JUNE 2019

Defenceupdate

FOR MEDICAL PRACTITIONERS

CASE BOOK

- Gun control
- Sexual misconduct
- Declined treatment

My Health Record: are you prepared?

PREVENTION IS BETTER THAN CURE

INFORMATION SECURITY

FIRST DEFENCE

New feature section for doctors in training

MDA National

WELCOME

Welcome everyone to *Defence Update*. I hope you enjoy the magazine's new look and our refreshed branding.

I'm delighted that three of our members have contributed articles in this edition of *Defence Update*. On page 7, Dr David Chong relates his heart-warming recent experience in Madagascar.

We have expanded *Defence Update* to include *First Defence*, a section for junior doctors, in which we hear from Dr Lily Vrtik (page 28) about the concept of Ikigai and how it helped shape her career path. And Dr Eric Richman (page 27) shares his insights on why we shouldn't have to fight with our colleagues, drawing on his own personal journey from junior doctor to staff specialist.

Our medico-legal pull-out feature sheds light on information security and includes a handy flowchart to help you in decision-making about reporting a privacy breach. In our case book, we discuss sexual misconduct, the doctor's role in gun control, and managing situations when patients decline treatment.

Finally, I would like to warmly thank Dr Sara Bird who has been editor of *Defence Update* for many years. Her tireless work since the launch of this magazine has ensured its high quality, and she has contributed many fascinating articles over the years. I have taken over Sara's role, and will continue to bring you the latest in the medico-legal world and other articles of interest to you, our members.

Dr Jane Deacon
Manager, Medico-legal
Advisory Services

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Have an editorial enquiry?
Please contact Niranjala Hillyard,
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Member contributions
Dr David Chong, Dr Lily Vrtik,
Dr Eric Richman

Medico-legal review
Dr Jane Deacon, Dr Sara Bird,
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In this issue

NOTICE BOARD

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Indemnity cover for vaginal rejuvenation

The following criteria apply from **1 July 2019** if you are planning to perform vaginal rejuvenation with energy-based devices:

- Members must apply to MDA National for confirmation of cover for energy-based vaginal rejuvenation procedures.
- Where there is any ambiguity as to whether a particular procedure constitutes vaginal rejuvenation, MDA National should be approached for review.
- Details of the procedure as well as copies of the member's consent procedure and relevant consent forms should be submitted for review.
- Assuming confirmation of cover, the performance of energy-based vaginal rejuvenation procedures will require coverage under level 6A–GP–Cosmetic.

If you previously received approval for performing the above procedures, the cover you have obtained will NOT continue beyond 30 June 2019, unless the above criteria are met.

Read our blog post at: mdanational.com.au/advice-and-support/library/blogs/2019/04/laser-vaginal-rejuvenation-risks

Keep on evolving

Our refreshed brand identity

We're always evolving to ensure you continue to receive the highest level of care, medico-legal expertise and extensive cover. Based on member feedback, we've launched a new website and refreshed our corporate identity.

Modern and progressive, members are telling us they love it!

Visit our new website

Designed to help you find what you're looking for with ease, based on your specific career stage.

Watch our brand story

Featuring several of our own remarkable members.

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Scan the QR code to watch the video or view it at youtu.be/ceWHSQsTGHU

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**.

Get social

You're welcome to share our video through your professional networks, and we'd love to see your comments on our social media posts. **#mdanational**

Renewal time — keep on practising with peace of mind

You should have recently received your 2019 Renewal Notice. Renew your Membership and Policy with ease by **30 June 2019**.

Check your Renewal Notice

If the information on your Renewal Notice is correct, you can make your payment via our **Member Online Services** or by phone on **1800 011 255**. If you've arranged for direct debit, we will debit your nominated account on the scheduled dates listed on your Renewal Notice.

Your Renewal Notice includes:

- your tax invoice/receipt which is valid upon payment
- your Certificate of Insurance which can be used as proof of indemnity upon payment.

You'll also be able to download these documents as part of our online renewal service.

Tell us about any matters arising from your practice

Ensure you have informed us of all claims, complaints, investigations, employment disputes, or any incidents you're aware of that may lead to a claim for indemnity under your Policy. This is a requirement under your Policy.

Review the risk category changes

- Read the *Risk Category Guide 19/20* and the *Risk Category Guide Significant Changes 19/20* (accessible from the Download Centre under Insurance Products at mdanational.com.au) to ensure you've selected the most appropriate risk category and estimated the most accurate Gross Annual Billings for your practice.
- If you don't have the accurate level of cover or are not in the appropriate billings band, you may be in breach of your AHPRA Registration Standards in relation to Professional Indemnity. This will also affect cover under your Policy.
- If there's a change to the level of cover or your gross annual billings, please contact us and we will re-issue you with a revised Renewal Notice.

Review the Policy changes

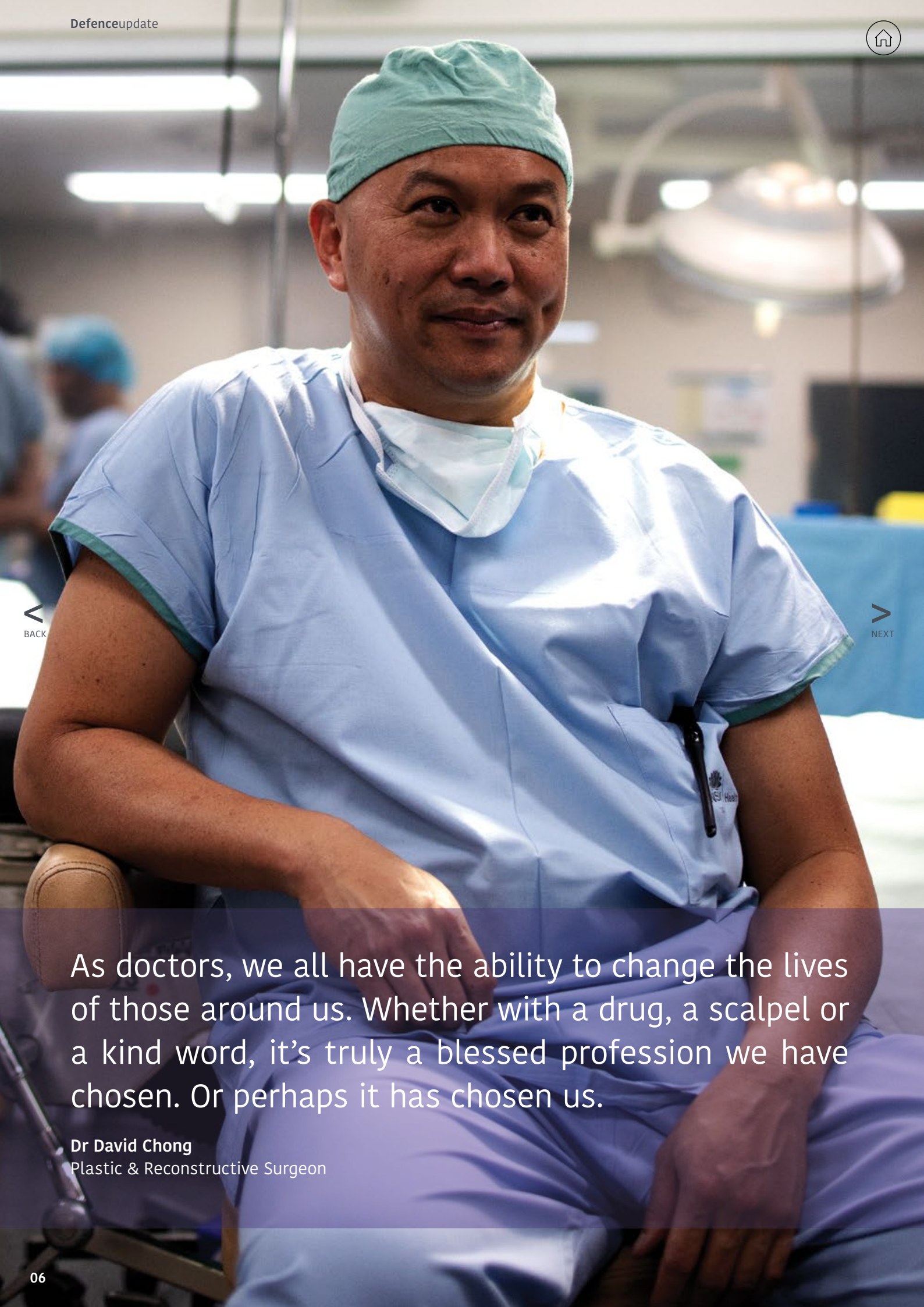
We have broadened the cover for 2019/20 and enhanced the Policy Wording to provide greater clarity. Some of the 2019/20 Policy enhancements include:

- increase in the sublimit for investigations and inquiries to $2 million
- provision of cover for mandatory notification costs arising from an unintended breach of the Privacy Act
- provision of automatic cover for a total of six months for practice outside Australia in specific circumstances
- increase in the cover for the costs of defending defamation claims against you.

