defenceupdate

Publication for MDA National Members

Winter 2015

MDA National
Support Protect Promote

Celebrating 90 Years

Editor's Note

The use of social media by doctors and patients is an emerging medico-legal risk area. HWL Ebsworth Lawyers provide a defence lawyer's view on the use of social media in the medical arena (pages 6 and 7). Our CaseBook section includes a recent Tribunal decision which highlights some of the risks when doctors use social media to communicate with patients (page 18).

Our Medico-legal Advisory Services team is also receiving an increasing number of calls from Members seeking advice about their patients' use of social media. Recent examples include a General Practitioner who received a Facebook "friend" request from the father of a disgruntled patient and a Surgeon who received contact via his professional LinkedIn profile from a "lovelorn" patient seeking a personal relationship with him. As always, please contact us for advice if you have any medico-legal questions or concerns.

The issue of doctors' health and wellbeing continues to be an area of concern for the profession. Involvement in a complaint or claim can have a significant emotional and physical impact on a doctor. On page 4, we outline the support programs we provide to Members involved in a medico-legal matter.

And finally, your Membership and Policy renewal is due by 30 June 2015. You'll find information on the renewal process and our risk category changes outlined on page 5. Our recently retired Board member, Dr Reg Bullen, provides a wonderful reflection on his MDA National Membership (page 3), highlighting the role of our doctor Members as a collegial group who support one another.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

Remember...

You can access *Defence Update* online at: **defenceupdate.mdanational.com.au**.

In This Issue

Doctors for Doctors

As in 1925, the doctor Members of MDA National remain a mutually supportive collegial group who will look after one another, and with increasingly sophisticated means of doing so.

Seemingly a lifetime ago (in 1975), an "aged" doctor attended my medical school late in our sixth year to recruit us to join the Medical Defence Association of Western Australia (MDAWA). It would only cost $100 per year for the doctors, at any stage of their career, and would protect us from the (then) unlikely event of being sued. All 88 of us joined!

I suspect we neither thought about it for very long, nor expected to get anything in return for our money. It was, after all, just insurance. At the time, Resident Medical Officers could expect an annual income of $12,200 with no overtime paid, and work an average of 100 hours per week except in ED... so it was probably good value.

Oh! How things have changed.

- MDAWA is now MDA National.
- I'm not a 23-year-old.
- (Almost) no one works 100 hours per week in a hospital.
- Even more patients and others (AHPRA, the Ombudsman, Medical Board, PSR/Medicare) want a piece of us.

So why do we bother?

The status, the money, the excitement, the joy, the collegiality of our profession, the satisfaction, the chase, the outcomes, the gratitude... or you can add your choice of other benefits. These then are the rewards! But, as with all endeavours worth the effort, the risk-benefit analysis is one crucial consideration we need to address.

As always, I have many good resources available to tip the risks somewhat in my favour, and therefore to my patients' benefit. These are my teachers (undergraduate, postgraduate, online and live), my texts (print and online) and increasingly, my MDA National Member benefits.

Since introducing medical education services as a Member benefit in the early "noughties", MDA National has expanded this service to help Members fulfil the requirements from CPD/QA assessments for many Colleges; broadened and deepened the subjects covered; and sought to increase its relevance to modern medical practice – and still manages to provide it at no additional cost to our Members!

There are times when mistakes occur – despite the expectations of courts, regulators and patients, we remain human doctors. And as in 1925 (yes, that long ago), the doctor Members of MDA National remain a mutually supportive collegial group who will look after one another, and with increasingly sophisticated means of doing so.

I'm glad I joined in 1975 – and I expect to eventually become a retired Member after benefiting from a professional lifetime of security, friendship, service and protection accorded to me by "my" medical defence organisation – MDA National.

Dr Reg Bullen

Dr Reg Bullen's journey with MDA National

1975: Joined MDA National as a student Member.

November 2000 – April 2004:
MDA National Mutual Board Director.

Finance and Investment Committee member.

May 2004 – November 2006:
Medical Claims Manager at MDA National.

November 2007 – March 2015:
MDA National Mutual Board Director.

Committee member –
Cases (Western/Central);
Clinical Underwriting;
Audit, Risk and Compliance.

Celebrating 90 Years

Notice Board

Celebrating 90 Years of Member Service

Celebrating 90 Years

Members and industry stakeholders are joining our 2015 milestone celebrations.





Health and Wellbeing Support

- **Doctors for Doctors Program:** Our Doctors for Doctors Program is available for Members during a medico-legal matter. It offers one to one peer support, so you can confidentially speak to another medical practitioner who understands the stress of being involved in a claim, complaint or investigation.
- **Professional Support Service:** Medico-legal claims and complaints can be personally and professionally distressing. This program offers Members additional emotional support during a medico-legal matter. Referred to the program via our Claims and Advisory Service, Members can access an independent psychiatrist. MDA National will pay for the cost of up to 10 consultations for the Member per Membership year.

Charity of Choice – *beyondblue*

One of MDA National's Charity of Choice associations is with *beyondblue* which ensures that we keep doctors' health and wellbeing top of mind throughout our organisation and the medical profession. We are working with *beyondblue* and relevant industry stakeholders to address the barriers that we know hinder doctors in seeking mental health support.

NRAS Review

A review of the National Registration and Accreditation Scheme (NRAS) for health professions was recently conducted by Mr Kim Snowball, the former Director General of WA Health.

A Consultation Paper released in August 2014* sought feedback on a number of issues, including the handling of complaints and notifications, advertising of health services and the mandatory reporting of health practitioners.

MDA National provided a submission in response to the Consultation Paper in which we outlined concerns regarding delays, and a lack of consistency in the assessment phase of notifications and the outcomes of investigations. We also reiterated our strong support for the national introduction of the legislative exemption which exists in WA, where practitioners are exempted from the mandatory reporting requirements when providing health services to other health practitioners and students.

* Available at: nhaa.org.au/docs/Submissions/Consultation_Paper_-_Review_of_NRAS_for_health_professions.pdf.

Proudly supporting beyondblue

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

Time to Renew

You should have recently received your 2015 Renewal Notice in the mail. Here are some steps to assist you in renewing your Membership and Policy.

Check your Renewal Notice

Are your medical indemnity needs and personal details correct?

If not, let us know and we will re-issue you a revised notice.

Are you in the correct risk category for the work you are performing?

This may affect your premium and cover under your policy. You can access a copy of the *Significant Changes to the Risk Category Guide* and the *Risk Category Guide 2015/16* at mdanational.com.au/downloads.aspx.

Have you informed us of all claims, complaints and investigations or any incidents you are aware of that may lead to a claim, investigation or inquiry?

Early notification enables us to support you better and can help to prevent matters from escalating.

Renew your Membership & Policy by 30 June

If the information on your Renewal Notice is correct, you can make your payment by phone, online, BPay or direct debit. If you've set up a direct debit arrangement, we will debit your nominated account on, or shortly after, 1 July 2015.

For your convenience, your Renewal Notice includes:

- your tax invoice/receipt which is valid upon payment. A receipt will not be sent unless you specifically request one
- your Certificate of Insurance which can be used as proof of indemnity upon payment. Once we receive your payment, we will automatically post you a Certificate of Currency or, you can print it out immediately after payment if you renew online
- a summary of significant changes to your Professional Indemnity Insurance Policy.

Please ensure you read and understand the Declaration on the Renewal Notice and the Important Information section of the document.

