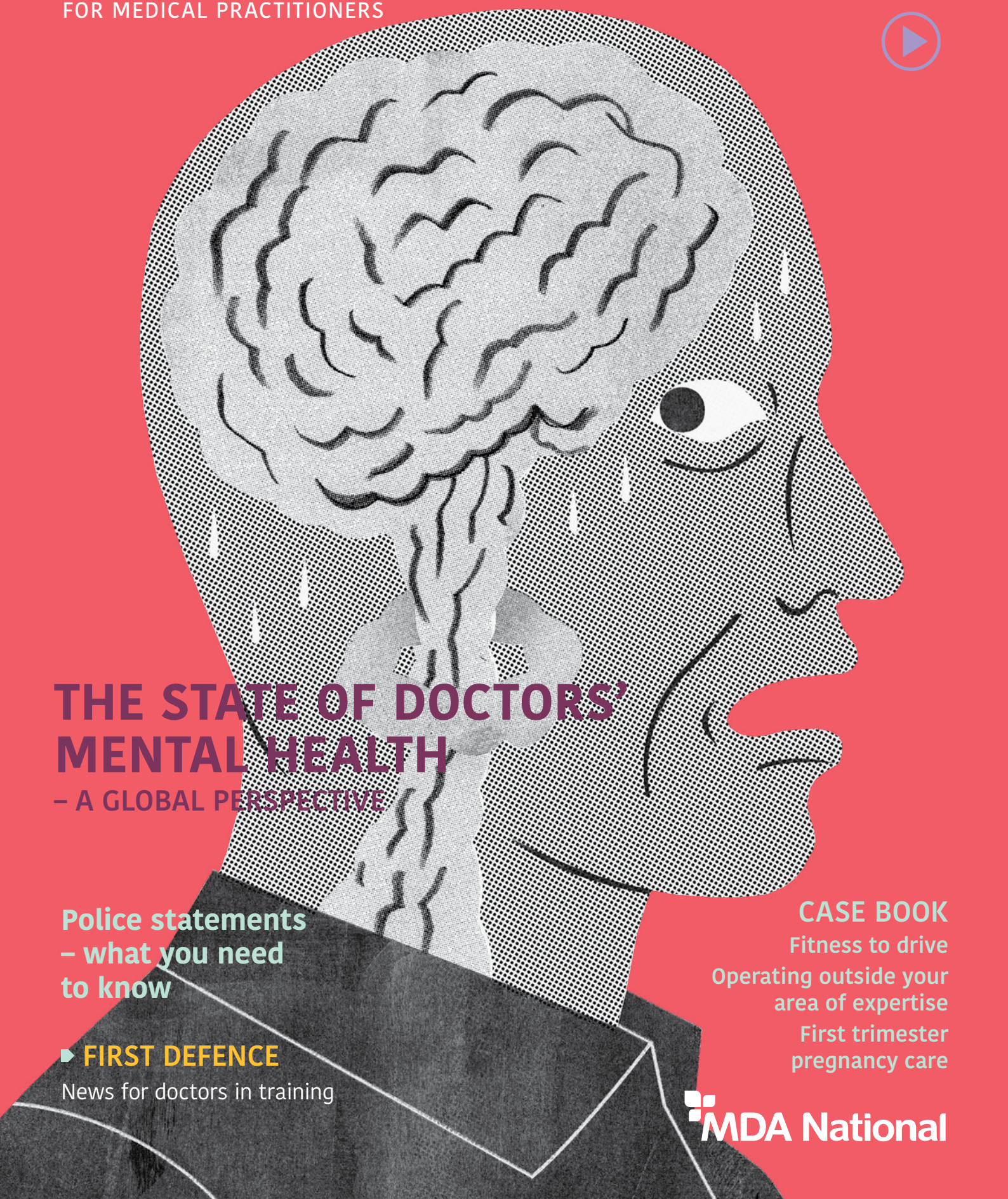
SUMMER 2019/20

Defenceupdate

FOR MEDICAL PRACTITIONERS



THE STATE OF DOCTORS' MENTAL HEALTH – A GLOBAL PERSPECTIVE

Police statements – what you need to know

FIRST DEFENCE
News for doctors in training

CASE BOOK
Fitness to drive
Operating outside your area of expertise
First trimester pregnancy care

MDA National

WELCOME

Caroline Elton, an occupational psychologist who has spent the last 20 years training and supporting doctors, presents her perspective on doctors' wellbeing (pages 6-7). Its not just about increasing doctors' resilience, systemic and organisational issues are a major contributor to physician burnout.

As we approach the holiday period, it is timely to think of patient care and some of our senior surgeons discuss their top tips to for managing patients when taking a well-earned break (pages 12-13).

Have you ever googled yourself, or looked up your reviews online? Its all too easy for people to type a comment or rate a service, and this has extended to medical services. It can be confronting to read a candid account from a patient that's less than complimentary. In this edition we take you through your options for this situation (pages 10-11).

We also have a 'how to' pull out guide for police statements (pages 15-18), which I hope will dispel the feeling of dread doctors may feel when faced with such a request.

Our casebook section discusses medico-legal issues with fitness to drive (pages 20-21), a subject on which we receive calls regularly, and issues with antenatal care (pages 24-25).

Prenatal testing is certainly a rapidly changing landscape and there is a lot to cover in consultations with newly pregnant patients. As well as having to be aware of the protocols and usual practice of local clinics and specialists, doctors also need to be aware of new developments and possibilities for prenatal testing. Explaining the possibilities and limitations of prenatal testing can be complex and time consuming.

I hope you enjoy this edition of Defence Update.

Dr Jane Deacon
Manager, Medico-legal
Advisory Services

Have an editorial enquiry?
Please contact Charlotte Mitchell,
Marketing Content Manager
cmitchell@mdanational.com.au

Contributions
Dr Caroline Elton
Dr Angus Turner
Dr Benjamin Veness

Medico-legal review
Dr Jane Deacon, Dr Sara Bird,
Ms Deb Jackson

Editing & project management
Charlotte Mitchell and Nerissa Ferrie

In this issue

< BACK

NEXT >

Prescribing drugs of dependence

A common reason for medico-legal investigations, such as complaints and coronial inquests, is the prescribing of drugs of dependence. The concerns may arise from a doctor's lack of knowledge and understanding of the legislative requirements imposed on them when prescribing S8 drugs.

Key issues

- If a patient is drug dependent (someone who, as a result of the repeated consumption of a drug of addiction/dependence, acquires an overpowering desire for the continued consumption of such a drug, and is likely to suffer mental or physical distress upon ceasing the drug) it is a mandatory requirement for doctors to seek an authority/permit from the relevant state or territory health unit before prescribing a S8 drug.
- This authority is required regardless of whether the prescription is provided under the PBS – the PBS Authority process is different and does not authorise prescription of a S8 medication to a drug dependent patient.
- If a patient is not drug dependent, there are strict time limits (generally two months) that S8 drugs can be prescribed before an authority/permit is required, although these requirements vary in each state and territory.
- Of note, an authority/permit may be required before prescribing alprazolam or flunitrazepam (S8 drugs) to any patient.

More information about your obligations is available in our e-learning course, 'Prescribing Opioids'.

Visit mdanational.com.au/member-benefits/education to find out more.

< BACK

> NEXT

Annual Report

our highlights from 2019

Recently, you would have received a copy of our Annual Report 2019: Supporting you to keep on. It has been a rewarding year for your MDA National, and we're excited to share these achievements with you.

We have continued to enhance the service we provide our members, while building a strong and sustainable business that can meet their evolving needs into the future.

Here are some of our highlights from the past year:

- refreshed MDA National brand identity
- launched new website with a member-centric focus
- upgraded core insurance system for operational agility
- introduced on-demand education webinars for members
- Net Promoter Score of +66% indicating strong member satisfaction
- retained 96.4% of practicing doctor members at year-end renewals
- practice policies increased by 14%
- received 9,212 medico-legal enquires.

To read the report in full, visit our website mdanational.com.au/about-us/our-performance

Get involved

Members are at the heart of everything we do, and that includes our branding. If you'd like to be part of our upcoming editorials and photoshoots, please let us know at **brandcomms@mdanational.com.au**.

Eye care in the outback

Dr Angus Turner
Ophthalmologist

Teleophthalmology in Western Australia is improving patient outcomes, reducing waiting times for patients, and boosting attendance rates to 97%.

Lions Outback Vision has been providing teleophthalmology consultations to rural Western Australia since 2011. The telehealth clinics augment regular ophthalmology and optometry outreach clinics, and support resident local optometrists. The evolution of telehealth in Australia has moved the service from pilot studies and novelty projects, to an integrated daily service which reduces waiting times, enhances continuity of care, and improves the efficiency of outreach ophthalmology trips. All this leads to better outcomes for the patients and improved satisfaction with the services.

For ophthalmology, the diagnostic imaging of the eye has improved with the increased availability of optical coherence tomography (OCT) which enables the detection of common pathology such as diabetic maculopathy and neovascular 'wet' macular degeneration. Functional tests such as visual fields also support imaging to manage glaucoma. After research and subsequent advocacy to government, Medicare rebates were introduced for optometrists to support telehealth in 2015. There are minimal further infrastructure costs, since ubiquitous platforms such as Skype are used for the video-consultation to consent patients for management and any planned procedures.