Please read the Supplementary Financial Services Guide & Product Disclosure Statement including Amendments to the Policy Wording V.12 included in your renewal pack for details of all changes prior to renewing for 2019/20.

Any queries about renewal?

Contact our Member Services team on **1800 011 255** on weekdays between 8.30am and 8.00pm (AEST) or email **peaceofmind@mdanational.com.au**.



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As doctors, we all have the ability to change the lives of those around us. Whether with a drug, a scalpel or a kind word, it's truly a blessed profession we have chosen. Or perhaps it has chosen us.

Dr David Chong
Plastic & Reconstructive Surgeon

DOCTORS FOR DOCTORS

I've just got home from Madagascar. It's a strange feeling but one I've grown accustomed to. Three weeks ago, I sat confronted by the dilemma of a stunted health system. In a country of 24 million people, where the majority of people eke out life with daily earnings less than a dollar a day, I spent time in a hospital that served three million people, had a budget of $60,000 a year, no medically trained anaesthetists, and the majority of staff volunteering.

Around me were countless unsung local heroes. People who toiled 24-hour shifts to look after those who could somehow afford to be admitted. Yet, I was surrounded by optimism and smiles that surpassed the severe situation. No joyless words complaining of injustice, no helpless inaction, no hopeless apathy.

I spent the time training one of the local general surgeons on cleft lip and palate surgery. A kind, happy man. Good hands... that nod of approval that us surgeons like to give our fellows. My sole role was to educate him in cleft surgery and get him credentialed so he could take on the endless tide of facially different children on top of his already insurmountable workload. He had taken two weeks off from his job that paid $50 a week to learn from me.

The week ended. I felt proud of him. A connection forged over laughter and learning as we wrestled facial deformities with my infantile French and his halting English. At the insistence of the program coordinators, we made a trip to the patient shelter. Together as a team, with Malagasy volunteers and overseas counterparts. The patients wanted to thank us.

We slowly climbed the hill in our buses, rising up on the dusty road that separated us from the patients and their families. I couldn't help feeling the ascent like a wall that separated us. We had so much. They had so little. As I descended the steps of the bus, I became aware of a deep warmth that radiated towards me. A lump rose to my throat, one that I wanted to fight.

There they were. A sea of smiling brown faces. Grandparents, mothers, fathers, children. Family.

We started just watching each other and smiling like girls and boys kept separate at the start of their first high school dance. Waving ridiculously at each other. Then spontaneous cheering followed by clapping and an energy borne of its own, as laughter and gratitude carried into dancing, singing and heartfelt hugs that drew us together into our common humanity. The wall was gone, and we were embracing as though we had been liberated from our enemies. For a moment I wondered if there was a heaven, perhaps it would feel like this.

Now I'm home again. I just turned on the tap, grateful for the clean water that gushed effortlessly out of it. With all I've been given, I wonder how much more I can give, or am willing to give. This miraculous life that defies explanation, this spinning blue-green planet suspended impossibly in an infinity of space and stars, full of its beauty and inequalities and kindnesses and contradictions – what does it ask of me?

In gratitude, I contemplate the path ahead unwritten. Thankful for the ability we all have as doctors to change the lives of those around us. Whether with a drug, a scalpel or a kind word, it's truly a blessed profession we have chosen. Or perhaps it has chosen us.

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"With all I've been given, I wonder how much more I can give, or am willing to give."

My Health Record — are you prepared?

Karen Stephens
Risk Adviser, Support in Practice

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Over 90% of Australians now have a My Health Record (MHR). With MHR becoming a more routine part of your medical practice, this is a good time to consider whether you're prepared.

Visit the ADHA website for more information on MHR for healthcare professionals
myhealthrecord.gov.au/for-healthcare-professionals

Patients can access more information on MHR from the OAIC website
oaic.gov.au/individuals/my-health-record/manage-your-my-health-record

What is an MHR?

It is a collection of patient health information accessible online by authorised users. It's not a 'complete' health record and doesn't replace a doctor's own medical records. It can include Medicare and PBS data, immunisation records, organ donor status, discharge summaries, pathology and diagnostic imaging reports, referrals, advance care plans and emergency contact details. It may also include a Shared Health Summary (overview usually created by the patient's regular GP) and Event Summaries (significant information that may be useful for future treatment, which can be created by any authorised provider).

The Australian Digital Health Agency (ADHA) is the MHR system operator.

What control and access do patients have?

Patients can:

- access their MHR through their myGov account or an authorised mobile app
- cancel their MHR at any time or opt back in
- ask healthcare providers not to add particular information to their MHR
- remove documents from view (but can't edit documents)
- add personal health information, advance care plans and emergency contact details
- choose to give access to another person (nominated representative)
- restrict access to specific documents (access is still available in an emergency)
- restrict access to their entire MHR so particular healthcare organisations can't access it (access limits apply to organisations, not individual staff)
- obtain SMS or email alerts to notify the first time a healthcare provider accesses their record, and other notifications
- access the history of their record at any time.

Carers or authorised representatives can access and/or control the MHR of someone in their care (parents or guardians of children are automatically authorised representatives if they're on the same Medicare card).

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When a child turns 14, the carer or nominated representative can no longer access the child's record. A young person aged 14-17 years can elect to control the MHR themselves – they will need to set up a myGov account[1] or authorise a nominated representative.

How do I access a patient's MHR?

- Practices must register to be part of the system and obtain a Healthcare Provider Organisation Identifier (HPI-O).[2]
- Individual providers must also register, using their HPI-I number issued by AHPRA (you can find this on your AHPRA account).[3]
- Access can be via clinical software that meets MHR requirements or via a Provider Portal (which is read-only).
- Anyone who is registered can access an MHR for the purpose of providing health care.
- You can download documents from the MHR into the patient's records on your practice's system.

Must I access a patient's MHR?

- You're not compelled to open a patient's MHR as a matter of routine – you should decide whether this would be clinically useful.
- There's no legal obligation for individual doctors to participate in the MHR system.

Do I need patient consent to upload documents?

- You're not legally required to get patient consent to add a document to their MHR.
- If the patient is with you or the information is sensitive, it may be best to get verbal consent.
- You must not upload information that a patient has explicitly requested not to be uploaded. To prevent a prescription being uploaded, uncheck the 'consent to send to My Health Record' flag on an e-prescription. For pathology and radiology reports you can check 'Do not send to My Health Record' in the clinical software or the paper referral form, or handwrite the instruction on the form.
- You must not upload information you know to be inaccurate, out of date, misleading or defamatory.

Can I bill Medicare?

- There are no MBS item numbers for uploading to an MHR.
- The time taken to prepare documents for uploading counts toward consultation time for billing the MBS, as long as the document preparation was part of providing a clinical service and the patient was present.

What about privacy breaches?