I'd like to extend a heartfelt thank you to the MDA National team. You treated me as if I was your most important Member. Words that I'll use when I recommend MDA National to others are: professional, reassuring, prompt replies to all queries and faultless.

Dr Sarah Kurian, Perth WA

I am part of MDA National because they support the profession with relevant education that goes beyond the purely medico-legal aspects of looking after patients. This focus on both the professional and personal aspects of being a good doctor goes to the heart of what they stand for.

Dr Andrew Perry, Adelaide SA

Review the risk category changes

Please review the changes to the *Risk Category Guide for Medical Practitioners* outlined below (effective from 1 July 2015) to ensure you have chosen the most appropriate risk category for your practice.

Employer Indemnified category

We have extended the cover under this category to medical practitioners in all specialties who practise in an employer indemnified capacity and generate up to $10,000 per annum in private billings irrespective of non-procedural or procedural practice. If your Gross Annual Billings for the policy period have exceeded or will exceed this limit, you will need to select the appropriate private practice category and appropriate Gross Annual Billings.

General Practitioner categories

The following procedures have been re-categorised from a higher category to reflect contemporary Australian medical practice:

- General Practice – Non-Procedural – Level 1:
  - Breast biopsies – Fine Needle Aspiration Biopsies (FNAB) and Core Needle Biopsies (undertaken within a breast clinic). Core Needle Biopsies undertaken outside a breast clinic remain categorised as GP Procedural Level 3
  - Medical termination of pregnancy (provided practice is in line with RANZCOG Guidelines)
  - Mesotherapy (excluding cosmetic applications)
  - Platelet Rich Plasma (PRP) therapy for skin rejuvenation.
- General Practice – Limited Procedures – Level 2:
  - Excisional biopsy of lymph gland
  - Ophthalmology – curetting or excision of meibomian cysts or chalazion and syringing of tear duct
  - Vasectomy
  - Zadek Procedure – total excision of nail bed.

There have also been wording changes to clarify the extent of cover under the General Practice categories. Please refer to the *Significant Changes to the Risk Category Guide* and the *Risk Category Guide 2015/16* – available at **mdanational.com.au/downloads.aspx**.

We value your Membership and ongoing loyalty, and look forward to continuing to support and protect you.

Any queries about your policy? Need changes to your Renewal Notice?

Please phone our Member Services team on **1800 011 255** or email **peaceofmind@mdanational.com.au** between 8.30am to 8.00pm (AEST) Monday to Friday.

Social Media and Medicine:

A Case of #medicalmadness?

Whether you are a savant or a snail with social media, it is rapidly making its mark on the professional front. In a forum where a "relationship" is only a click, wink or swipe away, it is no surprise that it has been embraced so rapidly – professionally as well as socially. But at what point does it blur the boundaries of the practitioner-patient relationship, and is it acceptable for a practitioner and patient to be virtual "friends"?

When private information becomes public property

The practitioner-patient relationship prides itself on privacy and confidentiality. In contrast, social media craves broadcast and is generally far from secure – once you hit "send", the content becomes free for all. An anonymous post or blog by a practitioner simply venting with colleagues about their day could contain sufficient information to identify a patient – breaching both privacy and confidentiality – and the potential for that information to be misused or corrupted. Given the ease with which comments on social media can become a viral sensation, there is also the risk of defamation rearing its ugly head.

And what of the medical practitioner who develops a Facebook page to promote their practice, inviting "friends" to like and share their page? While these pages may start off filled with good health advice, healthy alternatives or survival tips for new mothers, they can quickly plummet to an exposé of the practitioner's weekend habits and recreational activities, doing little to promote their reputation or protect their privacy. Beware also the potential that this form of self-promotion (or simply comments from the public about the content of a practitioner's page) can easily fall foul of the law governing the advertising of regulated health services.[1-2] For example, it is an offence to publish testimonials on a website or Facebook page that is under your control.

Blurring of practitioner-patient boundaries

In the context of disciplinary proceedings, there is often a necessity for the courts to consider at which point the boundary of practitioner-patient relationship became blurred, when determining whether a practitioner has engaged in professional misconduct, particularly in cases involving an alleged sexual relationship between the practitioner and patient.

Recent case law suggests that the courts will not shy away from scrutinising a practitioner's virtual persona if the practitioner has engaged in social media with the patient – not only to ascertain whether the conduct complained of occurred, but to also gauge the practitioner's credibility. The use of computer experts to assist a court with evidence is not a new concept; however, computer experts are now also being asked for their input on aspects of social media, including whether messages were sent and received and whether they have been manipulated.

This also leads to the potential impact that social media might have on the standard of care owed by a practitioner to their patient. Given the potential for information to go astray on social media or for messages to be misconstrued, if a practitioner gives medical advice or results via this forum, the courts could be inclined to impose a higher standard of care if a case of medical malpractice arises.

It will also need to be considered whether a practitioner's professional indemnity insurance policy extends to any cyber dalliances between a practitioner and their patient, if the conduct complained of or the claim made does not call into question the medical judgement of a practitioner.

It's not all bad news

The use of social media in the medical arena is certainly not all bad. It is not surprising that a medium which allows its users to create and share content and disseminate that content exponentially has its benefits professionally. In a medical context, it allows spreading the word to the public at large on good health tips, recommendations and breakthroughs. It also provides an avenue to connect patients who suffer the same illnesses so they can lend each other support.

Medical practitioners can now join groups with their international peers who have similar interests or specialties and "chat" about various cases or treatments without having to attend conferences. It provides a useful resource whereby ideas can be bounced off other practitioners anywhere in the world when presented with an unusual case.

There has also been the advent of the "digital practitioner", a forum in which patients can attend a consultation online, affording the ease of a medical consultation without having to leave your home and expose yourself to, or aid in, the spread of infectious diseases.

While most current social media sites are not set up for the practitioner-patient relationship, it is only a matter of time until the right "apps" are developed which will undoubtedly ease the load of the practitioner's burden, particularly so on the administrative front. And behold the potential benefits of an app that could compile a patient's complete electronic clinical records from all over the world at the click of a button! Adapting social media for use in a therapeutic context is likely to bring with it considerable savings in terms of time and cost, which could either be passed on to the patient or aimed at diverting funds to areas of greater need like education, prevention and research.

Proceed with care and caution

Recent warnings are ringing from the legal system that practitioners who seek to engage in social media to provide medical advice and test results should ensure that clear policies have been developed on the subject of a patient's informed consent. Many peak bodies have developed social media policies to remind them of their professional duties when utilising social media.[3-4]

If you are inclined to engage in social media as part of your practice, use it cautiously and keep it professional in order to minimise your risk of exposure to litigation or disciplinary proceedings. If the boundaries between professional and social are on the verge of being blurred, it may simply be better to just "delete" or hit "ignore" to avoid a case of #medicalmadness.

Diane Usback, Senior Associate, Health
Kerrie Chambers, Partner, Health

HWL Ebsworth Lawyers

1 Australian Health Practitioner Regulation Agency. Social Media Policy. 2014. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Social-media-policy.aspx.

2 Australian Health Practitioner Regulation Agency. Guidelines for Advertising Regulated Health Services. 2014. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-advertising-regulated-health-services.aspx.

3 Royal Australian College of General Practitioners. Social Media. Available at: racgp.org.au/digital-business-kit/social-media/.