Through telehealth the direct booking to surgery for those patients in need has achieved three main outcomes:

1. It has eliminated the 'wait for the waiting list', which is the well-documented wait of up to one year for public service outpatients, prior to being placed on the waiting list for surgery.[1]
2. The outreach trips ratio of surgery:clinic has reversed with more surgical management and therefore greater impact of the visiting team on visual outcomes.
3. The distillation of the pathology means a higher proportion of primary eye care is being appropriately managed by optometry with less duplication of patient assessment.

A significant highlight of telehealth has been the extraordinary attendance rate with only 3% non-attendance. This is in stark contrast to the average of 50% in the community visits. Patients also demonstrated very high satisfaction, as highlighted in a study published in 2015.[2] "On call" telehealth was introduced in 2017 to improve the access for Aboriginal and Torres Strait Islander patients living in remote areas, since optometrists may only visit for one day and the online booking system was not appropriate. An evaluation of this service has seen the odds of Aboriginal patients accessing teleophthalmology significantly increase 11-fold.[3]

Engagement and uptake with optometry have been remarkable with 94% of optometrists in the regions visited by Lions Outback Vision participating in telehealth in the first year of the new MBS item numbers being introduced.

The telehealth services will continue to evolve as videoconference technology becomes ubiquitous, in the form of smart phones/tablets, the use of OCT becomes standard and more available, and as cellular reception improves. New trials with hospital-based optometrists and registrars in the regions are underway. The use of artificial intelligence to assist primary care providers is currently being investigated in a research partnership with Google with an aim to improve access to eye care in remote areas and tackle the long-term workforce maldistribution.

Stephen Copeland (Optometrist) with a patient in Jigalong discussing cataract surgery
Photo courtesy of Alan McDonald

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/eye-care-in-the-outback

Dr Caroline Elton
Clinical Psychologist

Perhaps, just perhaps, the narrative is starting to shift. Across the world there seems to be a growing realisation that the wellbeing of clinical staff isn't just an individual matter, but instead requires sustained leadership, right from the top of each organisation.

A global perspective on doctors' mental health

< BACK

> NEXT

Concern about doctors' wellbeing is truly a global phenomenon. This fact becomes immediately apparent when you type a term such as 'burnout' into a medical database and find that in the last three months alone, over 500 abstracts have been published. Of course these academic papers aren't only about doctors (nurses, social workers and firefighters – amongst others are also the subject of research). But even in the last three months, there have been studies on physician burnout from countries as diverse as Bosnia, Mexico, Taiwan, the USA, Canada, China and Spain.

How organisations treat their staff is the most significant determinant of staff psychological wellbeing – not the personal resilience of staff members.

< BACK

Much of the research into physician burnout looks at ways of building resilience. Over the same period of time, there have been studies on resilience building strategies ranging from a trip to the local art gallery (to encourage engagement and reflection) peer-mentoring, and incorporating a wellness rotation into junior doctors' schedules. This is all good stuff and such initiatives are to be encouraged. However, resilience building alone is never going to be a sufficient way of ensuring doctors' wellbeing. Never. And the reason for this is quite simple – burnout is primarily a product of the organisational demands placed on doctors, nurses, firefighters etc – rather than it being a problem of having inadequately resilient workers carrying out these all-important roles.

None of this should be a surprise. If we extend the notion of evidence-based practice to include not only patient care but also organisational science, then there is a significant body of research that clearly demonstrates the systemic roots of staff wellbeing. In other words, how organisations treat their staff is the most significant determinant of staff psychological wellbeing – not the personal resilience of staff members. To find out more about this, you could take a look at studies carried out by Professor Tait Shanafelt at Stanford Medicine in the US. Shanafelt, an oncologist, is also an expert in physician wellbeing and in 2017 was appointed as the Chief Wellness Officer, leading Stanford's pioneering program in the field. Crucially, his research highlights how of the nine different organisational strategies to improve physician wellbeing only one focusses on promoting the resilience of the individual doctor.

So what other strategies have Shanafelt and his colleagues identified? These include targeted interventions that improve the working lives of the small groups and teams in which medical work is carried out, promoting flexible work schedules, improving work-life integration and cultivating community at work. This organisation wide approach entirely accords with my own experience as an occupational psychologist who specialises in supporting clinical staff; again and again I see how it isn't a lack of personal resilience that causes doctors to be significantly distressed, but rather them having too many patients to care for within a given space of time so that they constantly worry about the quality of the care they are providing, or being on the receiving end of bullying, or being separated from family and friends, and having no time to maintain these all-important personal connections. Attending a mindfulness course – useful as that can be – won't tackle these sorts of systemic issues.

> NEXT

In good news for Australia, in February 2019, Sydney Local Health District appointed Dr Bethan Richards as the country's first Chief Medical Wellness Officer with a brief to drive cultural and systemic change in health, and reduce stress and burnout among junior and senior doctors. Dr Richards, the only non-American invited to attend Stanford University's inaugural Chief Medical Wellness officer course in California last year, will also head up Australia's first Wellness Centre for doctors based on the Stanford model.

Off-label prescribing – what you need to know

Marika Davies
Medico-legal Adviser

Off-label prescribing is the prescription of a registered medicine for a use that is not included in the Therapeutic Goods Administration (TGA)-approved Product Information. A medicine can be legally prescribed off-label, and many drugs are routinely used in this way.

< BACK

> NEXT

Case studies

- A psychiatrist assessed a 22-year-old student by video link and diagnosed him with bipolar disorder. She wrote to the patient's GP and recommended treatment with topiramate. The GP was concerned that the medication was not listed in the therapeutic guidelines for use in bipolar disorder.
- A young mother consults her GP with concerns about her breastmilk supply and asks for domperidone to boost her supply.

A question of clinical judgement

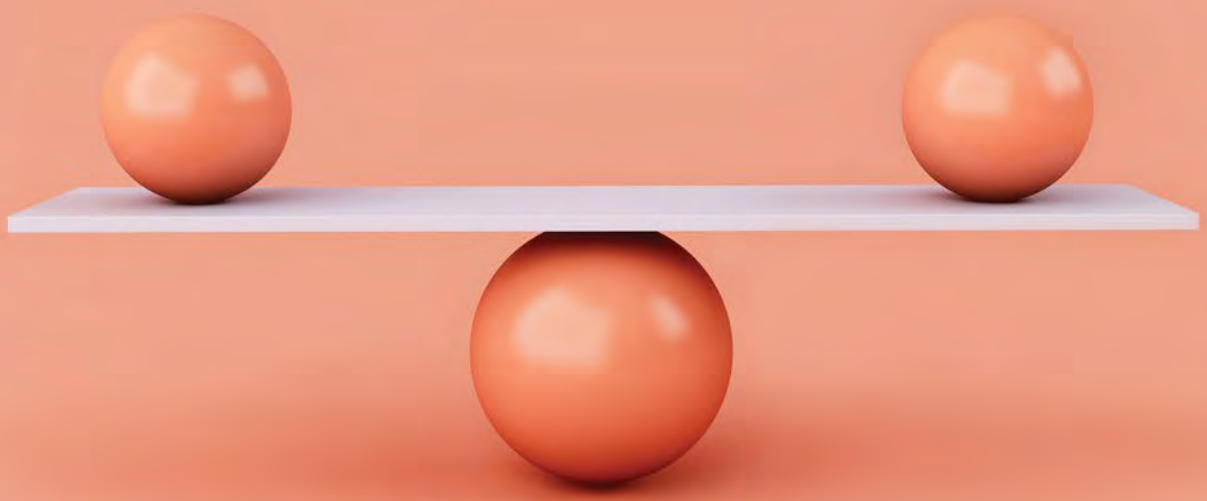
The TGA recognises that off-label prescribing may be clinically appropriate in some circumstances but advises doctors to use caution when considering it. In general, off-label use of a medicine should only be considered when the TGA-approved use of a registered medicine does not address the clinical needs of a patient. The decision to prescribe off-label must take into account the risks and benefits to the patient, and the evidence supporting the safety and efficacy of the proposed treatment.

Clearly communicate the potential risks and benefits with your patient so they can provide informed consent, and answer their questions about the proposed treatment. Keep a clear record of the medications prescribed and your reasons for prescribing an off-label medicine, especially if you are not following common practice.

Follow up essential

Ensure that the patient is appropriately monitored and followed up. The TGA encourages doctors to report any adverse events that occur during off-label use.

Guidance published by the Council of Australian Therapeutic Advisory Groups says that, in the event of harm to the patient, "if the off-label use of the medicine in a particular situation is accepted by the practitioner's peers as constituting competent professional practice, and the patient has given informed consent for its use, then prescribing off-label should not imply negligence."



BACK

NEXT

In summary

The Council of Australian Therapeutic Advisory Groups sets out guidance for doctors in public hospitals considering the use of an off-label medicine:

- Only consider an off-label use of a medicine when all other options are unavailable, exhausted, not tolerated or unsuitable.
- Use high-quality evidence to determine the drug's appropriateness.
- Involve the patient/carer in shared decision-making so that they may provide informed consent.
- Consult the Drug and Therapeutics Committee (except when off-label use of a medicine is considered routine).
- Ensure appropriate information is available at all steps of the medicines management pathway.
- Monitor outcomes, effectiveness and adverse events.

A patient or specialist asks you to prescribe a medicine in a way that is not indicated in the drug's product information – how would you handle this situation?

Further information:

catag.org.au/wp-content/uploads/2012/08/OKA9963-CATAG-Rethinking-Medicines-Decision-Making-final1.pdf

tga.gov.au/publication-issue/medicines-safety-update-volume-8-number-4-august-september-2017#offlabel

mja.com.au/journal/2006/185/10/label-use-medicines-consensus-recommendations-evaluating-appropriateness

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/off-label-prescribing-what-you-need-to-know

Negative feedback can be difficult to accept, but when you're a doctor who takes enormous pride in their work, a negative online review can feel overwhelming and a little soul destroying.