- Unauthorised access to the MHR carries significant civil and criminal penalties.
- Unauthorised "collection, use or disclosure" of information in an MHR or compromised security of the MHR system must be reported to the ADHA, the OAIC, and possibly affected patients. Failing to report carries significant penalties.

How can practices prepare for MHR?

- Check whether your practice software is 'MHR conformant'.[4]
- General practices who meet particular requirements can receive incentive payments.[5]
- Train yourself and your clinical and non-clinical staff in the use of MHR. The ADHA has a number of training resources.[6]
- Establish team members' roles and responsibilities, e.g. designate a Responsible Officer and an Organisation Maintenance Officer.
- Create an MHR policy – this is a legal requirement for participating practices. The policy must include staff training, how staff are authorised to access MHR, how individuals' access to MHR is communicated to the system operator, physical and information security measures, and how security risks are identified and acted upon.
- Visit the RACGP website's 'My Health Record resources' section for useful information including a template policy for general practices.[7]

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/mhr-are-you-prepared

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A patient comes to you wanting your help with voluntary assisted dying – how would you deal with this?

Voluntary assisted dying — what you need to know

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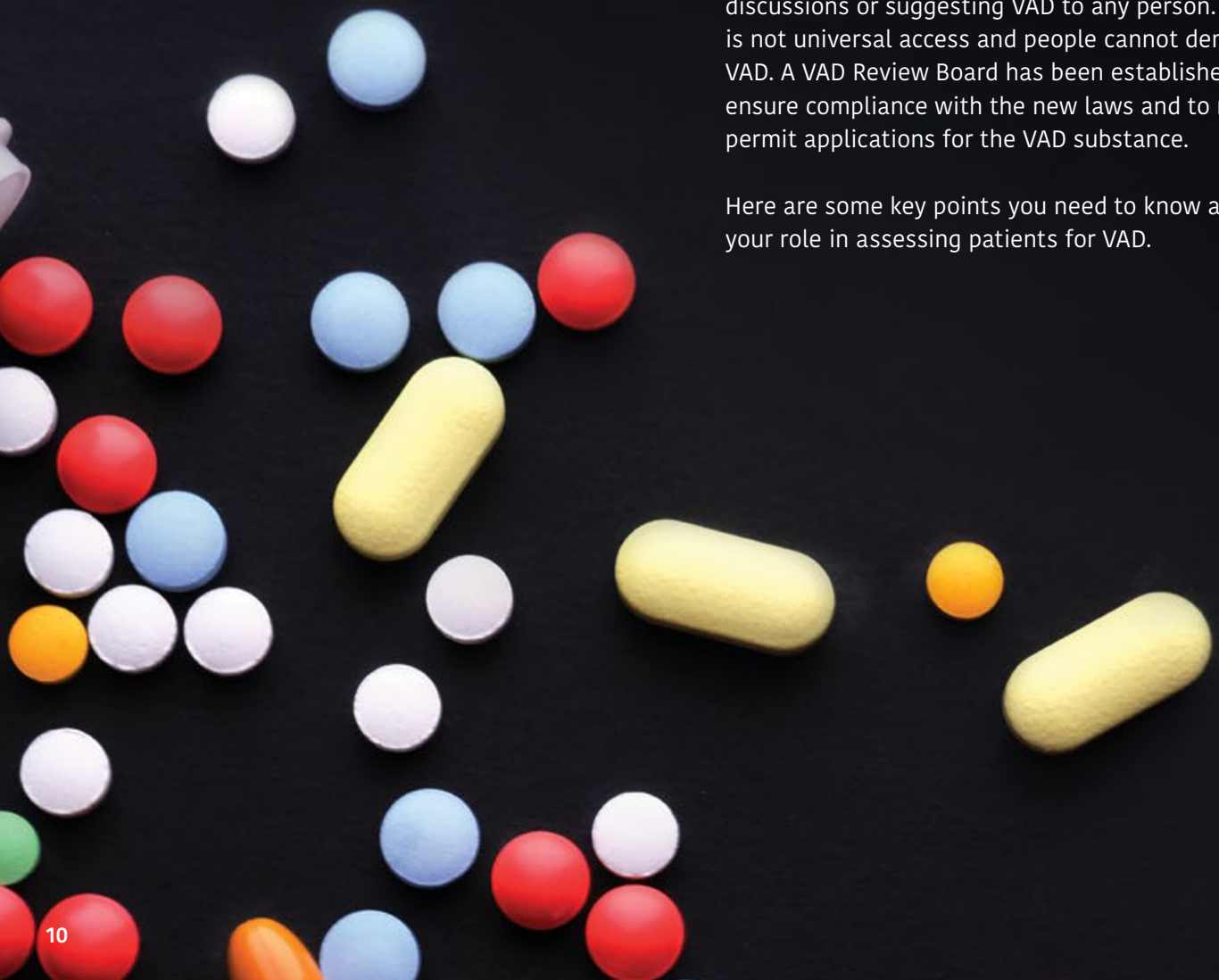

Voluntary assisted dying (VAD) laws will come into effect on 19 June 2019 in Victoria. Importantly, medical practitioners are prohibited from initiating discussions or suggesting VAD to any person. There is not universal access and people cannot demand VAD. A VAD Review Board has been established to ensure compliance with the new laws and to monitor permit applications for the VAD substance.

Here are some key points you need to know about your role in assessing patients for VAD.

Gayle Peres da Costa
Medico-legal Adviser

Who is eligible for VAD?

To be eligible for access to VAD, a person must:

- be over 18 years of age, an Australian citizen or permanent resident, and a resident of Victoria for at least one year; and
- have decision-making capacity in relation to VAD; and
- be diagnosed with a disease, illness or medical condition that is:
  - incurable; and
  - advanced, progressive and will cause death; and
  - expected to cause death within weeks or months, not exceeding six months (or 12 months for a neurodegenerative condition); and
  - causing suffering to that person which cannot be relieved in a tolerable manner.

What medical assessments are involved?

A medical practitioner may decline to assist a person seeking access to VAD on the basis that they are a conscientious objector or are unavailable. They can refuse to assist in any process related to VAD.

The first practitioner who agrees to assist becomes known as the 'Co-ordinating Medical Practitioner'. This practitioner becomes responsible for assessing the person's eligibility, providing information, reporting to the VAD Review Board, arranging an assessment from a second medical practitioner, and forwarding various documentation to the VAD Review Board when applying for a permit.

The second practitioner, who becomes known as the 'Consulting Medical Practitioner', must consider the same eligibility criteria and provide the same information before providing a second assessment to the VAD Review Board.

What information do you need to give the patient?

Once eligibility for VAD has been established, the person must be counselled regarding:

- diagnosis and prognosis
- treatment options and the likely outcome of treatment
- palliative care options and likely outcomes of care
- the potential risk of taking a VAD substance and that death is the expected outcome.

The person must also be made aware that they may decide at any time not to continue, and should be encouraged to consult other treating doctors in relation to the request.

Who can access VAD?

A person can access VAD if:

- they have met the eligibility criteria; and
- they have been given the information (as outlined above) by both the Co-ordinating Medical Practitioner and the Consulting Medical Practitioner; and
- they are acting voluntarily and without coercion; and
- their request for VAD is enduring.

Two self-explanatory types of permits are available for VAD – a Self-Administration Permit and a Practitioner Administration Permit.

What are the safeguards?

- Both the Co-ordinating Medical Practitioner and the Consulting Medical Practitioner must undergo approved assessment training before commencing an assessment.
- If either medical practitioner is unable to determine whether a person has decision-making capacity in relation to VAD, they must refer the person to a medical practitioner with appropriate skills and training, e.g. a psychiatrist.
- If either medical practitioner is unable to determine whether the person's disease, illness or medical condition meets the eligibility requirements, they must refer the person to an appropriate specialist.
- VAD substances will only be available at the pharmacy at the Alfred Hospital in Melbourne.
- A 'Contact Person' must be appointed to return any unused or remaining VAD substance to the dispensing pharmacist.
- A medical practitioner who supplies a VAD substance to a patient without a permit will be guilty of aiding and abetting suicide.