4 Australian Medical Association. Social Media and the Medical Profession: A Guide to Online Professionalism for Medical Practitioners and Medical Students. Kingston, ACT: AMA, [2011]. Available at: amawa.com.au/wp-content/uploads/2013/03/Social-Media-and-the-Medical-Profession_FINAL-with-links.pdf.

Workplace Bullying and Sexual Harassment

It must be almost 30 years ago that I assisted a Surgeon in taking off a BCC on the tip of the nose and replacing it with a full-thickness Wolff graft – using skin taken from behind the ear. A student asked "Why are you taking skin from behind the ear? Aren't Wolff grafts usually taken from the crook of the elbow?" The Surgeon apparently did not hear the question as he launched into an especially foul joke. The 21-year-old scrub nurse blushed. The Surgeon then pointed to her and said, "If you take blushing skin to put on a blushing area, it will blush and not just stay white when the patient blushes."

Sexual harassment?

Yes!

The Australian Human Rights Commission defines sexual harassment broadly as "... any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated."[1]

Also, the *Sex Discrimination Act 1984* (Cth)[2] in Division 3, Part 2, s28A makes clear that sexual harassment includes "making a statement of a sexual nature to a person, or in the presence of a person, whether the statement is made orally or in writing...".

Reverting to the anecdote:

- locker room humour is not appropriate in theatre and could well be seen as "unwanted or unwelcome sexual behaviour"
- using the nurse's embarrassment to make a point was cruel.

I suspect that if that incident happened today, in many cases, the offended staff – male or female, nursing or medical – would shut down that list by walking out and the Surgeon would face a disciplinary process.

The *Sex Discrimination Act 1984*[2] clearly states:

(1) For the purposes of this Division, a person sexually harasses another person (the person harassed) if:

(a) the person makes an unwelcome sexual advance, or an unwelcome request for sexual favours, to the person harassed; or

(b) engages in other unwelcome conduct of a sexual nature in relation to the person harassed;

in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated...

That incident from 30 years was also an episode of bullying, related to power imbalance. The scrub nurse and the Surgeon knew that the nurse could not just walk out.

Now, she still might not, but either she or the nurse unit manager may immediately reprimand the Surgeon and then later lodge a formal complaint which is likely to be upheld.

Some doctors who have been around for a while may see the bullying they experienced as students and juniors as a "rite of passage" – a transitional period that ensured they had the fortitude as well as the knowledge and experience to survive life in the profession: *"It turned me into the doctor I am today – and will do the same for my interns and residents."*

However, today's young doctors are exposed to a level of pressure many orders of magnitude greater than their seniors were when they were juniors. The recently reported suicides of four junior doctors in Victoria are sad and alarming evidence of this. Perhaps some of the doctors of my era need to unbolt and remove the armour they bolted on to block their awareness of the distress exhibited by some of the people they work with.

Brian Owler, President of the AMA, in a recent newspaper article[3] quoted the late Professor Yvonne Cossart of the University of Sydney who had said to him, pointing to the Royal Prince Alfred Hospital: *"Those guys are really mean to each other when it comes to politics, but when one of them is in trouble, they will do everything they can to help..."* He also quoted the words of the late Professor Chris O'Brien who said: *"We are all colleagues; we may have different seniority, but we are all members of the profession."*

If we extend that principle to all the people we work with, we will be impelled to show them the grace and courtesy that lies within all of us, and to which they are entitled.

Dr Paul Nisselle AM
Mutual Board Director
MDA National

1 Australian Human Rights Commission. Sexual Harassment. Available at: humanrights.gov.au/our-work/sex-discrimination/guides/sexual-harassment.

2 *Sex Discrimination Act 1984* (Cth). Available at: comlaw.gov.au/Details/C2014C00002.

3 Owler, Brian. Misogyny in Medicine: Don't Put Up With It. The Age (Melbourne) March 25, 2015 p47.

Beware Medicare

MDA National has become aware of a number of recent Medicare audit activities affecting GPs and other specialists.

General Practice – Chronic Disease Management Plans (CDMP)

These services include item numbers **721** (Care Plan), **723** (Team Care Arrangements), **732** (GP Management Plan), **732** (Coordinating a Team Care Arrangement), **731** (Contribution/Review of Multidisciplinary Aged Care Resident Plan) and **729** (Contribution/Review of Multidisciplinary Care Plans).

Importantly, since 1 November 2014, a time-based consultation and a CDMP cannot be billed on the same day.[1]

It is crucial to ensure that the relevant Medicare descriptors are met,[2] including that the CDMP is more than just a template "cut and paste" of other data, and that formal requirements such as patient consent and collaboration, as appropriate, are met. Otherwise partial or complete repayment of these services may be required by Medicare, potentially including an administration penalty of up to 20% if the payment is more than $2500.[3]

Radiologists – provision of diagnostic imaging services

The Department of Human Services is auditing diagnostic imaging providers, concentrating on billing and incoming referrals. This will include confirmation that the specific service was requested by a referring doctor. Referrers may also be contacted for a copy of the original referral and associated reports (patient test results can be redacted).

Other non-GP specialists – initial and subsequent attendances

A number of non-GP specialist Members (particularly Ophthalmologists) have contacted us regarding Medicare audits of item numbers **104** (initial attendance, referred consultation) and **105** (subsequent attendance) in relation to the need for a new referral. These matters also raise a number of questions regarding referrals and what constitutes an initial attendance.

Some Members have been required to repay incorrectly rendered services. It is important to ensure your administrative staff are trained to recognise such situations prior to the consultation to allow for a referral to be provided.

A patient attends with no referral

If a patient attends without a valid referral, a non-GP specialist will need to consider several options:

- Is the consultation for emergency treatment that needs to be rendered "as quickly as possible"?[4] In this case, the account, receipt or assignment form must be endorsed "emergency referral". No referral is required for this initial consultation.
- Will the consultation be billed to Medicare using unreferred (time-based) MBS item numbers (**52**, **53**, **54**, **57**)?
- Has the referral been lost, stolen or destroyed? If so, the assignment form must show the referring practitioner and their address/provider number, if known. The words "lost referral" must be included when billing the initial consultation. A copy of the referral should be obtained for subsequent consultations.
- Can a new referral be obtained before the service is rendered?

A patient attends with a new problem and has an existing unrelated referral

The presentation of an unrelated illness, normally requiring the referral of the patient to the specialist's care to initiate a new course of treatment, requires a new referral. For example, a pre-existing referral for glaucoma will not cover an unreferred presentation for a pterygium – a new referral will be required.[5]

If no new referral is available, an initial attendance (**104**) can only be billed in circumstances described above.

A subsequent attendance (**105**) can only be charged if the consultation relates to the continuing management encompassed by the original referral. This may mean that a broad initial referral may allow several subsidiary conditions relevant to that referral to be billed as part of the ongoing treatment. However, this will still not permit multiple initial attendances (**104**) to be billed to the same referral. An example would be a referral for "assessing the patient's visual symptoms" which might encompass both an initial **104** for glaucoma and a later **105** (not **104**) for a pterygium under the same referral.