Nerissa Ferrie
Medico-legal Adviser

Managing negative reviews

Most reviews are written in haste and never thought of again, and it is a sad indictment of modern society that a doctor's reputation can be treated in the same way as a cold burger at a fast food restaurant.

Where do reviews appear?

Reviews can appear in many places, including Google Maps, RateMDS, Whitecoat and Facebook. Some sites allow you to "claim" your profile – but this doesn't mean you have control over the reviews.

If your practice website or Facebook page allows reviews, you should view our advertising webinar. Positive reviews (or testimonials) under your control breach the AHPRA advertising guidelines and can be more problematic for you than negative reviews.

What can you do?

Your right of response is limited by patient confidentiality and protecting your professional reputation. If the review is sensible and genuine, and the therapeutic relationship can be salvaged, contact the patient in the same way as you would respond to a written complaint to the practice. The best way to address a negative review is for the patient to voluntarily remove the review.

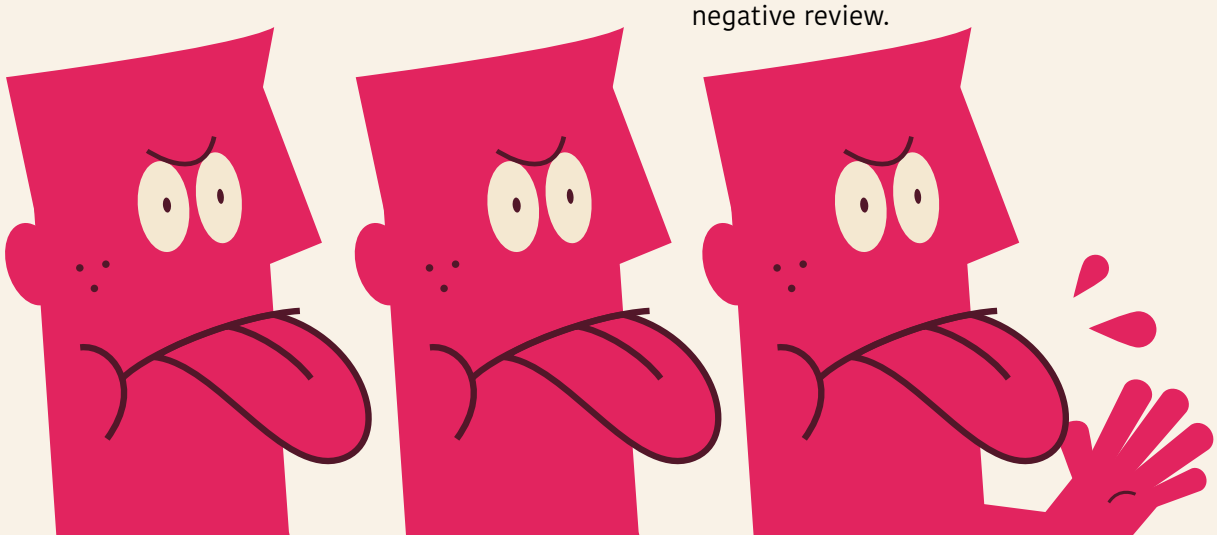
Often the matter can't be addressed offline because:

- you can't identify the patient
- the therapeutic relationship is irretrievable
- the review is vitriolic and cannot be addressed sensibly.

What happens if I respond online?

If the review appears on a website where you can "own" your page (e.g. Google, RateMDs), it is tempting to respond online. If you respond, we recommend any response should be neutral, such as "we take all patient complaints seriously so please contact the practice so we can resolve your concerns." Anything further may breach patient confidentiality. The patient can talk about their medical problems in an open forum, but you could face an AHPRA or Office of the Australian Information Commissioner complaint if you do likewise.

You should never respond to a vitriolic review in kind. Negative reviews can be made worse by a frustrated doctor posting an angry response which harms their reputation more than the negative review.



< BACK
NEXT >

How do I flag a review?

Each site has its own terms of service (ToS), and this is the best starting point if you intend to flag a review for possible removal. Most review sites won't remove a review because you don't like it.

Common ToS include:

- Reviews should be based on your experience and should not be a forum for general political, social commentary, or personal rants.
- Reviews should not contain obscene, profane, offensive language or gestures, or dangerous or derogatory content.
- You shouldn't post multiple ratings for a single doctor.

ToS are updated regularly, so you should check the site where the review appears. If you mirror the language used in the TOS, you are more likely to have your request taken seriously.

What are the downsides to a written request?

It is important to be aware of services such as Lumen which "collects and analyzes legal complaints and requests for removal of online materials". If you use inappropriate language, personally disparage the reviewer or disclose personal health information, you could end up on the receiving end of a complaint.

Is the review defamatory?

Defamation as a legal remedy is gaining traction due to some recent high-profile celebrity cases, but aside from being notoriously expensive and very public, there are some defences to defamation which are applicable to online reviews being:

- Truth or justification – which applies when the comments in question are true or substantially true.
- Fair comment (the comment must be fair) or honest opinion (opinion be held honestly). Either must be made without malice.

Further barriers to an action in defamation include failing to positively identify the author, suing a website which is domiciled in the US or another jurisdiction where the laws differ from Australia, and a $20,000 excess on your policy.

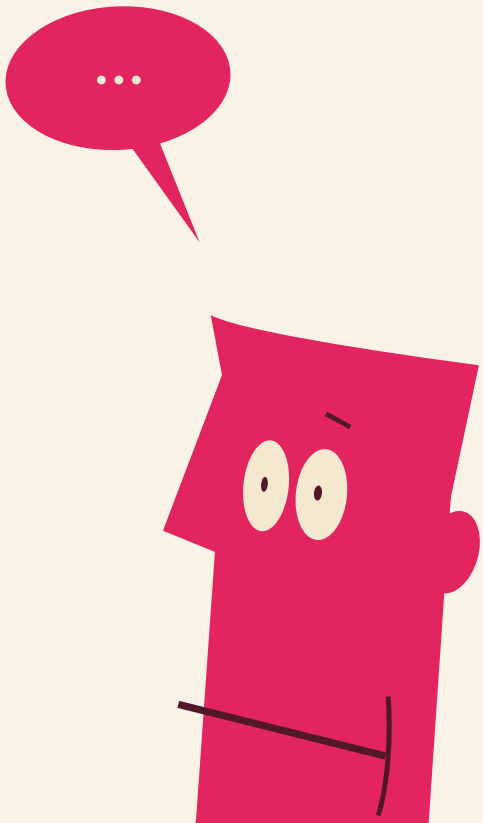
Are there any positives I can take away from this?

Not all reviews are polite or helpful, but if you receive repeated negative comments about communication issues or wait times, the best way to prevent further negative reviews is to address the issue.

If the review is offensive or off topic, most people will simply ignore it. Consumers turn to review sites for genuine reviews which detail the negatives and the positives, so they can determine whether the service might be right for them.

< BACK

> NEXT



We know negative reviews are frustrating, but sometimes it really is better to maintain a dignified silence and focus on all the grateful patients who are happy with your care. Don't waste your precious time and energy on the vocal minority – most consumers will prefer the opinion of a trusted friend or doctor over an ill-informed review.

Surgeons and holidays – what are the risks?

Nerissa Ferrie
Medico-legal Adviser

All medical practitioners should take time out to enjoy a break with the family or embark on a travel adventure, but some specialties require more advance planning than others.

Experience tells us that claims and complaints are more likely to arise when a treating surgeon begins a period of leave during a patient's post-operative recovery. This has been a topic of discussion around the tables of both our Western and Eastern Cases Committees, so we take a closer look at how to mitigate the risks for you and your patients.

What are the risks?

We spoke with some of our well-respected surgical members to seek feedback on this challenging issue, and all agreed that the profession is generally unaware of the increased risk of a surgeon taking leave in the post-operative period.

We have identified the common risks associated with a poorly managed period of leave, including:

- inadequate cover
- the covering surgeon not being familiar with the patient or any peri-operative issues
- a rushed or inadequate handover
- a reluctance to take the patient back to theatre – or a premature decision to do so
- ED doctors being left to deal with post-operative complications
- the covering surgeon not being aware of the treating surgeon's usual preferences
- family members trying (unsuccessfully) to contact the treating surgeon because they don't know the surgeon is on leave.

Top tips to reduce your risk

To make the most of the collective wisdom of our surgical members, we have compiled some practical tips to reduce your risk of a claim or complaint.

- Notify your patients of your planned absence and arrange cover ahead of time.
- Give your patient the option to postpone the surgery until your return.

I advise the patient I will be away and will be covered, but I give them the choice to postpone the procedure. I don't book big cases before I go on leave unless I am well covered by a colleague who will see the patient as a routine to assess progress and reassure the patient.

Gerard Hardisty, Orthopaedic Surgeon

- Prior to an emergency procedure, ensure the patient is aware (where possible) that you will be performing the surgery, but another doctor will be caring for them in the post-operative period.
- Avoid major elective cases immediately before leave unless a trusted colleague has had adequate handover and is prepared to provide the same level of post-operative care you would provide yourself.

In my own practice I do not schedule patients for surgery in the week prior to taking leave. If urgent or semi-urgent surgery is required during this week, then I will arrange for it to be performed by one of my practice associates. This will allow the patients to have continuity of care.

