defenceupdate

Quarterly Publication for MDA National Members

Winter 2014

MDA National
Support Protect Promote

Editor's Note

In this issue of *Defence Update*, our President, A/Prof Julian Rait, discusses the proposed merger of MDA National and Medical Insurance Group Australia (MIGA). On page 3, Julian outlines the rationale behind the proposed merger and the anticipated benefits of the proposed new organisation. Members are encouraged to contact us with any questions about the proposed merger.

For MDA National staff, it remains "business as usual". In this edition, we address a number of emerging and perennial medico-legal topics that have an impact on our Members and their practices.

A unique perspective on bariatric surgery is provided by two of our Members, GP Dr Natalie Sumich and Physician A/Prof David Watson (pages 6-7).

On page 8, our Medico-legal Advisory Services team addresses a topic that our Members frequently contact us about – the legal requirements and recommendations for the retention and destruction of medical records.

The March 2014 amendments to the *Privacy Act 1988* (Cth) changed the legislative requirements with respect to privacy policies. This has prompted us to provide a comprehensive overview to assist you in reviewing your practice's privacy policy (pages 9-12).

The integral role of empathy in medical practice cannot be overemphasised. Discomfort when having conversations with patients that involve emotional matters can be interpreted as indifference, which can lead to complaints and claims. Nicole Harvey from our Education Services team provides some practical tips on communicating empathically (pages 14-15).

Finally, some recent enquiries from Members about the delegation of cosmetic Schedule 4 injections and the use of patient testimonials are discussed in our regular CaseBook series (pages 16-18).

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

From the President

A New Force in Medical Indemnity

"To improve is to change; to be perfect is to change often." *Winston Churchill*

Certainly in the corporate world, more competition, greater regulation, improving technology and higher customer expectations have been driving business performance like never before. And in recent years, some of the most successful businesses have been those that have embraced real innovation, pursued lateral thinking and become ever more inventive and differentiated in order to grow.

Less than two decades ago, MDA National was a state-based Medical Defence Organisation (MDO) with a few thousand Members and net assets of less than $10 million. However, a bold decision made by your Mutual Board in the year 2000 saw the business embrace Members from other states and invest in a nationwide presence. Today, MDA National has an office in every state with NSW, VIC and QLD accounting for 57% of our medical Membership, and our net assets continue to grow from the $145 million reported at 30 June 2013.

Nonetheless, despite this achievement, our Managing Director Peter Forbes has not been complacent. For some years, Peter has been a public advocate for greater industry consolidation to improve efficiency. So during 2013, the MDA National Mutual Board began exploring whether we could create a new group in partnership with another MDO, to take the best of the two organisations and create an even stronger and more influential player in the industry.

Whilst transformational change can be surprising and even unsettling for some, the need for even higher performance has led your Mutual Board to recommend a carefully considered proposal to pursue a merger with another mutually-based MDO, namely Medical Insurance Group Australia (MIGA). The focus is clearly directed towards the bigger picture for Members in the long term.

Not unsurprisingly, MDOs are some of Australia's oldest mutual organisations.

MDOs like MDA National and MIGA are mutually-owned structures that exist for the benefit of the medical profession, through the provision of professional support and advice, together with access to professional indemnity insurance. MDOs provide these benefits through a unique structure of doctor ownership supported by a wholly owned, licensed and regulated professional indemnity insurance company.

The new organisation – to be called Medical Defence Australia Ltd – will remain a Member-owned organisation formed from the merger of MDA National and MIGA with a majority of Member doctors as Directors. This will ensure that responsive Member representation continues and that the interests of the profession are always at the heart of the organisation.

Furthermore, your non-medical Directors will bring additional skills and experience to support Members' interests, and help us to remain focused on delivering the highest level of professional service.

The merger of MDA National and MIGA will build on the existing national footprints of each organisation, with a more diverse and significantly larger combined Membership, whilst maintaining the strong capital ratio of each pre-existing insurance business. Geographically, we are quite complementary with our combination filling the gaps in our individual networks; while financially we will become a much better resourced and more effective provider of indemnity and advocacy services for the medical profession.

As the Chairman-elect for the proposed new Medical Defence Australia Ltd, I can reassure you that the new organisation will reflect the importance we have historically placed on our Member-focused ethos and our hitherto strong prudential management. This will ensure that benefits continue to flow to Members in an enduring, profession-focused structure.

I remain very much influenced by my own long association with MDA National and must fully acknowledge our unique culture and all that Peter Forbes has achieved with our highly dedicated staff. However, we anticipate that the proposed merger will lead to greater innovation, increased efficiency and a more comprehensive range of services and benefits for Members.

Although this merger will be subject to court, regulatory and Membership approval, we consider our proposal as being a natural evolution of MDA National's long history of continuing improvement and strategic initiative. We therefore trust our Members will also endorse this exciting proposal. Consequently, I would encourage you to support the merger in order to bring an evolutionary and more progressive MDO into fruition during the final quarter of 2014.

Should you have any questions regarding the merger, please do not hesitate to personally contact me to discuss.

A/Prof Julian Rait
MDA National President

Notice Board

(Left to right) MDA National President A/Prof Julian Rait with ASO President Dr Arthur Karagiannis.

MDA National and ASO Preferred Insurer Alliance

MDA National Insurance has formed an alliance with the Australian Society of Ophthalmologists (ASO) as a preferred insurer. Formed in 1982, the ASO is the peak professional body representing the medico-political interests of Ophthalmologists within Australia.

As part of our alliance we will support the Indigenous and Remote Eye Health Service (IRIS) which is a joint initiative of the Australian government and the ASO, established in mid-2010 to provide a national approach to the delivery of eye health services in rural and remote communities via an IRIS Taskforce. IRIS will be one of our Charities of Choice for 2014/15 as part of our Corporate Social Responsibility program.

For more information about the ASO or IRIS, visit **aso.asn.au**. For more information about how our alliance with the ASO will benefit our Ophthalmology Members, please call our Member Services team on 1800 011 255 or email peaceofmind@mdanational.com.au.

Error in PSS Important Information booklet

Our 2013 *Premium Support Scheme (PSS) Important Information* booklet contained an error on pages 12 and 13, where it incorrectly stated that the definition of Gross Indemnity Costs does not include charges imposed for quarterly instalment premium payments.

For the purpose of the PSS, charges imposed for quarterly instalment premium payments *are* considered to be included in the definition of Gross Indemnity Costs as a component of premium for medical indemnity cover in respect of private medical services.

This error purely related to this document and it has been corrected in the online version of the booklet on our website, as well as in the 2014 *PSS Important Information* booklet.