New referral for an existing condition

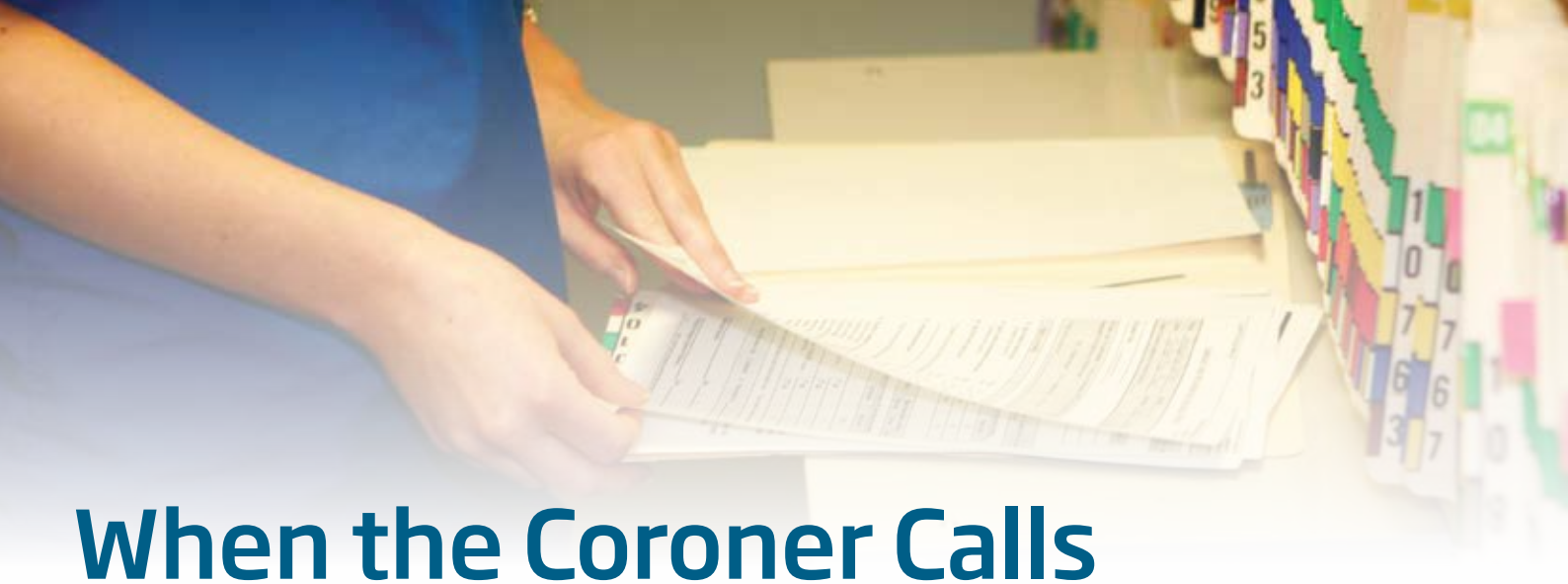
A new initial attendance (**104**) may be billed where the initial referral has expired, a new referral for the same condition has been issued, and more than nine months have elapsed since the last consultation with the specialist.

Indefinite referrals

These will permit an initial consultation (**104**) charge, then ongoing subsequent attendances (**105**) thereafter, irrespective of the timeframe between consultations.[4] Repeat initial consultations (**104**) should not be billed against an indefinite referral,[5] even if the consultation is held more than nine months later.

Dr Julian Walter
Medico-legal Adviser
MDA National

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



When the Coroner Calls

Our Medico-legal Advisory Services team regularly receives phone calls from Members who have been contacted by the Coroner's office in relation to an investigation involving the death of a patient. This article addresses some of the most frequent questions and concerns raised by Members.

Q. I have been asked to send the medical records to the Coroner – should I comply, or do I need authority from the family or executor of the deceased patient's estate?

A. You should comply with this request and send the records to the Coroner's office. Doctors have a professional obligation under the Code of Conduct to assist the Coroner when an inquest or inquiry is held into a patient's death, by responding to their enquiries and offering all relevant information.[1]

Q. I have been asked to provide a report or statement to the Coroner – what should I do?

A. We recommend that you always contact MDA National for advice before providing a report to the Coroner.

If you are a hospital employed doctor, you may be asked by your hospital administration to prepare a report or to be interviewed for a statement. If you are in private practice, you may receive a request for a report directly from the Coroner's office or from the police assisting the Coroner. In either case, MDA National can assist you. Hospital employed doctors may also be able to seek assistance from their hospital's legal representative.

A well prepared report or statement can greatly assist the Coroner in understanding your role in the care of the patient.

Q. Do I need to see the medical records before I prepare my report or statement?

A. Yes, it is important to refresh your memory from the records when preparing a report or statement. If you are hospital employed, you will generally be provided with access to the medical records by the hospital.

Q. Will the matter proceed to a hearing or inquest?

A. The Coroner's office will review all the relevant information obtained from the police, the forensic pathologist, the medical records, and statements provided by treating doctors and other interested parties, including the family, before deciding whether the matter should proceed to an inquest. Generally, less than 5% of deaths reported to the Coroner proceed to an inquest.

Q. I have received a summons to give evidence at an inquest – what should I do?

A. We recommend that you contact MDA National as soon as possible to discuss the matter and determine what assistance you may require.

Q. What is a letter of adverse outcome and what does it mean?

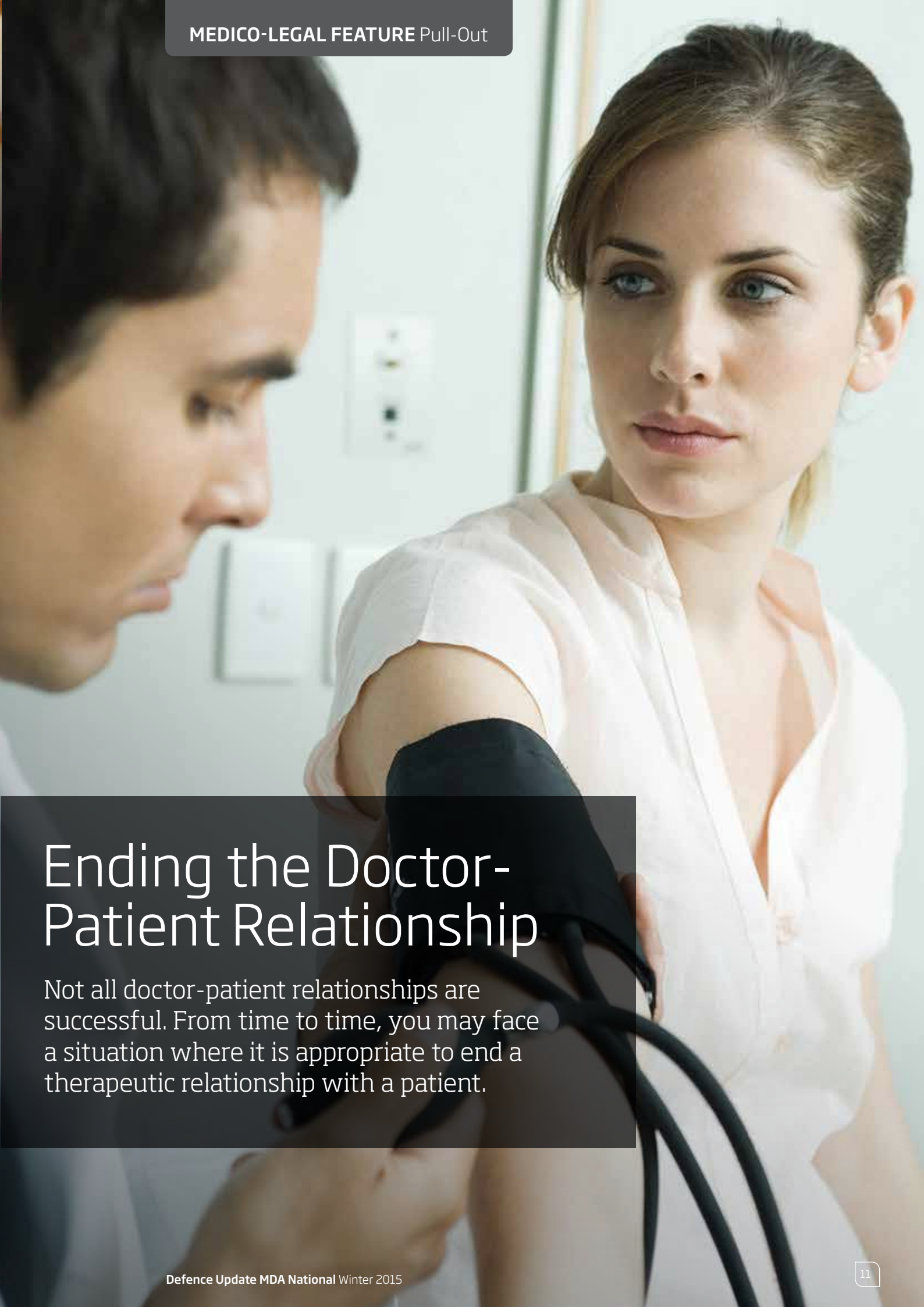
A. During the lead-up to an inquest, the Coroner may raise concerns about the care provided by an individual doctor and issue a letter advising the doctor that there may be an adverse finding made which could lead to a referral to the Medical Board. It is essential that you obtain legal advice and assistance in this situation.