Frank J Martin, Ophthalmologist

< BACK
NEXT >

- Ensure your handover includes details about the patient's condition, any peri-operative issues, and your best contact details if you prefer to be informed of any serious post-operative complications.

I believe in notifying patients of your planned absence, avoiding major cases in the five days pre-departure, and informing your colleague who is willing to cover of your patient's condition, any relevant operative details and, these days, email or mobile contacts.

Stephen Quain, Orthopaedic Surgeon

- Have a general backup plan in place in case your leave is unexpected (e.g. an urgent health problem) and cover cannot be arranged in advance.

Good communication is paramount

There are several points of contact where good communication can result in a better experience for the patient, including:

- the pre-operative discussion between the surgeon and the patient, including advance notice of any planned leave and management of patient expectation
- GP input if the patient is offered a postponement of the procedure
- ensuring the hospital and the patient's next of kin know who to contact in the case of a post-operative complication
- handover between the treating surgeon and the covering surgeon
- follow up if any issues arise during your absence.

The patient and their family generally have good rapport and communication with the surgeon. This communication may break down if this same level of communication has not been achieved with the relieving surgeon.

Frank J Martin, Ophthalmologist

Where to from here?

Patients do not like a surgeon operating and leaving them in someone else's care. The fact that it is done so often, and nothing goes wrong, is testament to the competence of our surgeons.

Max Baumwol, General Surgeon

Surgeons operate across a wide range of specialties, and some procedures carry a greater risk of post-operative complications. There is no "one size fits all" approach to managing periods of leave, but it should be front of mind because patients place an enormous amount of trust in their treating surgeon.

Leave is important, but you can decrease your medico-legal risk if you manage it well. Before your next break, take time to consider the tips provided by your surgical colleagues, and plan ahead so you can enjoy a stress-free holiday.

< BACK

> NEXT

Q&A from our May webinar

Using observers during intimate examinations

Do we really need chaperones for routine examinations?

Exploring the need for an observer with a patient is part of good medical practice. This is particularly relevant when examining minors or those unable to give consent and when performing obstetric and gynaecological/breast examinations – patients in these situations are particularly vulnerable to sexual abuse[1] and misunderstandings.

If you're concerned about how a patient may react to physical contact, having another person present should be considered and is strongly recommended to protect both you and your patient. It can be useful to think of using an observer as not being something you 'ask' the patient about but something you just say is part of standard practice.

What are your thoughts on having your personal assistant as an observer?

An observer should be a qualified health professional, e.g. a registered nurse, someone trained to understand their role as a support person, or someone chosen by the patient.[2] In a survey of 687 patients across 13 general practices in regional New South Wales, slightly more than half of respondents said they'd feel uncomfortable with reception staff/practice manager having an observer role.[3]

Can a patient request someone, like a family member, to be present in the examination?

In general, a family member can be present if requested by the patient. Not every environment facilitates observers being able to be provided 'on demand'. In these cases, it's important to state on an information sheet that patients are welcome to bring their own person to act as observer if they wish. Though be mindful that this can add difficulties to the process.[1] Aim to just use observers during a physical examination, not the general consultation.[1]

What if there is disagreement about an observer being present?

A person's request for the presence and/or gender of an observer should be respected and documented, as should their declining of the offer.[4,5] If a suitable observer isn't available the examination can be postponed if it's not urgent and won't impact the patient's health.[4,6]

If, for example, a female doctor has the impression that a male patient is requesting an intimate examination when there's dubious indication, then they should either decline to perform the examination if it's not clinically indicated, or have an observer present. You can decline to perform an examination if the patient declines to have an observer.

Seek assistance from our Medico-legal Advisory team if a patient behaves inappropriately.

More resources

Watch our webinar recording: 'Intimate Examinations: Respect and Responsibility'
members.mdanational.com.au/My-Resources/Webinars

View our article on maintaining physical contact boundaries
mdanational.com.au/advice-and-support/Library/Articles-and-Case-Studies/2014/12/boundaries-physical-contact

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/using-observers-during-intimate-examinations

< BACK

> NEXT

MEDICO-LEGAL FEATURE

Dr Julian Walter
Medico-legal Adviser

A DOCTOR'S GUIDE TO POLICE STATEMENTS

You have been asked to provide the police with a statement regarding a patient who attended for review or management of injuries usually following an assault. Your heart sinks, and you wonder where to start.

What is a 'police statement'?

A police witness statement assists the court in relation to charges against a third party. Usually the court is seeking information about the injuries and recovery prognosis. Your statement will become part of the brief of evidence and various parties may have access including lawyers, police, judge, the accused, and other witnesses. You may need to give evidence based on the statement.

This article does not address statements being provided where your conduct is being scrutinised.

In the case of an alleged sexual assault, the statement will generally be limited to discussion of the injuries, not detailing the prior events. Providing an opinion about the mechanism of injury should generally be avoided unless you have relevant expertise, and are specifically requested to provide it.

Requests for police statements

Most police statements follow a set pattern and requests can be dealt with relatively simply. If you are unfamiliar with the process or have any queries, contact MDA National for advice.

The provision of a statement may allow the court to accept your evidence without your attendance in person, but you may still be subpoenaed to give evidence at the trial. A well written statement gives you the best chance of not having to attend court to give evidence.

< BACK
NEXT >

Why does the court need your statement?

Criminal charges are based on injury severity. A minor injury may result in lesser charge than a more serious injury, even if they stemmed from the same type of injury mechanism. The court may need to obtain medical evidence directly from a relevant health practitioner, by written statement, and/or by way of evidence given at trial, to determine the relevant charge.

Occasionally you will be asked to provide a statement which focuses on issues indirectly related to the clinical care e.g. because you witnessed a specific conversation or interaction.

Your role as an expert

You will usually be asked to provide the statement as a treating doctor, as opposed to an independent medical expert who won't be involved in the treatment of the patient. Your statement will predominantly be factual, based on what you observed. There will likely be some basic opinions to provide (prognosis; consistency of the injuries with the alleged mechanism of injury). Sometimes you will be summarising the care of others. You should make it clear what the source of information is for each fact, especially if you are discussing any care you were not involved in e.g. "Based on my review of the records I understand that Dr X …".

When providing an opinion, consider whether you have relevant facts on which to base your opinion; whether you have the relevant expertise to answer the question; and whether you could support your opinion in court. Thoroughly review any relevant documents before drafting the statement.

Treating doctors normally only need to provide a very limited scope of opinion (discussed below).

Before you begin

Why is the statement needed?

Usually it will be to detail injuries and prognosis. Ask the police for a written request, including whether there are any specific issues they would like you to address.

Patient consent?

You have a legal and professional duty of confidentiality to your patients and a request for a statement does not override this. Ensure patient consent has been obtained. Consent is usually arranged by the police, although consent can be obtained, either verbally or in writing, by you, or your employer. In a hospital circumstance, you may be directed to provide the statement by your employer.

Do I have the relevant records?

Carefully review the relevant medical records. Ensure you have the best possible understanding of the matter before you commit yourself to a written statement. You may be giving evidence based on this statement.

Due date and case reference

If you ever enquire about the matter, it will usually be referenced by the trial title (e.g. Queen (R) v Smith) for the accused, not the name of your patient. Knowing the case title can be time saving down the track. Failure to provide a statement by the due date can result in you being subpoenaed to give evidence in person.

Why me?

You may have been the doctor who examined the patient in the emergency department. At times a hospital doctor may be asked to provide a statement regarding a patient they have never seen, in which case you should preface your statement with this information. You don't have to be involved in the care of the patient, but non-involvement might limit the information you can provide. Most matters are not that complex and a statement can be provided that will satisfy the requirements of the court.

Where possible, limit the statement to the care you provided, unless contextually relevant, or you are specifically asked to provide a statement which includes the overview of care provided by others.

What if I refuse to provide the statement?

Failure to provide a statement may result in action by your workplace, and/or a subpoena to give evidence at trial. Refusal to provide a statement could result in a complaint to a health complaint body such as AHPRA.

Who can assist me?

Contact us for advice. Your employer may wish to see a pre-final draft.

When providing an opinion, consider whether you have relevant facts on which to base your opinion; whether you have the relevant expertise to answer the question; and whether you could support your opinion in court. Thoroughly review any relevant documents before drafting the statement.

< BACK

NEXT >

What to include in the statement?

Format

The format of the statement may be state, territory, or even court specific. There may be no specific requirement as to format. In some states, the police may forward an electronic template statement for you to use. We offer a generic template which can then be pasted into the specific police format. To improve readability and referencing, use numbered paragraphs, page numbers, 1.15 – 1.5 line spacing, and sub-topic headings. You may have to acknowledge you have read and agree to certain legal obligations (e.g. your role as an expert witness). Make sure you read and understand the actual obligations!

Provide layperson terms to avoid being called to court to explain medical jargon.

Witnessing and signing requirements vary between jurisdictions. The police can advise as to local requirements and may arrange for a police witness to the statement, if required. The last page of the statement should not just be your signature – at least one numbered paragraph should also be included on the last page.

The police are typically happy with a PDF copy of the final signed statement, but occasionally may also require the original to be produced. You should keep a digital copy of the final signed document and a copy of the draft pre-final editable document.

Attaching documents

Most statements do not require other documents to be attached.

If necessary, documents can be attached as annexures.

Addressee, file and contact information header

Unless dealt with by the template, the statement should be addressed either to the police officer requesting the statement, or "To the Court", not "To whom it may concern". Include the matter name and number if possible and patient's name and DOB (but not the patient address). Include your business contact details, and not your private contact information.