We have continued to calculate and process PSS payments correctly and none of our Members have been disadvantaged as a result of this error.

Please accept our apologies for any confusion this may have caused.

Growth in Junior Membership

MDA National has focused on an emerging market strategy over several years in order to grow our "doctor in training" segment which, in future years, will transition to a "doctor in practice" category. This key focus has contributed to a continued growth in our Doctor in Training Membership since 2007.

At the start of 2014, MDA National once again participated in numerous student orientation week events across the country. We are pleased to report that 84% of the total first year medical student cohort chose to become MDA National Members.

MDA National also ran graduation events in late 2013 and participated in intern orientation events in early 2014. New interns were given information on medical indemnity, policy coverage, membership services and benefits. MDA National has achieved an exceptional 80% of the total intern market as Members and policyholders.

The results represent considerable success in market penetration which will translate to MDA National Group's financial performance at a future stage.

Our Reputation and Commitment to Members

MDA National rolled out a reputational survey to a random selection of our Members, staff and industry stakeholders in late 2013 to help us better understand our current reputation and the key issues. The results confirm that MDA National remains a well-respected and admired organisation with a reputation strongly aligned to the mutual values that are fundamental to our commitment to Members:

- **Products and Support Services**

  MDA National's commitment to training, education and on-the-ground support is strongly acknowledged by all stakeholders. This reiterates that the industry strongly associates MDA National with these value-added services over and above our core insurance products.

- **Mutuality**

  MDA National's focus on protecting and promoting Members and mutuality is strongly associated with our unique reputation. Our commitment to "support" our Members also stands out strongly.

- **Universities and Hospitals**

  MDA National's grass-roots initiatives and Member engagement stands out.

- **Trust**

  MDA National stands out in meeting and consistently delivering the service expectations of Members and other stakeholders.

Your Renewal Invitation

Membership and Policy renewals are due on 30 June 2014

You should have received your Renewal Notice in the mail recently. It includes your Certificate of Insurance, which can be used as proof of indemnity upon payment. Upon receipt of your payment, we will automatically post you a Certificate of Currency or, if you renew online, you can print your Certificate of Currency immediately after payment.

How to renew

1. Check your details

Check the details on your renewal invitation to ensure that your medical indemnity needs and other details (such as your address or practice) are correct. Let us know if any information needs to be updated and we will re-issue you a revised renewal invitation.

2. Check the Risk Category Guide

Ensure that you are in the correct risk category for the work that you are performing. It may make a difference to your premium and your cover under your policy. Our *Risk Category Guide* can assist you in doing this – you can access a copy from the Downloads section of our website at mdanational.com.au.

3. Report any matters

Let us know of any claims, complaints and investigations or any incidents that may lead to a claim, investigation or inquiry which you are aware of, if you haven't done so already. Early notification helps to prevent matters from escalating and can enable us to support you more.

4. Make payment

If the information on your Renewal Notice is correct, you can make your payment using one of the payment options listed on your Renewal Notice – online, BPay, direct debit or by phone. Don't forget to make your payment by 30 June 2014 to ensure you have the cover you need.

If you have set up a direct debit arrangement, there's nothing further you need to do to renew. We will simply debit your nominated account with the amount specified on your Renewal Notice on, or shortly after, 1 July 2014. Please contact us immediately if you wish to cancel your direct debit arrangement.

Your Renewal Notice includes your tax invoice/receipt which becomes valid upon payment. A receipt will not be sent unless you specifically request one.

Risk category changes

We have reviewed the scope of the cover we provide in our risk categories and are pleased to advise you of the following changes that may be applicable to your practice:

General Practice categories

The following procedures relating to skin grafts have been re-categorised:

- Free grafting (split skin) of granulating area excluding the face is covered under the Level 1 Non-Procedural GP category.
- Full thickness skin grafts up to 3cm excluding the face are covered under the Level 2 – General Practice – Limited Procedures category.
- Free grafting (split skin) of granulating area on the face and full thickness skin grafts above 3cm including the face are covered under the General Practice – Procedural Level 3 category.

Termination of pregnancy:

- The wording has been updated to clarify that both medical and surgical termination are categorised as General Practice – Procedural Level 3.

Other Specialty categories

Surgical Assisting – Level 1B:

- The wording clarifies that this category is not appropriate if you are a medical practitioner acting in the capacity of a medical educator or training surgical registrars in clinical procedures. The appropriate Surgeon category commensurate with your experience and qualifications will need to be selected.

Please refer to the *Risk Category Guide* for further details regarding these changes and other risk categories. As mentioned above, you can access a copy from the Downloads section of our website at mdanational.com.au.

Policy changes

We have made some changes to our Professional Indemnity Insurance Policy for the 2014/15 policy period as part of our annual review cycle to ensure that the Policy reflects contemporary Australian medical practice.

A summary of the Policy changes have been outlined in your Renewal Notice and provided in detail in the ***Supplementary Financial Services Guide, Product Disclosure Statement and Endorsement to the Policy Wording*** included as part of your renewal pack. It is important that you read this in conjunction with the ***Combined Financial Services Guide, Product Disclosure Statement and Policy Wording V.10***. You can download these documents from the Downloads section of our website at mdanational.com.au.

Our Member Services team is here to help

If you have queries about your policy or wish to make any changes to your Renewal Notice, please email **peaceofmind@mdanational.com.au** or phone **1800 011 255**. Our team is available from 8.30am to 8.00pm (AEST) Monday to Friday to assist with your enquiries.

Thank you for your loyal Membership. We look forward to continuing to support and protect you.

Bariatric Surgery

Bariatric surgery continues to be an area of clinical practice where our Claims and Advisory Services team deals with a number of patient claims and complaints. In this two part series, we have asked a GP, a Physician, an Anaesthetist and a Bariatric Surgeon to provide their perspectives on bariatric surgery.

A GP's Perspective:

Bariatric Surgery – The GP as Gatekeeper

In our current climate of instant gratification, the idea of the bariatric procedure being the panacea for obesity is welcomed by many. As GPs, we work as the "gatekeepers" of the referral process for this often misperceived "quick fix". Given the exponential rate of these procedures, we also have a duty to maintain a level of awareness of the potential short and long term complications unique to this set of patients.[1]

We all know examples of the heart sink morbidly obese patient, the chronic diabetic, the desperate infertile young woman with polycystic ovarian syndrome or the middle-aged chronic osteoarthritic patient who is too overweight to receive a new hip or knee. The improvement in these patients' quality of life from bariatric procedures is inarguable. This visible and often dramatic change encourages others, often less suitable, to consider a surgical weight reduction option – but at what cost? Are we doing our patients a service or disservice when we refer them for a bariatric procedure? And what should we be aware of to provide optimum care for these patients post procedure?