It is important to contact MDA National as soon as possible when you become aware of a request for medical records, a report or statement to the Coroner or an inquest into the death of one of your patients. The sooner we know about the matter, the more effective our assistance will be. We can provide you with personal support and help you with:

- understanding the Coronial process
- preparing reports and statements
- preparing for an inquest.

Janet Harry
Medico-legal Adviser
MDA National

1 Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. Section 8.10.3. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.



Ending the Doctor-Patient Relationship

Not all doctor-patient relationships are successful. From time to time, you may face a situation where it is appropriate to end a therapeutic relationship with a patient.

Ending the Doctor-Patient Relationship

In most cases, the decision to terminate a doctor-patient relationship is a difficult one for the doctor to make. By the time Members contact us for advice, they have generally tried a range of strategies to try to preserve the relationship and the decision to end the doctor–patient relationship is the only option available.

For many doctors, acknowledging that they are no longer able, or willing, to look after a patient is not easy and goes against their understanding of their professional obligations as a doctor. Some doctors may be worried about potential liability, based on the American concept of "patient abandonment". However, it is important to be aware that it is acceptable and, in certain circumstances, advisable to terminate a therapeutic relationship with a patient. The key issues are to recognise when it is appropriate to do so, and know how to do it without breaching your legal and professional obligations as a doctor.

Grounds for ending the doctor-patient relationship

There are a variety of reasons why doctors decide that a doctor-patient relationship has irrevocably broken down. These include:

- unacceptable patient behaviour – this may involve verbal abuse, threatened or actual violence, harassment and other boundary violations including "lovelorn" patients; the behaviour may also involve unacceptable behaviour towards practice staff, rather than the doctor
- a loss of mutual trust and respect and/or a breakdown in communication
- continual non-compliance with management recommendations
- criminal acts by a patient, such as obtaining drugs fraudulently or forging certificates
- a patient who tries to coerce the doctor to provide medical treatment that the doctor disagrees with.

Not all therapeutic relationships are going to be successful. It is important to remember that one doctor's difficult or "heartsink" patient is not necessarily another doctor's difficult patient. If you are feeling anxious, fearful, angry or emotionally wound up about a particular patient, then you are not being the best doctor you can be, and the patient is likely to receive better and more effective care from another doctor.

Legal obligations

In general terms, there is no legal obligation imposed on a doctor to see any particular patient, except in a genuine emergency situation. Therefore, there is no legal duty to continue a doctor-patient relationship once it has commenced. However, it should be noted that some employed doctors may be under a contractual obligation to see certain patients, e.g. in an Emergency Department setting.

It is also important to be aware that health practitioners must not refuse to treat patients based on unlawful discrimination – that is, treating a particular patient (or group of patients) less favourably than they would another patient without a particular characteristic such as disability, race, religion, sex or gender identity.

Professional obligations

Doctors need to comply with the Medical Board of Australia's *Good Medical Practice: a Code of Conduct for Doctors in Australia* when ending a doctor-patient relationship. The Code states:

Ending a Professional Relationship

In some circumstances, the relationship between a doctor and patient may become ineffective or compromised, and you may need to end it. Good medical practice involves ensuring that the patient is adequately informed of your decision and facilitating arrangements for the continuing care of the patient, including passing on relevant clinical information.[1]

Therefore, the onus is on you to:

- ensure the patient is informed of your decision
- facilitate the handover of clinical care
- forward relevant clinical information.

Ending the doctor-patient relationship: steps to follow

So how should a doctor end a therapeutic relationship? Depending on the circumstances, the doctor-patient relationship can be terminated in a face to face meeting or consultation with the patient, by phone and/or in writing.

Regardless of the method used, it is important to note the following:

1. Inform the patient that the doctor-patient relationship has irrevocably broken down and therefore it is in the patient's best interests to seek ongoing medical care from another doctor. You may also need to inform the referring practitioner, other specialist colleagues involved in the patient's care and/or the local hospital that you are no longer involved in the patient's care.
2. Advise the patient and, if relevant, the referring practitioner(s) of any outstanding clinical issues that require follow-up and a timeframe for doing this.
3. If the patient will be attending another practice, ask the patient to inform your practice in writing of the name of the patient's new treating doctor so that a copy or a summary of their medical records can be promptly forwarded, to facilitate continuity of the patient's medical care. In this situation, it is generally appropriate to waive your usual fee for transfer of medical records. You may also wish to provide a transfer of medical record form for the patient to complete.
4. Inform your practice staff that the doctor-patient relationship has been terminated, so that no further appointments are made for the patient with you. Also remember to cancel any reminders in the record keeping system.

The key issues are to communicate the termination of the therapeutic relationship in clear and unambiguous terms, "drawing the line in the sand", and confirming that the decision has been made in the best interests of the patient.

In some situations, it is necessary to end the professional relationship with a patient at a practice level, rather than just with an individual doctor. This may occur when a patient has behaved inappropriately towards staff members or made threats against you, necessitating this step to protect you and your staff.

If you find yourself in the difficult situation of having to end a doctor-patient relationship, we encourage you to contact our Medico-legal Advisory Services team for advice and support. In particular, we can assist you in drafting a letter to the patient to inform them about the end of the doctor-patient relationship, to ensure that your legal and professional obligations in this situation are met.

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

The provision of advice to Members about ending a doctor-patient relationship comprises 6% of the advisory calls received by our Medico-legal Advisory Services team.

1 Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.

Template Letter

Ending the Doctor-Patient Relationship

In general terms, a letter to a patient which ends the doctor-patient relationship should be kept short and simple. The more details you provide, the more likely it is that the patient will attempt to argue the points.

Here is a sample letter for ending the doctor-patient relationship. You can adapt this letter to suit your particular circumstances.

PRIVATE & CONFIDENTIAL

ADDRESSEE ONLY

Dear [*insert patient's name*]

As discussed with you on [*insert date*], I am writing to confirm that I am unable to continue as your treating doctor.