View more information from the Victoria Health website
health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying

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Communicating urgent pathology test results

Karen Stephens
Risk Adviser, Support in Practice

When urgent test results can't be communicated in time to the medical practitioner or medical practice requesting the tests, it can lead to serious consequences.

Pathologists who are MDA National members have had several cases where an urgent result has come in after hours and they were unable to contact the requester or their practice. They then called the patient, but the patient wouldn't answer a call from an unknown number or the patient was suspicious about speaking to someone they didn't know and refused to follow an instruction to go to hospital.

Such situations can lead to tragic consequences.

Real-life examples

- Delayed delivery of blood test results contributed to the death of a toddler from staphylococcus infection.[1]
- A cancer patient's test results were faxed to the wrong number and media reported he died alone in a hotel room.[2]
- A frustrated radiologist hung up when he got the doctor's answering service, and faxed and emailed reports of a DVT to the doctor's surgery. The reports had not been read when the patient died from a pulmonary embolus the following day.[3]

The Royal College of Pathologists of Australasia (RCPA) guidelines

Guidelines from the RCPA[4] include that the Requester's responsibility does not cease with the transfer of the request to the Pathology Provider, but remains until the Requester has taken appropriate clinical action in response to the report generated by the request. The guidelines state:

3.2 (1) (g) In the absence of the original Requester either during or outside normal business hours, a suitable delegate has been nominated to receive and act on the result.

7.1 (7) As Requesters may not always be available to receive pathology reports, they should have in place a mechanism by which Pathology Providers can communicate unexpected life-threatening test results to the Requester or their Nominated Delegate in a clinically appropriate timeframe.

7.2 (13) In cases where the Pathology Provider is unable to communicate life-threatening test results to the Requester or their Nominated Delegate or a suitable substitute in a clinically appropriate timeframe, the Pathology Provider should endeavour to contact the patient, or their responsible carer as appropriate.

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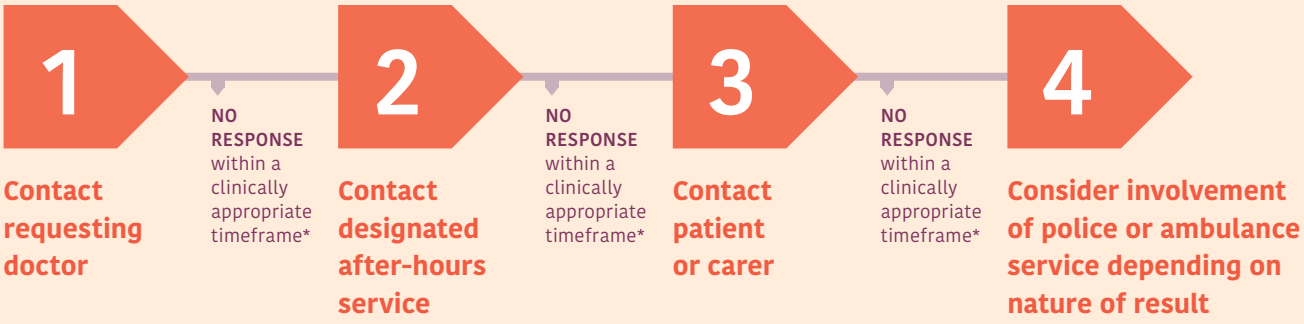
Escalation of test results

Below is an example of an escalation procedure for community patients sourced from the RCPA Guideline – *Management and communication of high-risk laboratory results (jointly endorsed by RCPA and AACB).*[5]



*Clinically appropriate timeframes will differ between different categories of high-risk results and should be pre-determined in the laboratory procedures.

The Royal Australian College of General Practitioners (RACGP) guidelines

The RACGP has developed its Standards for general practices (5th edition)[6] to protect patients from harm by supporting general practices in identifying and addressing gaps in their systems.

The GP Standard 2.2E within these guidelines focuses on the follow-up of high-risk (seriously abnormal and life-threatening) results identified outside of normal opening hours, and states:

- *Your practice must manage seriously abnormal and life-threatening results identified outside of normal opening hours so you can provide prompt and adequate follow-up.*
- *Your practice must have a process so that pathology and diagnostic services can contact the practice in urgent circumstances so information about the patient can be accessed.*
- *You need to explain to deputising doctors what you expect them to do if they receive urgent and life-threatening results for one of your patients, as they have a responsibility to contact the general practice in such circumstances. This could be documented in a formal agreement between your practice and the service providing after-hours care.*

Ultimately, responsibility lies with both the requester and the pathology provider for keeping after-hours contact details up to date.

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/urgent-pathology-test-results

Crossing the line with patient boundaries

Dr Sara Bird
Executive Manager,
Professional Services

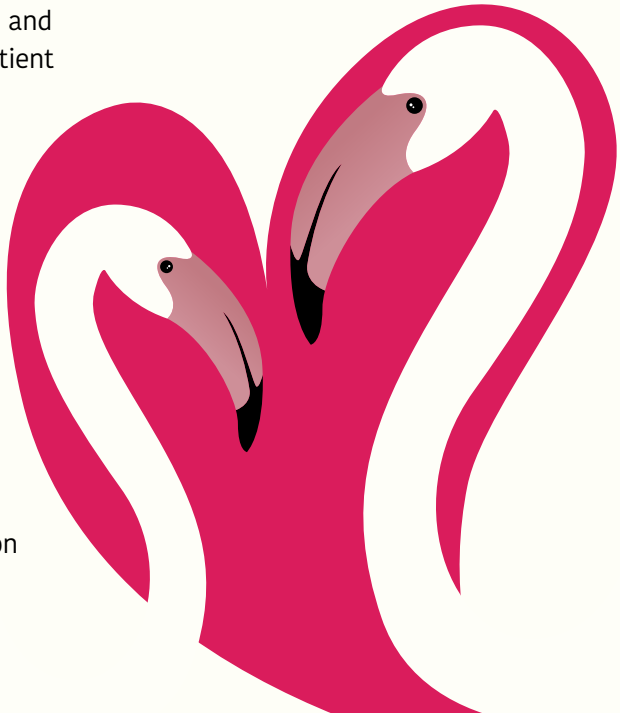
Released on 12 December 2018, the Medical Board of Australia's guidelines, *Sexual boundaries in the doctor–patient relationship*, are essential reading for every doctor and medical student.

Key points

- Conducting a physical examination that is unwarranted, not clinically indicated or when the patient has not consented to it, may constitute sexual assault. This includes conducting or allowing others, such as students, to conduct examinations on anaesthetised patients when the patient has not given explicit consent to the examination.
- AHPRA will advise people who make a complaint to them about alleged criminal conduct by a doctor, such as sexual assault, to report the behaviour to the police.
- It's never appropriate for a doctor to engage in a sexual relationship with a current patient. And it may be unethical and unprofessional for a doctor to have a sexual relationship with a former patient, or with an individual who is close to a patient under the doctor's care.
- The National Law requires all registered health practitioners, employers and education providers to report 'notifiable conduct' to AHPRA (except for treating doctors in WA). This includes reporting a doctor who is engaging in sexual misconduct in the practice of medicine.
- A doctor may choose to have an observer present in any consultation, such as during an intimate examination (breasts, genitalia, PR or PV examinations). The patient has the right to decline the presence of an observer and, if so, the doctor can choose not to proceed and help the patient to find another doctor.
- Other breaches of sexual boundaries include:
    - asking a patient about their sexual history or preferences, when these are not relevant to their health care and without explaining why it is necessary to discuss these matters
    - asking a patient to undress more than is necessary or providing inadequate privacy screening or cover for a physical examination
    - making sexual remarks, including sexual humour or innuendo.
- Engaging with patients via social media can blur professional and personal boundaries, and may affect the doctor–patient relationship. If a patient tries to engage with a doctor through social media or other digital communication about matters outside the professional relationship, the doctor should politely decline to interact and direct them instead to the usual professional healthcare communication channels.