Background

Provide a brief list of your relevant qualifications and employment summary, and your role and title at the time that you saw the patient.

Source documents/information

List any documents you have reviewed or will be relying on and where these were sourced. For example, the medical records.

Chronology

If relevant, detail whether the patient was known to you prior to the consultation(s) in question. Briefly describe how you came to be involved in the patient care for the purposes of the statement (e.g. did you take a history and examine the patient).

Mechanism of injury

Describe the patient's reported ("alleged") mechanism of injury. You typically won't have witnessed the injury, so you will be relying on the testimony of others to describe the mechanism. Unless specifically asked by the police, keep this portion of the statement limited to what is clinically relevant to the injuries and avoid providing unnecessary non-clinical detail unless specifically requested.

Injuries

List the injuries as determined by history and/or examination. Provide as much detail as you can (location; size; side). Detail any relevant investigations. You can also include the management of each injury, or you can detail your management under a separate heading "Treatment" if the treatment of each injury is extensive. You typically don't need to list negative findings. Explain any prior existing abnormal findings.

Opinion

If you don't have the relevant facts or qualifications or experience to comment, then explain this in the statement.

(1) Are the injuries consistent with the alleged mechanism of injury? This does not exclude other mechanisms of injury from causing the injuries.

(2) What is the prognosis of the injuries? This is an opinion for which you may lack relevant facts and/or expertise to answer (in which case, indicate why you cannot answer).

(3) Comments relevant to the legal injury threshold definitions (see the discussion above). Don't refer to the legal terms, but where possible, use similar phrasing to the legal definition you have been provided to offer guidance to the court on a medical common-sense basis as to the clinical seriousness of the injuries.

Signing, witnessing and the jurat

The jurat is a paragraph in a statement where you take legal responsibility for the truth of the document and authorship. The form and location of the jurat may be determined by the jurisdiction in which you are providing the statement.

Conclusion

Although initially daunting, most police statement requests can be addressed by a relatively simple submission. For those unfamiliar with the process, or for unusual requests, early assistance from us can be invaluable.

< BACK

> NEXT

A SAMPLE POLICE STATEMENT

Constable A Cop
Somewhere City Police Dept

c/o MDA National
advice@mdanational.com.au
Ph 1800 011 255
Fx 1300 011 235

Re: Statement by Dr Alex Smith
Patient Jean Doe (1 Dec 2000)

This statement made by me is true to the best of my knowledge and belief, accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. I make this statement knowing that if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true.

1. On Tuesday 1 January 2019 I was contacted by Constable A Cop from Somewhere City Police Department and requested to provide a statement in relation to the care of Jean Doe (Patient). Constable Cop provided a copy of the Patient's consent to disclose confidential information to the court.
2. In preparing this statement, I have referred to the medical records of the Patient held at All Care GPs, Somewhere City (Practice).
3. I have a good recollection of the events discussed in this statement and have refreshed my recollection by referring to the medical records.

Professional Qualifications and Employment:

4. I have been a qualified registered Medical Practitioner for 10 years and a specialist GP for two years.
5. My qualifications include:
   a. MBBS 2009 Somewhere City, Australia
   b. Fellowship of the Royal Australian College of General Practitioners 2017
6. I am employed by the Practice as a GP. I have been employed in this capacity since 2019.

< BACK

> NEXT

Chronology:

7. On Saturday 1 January 2019 I was working at the Practice in my role as a GP. I first became involved in the care of the Patient on at 1000 hrs when I examined a person not previously known to me (although had attended the Practice previously), who identified themselves as the Patient.
8. The Patient presented for an alleged assault, which the Patient stated had occurred three days prior (28 December 2018).
9. The Patient described that they had been punched in the face (Mechanism of Injury).
10. Following review of the history, examination and investigation of the Patient, I noted the following injuries (the Injuries):
    a. A deformed nose (fractured nasal bone deviated to the right). The Patient was referred to an ENT surgeon for management.
    b. A laceration of the right nostril (nare) 4mm long. The wound was stitched under local anaesthetic by me and the Patient was discharged on topical antibiotics with sutures to be removed by the ENT surgeon in one week.

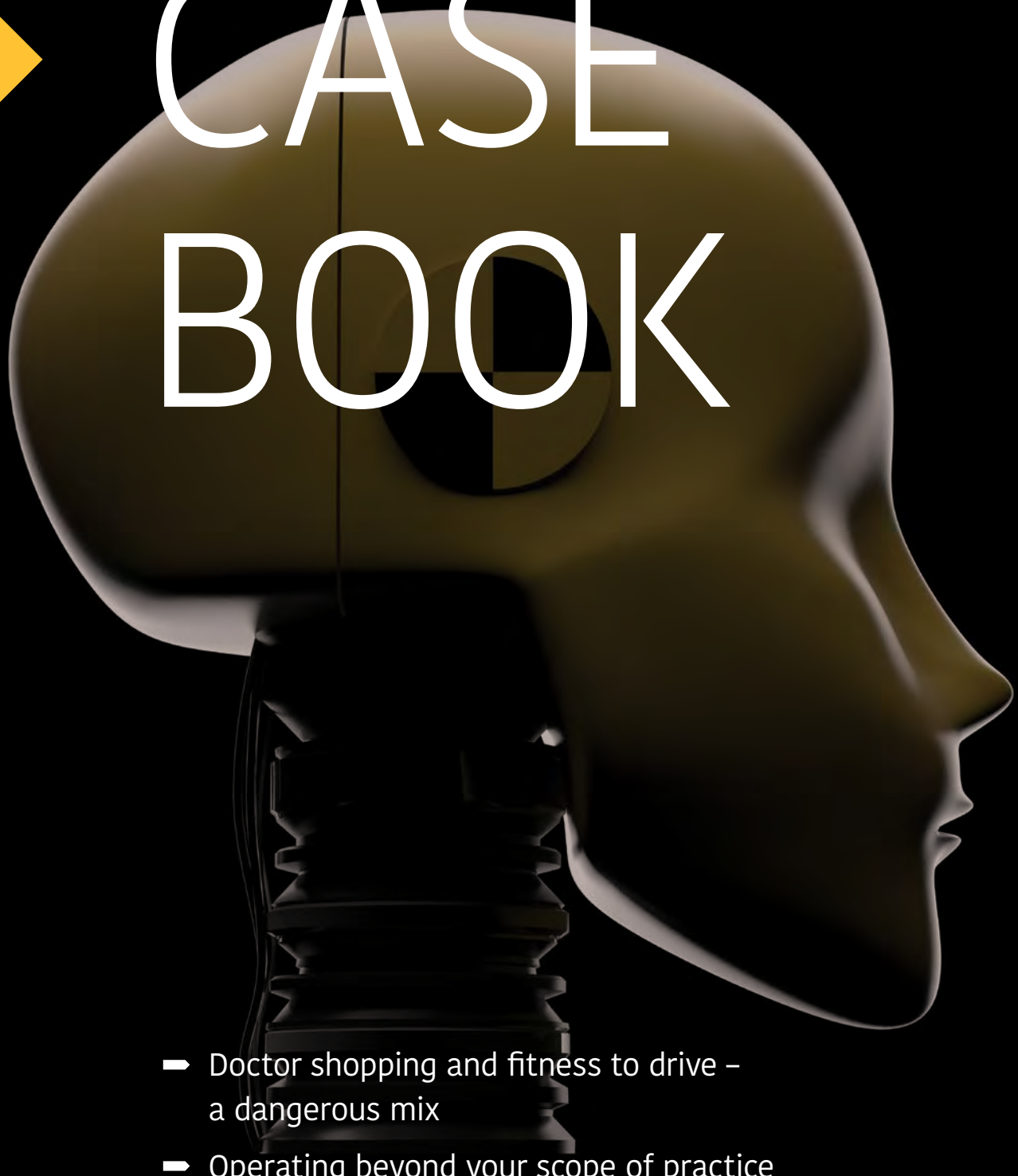
Opinion:

11. My opinion is that the Injuries were consistent with the Mechanism of Injury.
12. Based on my review of the records, the patient was seen 1 NOVEMBER 2019 by another colleague at the practice and the Injuries had resolved. I am unaware if there are ongoing mental health concerns.
    a. The injuries did not likely pose a threat to life. Untreated, the nasal fracture and nasal laceration would have likely led to permanent facial deformity and scarring.
    b. The laceration penetrated all levels of the skin.
    c. The injuries would likely have interfered with bodily comfort.

A Smith

Dr Alex Smith
Signed at Somewhere City on this day, Friday 1 November 2019

CASE BOOK



- Doctor shopping and fitness to drive – a dangerous mix
- Operating beyond your scope of practice
- First trimester pregnancy care – don't miss the window

BACK

NEXT

< BACK

NEXT >

Doctor shopping and fitness to drive – a dangerous mix

This case is an important reminder to be wary of a patient who requests certification of fitness to drive at their first consultation.

Julie Brooke-Cowden
Manager, Professional Services

Case history

Ms C was the driver at fault in a fatal motor vehicle accident on 18 July 2013. Her licence had been reinstated only seven days earlier, after being cancelled in February 2012.

A coronial inquest was held into Ms C's death in August 2016[1]. It was noted that Ms C had attended the same GP practice from November 2005 until April 2012, receiving treatment for multiple issues including insomnia, osteoarthritis, chronic lower back pain, sleep apnoea and multiple falls. Ms C had a prolonged admission to hospital in November 2011, following a fall, which was the sixth in 12 months. It was during this admission that Ms C was advised not to drive, because of her unsteadiness, and an assessment by her GP of her fitness to drive.