Our doctor-patient relationship has broken down and it is in your best interests to seek ongoing care from another doctor [*this paragraph can be altered to suit the particular circumstances*].

I would be grateful if you would let our practice know in writing of the name of your new treating doctor. We will promptly forward a complete copy of your medical records at no cost to you, to ensure continuity of your medical care. I enclose a transfer of medical record form for you to complete.

If any urgent health issues arise in the meantime, please attend your local Emergency Department.

Yours sincerely

Dr Y

Our Medico-legal Advisory Services team is happy to review any draft letter you intend to send to a patient. You can send documents to us by email: **advice@mdanational.com.au** or fax: **1300 011 235.**

Need more information or advice?

Contact our Medico-legal Advisory Service on **1800 011 255** or email **advice@mdanational.com.au**.

You can access this letter template online at: **defenceupdate.mdanational.com.au/template-letter-end-relationship**.

CaseBook

Failure to Make a Mandatory Notification

Case history

Dr Al-Naser, a General Practitioner, owned and managed a Medical Centre in the ACT. In 2012, he engaged Dr Khalil to work at the Centre. From 24 February 2012 to 29 October 2012, Dr Khalil engaged in a sexual relationship with a patient which led to proceedings against him in the Medical Tribunal. Dr Al-Naser was unaware of this relationship until 29 October 2012.

On 29 October 2012, the patient attended a consultation with Dr Al-Naser and then had a further five consultations with him up to 25 March 2013. Each of these consultations focused on the relationship between the patient and Dr Khalil and the effect of that relationship on the patient's health.

During these consultations, Dr Al-Naser engaged in physical contact with the patient and made comments of a personal nature regarding the patient's youthfulness, her looks and her similarity to his former girlfriend.

At the final consultation, Dr Al-Naser prepared a Mental Health Treatment Plan and, at the patient's request, referred her to Dr Eryn Davies, Clinical Psychologist. Dr Davies and the patient subsequently made a notification to the Medical Board.

Tribunal decision

The complaint against Dr Al-Naser proceeded before the ACT Civil and Administrative Tribunal on 4 February 2015.[1] The Tribunal stated that Dr Al-Naser was in breach of his obligations under the National Law in failing to notify the Medical Board of Dr Khalil's conduct. Dr Al-Naser had taken no action against Dr Khalil and allowed him to continue to work at the Medical Centre.

The Tribunal further commented that Dr Al-Naser had treated the patient despite the existence of a conflict of interest and not referred the patient to another practitioner, Dr Davies, until 25 March 2013. The comments made by Dr Al-Naser of a personal nature were inappropriate, particularly as the patient was a victim of a sexual misconduct boundary violation.

The Tribunal found that Dr Al-Naser had engaged in professional misconduct. The Tribunal ordered that he be reprimanded and imposed conditions on his registration, including restricting his role as supervisor. He was also required to have a mentor and undertake a clinical communication program.

Karen McMahon
Medico-legal Adviser
MDA National

Summary points

- Health practitioners and employers have a duty to report "notifiable conduct" to AHPRA as defined in the National Law. Notifiable conduct means the practitioner:
  a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
  b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
  c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
  d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.
- The threshold to be met to trigger a mandatory notification in relation to a practitioner is high. The practitioner or employer must have first formed a reasonable belief that the behaviour constitutes notifiable conduct. A reasonable belief requires a stronger level of knowledge than mere suspicion. Mere speculation, rumours, gossip or innuendo are not enough to form a reasonable belief.
- This decision confirms that a practitioner may be the subject of disciplinary proceedings if they fail to make a mandatory notification to AHPRA when required to do so.[2]

1 *The Medical Board of Australia v Al-Naser* [2015] ACAT 15.

2 AHPRA Guidelines for Mandatory Notifications. Section 4. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx.

CaseBook

A Matter of Informed Consent

It is well recognised that medical practitioners have a duty to explain to patients – in terms they can understand – the nature of their illness, treatment options and the general, specific and importantly, material risks of a proposed course of treatment. The recent decision of *George v Biggs & St Vincent's Hospital* [2015] NSWDC 11 reinforced this duty, especially in complex health situations confounded by language barriers.

The Court dealt with a number of issues in this case, including expert and conflicting evidence, the scope of duty in informed consent where there is limited understanding of English, and the risks of using untrained interpreters. Other issues included the value placed on evidence of usual practice where there was inadequate support for it, and the benefit of good clinical record keeping.

Case history

Mrs George, a 63-year-old Macedonian lady living in Moree was diagnosed in late 2008 with a right-sided acoustic neuroma. After a series of consults with medical practitioners and hospital staff, she underwent surgery to remove the tumour in November 2009. During the procedure, she suffered an injury to her seventh cranial nerve resulting in permanent facial paralysis.

An ENT team from St Vincent's Hospital conducted clinics in Moree. Mrs George had been referred to the clinic by her General Practitioner after experiencing hearing loss and problems with balance. She attended two consultations at this clinic – one in March 2009 with Professor Fagan and a second with Dr Biggs in April 2009. Mrs George asked to have a Macedonian translator present as her understanding of English was limited, but this did not occur. Mrs George was accompanied to the consultations by a friend. Unfortunately for Mrs George, her friend's understanding of English was not much better than her own. Further appointments (pre-admission and pre-anaesthetic clinics) were conducted at St Vincent's Hospital with the assistance of trained interpreters, in person and by telephone.

Medico-legal issues

It was alleged that both Dr Biggs and St Vincent's Hospital were negligent in that they had failed in their duty to properly inform her of the risks of the procedure; and further, had she been properly informed of the nature of her condition, options and risks, specifically facial paralysis, she may not have undergone the procedure. Dr Biggs and St Vincent's Hospital (as employer of other staff involved in Mrs George's care) held that facial nerve damage was an inherent risk of the procedure that she had been warned of and therefore she would have, in any event, proceeded with surgery.

When does the consent process start?

At the clinic visit in March 2009, Mrs George acknowledged she was told she had a tumour. However, her evidence was that it was a "very bad" tumour located in her brain and that she required surgery. The records of Professor Fagan indicated the information meant to be conveyed to Mrs George about the tumour was very different.

The Court held that this appointment, while not part of the actual consent process, formed the basis upon which Mrs George was to make decisions about her care and treatment. The medical records and letter back to her GP contained evidence of the discussion, but did not include evidence of Dr Fagan assessing Mrs George's understanding of her situation. He stated that his usual practice was to be guided by the reactions of the patient and this acted like a filter and allowed him to amend how and what information he provided to the patient.

The Court held that relying on usual practice in this instance was not ideal as the situation was not routine. There were clearly language issues and additional care should have been taken in communicating with the patient, especially because of an untrained interpreter. Importantly, it was stressed that using an untrained interpreter provided no opportunity for the medical practitioner to assess what the patient understood.

The Court outlined the recognised risks of using an untrained interpreter as follows:[1]

- there were likely to be significant misunderstandings with regard to history, symptoms, diagnosis and treatment, especially risks
- the more complex the situation, the greater the scope for misunderstandings
- filtering, playing down what is said, altering and censoring of content was likely to occur
- cultural factors would invariably impact on communication.

The Court confirmed that obtaining consent is a fluid process which consists of a sequence of discussions.[2] Therefore the second consultation in April 2009 was considered to have commenced a more formal consent process.

Engaging a trained interpreter early in the process ensures that a thorough history can be obtained, appropriate information can be imparted, and the patient's understanding can be assessed and confirmed prior to instigating any treatment.