Clear communication and being conscious of patient boundaries are the most effective ways to avoid misunderstandings in the doctor—patient relationship.

Read the case study on page 22 that highlights the importance of maintaining professional boundaries and the risks of engaging with current or former patients via social media.



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In medical practice, you're legally required to take reasonable steps to protect the security of the personal information you hold. Failure to do so increases the risk of privacy breaches, harm to patients, reputational damage, disruption to the functioning of your practice, and substantial fines or penalties.

PREVENTION IS BETTER THAN CURE

Gae Nuttall
Risk Adviser, Support in Practice

Here are some practical steps you can take to protect the information you hold.

Plan

- **IT service provider contract:** Check their qualifications and experience, response times, backup frequency, security provided and monitoring. The Australian Cyber Security Centre (ACSC) website has useful questions to ask your provider to make sure they're protecting your system and your data.
- **Data breach response plan:** This can be a fairly simple document which sets out the roles and responsibilities for assessing and responding to a data breach and managing the incident from start to finish. The OAIC has a useful guide to help develop your own plan.
- **Policy for electronic communications with patients:** E.g. email, SMS and weblinks. The RACGP has an internet and email policy template that you can customise to suit your practice.

Train

- **Regular staff training:** It's helpful to keep staff updated and aware of cyber security and scams, e.g. what a phishing email looks like and what to do if you suspect one. Some basic material for training can be found in the Australian Digital Health Agency's information security guide, and the ACSC has advice on improving staff awareness.

Access limits

- **Staff access:** Limit staff access to your data systems as appropriate to their role, e.g. most clinical software programs allow different access levels for administrative, nursing and medical staff. Restrict the ability to add new system software to the administrator only.
- **Screensavers:** Use password-protected screensavers to prevent others accessing the system.
- **Passwords:** Change passwords frequently, with a password of at least eight characters and a mix of letters (uppercase and lowercase), numbers and symbols, or use a lengthy passphrase. Do not share passwords – see advice from the ACSC on understanding passwords.
- **Staff members leaving:** Cancel system access, change passwords, and change access codes.
- **Upgrading or replacing devices:** Remove sensitive data – don't just 'throw it in the bin'!

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Network and device security

- **Firewall/virus protection:** Ensure your systems have a good firewall to protect against intrusion by hackers and malicious viruses. This will also help prevent confidential information from being sent out from your computer without your permission.
- **Install updates:** Don't delay with installing updates when requested by your provider. These updates are designed to ward off the latest threats. The same applies to 'patches' – keep them up to date.
- **Medical equipment:** Equipment that contains patient data, has access to patient data, or has offsite backup provided by the manufacturer/distributor (e.g. ECG, spirometry, skin detection or ultrasound machines) must be kept secure. Also ensure upgrades are installed and patches are up to date. Check frequently and keep a log noting the date, time and the person who did the check.
- **Filtering:** E.g. email spam filtering, whitelisting (listing rules for applications that are allowed to run on your computers) and blacklisting (blocking material known to be harmful).
- **Mobile devices:** Consider mobile devices such as phones, portable data storage, remote access login and cameras – who has access, how many are there, are they safe? Aim for two-factor authentication and the ability to delete data remotely in case of theft or loss. Consider using a program to encrypt mobile devices and having a mobile phone that can be deactivated remotely in case it's stolen.
- **Virtual Private Network (VPN):** Consider a secure VPN for remote access login.
- **Disabling:** Disabling functions such as AutoPlay or remote desktop, if not required, can make it harder for malware to run or an attacker to gain access.
- **Disconnect:** If you suspect an electronic appliance is infected with malware, remove it immediately from the system and power.

Storage and backups

- **Backups:** Perform backups frequently (minimum daily), with backup drives ideally to be physically separated from the network. Regularly check that backups have worked (every 3-6 months) and know the location of your server.
- **Appointment systems:** Enable access to the appointment system in an emergency, e.g. hard copy printed at the end of each day for the next day.
- **Cloud storage:** It's recommended that the server is located in Australia, to avoid the strict obligations under privacy law (APP8) if patient data is stored outside of Australia. It's also recommended to have a reputable and preferably accredited provider, a contract specifying that you own the data, data encryption and multifactor authentication, and encrypted backup stored offline or with another cloud provider. The contract should also have a clause requiring the provider not to breach the Australian Privacy Principles (APP). The ACSC has a guide to cloud computing security.

More resources

Australian Cyber Security Centre
cyber.gov.au

Australian Digital Health Agency
digitalhealth.gov.au

Office of the Australian Information Commissioner
oaic.gov.au

RACGP
Information security in general practice
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MUST I REPORT THIS PRIVACY BREACH?

Karen Stephens
Risk Adviser, Support in Practice

Here's a handy flowchart to help you assess each situation and make an informed decision about reporting the privacy breach.*

1. Has there been a data breach?

Consider whether the incident has caused:

- unauthorised access to personal information
- unauthorised disclosure of personal information
- loss of personal information likely to result in unauthorised access or disclosure

Case scenario

You come into work to discover you cannot access any medical records and the computer displays a ransom notice demanding payment in bitcoin for access to the records.

Yes — No ▸ No need to notify

2. Is it likely to result in serious harm?

Consider factors such as:

- how sensitive the information is
- whose information it is
- number of people affected
- potential recipients of the data
- whether the data is encrypted, anonymised or otherwise protected

Case scenario

Hackers have the medical records containing highly sensitive information.

Yes — No ▸ No need to notify

3. Can you prevent the likelihood of serious harm?

Look into things such as:

- whether the information on a stolen laptop can be remotely locked or deleted
- whether the recipient can be trusted to return the information unopened

Case scenario

Seek IT advice to help make a decision, i.e. have the hackers accessed or uploaded the records for others to access, or have they locked them down without accessing the information contained in the records?

No — Yes ▸ No need to notify

Action 1: Notify the OAIC

Notification to the Commissioner can be made using the **OAIC's Notifiable Data Breach Form.**

Action 2: Notify individuals (3 options)

Option 1: Notify all individuals whose information was breached.

Option 2: Notify only those individuals at risk of serious harm.

Option 3: Publish a notification.

Refer to more information about how to do this on the **OAIC website**: oaic.gov.au

*This information is based on the *Privacy Amendment (Notifiable Data Breaches) Act 2017* which came into effect on 22 February 2018.