Each bariatric surgical procedure carries its own set of pros and cons which need to be carefully considered in selecting patients. The commonly known "lap band" procedure has been mostly accepted in this country to date.[2] This is due to its relatively low immediate peri-operative risk compared to its counterparts. However it produced the lowest percentage weight loss and highest re-operative rates, mainly due to band migration/slippage (15-20%), erosion (4%), unsatisfactory weight loss and untreatable reflux.[3,4,5] Additionally, the burden of lifelong follow up with the band should be considered, along with patient-reported reduced quality of life. It is well known that many patients abandon the weight control benefits of having saline in the band completely, due to its significant impact on their lifestyle. It is noteworthy that the success of the band is directly linked with the quality of long term post-operative care.[5]

This is important, from a GP perspective, when considering whether to refer for bariatric procedures and to whom. This is because all surgical interventions carry short and long term risks which, when balanced against positive outcomes, is clear for morbidly obese patients only, i.e. a BMI > 40, or 35 with associated co-morbidities, who are referred to practitioners who actively promote long term follow up.[3, 4, 5] This is particularly relevant when considering patients who are close to these cutoffs or whose co-morbidities could be considered "soft". Helping patients adjust their expectations of bariatric surgery and improve their understanding of the relevant procedures is important prior to referral.

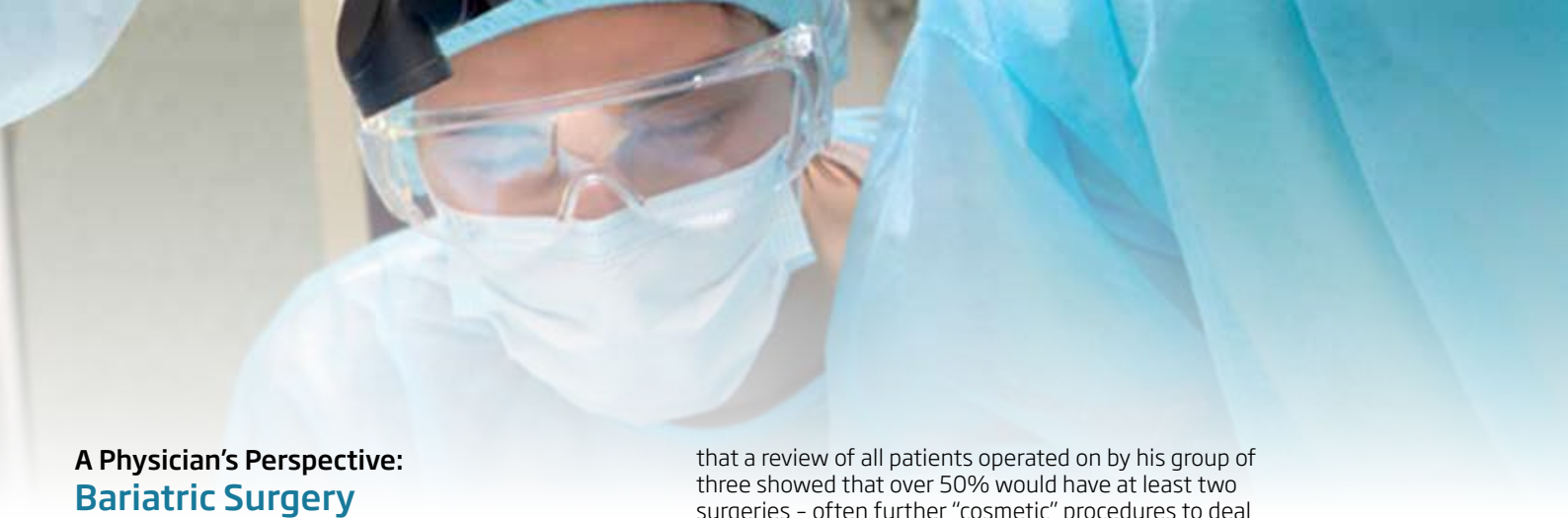
Lifelong follow up and increased awareness of complications is equally important at a General Practice level. New data published in the *Medical Journal of Australia* highlights the unique nutritional requirements of this set of patients and, as the primary provider of ongoing care for many bariatric patients, GPs have an important role in monitoring nutritional levels and providing appropriate advice.[6]

A recent Coronial case highlighted some of the long term serious complications unique to this set of patients. A middle-aged woman died 21 months after lap band surgery, following a bout of protracted vomiting, despite being seen by a GP in the days leading up to her death.[7] The Coroner determined that this likely preventable death was contributed to by the GP's lack of understanding of the seriousness of prolonged vomiting in this patient population and the misperception by the patient herself that vomiting was quite normal following bariatric procedures. The severe force of vomiting had caused herniation of the stomach through the band, obstructing its blood supply and causing gastric necrosis, respiratory aspiration and rapid death.

> Before we simply put a letter of referral together, it is our duty to inform ourselves and our colleagues of the overall long and short term risks and benefits of the available procedures, and to carefully consider the health outcomes for our patients. We must also remember that the real medicine is in the follow up – the science of maintaining behavioural change.

Dr Natalie Sumich, General Practitioner
WA PMLC Member, MDA National

For a full list of references visit
defenceupdate.mdanational.com.au/bariatricsurgery-gp.



A Physician's Perspective:
Bariatric Surgery – Is There Anything New?

The profession could be forgiven for thinking there is nothing new to be written about obesity, its malign effects on individual and global health outcomes and the complexities of management at both individual and population levels.[1,2,3] Nothing could be further from the truth. Any perusal of the literature reveals many new concepts in practice and research. Whilst it would be the experience of most of us that bariatric surgery has become safer as it has become more widespread, this is an area that continues to offer practitioners an increased litigation risk as it does an increased risk of regulatory intervention. For that reason, even in the face (and perhaps because) of changes in practice, it is worth looking at some of the current issues.

Clinical issues

Physicians become involved in bariatric surgery for several reasons. These include being involved in the management of obese patients where a recommendation for surgery starts the long process towards surgery. Physicians will also become involved in pre-operative patient assessment. Here, there is an interesting almost circular debate around "how safe is safe" in the presence of BMIs > 35 if surgery will inevitably reduce that risk. There is a fundamental question as to whether pre-operative Physician assessment should be a matter of routine or not – a question made more complex because of the shortage of General Physicians in Australia. Given the real or potential co-morbidities these patients have, it is inevitable that Physicians from a number of sub-specialties become engaged in the post-operative care of bariatric patients – a commitment that may continue for considerable times on occasions.