Mrs George, again accompanied by her friend as interpreter, advised Dr Biggs that she wanted to undergo surgery. Dr Biggs recalled his usual practice was to inform the patient of the risks of surgery, including injury to the facial nerve. Mrs George alleged that Dr Biggs did not inform her of options for conservative treatment or the risks associated with surgery. Significantly, there were no written records of Dr Biggs' consultation with Mrs George or a letter back to her GP. Dr Biggs stated that from his reading of Professor Fagan's medical records, the risks had been discussed with Mrs George.

The Court held that in the absence of any records of the consultation, Mrs George's recollection of events was to be believed over the recall and reliance of Dr Biggs on usual practice, including taking any steps to confirm the patient's understanding of her condition and treatment.

Attendance at St Vincent's Hospital

Mrs George attended St Vincent's Hospital in October 2009 for her pre-admission clinic. A trained interpreter was arranged. Evidence about the discussion or the notes provided by the interpreter did not provide any clarity about the nature of the discussions with Mrs George. The notes of that appointment were made by a resident medical officer. They indicated some discussions, but included errors. Dr Biggs stated he had made a hurried visit to the clinic to obtain consent from Mrs George; however, Mrs George alleged she had not seen Dr Biggs that day. Again, there were no notes of any interaction between her and Dr Biggs or of any discussion.

The Court held that this appointment, especially as a trained interpreter had been arranged, was the ideal opportunity for Dr Biggs and the hospital staff to take the time to thoroughly discuss with Mrs George her illness, treatment options and risks. The Court also held that a brief visit to the clinic to obtain consent was not ideal, as obtaining consent was more than just signing a form.

Mrs George's procedure was postponed due to the unavailability of ICU beds. She subsequently attended in late November 2009 for the surgery. Dr Mukherjee conducted a consultation with Mrs George via a telephone interpreter. The notes from that consultation indicated there was mention of risks, but this was not a detailed discussion. The Court held that it was definitely not too late at this point to take steps to clarify Mrs George's understanding of her condition and treatment, including other options.

Conclusion

From the evidence presented on the issue of consent, the Court found that Dr Biggs and St Vincent's Hospital had breached their duty to properly inform Mrs George because:

- language issues were obvious from the outset
- the medical practitioners should have recognised the risks of using an untrained interpreter
- these risks were a major factor which would, and did, impair consent discussions
- reliance on "usual practice" in the circumstances was far from adequate.

For a medical practitioner to discharge their duty to obtain valid informed consent, it is vital that:

- where language issues are evident or arise, steps are taken to facilitate discussion with the assistance of a trained interpreter
- discussions must include explanations of the illness/condition, treatment options, and the risks associated with those options and of not having treatment
- discussions must include an opportunity for the patient to ask questions and discuss any material risks.

Engaging a trained interpreter early in the process ensures that a thorough history can be obtained, appropriate information can be imparted, and the patient's understanding can be assessed and confirmed prior to instigating any treatment. In doing so, the practitioner enhances the therapeutic relationship, provides good clinical care and reduces the likelihood of complaints, disciplinary proceedings and negligence claims.

Allyson Alker
Senior Risk Adviser
MDA National

1 *George v Biggs & St Vincent's Hospital* [2015] NSWDC 11 at [532].
2 *George v Biggs & St Vincent's Hospital* [2015] NSWDC 11 at [474].

CaseBook

Boundary Violations: Finding of Professional Misconduct

The Health Care Complaints Commission (HCCC) brought complaints against a General Practitioner in the NSW Civil and Administrative Tribunal (the Tribunal) alleging she had failed to maintain proper boundaries with three patients.[1]

The allegations included that the GP had an inappropriate sexual relationship with one or more patients and inappropriately treated patients when she had close personal relationships with them. The case also raised issues as to the appropriateness of the GP's communications with patients via text messaging and social media.

Case history

The GP was practising in Broken Hill when she initially developed a friendship with Patient B in 2009 after she started attending, as a client, a business operated by the patient and communicated with her via text messaging and Facebook. The GP later met and treated Patient B's husband (Patient A), and Patient B's daughter.

In 2009, the GP also developed a close personal relationship with Patient D including socialising together and text messaging. The GP consulted with Patient D in August 2009, at which time she discussed the possibility of being in a sexual relationship with him.

The GP continued to socialise with Patient A and B allegedly whilst also providing treatment to them and to Patient B's daughter. This included providing medical advice to Patient B via Facebook and writing her a prescription for Maxolon.

The GP then commenced a sexual relationship with Patient A from June 2010 shortly after he separated from Patient B. At the time of the Tribunal hearing, the GP was in a de-facto relationship with Patient A and had a daughter with him, aged two and a half years. While she conceded that her conduct from June 2010 constituted professional misconduct, she did not accept that her conduct prior to that date was inappropriate.

In determining the nature and extent of the practitioner's relationships, the Tribunal examined telephone records, SMS messages and Facebook communications.

Tribunal findings

The Tribunal found that the GP's failure to refer Patient D to another practitioner in the second half of 2009 and failure to end the doctor-patient relationship with him was inappropriate. The Tribunal also found that the GP should have, by April 2010, ceased treating Patient A.

The Tribunal found the GP guilty of professional misconduct and unsatisfactory professional conduct and suspended her registration for three months. The Tribunal also made orders for a number of conditions to be imposed on her registration once she returned to practice, including that she should:

- not practise as a sole practitioner for three years
- undertake an approved ethics course
- meet with an approved mentor for at least 18 months.

Electronic communications with patients

As noted by the Tribunal in this case, while the use of text messaging and the internet to make and confirm appointments is widespread and has practical benefits, practitioners must observe appropriate care in their communications to ensure patient confidentiality is observed.

The Tribunal stated it is important for practitioners to bear in mind that information conveyed by text messages and social media can easily be corrupted or misused, and that any policy involving the disclosure of confidential medical information via email or social media should be the subject of a patient's informed consent. The Tribunal also took the opportunity to recommend that the Medical Board and other health professional Boards and Councils provide further guidelines for health practitioners in this area.

Karen McMahon
Medico-legal Adviser
MDA National

1 *Health Care Complaints Commission v Dr Nikolova-Trask* [2014] NSWCATOD 149.

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Education Activity – Winter 2015

You can receive professional development (PD) recognition for this *Defence Update* issue by answering a questionnaire online or using the hard copy form below.

Only MDA National Members can access the activity online. Log on to Member Online Services and enter the "Education" section.

See page 22 for more information.

Activity learning outcomes

By the end of this activity participants should be able to:

- explain when a mandatory notification to the Australian Health Practitioner Regulation Agency (AHPRA) is necessary about a health practitioner's conduct
- identify key points to include in a written workplace policy about how to end a doctor-patient relationship
- discuss necessary considerations for doctors using social media.