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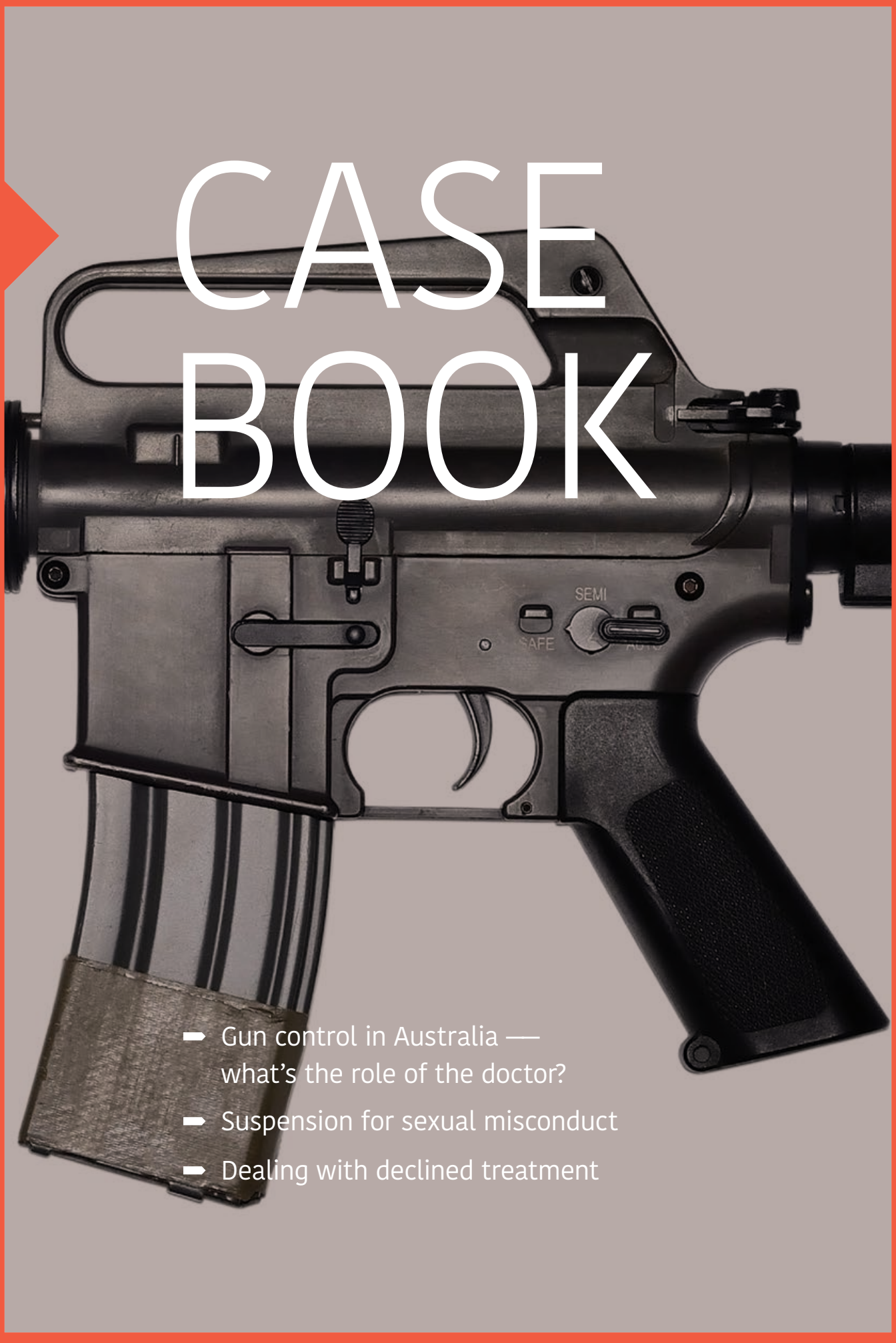
CASE BOOK



- Gun control in Australia — what's the role of the doctor?
- Suspension for sexual misconduct
- Dealing with declined treatment

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Gun control in Australia – what's the role of the doctor?

Dr Jane Deacon
Manager, Medico-legal Advisory Services

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A Tribunal decision

In 2015, a Queensland GP was consulted by a patient who asked him to provide a medical certificate that would allow him to overturn the suspension of his gun licence. The patient brought with him a letter from the police detailing the circumstances around the licence suspension, stating it was suspected that the patient suffered from dementia and various delusions.

The doctor signed the medical certificate without looking closely at the letter. Shortly afterwards, the police contacted the doctor and told him about the patient's various delusions and general confusion.

In due course, the matter was considered in the Queensland Civil and Administrative Tribunal. It was ruled that the doctor should have undertaken a more comprehensive medical assessment.

The Tribunal stressed the significance of doctors' obligations when assessing whether someone is fit to hold a firearm licence.

Following a finding of unprofessional conduct, the doctor was reprimanded and ordered to complete a four-hour course on appropriate assessment and certification in relation to firearm licences.

Gun legislation

There are over three million registered firearms and an estimated 500,000 unregistered firearms in Australia.[1]

Doctors can play an important role in notifying authorities if they have concerns about a patient and their access to guns. This may arise when a patient, who you know has access to a gun, has serious mental health issues, or discloses thoughts or plans of self-harm or harming others.

If the doctor has reasonable cause to suspect that the person may be a threat to themselves or others because of their access to firearms, the doctor should inform the authorities.

Although doctors have a professional and legal duty to maintain the confidentiality of health information disclosed to them by their patients, there are limits to this.

The Australian Privacy Principle (6.34) states that personal information can be disclosed when it is reasonably believed that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety.

The recent tragedy in Christchurch is a reminder of the terrible carnage that guns can cause in the hands of the wrong people. Health professionals have a role in gun control.

There is specific firearm legislation in every Australian state that enables and, in some states compels, doctors to disclose certain situations involving firearms.

- In the NT, SA and Tasmania, reporting is mandatory if you conclude there is a threat associated with the patient's possession or use of a firearm, either to the patient's own safety or the safety of other people due to the patient's medical condition at the time.
- In other states, reporting is not mandatory – but in all states the legislation provides protection from civil or criminal liability that may otherwise arise, including a breach of confidentiality, when disclosing information to the relevant authority.
- In SA and Tasmania, it is mandatory for doctors to notify authorities if they treat a patient with a wound inflicted by a firearm, and to also retain any ammunition or part of ammunition recovered from the wound.

Such scenarios highlight the difficult act of balancing the therapeutic relationship against the importance of acting to prevent threats to health and safety. It can be helpful to seek advice on your specific situation.

More resources

NSW Police Firearms registry
Disclosure of information by health professionals
police.nsw.gov.au/services/firearms?a=131155

QLD Police
Health and weapons – an information booklet
police.qld.gov.au/programs/weaponslicensing/licenceapplication/applicant/documents/qhealthweapons.pdf

AMA
Ethical guidelines for doctors on disclosing medical records to third parties
ama.com.au/position-statement/guidelines-doctors-disclosing-medical-records-third-parties-2010

Medical Board
Good medical practice: A code of conduct for doctors in Australia
medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/gun-control-role-of-doctor

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Suspension for Sexual Misconduct

Dr Sara Bird
Executive Manager,
Professional Services

A recent Tribunal decision[1] highlighted the importance of maintaining professional boundaries and the risks of engaging with current or former patients via social media.

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Case study

The GP, who was first registered in 2002, saw a patient, Ms YN, for a mole check in January 2014. From then until 23 June 2015, the patient saw the GP in consultation on 16 occasions.

Late June 2015: The GP and YN became friends on Facebook. In early October 2015, YN sent a Facebook message to the GP saying she had personal feelings for him and asked to meet at a local cafe. A week later they met at the cafe and, over the next month, exchanged text messages and met in person.

Mid-November & early December 2015: On two occasions, the GP and YN engaged in sexual activity at a motel.

Late January to September 2016: They continued to contact each other through Facebook messenger service and text messages.

Mid-April 2016: YN attended her local ED. While she was waiting to be seen, she exchanged text messages with the GP who then went to the ED to wait with her until she was seen. The next day, the GP contacted a colleague at his clinic and asked him to write a pathology request for YN. One week later, the GP sent a message to YN saying the test results were normal and she did not have glandular fever.

26 April 2016: YN sent an email to the GP explaining that she had consulted one of his GP colleagues about extreme stress. During the consultation, they had discussed her sexual abuse history, her marriage breakdown, and her more recent sexual activities.

YN had told the GP's colleague about their relationship, saying she had initiated it and that the relationship had not been conducted while she was a patient. The colleague had strongly advised YN to notify AHPRA and told her he was obliged, under mandatory reporting obligations, to notify AHPRA about the GP's conduct.

On hearing this, the GP notified AHPRA that he had acted in an unprofessional way with YN. The GP's colleague notified AHPRA the following day. YN never made a notification to AHPRA.

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View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/suspension-sexual-misconduct

Medico-legal issues

On 3 December 2018, the Tribunal found the GP guilty of professional misconduct for transgressing professional and sexual boundaries with a current or former patient. The GP was reprimanded and had his medical registration suspended for two months. A condition was placed on his registration that he should complete an education course on the identification and maintenance of professional boundaries and ethical decision-making.