Clinical issues apart from obesity will include psychiatric disorders, cardiovascular and neurovascular conditions, obstructive sleep apnoea, diabetes and upper airway access difficulties.

Management questions

There are complex management matters to be resolved by Physicians no matter when they become part of the team. There remains a considerable difference of opinion regarding medical versus surgical management of obesity[1,4] – a debate that is more intense now as bariatric surgery,[5] like other complex surgeries, has become safer with greater expertise. Even though most bariatric surgery will still be carried out in the private sector, we can anticipate a continuing trend to concentrate surgical and multidisciplinary management to ensure more is done by fewer surgical groups.

However, all bariatric surgery carries its own risks which vary with the type of surgery performed. One of my Perth surgical colleagues[5] indicated to me a year ago that a review of all patients operated on by his group of three showed that over 50% would have at least two surgeries – often further "cosmetic" procedures to deal with redundant tissue. However, there is also a significant incidence of re-operation for complications of bariatric surgery itself, and these surgeries may be necessary well after the primary procedure. Recognition and assessment of potential surgical complications may well not fall to the operating surgeon.

Future directions

The growth in demand for bariatric surgery is likely to continue for at least the next decade even if the direction that might be taken in private sector funding policies does not continue the current level of support. The difficulties for bariatric surgery to gain much traction in the public sector are likely to continue, as it is relatively resource-intensive. This means new strategies for management of the obese will be necessary, both in regards to prevention and non-surgical practices. Suggestions are emerging in the area of medical education[7] – the idea that this epidemic might be met by a whole new strategy in teaching a new generation has attraction for this and a number of other chronic "diseases".

There is also a need for the profession to consider a fundamental truth[8] in respect to its reluctance to discard management strategies. Scott and Elshaug advance a number of reasons for this, including concerns about litigation (defensive medicine), a tendency for intervention coupled with a "desire" to please referring clinicians particularly in the fee-for-service system that drives private practice.

In the complex field of obesity management, Physicians should play a major role in assessing and managing patients, particularly if bariatric surgery is involved. It is not safe to assume that patients are fully informed by "Dr Google". Care and time should be taken to discuss all the material issues with each patient at each step along the way. Physicians have important roles in overseeing the indications for surgery, evaluating and correcting co-morbidities where possible and assisting in post-surgical management in hospital as well as for a period of time in the community. Detailed documentation is essential given the increased risk of dispute later on.

A/Prof David O Watson, Consultant Physician
MDA National Member

Look out for the Anaesthetist's and Bariatric Surgeon's perspectives in our Spring edition of *Defence Update*.

For a full list of references visit
defenceupdate.mdanational.com.au/bariatricsurgery-physician.

Retention and Destruction of Medical Records

Medical records are an integral part of good quality patient care and can also significantly improve the defensibility of a claim or complaint.

Often patients may not present on a frequent basis or the medical practitioner may no longer recall the relevant consultation that is the subject of a claim or complaint. When a complaint is made about a patient's care to a complaints body, the production of medical records may also be required. For this reason, it is important to be aware of the legal requirements for the retention and destruction of medical records.

How long should I retain medical records?

From a medico-legal perspective, medical records should be kept until such time as there is little or no risk of a claim arising from the patient's treatment. This will depend upon the statutory limitation period (the time limits within which a claim must be commenced, within the relevant jurisdiction) and any applicable state or territory legislation governing the retention of medical records.

Unfortunately, it is difficult to be definitive about the applicable limitation period, as courts generally have discretion to extend it in certain circumstances. Accordingly, where there has been a patient complaint or an adverse outcome, or legal proceedings have been foreshadowed, the medical records should be kept indefinitely. Medical records for a patient who is subject to a Guardianship or other court or tribunal order should also be kept indefinitely, or until seven years after the patient's death.

In the ACT, NSW and VIC, there is legislation outlining the minimum period of time which medical records should be kept:

- for an adult – seven years from the date of the last health service
- for a child – until the age of 25 years.

In the ACT and VIC, medical records must be retained for the above period even if the patient is deceased.

MDA National considers these statutory minimum requirements to be appropriate in all Australian contexts.

Throughout the period that medical records are retained, reasonable security measures and safeguards must be in place to ensure that patient confidentiality is maintained and records are not lost, stolen, damaged, or subject to unauthorised access or misuse.

How should I dispose of medical records?

Medical records must be disposed of in a manner that preserves patient confidentiality. This involves taking reasonable steps to destroy or permanently de-identify patients' personal health information.

In the ACT, NSW and VIC, there is a legal obligation when disposing of medical records, to keep a register identifying the:

- name of the individual to whom the health information is related
- period of time over which the health record extends
- date on which the record was deleted or disposed.

If a commercial company is used to dispose of the records, the company should provide certification to confirm confidential destruction. A copy of this certificate should be retained.

You can find further information in relation to all aspects of medical record keeping in our brochure available at **mdanational.com.au/support-in-practice/publications/medical-records.aspx**. You can also contact MDA National's Medico-legal Advisory Service on **1800 011 255** or email **advice@mdanational.com.au**.

Dannielle Stokeld, Medico-legal Advisor (Solicitor)
MDA National

Privacy Policy

More prescriptive requirements have been introduced, following the changes to the *Privacy Act 1988* (Cth) on 12 March 2014, which require medical practices to have a clearly expressed and up to date privacy policy.

Privacy Policy

On 12 March 2014, amendments to the *Privacy Act 1988* (Cth) came into effect. The amendments introduced 13 Australian Privacy Principles (APPs) to replace the National Privacy Principles (NPPs).

As part of the changes, under the new APP 1:[1]

- a medical practice must have an up-to-date privacy policy clearly specifying: what personal information will be collected, how it will be collected and stored, how it will be used, how an individual may access information held about them, a process for individuals wishing to complain about privacy breaches, whether the practice is likely to disclose personal information to overseas recipients and, if so, the countries in which these recipients are likely to be located.
- a medical practice must take reasonable steps to make its privacy policy publicly available, with copies provided free of charge and, if required, in the format requested by an individual, e.g. print and email. This may also include making copies available in other languages.

Developing a practice privacy policy[2]

Guidelines produced by the Office of the Australian Information Commissioner (OAIC) state that a privacy policy must cover:

- the kinds of personal information collected and held by the practice
- how personal information is collected and held by the practice
- the purposes for which personal information is collected, held, used and disclosed by the practice
- how and for what purpose an individual may access their personal information and seek its correction
- where access by the individual is withheld, why, and how the individual is notified
- the consent process for the collection of information and situations where consent is not required
- the complaints process for individuals who wish to complain about a breach of privacy or confidentiality
- whether the practice is likely to disclose personal information to overseas recipients and to what countries, if it is practicable to specify those countries in the policy.