On 9 January 2012, three of Ms C's friends attended the local Police Station to express concerns about her ability to drive.

Following receipt of this notification, a police officer visited at her home on 13 January 2012. The officer completed a report to the driver licensing authority (DLA), noting that Ms C appeared frail and struggled to walk. Ms C informed the officer that she would continue to drive, notwithstanding the advice she had received from her treating doctors.

On 25 January 2012, the DLA wrote to Ms C proposing to cancel her licence and seeking a medical certificate confirming her fitness to drive. Ms C requested a certificate from her GP on 23 February 2012, but was advised that she would first need to undergo a driving assessment. Ms C's licence was cancelled on 27 February 2012.

On 26 November 2012, Ms C attended another GP, Dr P, who she had seen previously. She requested a certificate confirming her fitness to drive, which Dr P declined to provide to her.

However, at Ms C's 17th consultation with Dr P on 1 July 2013, he provided her with a medical fitness to drive certificate.

Medico-legal issues

The Coroner noted that Dr P had not requested copies of Ms C's clinical notes from her previous treating GP, despite not having seen her for seven years. Further, although Dr P knew that Ms C's licence had been cancelled, he did not ask why.

The Coroner rejected Dr P's conclusion that Ms C had good mobility at an assessment on 1 July 2013, because this was inconsistent with all other medical evidence. The Coroner also observed that Dr P's notes were extremely sparse.

The Coroner found that:

- Ms C was not fit to hold a drivers licence
- Dr P had failed to follow and apply the relevant Austroads guidelines[2], or to obtain any corroborating information about her medical history
- Dr P had not demonstrated any insight into his conduct and failings.

However, despite this, the Coroner decided not to refer Dr P to a professional or disciplinary body.

Discussion

Beware of the patient who requests certification of fitness to drive at their first consultation – you can and should refuse to provide certification if you feel uncomfortable doing so. At a minimum, having access to copies of the previous GP notes is essential.

Providing an inaccurate medical certificate to a patient can have very serious consequences for your medical registration.

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/doctor-shopping-and-fitness-to-drive

< BACK
NEXT >

CASE BOOK

Operating beyond your scope of practice

Marika Davies
Medico-legal Adviser

This medical negligence claim serves as a cautionary tale about informed consent and knowing the limits of your expertise.[1]

< BACK

> NEXT

Case study

A 73-year-old man with headaches was seen by a neurosurgeon, Dr D, on 2 March 2011. A CT scan showed a meningioma at the base of the skull, which Dr D considered was unlikely to be malignant. However, he advised surgical removal because of the risk of stroke or dementia. It was decided at that consultation that Mr J would undergo endoscopic surgery to remove the tumour through the nasal passage.

Dr D gave Mr J a document explaining craniotomy surgery and its risks, but the document did not describe the endoscopic procedure which Dr D was recommending.

On 31 March 2011, Mr J underwent endoscopic surgery to remove the tumour. This was the first time that Dr D had performed this particular surgery, although he had performed other transnasal endoscopic procedures and had removed brain tumours by craniotomy. The hospital had to acquire the specialised endoscopic equipment required for the surgery.

There were no complications during the operation, but later that day Mr J suffered a cerebral haemorrhage. He underwent several further procedures, including the placement of an external ventricular drain, and was finally discharged home in December 2011. He was left considerably disabled.

Mr J brought a claim against Dr D. It was not alleged that the surgery was negligent, and it was accepted that he had suffered a recognised complication. However, it was alleged that Dr D had not obtained proper consent and that he did not have the appropriate training and experience to carry out the surgery.

Dr D denied any negligence and the case proceeded to trial.

The trial

The liability experts agreed that surgery was not the preferable course of action on 2 March, because at that time there was not an appreciable risk of Mr J suffering either dementia or a stroke if his tumour was not surgically removed.

The experts said that it would have been preferable to monitor Mr J's condition, and that surgery should only have been an option if his condition deteriorated, as the result of tumour growth or increase in the oedema in his brain. They considered it was unreasonable for Dr D to have presented the alternative, conservative approach as a poor option.

The experts also agreed that Dr D 'probably' did not have the training and experience to perform the surgery endoscopically. They said that Dr D should have disclosed to

Mr J that this was his first time performing such surgery, and that he should also have advised Mr J that it carried a 5-10% risk of the catastrophic complications which he did in fact suffer.

Under cross-examination Dr D made several concessions which supported Mr J's case. He agreed that there was then no real prospect of Mr J's tumour causing dementia or stroke within six months and conceded that, at the time, he had a preference for the surgical option. Dr D maintained that he had the appropriate skills to carry out the surgery, although he had not undergone the available advanced fellowship training nor observed this procedure himself.

The outcome

The court found that Dr D should have advised Mr J that a conservative approach should have been the first treatment strategy, before deciding to pursue surgery. In summing up, the judge said it was 'quite implausible' that Mr J would have agreed to have surgery in March 2011 if he had been advised about the serious risks of the surgery when compared with the risks of conservative management, and if he had been informed that it was a procedure that Dr D had never done before.

Mr J's claim against the surgeon was successful.

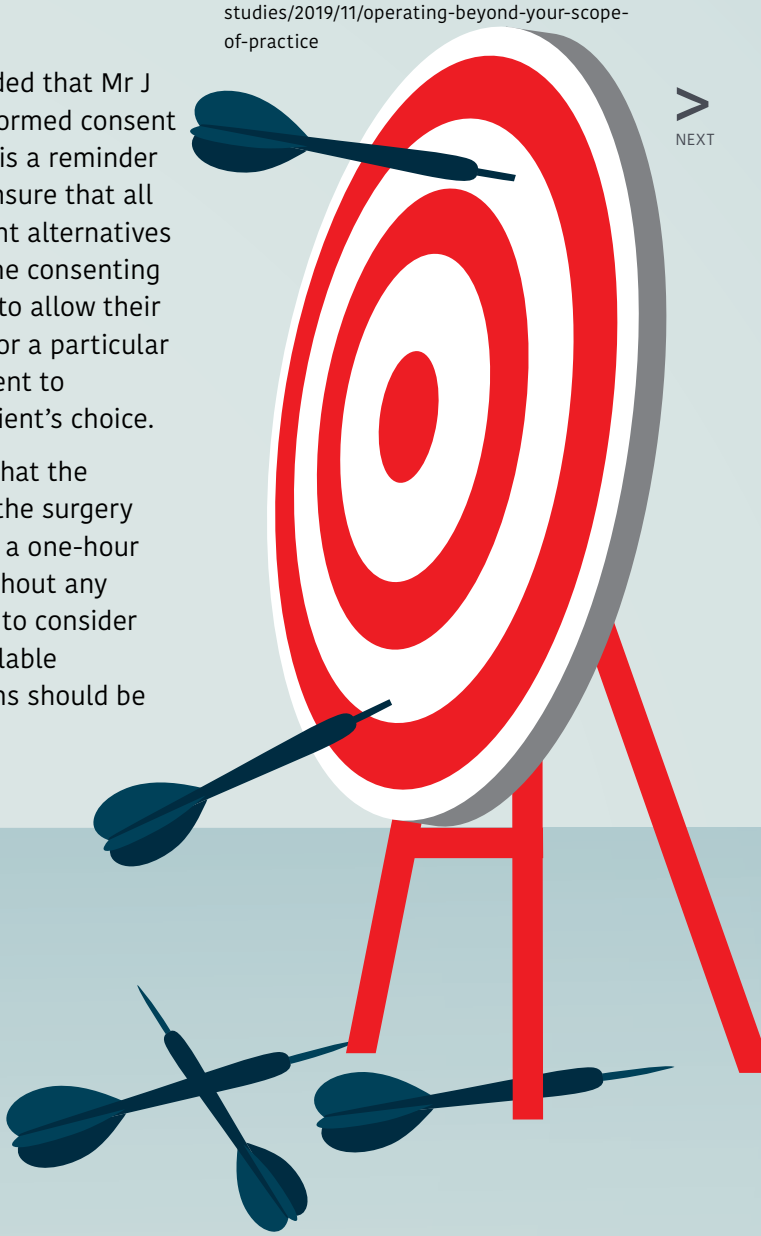
Discussion

- The court concluded that Mr J had not given informed consent in this case. This is a reminder to clinicians to ensure that all relevant treatment alternatives are explored in the consenting process, and not to allow their own preference for a particular course of treatment to influence the patient's choice.
- The court noted that the decision to have the surgery was made during a one-hour consultation, 'without any time being taken to consider which of the available alternative options should be pursued, or another opinion being obtained.' Ensuring that patients have sufficient time in which to make their decision is an important element of obtaining valid consent.
- This case is also a reminder to doctors to always act within the limits of their competence and their scope of practice. The court was clear that, given his lack of experience and training in the procedure he recommended, Dr D should have disclosed this to Mr J and 'should not himself have undertaken that surgery'.

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/operating-beyond-your-scope-of-practice

< BACK

NEXT >



CASE BOOK

First trimester pregnancy care – don't miss the window

When a pregnant patient found out she had missed the opportunity to have combined first trimester screening, a complaint was filed. This highlights the need for healthcare providers to work together to be aware of upcoming antenatal visits and stay up to date with screening recommendations.

Dr Kiely Kim
Medico-legal Adviser

BACK

NEXT

Case history

Lisa, 33 years of age, presented to her GP holding a home pregnancy test with a positive reading, excited to be pregnant for the first time.