The Tribunal found that when the sexual relationship between the GP and YN ended, a substantive doctor–patient relationship was re-established – if not when he sat with her in the ED, then when he once again became involved in her treatment in providing blood test results to her.

The Tribunal noted:

There is every risk that YN's attraction [to the GP] was grounded in the doctor–patient relationship, perhaps with charisma attaching to the doctor in the eyes of YN … the confusion of roles between doctor–patient and a relationship between two consenting adults is what should have been avoided in the first place.

The GP's lawyer had submitted there was no need to suspend his registration because he was remorseful, had learned from the experience and the risk, if any, of him repeating such conduct was remote.

While the Medical Board of Australia had sought a nine-month suspension, the Tribunal ultimately imposed a two-month suspension, stating it was important to send:

the strong message to the profession of the severe consequences of entering into non-clinical relationships with patients, even where on one view, perhaps the doctor's view, the doctor–patient relationship had ended.

Summary points

- It's never appropriate for a doctor to engage in a sexual relationship with a patient.
- It may be unethical and unprofessional for a doctor to have a sexual relationship with a former patient.

More information

Sexual boundaries in the doctor–patient relationship
medicalboard.gov.au/codes-guidelines-policies/sexual-boundaries-guidelines.aspx

Social media policy
medicalboard.gov.au/codes-guidelines-policies/social-media-policy.aspx

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CASE BOOK

It's well known that a doctor needs to have the informed consent of the patient (or their substitute decision-maker) before any treatment can be provided, except in emergencies. The patient needs to be able to understand and remember the information they've been given about the treatment, demonstrate their understanding of the nature and effect of their decision, and communicate the decision in some way (in writing or orally).

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Dealing with declined treatment

Janet Harry
Medico-legal Adviser

Case study 1

Helen, an emergency department nurse, was diagnosed with probable ovarian cancer. When imaging studies revealed a 17cm ovarian mass thought to be almost certainly malignant, she was scheduled for surgery. However, she cancelled at the last minute after a visit to a 'healer/hypnotherapist' recommended to her by a paramedic. The healer treated her with black salve. Helen died in April 2018 of ovarian cancer.

Case study 2

Your patient, aged 92, declines investigation for chest pain. On discussing it with her, she explains that she feels she has had a full and complete life and doesn't wish to undergo all the "prodding and poking" involved. She thanks you for your careful explanations and all the options you've outlined, but says she doesn't want to be referred. True to her word, the patient doesn't seek any further treatment. Several months later she suffers a myocardial infarction and dies at home.

What if your patient refuses recommended treatment?

It's important to keep detailed and meticulous documentation of all discussions and ensure that the patient understands:

- the rationale and benefits regarding the proposed treatment
- potential side effects and risks of the proposed treatment
- potential risks of not receiving the treatment.

Capacity

A patient with capacity can decline treatment. Capacity is the ability to make and understand information relevant to a decision, and the ability to appreciate the reasonably foreseeable consequences of a decision (or lack of a decision).[1]

Adults are assumed to have capacity. They are free to make their own choices regarding treatment. If a patient declines recommended treatment, it doesn't follow that they lack capacity. However, the decision must be given voluntarily. This means the decision must be made freely and not under undue pressure, coercion or manipulation.

A decision to decline treatment for a child is more complex. Parents generally make decisions for children who are not mature minors. Parental power should be exercised in the best interests of the child and is not unlimited. It's advisable to obtain legal advice in relation to such matters.

Consent

Consent is not necessarily a single conversation. You may need to allow for a number of discussions and be sensitive to any particular circumstances.

- Consider involving the patient's family in the discussion, with your patient's permission.
- An interpreter should be involved if needed.
- Referring the patient to a colleague is a valuable strategy.
- Consider writing a detailed letter to the patient containing your explicit advice and recommendations, inviting the patient to return.

Conclusion

The potential medico-legal consequences of treatment refusal may involve litigation, investigation by the Coroner and a complaint to AHPRA – so it's important to ensure the situation has been properly managed and documented.

View our article on assessing capacity
defenceupdate.mdanational.com.au/articles/assessment-of-capacity

If you have any concerns or would like to discuss a case, our Medico-legal Advisory team is here to help – call **1800 011 255** or email **advice@mdanational.com.au**.

View the references at: mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/06/declined-treatment

Firstdefence

FOR DOCTORS IN TRAINING

- Why you (almost) never have to fight
- Finding your niche in medicine
- Surviving internship and beyond

Dr Declan Scragg
Junior House Officer, QLD

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Why you (almost) never have to fight

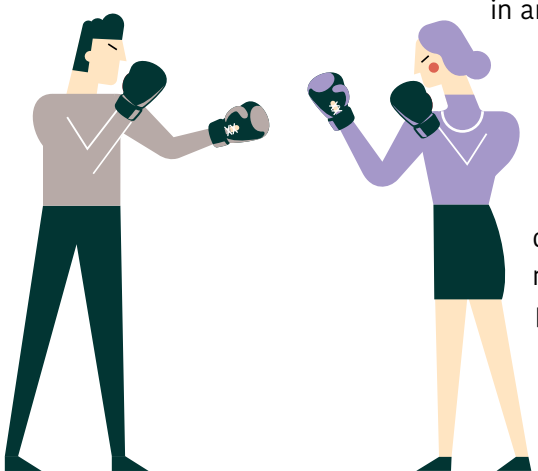
As a resident, I found myself confused as to why some colleagues struggled to achieve agreeable outcomes, while others seemed to float through their interactions with ease. Lacking the insight to see where the first group was going wrong and the second right, I found myself in the first group. Eventually, I did gain this insight with guidance from mentors, and hope I can save you the discomfort of having to go through that same learning process.

Maybe they're right

When you disagree with someone else, stop and listen. Hear what's being said and seek clarification – they may have a point you haven't appreciated and is worth considering. It helps to develop the mindset of 'we have this challenge out there' instead of 'I have this challenge with you'. If you're still comfortable with your position, move forward to the next steps. Even if you can't agree, you can gain social capital by listening and respecting others' opinions.

Power differentials are real

There is a significant power differential between residents, registrars and consultants. It's quite simply inappropriate to have arguments between levels. Discussions or questions? Yes. But a battle of wills? No. A disagreement will be clouded by the power differential and isn't in anyone's interest.



It's not a resident's job to 'fight'

Residents should never 'fight' over a management plan, request, or other aspect of patient care. The resident's position is to learn and help enact the team plan formed by the registrars and consultants. If two residents still disagree after listening and considering both sides, then simply pass it up to your registrars and go back to your day.

A registrar should advocate, but not to the point of frustration

While registrars develop management plans and advocate for their patients, it's not their job to make the final decision. If you disagree with another registrar, then stop and listen to their counterpoint. Work together against the external challenge and come to a mutually agreed plan. If this isn't possible, then don't 'fight'. Kick it up to your consultants and let them figure it out.

What about 'toxic' colleagues?

It's rare for someone to genuinely come to work to do a bad job. Labelling the overworked or stressed colleague as 'toxic' goes against the idea of 'you-and-me-against-that'. If they are one of the rare toxic individuals, there's all the more reason to use the strategies discussed.

The simple truth is: We are a team, working together for the patient, the hospital and the system. We see the problem as external to the two of us.

Eric's recommendations

Watch the video
***Timing, Tribes and STEMIs* by Dr Victoria Brazil: vimeo.com/95243749**

Read the book
***Getting to Yes* by Fisher et al**

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Finding your niche in medicine

There were times during my surgical training when I developed doubts as to whether I was on the right career path. I wondered if surgery was really for me, or vice versa.

Dr Lily Vrtik
Plastic & Reconstructive Surgeon

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That seed of doubt sprouted again later in my career. I had lost my direction and questioned myself as to whether I enjoyed my work. That was when I came across 'Ikigai'.