Although not required under privacy law, it is recommended that the practice's privacy policy also covers:

- staff training and supervision
- the rights of particular groups of patients, e.g. children aged 15 years and over, or patients who may lack capacity
- who, other than the patient, can access personal information, and the conditions for access
- when the policy will be reviewed and how changes will be publicised
- the process for dealing with unauthorised access to individuals' health information
- how long the information is to be held and how it will be destroyed
- circumstances where it is reasonable for the patient to request to be anonymous or use a pseudonym.

Presenting the information

It is important to cover these factors clearly and concisely to explain the practice's obligations, and to set out the rights and corresponding responsibilities of patients. Remember, the policy is for your patients and their carers to read, rather than for staff – so it needs to be written with this in mind.

Drafting the policy

A policy generally starts with a statement or purpose. For a privacy policy, this would be a statement that confirms a commitment to protecting the privacy of patients in compliance with legal and professional obligations of practitioners and their staff.

Subheadings are helpful to the reader. Using the APPs as subheadings can outline the obligations of the practice to protect privacy and ensure all relevant factors are addressed. However, care should be taken with this as aspects of the principles overlap and some of the APPs may not be applicable, so it may be preferable to use your own headings.

The policy could include a statement that any child aged 15 years or over is regarded as having the capacity to consent to the collection of their information and to restrict

who will have access to it, although this may be assessed on a case by case basis by the treating doctor. This kind of statement recognises the rights of a specific group of patients and also how this will be managed. Likewise, statements covering the use of family members as interpreters and where this may not be suitable and what actions might be taken to manage this situation may be included, e.g. the use of formal translating services. Including these factors in a privacy policy is an individual decision.

It is recommended that the policy includes a review timeframe and that this occurs every 12 months. **We have provided a sample privacy policy as a guide on page 12 of this issue of *Defence Update*.**

The following key concepts which relate to privacy and to a privacy policy require additional explanation.

Complaints

A key aspect of a privacy policy should be a description of a practice's complaints handling process. This does not require a separate process from how the practice normally deals with a complaint. Having a consistent approach in handling complaints across the practice reduces the likelihood of confusion for staff.

Importantly, it must include timeframes so that patients' expectations can be managed and complaint handling is made a priority. The OAIC recommends that a response is given within 30 days of the receipt of the complaint. For any assistance with handling a significant complaint, and prior to writing any response, you should contact MDA National's Medico-legal Advisory Service on 1800 011 255.

In larger practices, it may be advantageous to appoint a Privacy Officer whose role and responsibility includes:[3]

- receiving all requests for access to information
- facilitating access
- investigating complaints about privacy breaches
- monitoring staff training and compliance
- conducting privacy/confidentiality audits to identify potential risk concerns, e.g. unauthorised access to information.

Information security

It is not uncommon for practices to overlook security of their information handling and computer systems. Even though this may be unrelated to a privacy policy, due to the sensitive nature of information held, practices have a high obligation to ensure systems are secure. Under APP 11, the expectation is that reasonable action will be taken to ensure information is protected.[4]

Features of information security may include:

- security software, i.e. antivirus, anti-spam and firewall programs
- frequency of upgrades
- individual passwords and levels of access
- staff training and compliance
- access to information in the event of power or system failure
- frequency of system backups
- physical security, i.e. the location of computer terminals, access and storage of patient files.

If the practice has not assessed its computer systems or information handling systems and, in particular, if considering an upgrade or review of computer systems, then it is strongly recommended that a privacy audit is completed.

Sending information overseas

Sending information to a location outside of Australia is known as cross-border data transfer (see APP 8). If you use or are considering the use of overseas transcription services or if you are sending patient information to third parties outside Australia, it is imperative that you understand what the privacy law changes mean for your practice. The OAIC guidelines, ***Cross-border Disclosure of Personal Information***, can be accessed from the OAIC website: oaic.gov.au/privacy/applying-privacy-law/Page-2.

Overseeing compliance

The OAIC is responsible for overviewing APP compliance. Under the amended legislation, the Information Commissioner has been given significantly greater powers to encourage and enforce compliance. These powers include investigation and audit, making determinations and commencing legal proceedings. Serious and repeated interference with the privacy of an individual may result in a fine of up to $1.7 million for an organisation or up to $340,000 for an individual.

More information on the privacy law reforms including a wide range of useful resources are available on the OAIC website:

Privacy law reform: **oaic.gov.au/privacy/privacy-act/privacy-law-reform**

Privacy resources: **oaic.gov.au/privacy/privacy-resources/all/**

1 Office of the Australian Information Commissioner. *Privacy Law Reform.* Available at: oaic.gov.au/ privacy/privacy-act/privacy-law-reform.

2 Office of the Australian Information Commissioner. *Australian Privacy Principles: Privacy Fact Sheet 17.* Canberra: OAIC, 2013.

3 Office of the Australian Information Commissioner. *Ten Steps to Protect Other People's Personal Information: Fact Sheet 7.* Canberra: OAIC, 2012.

4 Office of the Australian Information Commissioner. *Guide to Information Security: 'Reasonable Steps' to Protect Personal Information.* Canberra. OAIC, April 2013.

Sample Privacy Policy Wording

The sample policy wording below can be used as a simple guide to developing your own privacy policy.

Purpose

This practice is committed to protecting the privacy of our patients. We will ensure that our processes for the collection, storage, access and destruction of personal and health information are in compliance with our legal obligations and professional expectations. We will inform patients of their rights and responsibilities.

Consent

Prior to any collection of your personal information, we will seek and obtain your consent or that of your carer/next of kin. We will inform you of your rights and responsibilities relating to privacy. You may alter or withdraw your consent at any time. However, you must let us know if you wish to change or limit your consent.

What we collect and why

This practice collects, stores and protects patient's personal information in order to provide patients with healthcare services. Your personal details, your condition and treatment will be kept confidential by medical and other practice staff.

We will only collect personal information related to activities necessary for us to provide care and treatment to you. This includes administrative and billing purposes, quality improvement, teaching and learning activities, provision of health care within the practice and by other providers we may refer you to. You are not obliged to provide us with information, and you can request to remain anonymous or to use a pseudonym. You need to understand that anonymity can affect the level of care and treatment we provide to you, and we may have to decline your request if it is impractical for us to agree.

Sharing your information

Your information will not be disclosed without your permission unless the law requires it to be given to a designated person or authority, e.g. Medicare. Your consent is obtained when you first come to this practice and will be confirmed with you from time to time. You can change or limit your consent, but you must discuss this with us.