The GP concluded she was six weeks pregnant, and proceeded to discuss her pregnancy care options. Lisa decided that she would like to be referred to the local public hospital as she did not have private health insurance.

She was provided with a referral to the hospital antenatal clinic, and a request form for routine antenatal blood tests with a copy of the results to be sent to the clinic. Her GP advised that as she did not provide shared antenatal care, she did not make any future appointments with Lisa. The GP believed Lisa would be seen by the clinic in the next few weeks.

Lisa, however, was not able to make an appointment with the antenatal clinic until she was 14 weeks pregnant. When she attended, prenatal screening tests were discussed and Lisa discovered it was too late to have combined first trimester screening. Other screening options such as cell free DNA testing and second semester serum screening were offered.

Lisa's GP later received a letter of complaint as the options of screening were not discussed at her consultation. There was also concern about the inadequate provision of information or counselling about optimising health in early pregnancy.

Discussion

During their first consultation, a pregnant patient may ask many questions with varying expectations for advice, and this can be challenging for GPs when they may have time constraints.

The Department of Health's Pregnancy Care Guidelines[1] recommend making an arrangement for a long appointment within the first 10 weeks of pregnancy. This acknowledges the need to discuss the many assessments and tests offered to women in the first trimester, as well as performing a comprehensive clinical and psycho-social assessment, and providing general advice regarding common issues of concern in early pregnancy.

In this case, the GP had assumed that the hospital antenatal clinic would provide early pregnancy advice and would be taking over the patient's care. However, the GP was not aware of when this may take place.

The RACGP's guide, Genomics in general practice, makes this recommendation.

"All pregnant women (i.e. regardless of age, ethnicity, family history) should be provided with information about prenatal screening tests for chromosomal conditions such as Down Syndrome. Screening options should be discussed in the first trimester whenever possible".[2]

The complaint in this case was made due to the option of prenatal screening tests not being discussed in a timely manner.

Summary

There are many issues to cover in a first antenatal consultation and these may need to be covered over several visits.

It is important to collaborate with other health care providers who may be involved and be aware of the timelines for future antenatal visits. The area of prenatal testing and reproductive carrier screening is evolving and it is important that health care providers are aware of and keep up to date with recommendations for these.

Prenatal screening – new developments

Recently released RANZCOG recommendations on reproductive carrier screening[3] state that: ***"information on carrier screening for the more common genetic conditions that affect children (e.g. cystic fibrosis, spinal muscular atrophy, fragile X syndrome) should be offered to all women planning a pregnancy or in the first trimester of pregnancy."***

Patients are increasingly becoming aware of these tests particularly with the 2018 Federal budget announcement of "Mackenzie's Mission" named after Mackenzie Casella, who died at seven months old from spinal muscular atrophy (SMA), and whose parents were not aware they were both carriers of SMA. The research project aims to screen 10,000 couples for carrier status for approximately 500 autosomal and X-linked genes. Research outcomes will include uptake of screening, psychosocial impacts, the ethical issues raised by reproductive carrier screening, and the health economic impacts of the test.

The project also aims to investigate how reproductive carrier screening should be provided as a national program, and become more widely available for every Australian couple who wants it.

There is no Medicare rebate available for this screening at present. With the increasing availability and awareness of genetic carrier screening it is important to provide information about the availability of these tests and to be able to identify referral to specialist services as required.

Further resources:

Australian Government Department of Health Pregnancy Care Guidelines 2019
beta.health.gov.au/resources/pregnancy-care-guidelines

Routine antenatal assessment in the absence of pregnancy complications
ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Routine-Antenatal-Assessment-(C-Obs-3(b))-Review-July-2016.pdf?ext=.pdf

Prenatal screening and diagnostic testing for fetal chromosomal and genetic conditions
ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Prenatal-screening_1.pdf?ext=.pdf

RACGP Genomics in general practice
www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Genomics-in-general-practice.pdf

Preconception and antenatal carrier screening for genetic conditions: The critical role of general practitioners
www1.racgp.org.au/ajgp/2019/march/preconception-and-antenatal-carrier-screening-for

Patient resources:

Pre-natal testing overview
genetics.edu.au/publications-and-resources/facts-sheets/fact-sheet-24-prenatal-testing-overview

Reproductive carrier screening
genetics.edu.au/publications-and-resources/facts-sheets/FS65REPRODUCTIVECARRIERSCREENING.pdf

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/first-trimester-pregnancy-care-dont-miss-the-window

Firstdefence

FOR DOCTORS IN TRAINING

- Clinical photography gone wrong
- What I like about psychiatry
- A fit and proper person – or not?

Dr Russell Thompson
2018 MDA National & RDAA Rural Bursary Winner, recent graduate
Member since 2018

Clinical photography gone wrong

Marika Davies
Medico-legal Adviser

In the digital age, the ability to share clinical images has become an efficient way to assist with patient care. All too easily, however, these photographs can be sent to the wrong place – with potentially serious consequences.

The case

A junior doctor working after hours in the paediatric emergency department saw a one-year-old child with penile swelling. She was concerned about a possible paraphimosis, and contacted the on-call surgical registrar who was working at a different site.

The patient had already been waiting for several hours, and the registrar was held up in theatre, so the registrar asked the junior doctor to send her photographs of the swelling. She agreed and noted down the registrar's mobile number in the medical records.

The doctor spoke to the child's mother and obtained her consent to take the photos and share them with the registrar.

Minutes after sending the photos to the registrar, the doctor received a call from an angry male who had received the photos in error. She apologised profusely to the man and requested he delete the photos. Although the man seemed satisfied with the explanation, he told the doctor he had already reported the matter to the police.

Looking back at her notes, the doctor realised she had entered an incorrect digit when sending the photos. She explained what had happened to the parents and apologised. She did not document the incident in the medical records and deleted the photos and text messages from her own phone.

A few weeks later the doctor was contacted by a police officer from the child abuse unit seeking an explanation for the photographs. She was also asked to attend a meeting with her head of department.

The doctor called our Medico-legal Advisory team for assistance. Fortunately, the police and the hospital were satisfied with her explanation and no further action was taken.

Further information:

ama.com.au/use-and-disclosure-clinical-images

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

Be photo-safe

- Clinical photographs are an efficient way of sharing information to assist with patient care, but you should be aware of the risk of potentially serious consequences for patients if images are inadvertently shared.
- You must take reasonable steps to keep photographs secure, including security settings, password and cloud access on your devices.
- Special care should be taken if images could be considered obscene or pornographic out of context.

Tips to reduce your risk

- Informed consent must be obtained before photographs are taken – this includes advising the patient how the photographs will be used, transmitted, stored and disposed of.
- Make sure you are aware of, and follow, any organisational policies on the use of clinical photography.
- If an image is sent to the wrong person, inform hospital management immediately and contact our Medico-legal Advisory team who will provide you with advice and support, 24/7 in emergencies.

< BACK
NEXT >

What I like about psychiatry

As someone interested in public policy, psychiatry is a perfect specialty for learning more about how politics affects health.

I didn't always want to do psychiatry. My initial interest was in ophthalmology – I devoured Fred Hollows' autobiography and was amazed by the black cataracts and enormous ocular tumour I saw on my medical school elective to Myanmar. Over time, however, I developed a deeper interest in the social determinants of health and in trying to understand how the mind works – and how it can spectacularly malfunction. Here's why psychiatry is the 'good enough' specialty for me.

Psychiatry is fascinatingly diverse

Our work spans from perinatal and infant mental health, through to psychiatry of old age. We work pretty much everywhere, and ideally try to see our patients where they live: outback communities, homeless shelters, suburban homes, inner-city apartments, prisons – you name it, a psychiatrist has probably seen a patient there.

Psychiatric practice combines psychotherapy, pharmacotherapy and sometimes procedures (e.g. electroconvulsive therapy), and most psychiatrists will use a combination of these in their work. I plan to spend the next two years doing advanced training in child and adolescent psychiatry, which primarily involves psychotherapy and working not only with a patient, but also with their family and school.

Psychiatry teaches you how politics affects health

During medical school, a generous psychiatrist, Lisa Brown, took me with her to visit patients in a women's prison. I remember meeting one young woman who had stabbed her mother, and as Dr Brown took her developmental history, it struck me that it was like ticking off every box in a list of risk factors for social disadvantage. My friend and fellow registrar, Marie Bismark, describes psychiatry as "the point of closest connection between health and social justice issues, including housing, employment, gender-based violence, inequality, discrimination, and stigma."

We have time to talk to our patients

Psychiatry is one of the few areas of medicine where it is expected that interviewing a patient takes a long time, especially the first occasion you meet them. There are no hard or fast rules, but 50-minute interviews are common. If you enjoy getting to know your patients in depth, then psychiatry can be very rewarding.

Psychiatry suits doctors who are curious

Psychiatry encourages and rewards curiosity, because curiosity opens up different diagnostic possibilities and provides the data and ideas for richer formulations. A formulation seeks to explain why this particular patient has presented at this particular time with these particular problems, and what their treatment and prognosis might be.

Psychiatry encourages and rewards curiosity, because curiosity opens up different diagnostic possibilities.

< BACK

> NEXT

There's a lot of work for psychiatrists

After a long history of stigmatising mental illness, Australian society is slowly coming to terms with the immense burden of disease that it causes, and the enormous economic and social benefits of increasing access to psychiatric care. I expect to see increased private and public investment in psychiatry throughout my career. The Australian Government predicts a shortage of psychiatrists in the medical workforce[1] which is not the case for many other specialties.