The concept of Ikigai

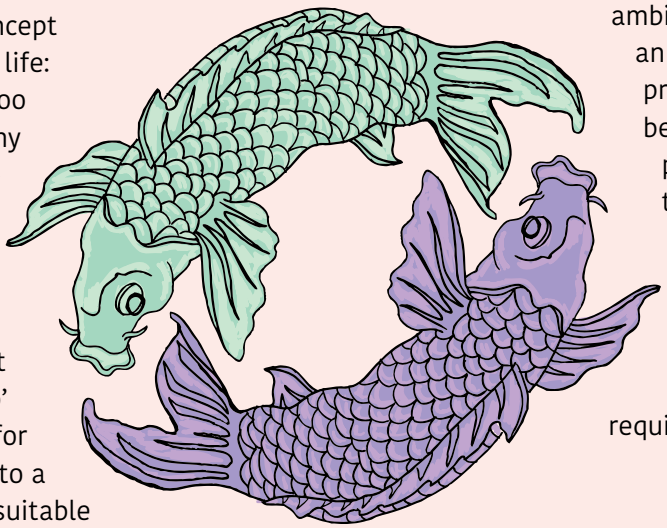
For those who aren't familiar with Ikigai, it literally means 'a reason for living.' It's a principle practised in Okinawa – where the world's longest-living people reside – a way of achieving a longer and more fulfilled life.

I decided to apply this concept to one specific part of my life: medicine. And to see if I too could prolong and enjoy my medical career. The key to finding Ikigai in one's career is to find the right balance between interests, remuneration, skills and ego. The perfect balance will change a 'Job' (something one turns up for because one gets paid) into a 'Niche' (a comfortable or suitable position in life and employment).

The search for answers

We often search for answers throughout our medical career, amongst many other self-finding conundrums:

- *What do I want to do?*
- *What would I like to specialise or sub-specialise in?*
- *What do I not want to do?*
- *What level of income and wealth would I want to achieve?*
- *What interests and reputation would I like to establish?*



Personal attributes to help with Ikigai

Obviously, in preparation for finding an answer, we need adequate exposure to the options of our individual interests, through avenues available during the early years of medical studies and training. However, personal maturity with insight is paramount in being able to use the Ikigai model with meaning.

It's essential for one to be truly honest with one's own feelings, desires, weaknesses and ambitions to be able to negotiate an authentic decision-making process. Being truthful can be a difficult and emotional process. It takes courage to admit to one's own limitations in capabilities, personality and life circumstances. To recognise them when making life-choices also requires utmost maturity.

Other personal criteria important in seeking Ikigai

- Satisfaction of various desires including ego, fulfilment, joy, wealth and any others – the priority and quantity of these desires are unique to each individual
- Positive encounters with others – it's through positive experiences that we form ambitions and find out what makes us happy
- Realisation in the value of our own lives – it's only when we value our own physical and psychological wellbeing that we're able to acknowledge the importance of the choices we make
- A life with love and happiness – this is essential to foster self-realisation. Without unconditional love from others and experiences of true happiness, we won't develop enough inner strength to satisfy our own Ikigai; instead, we will be enticed to fulfilling another's agenda in exchange for external validation.

Ask yourself some practical questions

Once armoured with all of the above attributes, it's time to ask yourself some practical questions.

Consider the four contributors to Ikigai – the four circles in the diagram below:

1. What are the things you'd love to do in your career?
2. What are the things you're good at?
3. What are the things in your career which you're well remunerated for?
4. What medical services are in demand in the current market and community?

By filling each circle, it becomes clearer as to what aspects of your career will fulfil different components of Ikigai – Passion, Mission, Profession and Vocation.

Exclusivity of one circle can also result in a negative impact, such as uselessness, uncertainty (self-doubt), emptiness and lack of wealth – reiterating that satisfaction of various desires is essential to achieve this fine balance.

It's only when all components are fulfilled that you're able to find Ikigai and develop your specific niche in medicine. This is an anchoring concept that may help you find purpose and direction in your work, prolonging an enjoyable career.

Ikigai was my first step in creating a career map for myself. It didn't give me specific answers, but it helped me rediscover the meaning in my work and guided me in finding my niche.

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Surviving internship & beyond

MDA National's *Live Well Work Well Retreat* held in March this year was designed to help junior doctors learn strategies on managing the stresses and work-leisure challenges during the training years and beyond.

Here are some key points from our retreat presenters* compiled specially for you into top 10 tips.

Niranjala Hillyard
Publishing & Content Manager

1 Put on your own oxygen mask first

Prioritise your own wellbeing so that you can look after your patients better. Get your own GP and see them regularly. Don't wait for hindsight to realise the importance of sleep, nutrition and fitness.

2 Build resilience

Bad outcomes are a certainty, but how you approach and recover from them makes the difference between post-traumatic stress and post-traumatic growth. Remind yourself what inspired you to become a doctor.

3 Have a personal credo

Find something quick you can tell yourself in times of stress, e.g. Dr Eric Richman cites his credo as, "I am a river rock, the water flows around me, but it does not flow through me".

4 Pace yourself

Your medical career is a marathon, not a sprint. Find ways to 'switch off' and take time each day to do something that uplifts you. Try using mindfulness apps such as Breathing Space on your phone.

5 Stay positive

Write down any good feedback you get from a colleague, patient or patient's family. On the 'not so great' days, reading these comments will motivate you.

6 Relationships matter

Work on your relationships with family, friends, colleagues and supervisors as much as you do on your medical career. You need a close support system to share the good and the bad with.

7 Consider job satisfaction

Think about your work values when planning your career, but be aware that your priorities may shift later in life, e.g. working hours, flexibility, salary and location may matter more once you start a family.

8 You don't have to know all the answers

It's ok to say, "I don't know but I'll find out". Find senior doctors who inspire you and seek them out as mentors. Stay humble and always be willing to learn.

9 Learn and grow

Say 'yes' to roles or tasks that interest you, even if you find them intimidating. This is how you will learn and develop. Know when to say 'no' to taking on roles that don't interest you.

10 Guard your integrity

Acting with honesty and staying true to your values will steer you in times of trouble. What makes you a great doctor is not what others think of you, but what you know about yourself.

* Dr David Chong, Dr Andrew Czuchwicki, Dr Jane Deacon, Dr Caroline Elton (UK), Dr Tahlia Gadowski, Dr Belinda Hibble, Ms Deborah Jackson, Dr Eric Richman, Dr Benjamin Veness, Dr Susannah Ward

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Podcasts

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e-Learning

Complete at your own pace; most online activities are recognised for professional development. Topics include surgeons' risk self-assessment; medical record-keeping; prescribing opioids; the challenging emotions of difficult news; applying for junior doctor positions; and planning your elective.

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

Face-to-face workshops

Practical Solutions to Patient Boundaries
Western Sydney, 24 August 2019

More information and registration
mdanational.com.au/member-benefits/events

- **More workshops and live webinars coming soon!**
  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.

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Behind the scenes...

Dr David Chong
Member since 1998

Dr Maria Li
Member since 2002

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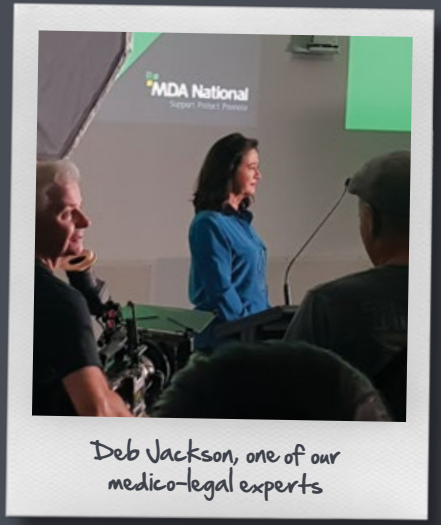

Deb Jackson, one of our medico-legal experts

Dr Eric Richman
Member since 2006

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  Southbank VIC
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- BRISBANE
  Level 8
  87 Wickham Tce.
  Spring Hill QLD
  4000
- ADELAIDE
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  Adelaide SA
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