Keeping your information safe

We will store information securely and protect it from unauthorised access, use or disclosure. We will not keep it any longer than necessary and it will be disposed of securely. We will ensure that your personal and health information is relevant, accurate and up to date. We will endeavour to collect information directly from you, unless we are unable to do so, e.g. in an emergency. We will make every effort to confirm with you the information collected from another source, e.g. a family member, as soon as practicable.

Each patient will have a confidential record kept of their illness and treatment, and access is limited to professionals involved in your treatment.

Requesting access to information

Access to information must be requested in writing by you. This assists us in handling all requests properly. All requests will be discussed with the treating doctor. Where access is denied or needs to be limited due to concerns about your health and wellbeing or that of another person, this will be discussed with you. Other access options, such as a review of the record with the treating practitioner, may be offered to you rather than providing you with a copy of the record. We will not charge you a fee to make a request for access to information; however, reasonable fees may be charged for providing the information to you, e.g. for photocopying records.

If you are requesting access to the information of another patient, we may not grant access without that person's consent. This can include access to a family member's health information. We recognise that children over the age of 15 can request that information about their health care is kept confidential. This will be managed on a case by case basis as assessed by the treating doctor.

Making corrections

We will provide access to the information we have collected about you, if you wish to check its accuracy. You must request access in writing and we will respond within one week of receiving the request. If any information is incorrect, necessary changes will be made as soon as possible.

Making a complaint

If you suspect your privacy may have been breached or you are unhappy with our response to a request for access, we ask that you speak with the practice manager or your treating doctor as soon as possible. We may request that you make your complaint in writing. Again, this helps us investigate your concerns thoroughly. We will respond within 30 days of receiving your complaint.

If you do not wish to make the complaint to us, you can contact the Office of the Australian Information Commissioner directly on 1300 363 992.

Cross-border data transfer

This sample policy does not cover the obligations associated with sending information overseas. If you use or are considering the use of overseas transcription services, it is imperative that you understand what the privacy law changes mean for your practice. Please refer to the OAIC guidelines, ***Cross-border Disclosure of Personal Information***, which can be accessed from the OAIC website: oaic.gov.au/privacy/applying-privacy-law/Page-2.

A Member Profile:
Dr Catherine Engelke

The life of a doctor can be incredibly rewarding, but also very isolating if you don't master the art of staying connected. Dr Catherine Engelke employs this concept in every facet of her life including family, work and culture.

Growing up among the Kija people, Catherine's early primary school education, although idyllic, was far from mainstream. Catherine recalls being called "dumb" for not meeting the standard testing criteria applied to her age group, and this false belief stayed with her for many years.

Recognising the importance of a good education, Catherine's parents sent their children to a boarding school in Perth. At age 11, Catherine was separated from her "big, close family" in Halls Creek. "I understood why I was there, but I remember feeling homesick and just wanting to go home," she recalls.

Catherine excelled academically and obtained her Nursing Degree, followed by a Graduate Degree in Community Health and Development and a Post Graduate Diploma in Clinical Midwifery. After working in Perth and the Kimberley, Catherine took up a three-month contract developing the WA Aboriginal Health Plan. It was here that she met Dr David Atkinson, the man she credits with reigniting her desire to study medicine.

The suggestion forced Catherine to confront her long-held belief that she wasn't smart enough to be a doctor. She had always wanted to study medicine, and the encouragement she received from Dr Atkinson was enough to prompt her to raise the prospect with her husband, Jim, who was incredibly supportive of her dream.

Already a mother to two small children, it was a big decision to relocate the family to Perth – but with the support of her family and the School of Indigenous Studies, Catherine graduated from UWA in 2008.

Catherine was grateful for the peace and quiet of Shenton House and the opportunity to spend time with the other Indigenous mature age students who were also dealing with the guilt of leaving young children at home and not being able to contribute financially to the family budget.

She candidly acknowledges, "If I had realised how hard it was going to be, I may not have done it." Catherine is clearly proud to be a role model for her children. "How could I tell them to follow their dreams if I didn't follow mine?" she said.

Catherine, a District Medical Officer at Kununurra District Hospital, knew from a very young age that she wanted to give something back to the remote community where she was born and raised.

It wasn't long before the Engelke family returned to their cultural and spiritual home. With her focus now firmly on providing excellent medical care in the remote Kimberly region, Catherine was surprised and delighted to be invited by the RACGP to attend the GP12 on the Gold Coast as the GP Registrar of the Year for 2012.

The recognition Catherine has received from her peers and the College has made the sacrifice and hard work worthwhile.

Being Empathic Helps You and Your Patients

The word "empathy" is used a great deal, often perfunctorily, in relation to how medical practitioners should behave and communicate. To become more comfortable with the vital role of emotions in health care, it is useful to regularly re-explore what empathy really is, how people convey and detect it, and its impact.

What is empathy and why is it important?

Empathy is communicating that you understand the views and feelings of another. The role of emotions in health care "cannot be overemphasised"[1] and it is vital to adequately discuss and respond to them. Yet there is evidence that exploring patients' feelings is commonly not done.

Conveying empathy and confidently responding to emotions helps doctors to:

- cope with the challenges of practising medicine
- improve patient outcomes
  - › empathy has favourable effects on patients' adjustment, distress, adherence and physical outcomes
  - › supporting patients to disclose useful information may allow issues to be resolved in a more timely manner.

Patients highly value the parts of communication with their doctors that generate trust, support and hope.[2] "Empathy is one of the most powerful ways of providing this support to reduce patients' feelings of isolation…"[3] Discomfort when having conversations that involve emotional matters can be interpreted as indifference which can lead to complaints and litigation.[4]

Empathy is not simple reassurance, agreement or saying "I know how you are feeling".

Tips for communicating empathically

- Whenever a person raises a psychological or emotional concern, an explicit empathic response is necessary.
  - › Use the NURSE mnemonic to respond to other people's emotions (see following page).
  - › Respond empathically as soon as possible after a worry or other emotion is expressed.[5,6]
  - › Aim to provide empathic responses at multiple points over a consultation – this is likely to improve efficiency and satisfaction for all.[6]
- Be alert for patient questions, stories and body language that have underlying emotions,[5,7] e.g. general nervous mannerisms, less social chit chat, disagreement, asking lots of questions and requesting referrals or prescriptions.[7] Then proactively ask open-ended questions that directly explore their emotional responses.
- Use the "Four Cs" of initiating constructive discussion: saying that you "care", are "curious", are "concerned" or are "confused".[8]
- Give information in small amounts, allowing people a chance to ask questions or express emotions.
- Allow patients to:
  - › lead where the consultation goes
  - › speak without being interrupted.
- If time possibly allows, continue to ask the patient if they have any questions until they have definitely asked them all. When time does not allow for this, apologise for the fact that you must be elsewhere and ensure that the patient knows you will come back to continue the discussion.
  - › Let people know how much time you have for a consultation at the start and acknowledge if there are many matters to discuss, meaning some will need to be left for another time. Let them choose which topics will be addressed in the current consultation.