Questionnaire

1 **Rate the extent to which you agree with the following statements (this is a personal reflection exercise):**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Social media should be used cautiously as part of practising medicine.	☐	☐	☐	☐	☐
My workplace has useful policies/guidelines about the use of social media that are adequately communicated to staff.	☐	☐	☐	☐	☐
The more details given in a letter to a patient that ends the doctor-patient relationship, the more likely it is that patients will try to argue about it.	☐	☐	☐	☐	☐
If you are feeling emotionally wound up about a patient, then they are likely to receive better care from another doctor.	☐	☐	☐	☐	☐

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

	True	False
Courts can scrutinise a doctor's social media contact with a patient to gauge the doctor's credibility.	☐	☐
Disclosing confidential medical information by email or social media should be the subject of a patient's informed consent.	☐	☐
It is an offence to include patient testimonials on a doctor's practice website.	☐	☐
The threshold to be met to trigger a mandatory notification to AHPRA in relation to a practitioner is high.	☐	☐
It is appropriate not to make an immediate mandatory notification to AHPRA after hearing from two allied health practitioners that they've heard from friends that a medical practitioner you refer patients to has a substance misuse problem.	☐	☐
To date, the Medical Board of Australia has not commenced disciplinary proceedings against a doctor for failing to make a mandatory notification.	☐	☐
Doctors' professional obligations require them to always consult with patients who request a consultation through standard processes.	☐	☐

Respond true or false to the following statements.

	True	False
If a doctor ends a therapeutic relationship with a patient, they have an obligation to facilitate arrangements for passing on relevant clinical information.	☐	☐
It is always illegal to end a professional relationship with a patient at the level of the entire practice.	☐	☐
If a Coroner asks to be sent medical records, authority from the family or executor of the deceased person's estate is required.	☐	☐
Less than one in 20 deaths that are reported to the Coroner proceed to an inquest.	☐	☐

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

List at least three questions to ask yourself before posting something about your medical work on social media.

How would you differentiate between a "reasonable belief" and "suspicion" in relation to notifiable conduct of a health practitioner? Briefly describe a realistic, fictional scenario in which you would make a mandatory notification about a health practitioner's conduct.

What points would you include when writing a workplace policy about how to end a doctor-patient relationship? Note at least four necessary steps below.

What could you do to make a positive contribution to reducing the amount of bullying and sexual harassment in medical workplaces?

Activity evaluation

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

	Not met	Partially met	Entirely met
Explain when a mandatory notification to the Australian Health Practitioner Regulation Agency is necessary about a health practitioner's conduct.	☐	☐	☐
Identify key points to include in a written workplace policy about how to end a doctor-patient relationship.	☐	☐	☐
Discuss necessary considerations for doctors using social media.	☐	☐	☐

2 **Rate to what degree your personal learning needs were met.**

☐ Not met ☐ Partially met ☐ Entirely met

3 **Rate to what degree this activity was relevant to your practice.**

☐ Not relevant ☐ Partially relevant ☐ Entirely relevant

4a **Has the content in *Defence Update* Winter 2015 caused you to consider making any change(s) to your practice?** ☐ Yes ☐ No

4b **If you answered "yes" to question 4a, what change(s) do you envisage making?**

5 **Please rate the quality of the following in relation to *Defence Update* Winter 2015.**

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

6 **Would you recommend this activity to colleagues?**

☐ Definitely not ☐ Probably not ☐ Unsure ☐ Probably ☐ Definitely

7 **What could be done to improve this activity?**

8 **What future educational resources would you like MDA National to produce? Feel free to nominate any topics and any delivery formats, e.g. "responding to errors, online presentation", "cross-cultural communication, face-to-face workshop", "managing staff, *Defence Update* article".**

9 **Please indicate your career stage:**

☐ Prevocational ☐ Vocational trainee ☐ Early career ☐ Mid-career ☐ Late career ☐ Retired

10 **If chosen, please indicate your specialty:**

Your details

Name	
Email	Phone
Address	
Name of college PD program in which you participate	
RACGP/ACRRM identification number (if applicable)	MDA National number

Please sign and date here

Signed **Date (DD/MM/YYYY)** / /

☐ Tick here if you do not wish to receive your completion certificate by email.

In completing this form, you consent to your comments being used for promotional purposes by the MDA National Group.

☐ Tick here if do not consent to your evaluation comments being used anonymously by the MDA National Group for promotional purposes.

Activity directions

- Read *Defence Update* Winter 2015.
- Complete the education activity questionnaire in hard copy or online. Fill out the activity evaluation and provide your details.
  - MDA National Members can access the questionnaire online:
    - Go to **mdanational.com.au**.
    - Log on to Member Online Services.
    - Click on the "Education" tab.
    - Select "Online Education Activities".
    - Select "*Defence Update*", then "*Defence Update* Winter 2015".
  - Submit a handwritten activity by:
    - **email** peaceofmind@mdanational.com.au
    - **fax** 1300 011 244
    - **post** Level 3, 100 Dorcas Street, SOUTHBANK, VIC 3006
- Receive your completion certificate.
- Report to your college's PD program if it is a self-reporting program.
- MDA National will report relevant points for the following programs on your behalf:
  - Royal Australian College of General Practitioners (RACGP) Quality Improvement and Continuing Professional Development (QI&CPD) Program
  - Royal Australian and New Zealand College of Ophthalmologists (RANZCO) CPD Program
  - Australian College of Rural and Remote Medicine (ACRRM) Professional Development Program (PDP).

Accreditation details

Visit **mdanational.com.au/publications/defence-update/defence-update-winter-2015.aspx** for this activity's PD recognition details.

This activity is usually accredited with colleges for General Practice, Emergency Medicine, Ophthalmology, Obstetrics and Gynaecology, and Radiology. Other specialists can receive PD recognition too.

What's On?

Medical Conferences

At MDA National, we are actively involved in various conferences of Australian Medical Colleges and Associations in order to support our collective Members.

Our friendly business development specialists and other professional experts will be on hand at the MDA National stand and involved in many presentations within the education and scientific program. Come and say hello and meet your MDA National team members. Here are just a few of the upcoming national and international conferences we will be present at:

August 2015

26-27	General Practice Training & Education Conference **TAS**

September 2015

20-26	Australian Society of Ophthalmologists (ASO) – Business International Vision Expo **Hanoi, VIETNAM**
21-23	GP15 – RACGP Conference for General Practice **VIC**

October 2015

9-11	Australian Orthopaedic Registrars Association (AORA) 2015 Conference **QLD**
11-15	Australian Orthopaedic Association (AOA) ASM 2015 Conference **QLD**
20-23	Australian Association of Practice Management (AAPM) & Practice Managers and Administrators Association of New Zealand (PMAANZ) Combined Conference 2015 **TAS**
22-24	Rural Medicine Australia (RMA) 2015 Conference **SA**

Complexities of Informed Consent Conversations

A highlight of our educational sessions this year is our "Complexities of Informed Consent Conversations" series of large group education events, aimed at strengthening doctors' knowledge and skills in facilitating optimal patient understanding and consent processes. We will be delivering this activity in five capital cities and two regional cities. We aim to rotate the regional locations each year based on Member need and demand.

Brisbane, QLD	3 June	**Crawley, WA**	18 & 20 June
Mackay, QLD	4 June	**Sydney, NSW**	25 June
Adelaide, SA	11 June	**Albury, NSW**	27 June
Brighton, VIC	13 June		

We will be adding many more educational sessions to our events calendar soon. So please keep an eye on our What's On page at mdanational.com.au to avoid missing out on the upcoming activities.

Time for a "health check"

Is your MDA National Membership record in good health?

Keeping your information up to date ensures that you maintain continuous cover and don't miss out on receiving important information about your medical indemnity. Keeping your account in good health is easy:

- Call Member Services on **1800 011 255**.
- Send an email to **peaceofmind@mdanational.com.au**.
- Log on to Member Online Services via **mdanational.com.au**.

MDA National
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It's my mda national

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

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

Dr Dror Maor
MDA National Member

Celebrating 90 Years

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

YouTube

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

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

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

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

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

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