I can live with the downsides

Everything has its downsides, and when choosing your specialty, it's imperative to ask yourself whether you can live with these. In psychiatry, our training tends to focus more on pharmacological than psychological therapies, but there are many opportunities for continual learning as a psychiatrist. Our training is quite long (at least ten, six-month rotations) and there are continual assessments, with a high paperwork burden. Other areas of medicine can speak disrespectfully of us and our patients, which is perhaps surprising given the burden of mental ill-health among doctors.

Patients get better

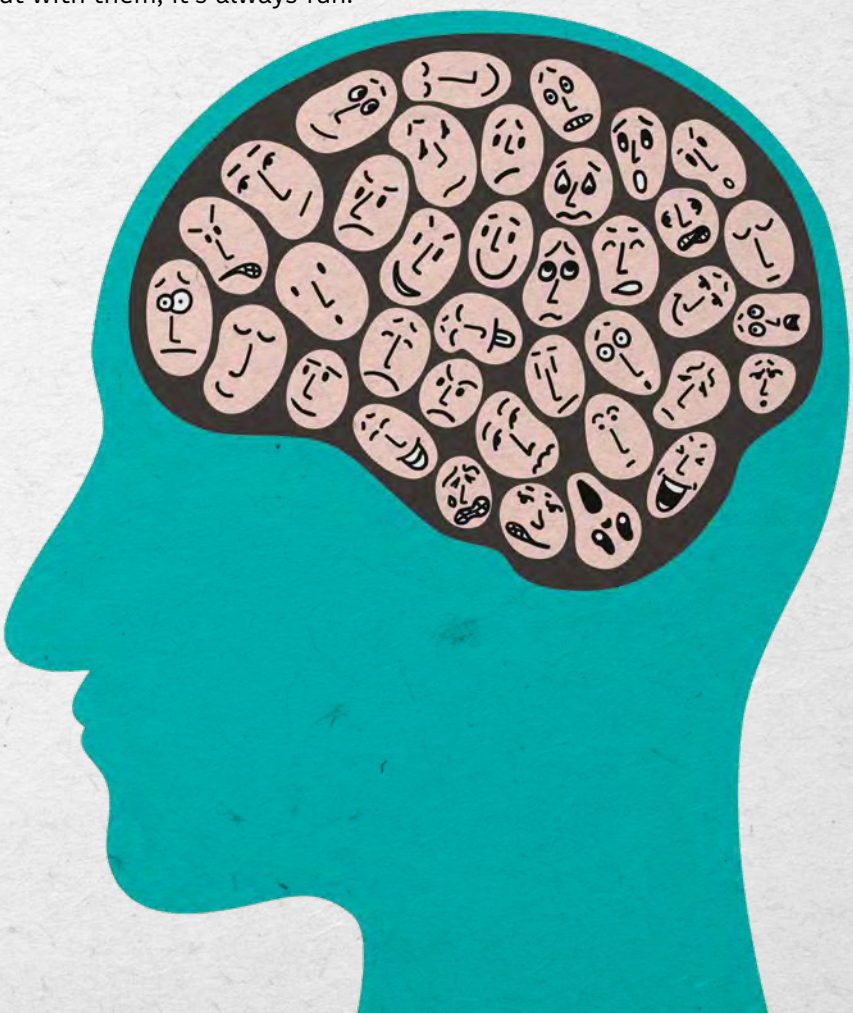
While I often wish for better psychiatric treatments, patients can get immeasurably better with the tools we already have. Lives can literally be turned around, with enormous positive impact on patients and their families. Even illnesses like schizophrenia are not synonymous with permanent disability. For a good example, see the 2012 TED talk by a professor of law who has schizophrenia, Elyn Saks.[2]

I've found my tribe

Someone once told me to 'find your tribe' in medicine. I really like my colleagues in psychiatry, who have a diverse mix of interests outside of work. They enjoy the arts, care deeply about human rights, and approach their work with curiosity and kindness. My study group has four wonderful female psychiatry trainees and I never thought I'd say this about studying medicine – but with them, it's always fun!

Dr Benjamin Veness
Psychiatry Registrar

Benjamin Veness is a psychiatry registrar in his third year of training, based in Melbourne. He is an MDA National member and is also a member of the MDA National State Advisory Committee in Victoria. You can follow him on Twitter @venessb.



View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/what-I-like-about-psychiatry

A fit and proper person, or not?

A recent Medical Tribunal hearing considered whether a junior doctor was a fit and proper person to be a doctor.

Dr Sara Bird
Executive Manager,
Professional Services

Case Study

Dr Z worked as an Intern and RMO at a regional hospital. Complaints were made that he breached professional boundaries in relation to three female patients, with whom he had had personal relationships. The allegations included:

- Taking antibiotics from the hospital to give to Patient A to treat recurrent UTIs. Dr Z did not take a history, perform an examination or make any medical records before providing her with the antibiotics.
- Taking blood from Patient A, ordering tests in another doctor's name, discussing the results and incorrectly interpreting the test results.
- Prescribing trimethoprim and amitriptyline to Patient B. Dr Z did not take a history, perform an examination or make any medical records.
- Engaging in sexual activity with Patient B in the hospital recreation room when he was rostered on night shift.
- During a night shift, paying Patient C a 'social' visit, lying on her hospital bed and watching a movie. Dr Z also charted medication for Patient C when staff had not requested he do so.

Medico-legal Issues

The complaints proceeded to a Medical Tribunal hearing in 2018. Dr Z denied many of the allegations, and only admitted to some of the conduct during cross examination. For example, he initially denied having sex with Patient B when he was on duty, but later conceded he did have sex with her at the hospital, but only during his meal breaks which "were my time".

The Tribunal found Dr Z guilty of professional misconduct. In view of his serious lack of insight, his medical registration was cancelled.

Thirteen months later, Dr Z applied for a review of the cancellation of his registration. The case proceeded to a second Tribunal hearing where Dr Z "consistently failed to acknowledge, much less address, his dishonesty in his responses and statement to the original Tribunal". The Tribunal found Dr Z's dishonesty was a relevant and important factor to be considered in determining his application.

The Tribunal was confident that if Dr Z returned to medical practice, he would not treat or prescribe drugs for partners or family members, nor would he have sex in a hospital whilst he was on duty or pay social visits to inpatient friends when rostered on. However, the Tribunal remained concerned that the incidents reflected defects in Dr Z's character or way of thinking which may give rise to him exhibiting different kinds of unsatisfactory professional conduct in the future:

A lack of honesty and frankness in the context of the practice of medicine poses an obvious risk to patients. A medical practitioner must be able to deal with the suggestion that he or she may have made a mistake in an open and forthright manner.

The Tribunal found that Dr Z was not presently a fit and proper person to be registered as a medical practitioner, and his registration remained cancelled.

Summary

- Do not treat friends or family, including prescribing medication
- Never have a sexual relationship with a patient
- Honesty is always the best policy.

< BACK
NEXT >

Keep on learning...

Members can enjoy **complimentary** education opportunities with us. You'll discover practical, evidence-based education to keep your knowledge up to date, participate in live activities, and access on-demand expertise.

e-Learning

Need to catch-up on CPD? These activities are available 24/7 – complete them at your own pace, from the comfort of your tablet or computer, whenever suits you best. Available topics include:

- medical record-keeping
- prescribing opioids
- informed consent
- the challenging emotions of difficult news.

More information and access
mdanational.com.au/member-benefits/education/online-activities

According to feedback from on-demand e-learning survey respondents in 2018–19:

- 89% planned to do something differently at work as a result of participating
- 92% agreed or strongly agreed that they enjoyed the activity.

< BACK

NEXT >

Webinars

Watch previous webinar recordings on topics including medical marketing; privacy and information security; avoiding misunderstandings around intimate examinations; and direct-to-consumer DNA testing.

Find them under 'video' content on our library webpage
mdanational.com.au/advice-and-support/library

Podcasts†

Listen and learn anywhere, anytime. Topics include coronial matters; avoiding common medico-legal mistakes; and treating yourself, staff and family.

Find them under 'podcast' content on our library webpage
mdanational.com.au/advice-and-support/library

- **Stay tuned for more workshops and live webinars in the new year!**
  Keep an eye out for email invitations or check out our events webpage: mdanational.com.au/member-benefits/events.
- **Have an idea for an education resource?**
  Send an email to: education@mdanational.com.au.

† Not pre-recognised with a CPD program

Keep on practising with confidence

Want to know more about the medico-legal issues that matter to you?

Visit our Medico-legal Blog, which delivers the latest news straight to your fingertips. Written by our team of experts, this blog is your trusted resource for medico-legal insight and advice.

Subscribe at mdanational.com.au

Dr David Chong
Plastic & Reconstructive Surgeon, VIC
Joined MDA National in 1998

mdanational.com.au
1800 011 255 peaceofmind@mdanational.com.au

- PERTH
  Level 3
  88 Colin St.
  West Perth WA
  6005
- SYDNEY
  Level 5
  69 Christie St.
  St Leonards NSW
  2065
- MELBOURNE
  Level 3
  100 Dorcas St.
  Southbank VIC
  3006
- BRISBANE
  Level 8
  87 Wickham Tce.
  Spring Hill QLD
  4000
- ADELAIDE
  Level 1
  26 Flinders St.
  Adelaide SA
  5000
- HOBART
  Level 1, ABC Centre
  1-7 Liverpool St.
  Hobart TAS
  7000