Useful phrases

- "I can only imagine how difficult this is for you."
- "I wonder if it is frightening to…"
- "Is there anything else that is troubling you about the situation?"
- "People going through your situation often report experiencing… Is that how you feel?"
- "I wish the news was better."[9]
- "I am sad for you that this has happened."

Useful behaviours

Remember that you communicate empathy nonverbally too.

- Eye contact is extremely important.
- Use facial expressions, head nodding, being physically close, hand gestures, open posture, and a forward lean.
- Avoid writing notes or reading a chart during a difficult news conversation and when exploring patients' emotions.

- Show distress if you feel it, e.g. you do not have to fight an urge to become teary. But check if your emotions are triggered by your patient's circumstance or your personal issues.[10,11]
    - › Clearly state that it is the patient's situation that has affected you. You can be distressed but it cannot affect your decision making.[11]

NURSE your way to effective responses

The NURSE mnemonic is a useful memory aid to assist you to comprehensively and appropriately respond to patients' emotions.[4,5] Remember, doctors need to NURSE too!

Openly acknowledge strong patient emotions

Never ignore strong feelings. Be mindful of how important it is to continually demonstrate empathy when patients are experiencing difficulty and emotional reactions – it is critical for them, their families and your own satisfaction.

Nicole Harvey, MDA National Education Services

For a full list of references visit
defenceupdate.mdanational.com.au/empathic-communication.

Name	• Identify the underlying emotion in a suggestive manner, e.g. "I wonder if you are feeling angry", "Sounds like you were really frightened when you got that news..."[2,6]
Understand	• Confirm that you understand what the person is feeling by discussing their experience, listening actively (do not be planning what you next want to say), and allowing silence. • Do not provide simple reassurance, disagreement, advice, clinical information or justification without definitely understanding what their true concern is. • Do not try to convey that you understand what someone is feeling by saying, "I know how you are feeling" because their reaction is often negative, with the person thinking "How can you possibly know how I'm feeling?" Rather, consider using phrases like, "People going through your situation often report experiencing... Is that how you feel?"
Respect	• Give verbal and nonverbal evidence that their reaction is important.[2] • Match the level of your response to their level of emotion, i.e. a strong emotion needs to receive strong acknowledgement and respect.[2] • Accept their perspective without judgement and validate their input. Acceptance of their view is not the same as agreement with it.[2]
Support	• Give a variety of help sources, provide opportunities to participate in decision-making, and validate their efforts to cope. • State your availability for them, preferably in a way that demonstrates a partnership.[2,12]
Explore	• Target questions to the specifics of what the person has said and show explicit interest in their emotions.

CaseBook

Delegation of Cosmetic Schedule 4 Injections

Recently, MDA National has had several Members contact us regarding the appropriateness of delegating cosmetic Schedule 4 (S4) injections to nurses, after receiving correspondence from either state-based Drugs and Poisons Units or regulatory bodies such as AHPRA. We have been advised that it is a current area of focus for some regulatory bodies as there still appears to be significant confusion regarding this issue.

S4 substances can only be supplied on the written prescription of an authorised medical practitioner. However, in some states, nurse practitioners, midwife practitioners, dentists and optometrists can supply S4 drugs if they are specifically authorised to do so under the relevant state based legislation. A registered nurse can only administer S4 medications under the supervision of a doctor and cannot independently purchase, obtain, administer or supply S4 medicine.

Case history

The NSW Health Care Complaints Commission (HCCC) conducted an investigation into allegations that a doctor had inappropriately delegated cosmetic S4 injections to a nurse.[1] It was found that the doctor had failed to supervise the nurse who was performing the cosmetic injections as he did not consult with the patients or prescribe the S4 medications prior to the nurse administering the injections. The HCCC was also of the opinion that it was inappropriate for a medical practitioner to give their name to a supplier to procure S4 medications on behalf of a nurse.[2]

After consultation with the NSW Medical Council, adverse comments were made to the doctor regarding his arrangements with the nurse.

Discussion

The Cosmetic Physicians Society of Australasia (CPSA) has stated that they are aware that the delegation of cosmetic S4 injections by medical practitioners to nurses is common practice.[3]

As a result of the HCCC decision, the CPSA developed a protocol for the delegation of cosmetic S4 injections (**see Table 1**). The NSW Medical Council has reviewed this protocol and stated:

This protocol is essentially consistent with the Board's Code of Professional Conduct and that it contains additional details, specific to cosmetic practice. The Board also stated that the draft protocol sets out a sensible set of circumstances in which medical review should be sought.[4]

In addition, the WA Department of Health Pharmaceutical Services Branch has issued an information bulletin regarding the prescribing and administration of botulinum toxin (Botox®, Dysport®).[5] The bulletin makes it clear that only a medical practitioner or a nurse practitioner (with an approved clinical practice guideline) can prescribe Botox and authorise the administration of Botox to a patient.

Further, it states that an authorised practitioner – after assessing the patient, reviewing the patient's medical history and conducting a physical examination – may direct a registered nurse to administer Botox to a patient. However, this direction must be in writing and specify the substance and dose to be given, the route and site of the administration, how many times the treatment can be repeated and how frequently it can be repeated. The direction can only be valid for up to 12 months. In addition, this administration or supply of the prescription medication must be recorded in the patient's clinical records.

The CPSA have also issued a policy regarding so called Botox parties, entitled **Cosmetic Injection Party Policy**.[6] This states:

CPSA considers the administration of anti-wrinkle injections or dermal fillers, or the performance of any cosmetic medical procedure in a party setting, to be incompatible with good medical care. The CPSA believes these types of non-invasive and minimally-invasive cosmetic procedures are medical procedures which should be conducted in the appropriate medical setting.

If you have any concerns regarding your current arrangements regarding the delegation of cosmetic S4 Injections to nurses, please contact MDA National's Medico-legal Advisory Service on 1800 011 255 for assistance.

Sharon Russell
Claims Manager (Solicitor), MDA National

For a full list of references visit
defenceupdate.mdanational.com.au/schedule-4-injections.

A registered nurse can only administer S4 medications under the supervision of a doctor.

