensland University – $16,000 donation to Queensland University and the medical students affected by Queensland floods.
- The Think Pink Foundation – sponsored the Think Pink Masquerade Ball to assist the Think Pink Foundation to continue to support people with breast cancer visit **www.thinkpink.org.au** to find out more about the Foundation.
- Serenity Productions –sponsored the play *Bill W and Dr Bob* during its July showing in Sydney which helped raise awareness and promote the need to support doctors' mental health and tackle substance abuse.
- Oxfam TrailWalker – in-kind donations to support Oxfam's work around the world. If you'd like to support Oxfam visit **www.oxfam.org.au**.
- Children's Equity – in-kind support to assist the Children's Equity Developmental Assessment, Review and Support (CEDARS) centre to support disadvantaged children.

2. Staff Volunteer Program

Our Volunteering program gives our employees a way to become actively engaged by providing employees with one day of volunteer leave per year. Staff can volunteer with one of the charities supported by MDA National or their own favourite charity.

Top left: L-R Elizabeth van Ekert, Program Manager and Professional Services Adviser (PyP), Kerrie Lalich, Executive Manager Professional Services and Julie Brooke-Cowden, Claims Manager (Solicitor) knitting for Wrap With Love

Top right: L-R Michelle Finnigan, Executive Manager Head of Marketing, Dr Sally Cockburn, MDA National Member, and Judi Pickett, Relationship Manager (VIC/TAS) at Think Pink Ball, May 2011

3. Workplace Giving Program

To date, this has included activities that assist charities in raising awareness and funds:

- Australia's Biggest Morning Tea, Cancer Council – staff donations
- Club Red Blood Drive WA, Australian Red Cross – staff blood drive
- Daffodil Day, Cancer Council – staff donations
- Cupcake Day, RSPCA – staff donations as well as baking 100's of cupcakes
- Movember – staff donations and Mo Bro contenders raising $1500 as at 17 Novmber 2011.

As part of our program, we will continue to support a variety of initiatives to help maximise the positive impact we have on our community.

Children's Equity

Children's Equity (CE) was formed in 2010 to benefit disadvantaged children. MDA National Member, Dr Michael Watson, along with assistance from the Freehills legal team, the Brand Agency and several other companies and individuals, started the charity to "make the world easier...one child at a time."

Dr Watson's own experiences with a child with developmental issues and the difficulties faced in engaging the healthcare system have resulted in the charity's first project – the Children's Equity Developmental Assessment, Review and Support (CEDARS) centre.

How can you help?

CE is looking for partners who can provide support in the medical or business fields. For more information contact Dr Michael Watson at **michael.watson.ce@bigpond.com**.

What's On?

Save the dates – first quarter of 2012

MDA National is promoting your well-being again in 2012 with a number of Cognitive Workshops on how to master work/life balance.

We are also supporting Members by sponsoring a number of state and local conferences and events in collaboration with colleges and associations. We welcome you to come and visit us at any of the events below.

Contact our Events and Sponsorship team on **events@mdanational.com.au** or 1800 011 255 to find out more or to register for any of these events.

January 2012

28 January

Royal Australian College of General Practitioners – Pre-exam Session for doctors in specialist training, SA and NT (sponsored event)

February 2012

8 February

Mastering Work/Life Balance Workshop, VIC (MDA National Event)

10-12 February

Royal Australian College of General Practitioners – Fellowship Preparation Program, SA (sponsored event)

15 February

Mastering Work/Life Balance Workshop, QLD (MDA National Event)

25 February

Mastering Work/Life Balance Workshop, WA (MDA National Event)

29 February

Mastering Work/Life Balance Workshop, NSW (MDA National Event)

March 2012

7 March

Mastering Work/Life Balance Workshop, NSW (MDA National Event)

17 March

Mastering Work/Life Balance Workshop, WA (MDA National Event)

17-18 March

RANZCR WA Annual Meeting Workshop, WA (sponsored event)

MDA National
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Have you moved?

Have your practice details changed?

To update your details, please call Member Services on 1800 011 255 or log on to the Member Online Services section of our website **www.mdanational.com.au.**

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

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