TABLE 1. CPSA PROTOCOL FOR DELEGATED COSMETIC S4 INJECTIONS

Suitably trained registered nurses may administer S4 medicines for cosmetic purposes after a doctor has consulted face-to-face with a patient and formulated a written treatment plan:

- to cover a time period no greater than a year
- stipulating the area to be treated
- stating which medications are to be used
- setting the maximum number of procedures
- stating the maximum dosages of the medication to be administered.

The patient and treatment plan would be reviewed:

- at the expiration of the set time period
- if unexpected side effects occurred
- if the patient or nurse were unhappy with the result
- if new indications for the ordered medications were contemplated
- if other medications were considered for the original or new indications
- if the original presentation was altered by, e.g. surgery, trauma, pregnancy or other procedures, for which the original treatment plan did not cater.

If the patient was taking new medications, the nurse would need to check with the supervising doctor prior to the procedure to ensure there were no contraindications to proceeding with the treatment plan.

Suitably trained registered nurses may perform such procedures at adequately equipped premises, distant from the doctor's rooms only if treatment plans for all patients had previously been formulated by the supervising doctor, following a face-to-face consultation. The doctor should be readily contactable, but need not be on site.

It is not acceptable for a doctor to on-sell S4 medications to a nurse or other person to then administer these to patients, regardless of any prior order for the administration of said medications.

Registered nurses performing such procedures must:

- have current registration in the relevant state or territory
- be covered by the practice insurance policy – an independent contractor must have his or her own insurance policy
- have had adequate training in the particular procedure/s
- be certified as competent where certification exists, or deemed competent by a trainer approved by the supervising doctor.

The CPSA does not endorse the use of injectors whose qualifications or experience is less than that stated above and is vehemently opposed to injections being given by non-paramedical persons such as beauty therapists.

All Members should ensure there are no additional requirements pertinent to their own state or territory which must be fulfilled.

CaseBook

Beware Testimonials

The Medical Board of Australia released revised *Guidelines for Advertising Regulated Health Services* (the Guidelines) effective from 20 May 2014.

This article outlines the requirements with respect to the use of testimonials in advertising.

Case history

The Plastic Surgeon developed a website for his practice. Several months after the website went live, he received a letter from AHPRA enclosing a complaint from a colleague that his website contravened legislative requirements because it included patient testimonials.

Medico-legal issues

The Surgeon contacted MDA National's Medico-legal Advisory Service for advice. A review of his practice website revealed a tab labelled "Testimonials" which included a number of positive comments made by patients about the outcome of procedures performed by him.

The Surgeon was advised to remove the testimonials from his website as soon as possible because this information was in breach of his obligations under the National Law.

The Medico-legal Adviser assisted the Surgeon in preparing a letter of response to AHPRA, stating that on receipt of the letter from AHPRA he had immediately sought advice and removed the testimonials from his website. He acknowledged that he had been unaware of his obligations under the National Law with respect to advertising. He confirmed that since receiving the complaint he had read the Medical Board of Australia's policies[1] – *Guidelines for Advertising Regulated Health Services* and *Social Media Policy*.

Discussion

Section 133 of the National Law states the following:

1. A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that:

a. is false, misleading or deceptive or is likely to be misleading or deceptive
b. offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer
c. uses testimonials or purported testimonials about the service or business
d. creates an unreasonable expectation of beneficial treatment
e. directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

It is important to note that testimonials are only prohibited if they are used for the purposes of advertising a regulated health service and/or practitioner. A breach of these advertising requirements is a criminal offence and a court may impose a financial penalty – up to $5,000 for an individual and $10,000 for a body corporate.

A testimonial includes recommendations, or statements about the clinical aspects of a regulated health service.

Testimonials in advertising include:

1. patients posting comments about a practitioner on the practitioner's business website, particularly when the website encourages patients to do so and/or selectively publishes patient comments
2. the use of patient stories to promote a practitioner or regulated health service.

This means it is not acceptable to use testimonials in your own advertising, such as on your website, in a print advertisement or on a practice Facebook page. However, practitioners are not responsible for removing (or trying to have removed) unsolicited testimonials published on a website or in social media over which they do not have control.

Summary points

- The National Law prohibits the use of testimonials in advertising only.
- Unsolicited public discussion and opinion sharing about health practitioners outside the context of advertising a regulated health service are not prohibited.
- The National Law does not prohibit a health practitioner using social media or providing comments in social media if they do not involve the practitioner (or their representative) advertising a regulated health service.

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

1 Medical Board of Australia. *Guidelines for Advertising Regulated Health Services*. Available at: medicalboard.gov.au/codes-guidelines-policies/guidelines-for-advertising-regulated-health-services.aspx. *Social Media Policy*. Available at: medicalboard.gov.au/codes-guidelines-policies/social-media-policy.aspx.

What's On?

Educational Events for Members

We're hosting numerous complimentary educational events to support you in providing quality health care.

June 2014

4	The Challenging Emotions of Difficult News – Making a Positive Difference at a Demanding Time **Brisbane, QLD**
10	The Challenging Emotions of Difficult News – Making a Positive Difference at a Demanding Time **Crawley, WA**
11	The Challenging Emotions of Difficult News – Making a Positive Difference at a Demanding Time **Crawley, WA**
21	Practical Solutions to Patient Boundaries **West Perth, WA**
24	Enhancing Patient Understanding – Health Literacy and Communication **Brisbane, QLD**

To find out more or to register for any of these events, please visit **mdanational.com.au** or email **events@mdanational.com.au**.

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

Join Our 2014 Sydney City to Surf Team!*

As part of our *Live Well, Work Well* program, you're invited to join our 2014 City to Surf team in Sydney! On joining our team, you will receive complimentary:

- virtual group training pep-emails on fitness, conditioning and nutrition to keep you motivated
- VIP access to our City to Surf Marquee including food, refreshments, massages and prizes
- MDA National participant's pack including water bottle, 2XU sports shirt, sports visor and more!

The Sun-Herald CITY2SURF Presented by Westpac

Sunday 10 August – Sydney 2014 City2Surf: MDA National Team

Further information: mdanational.com.au/about-us/corporate-social-responsibility/sydney-city2surf-2014.aspx.

If you've already registered and are keen to join the team, please email your bib number to: sydneyc2steam@mdanational.com.au.

We look forward to a great day of fitness for a great cause. **Register today, our team has limited places!**

Due to an overwhelming response, all places have been filled in our MDA National Team participating in the Perth 2014 City to Surf event on Sunday 31 August.

* MDA National Members are required to fund their own registration for this event.

MDA National
Support Protect Promote

REMINDER

Membership and Policy renewals are due on **30 June 2014.**
Make your payment on time to ensure you have the cover you need.
Please see page 5 of this publication for more information.

Have you moved? Have your details changed?

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

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

Freecall: 1800 011 255
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