defenceupdate

Publication for MDA National Members

Winter 2017

MDA National
Support Protect Promote

Editor's Note

Have you ever prescribed for yourself, family or friends? Over the past few months, we have received several requests for medico-legal assistance from Members who have done so. On page 17, Dr Jane Deacon explains the medico-legal problems that can arise when you prescribe for yourself or your family.

Another area of prescribing which has recently featured in coronial investigations is the use of hydromorphone. Any doctor who prescribes hydromorphone should read Dr Julian Walter's article on pages 14-15 about how to reduce errors when prescribing this opioid medication.

Prescribing cannabis is now a reality in Australia, following the inclusion of medicinal cannabis as a Schedule 8 drug. However, prescribing cannabis is a complex process. On pages 6-7, our Medico-legal Adviser, John Vijayaraj, provides a step-by-step guide on how to apply for approval to prescribe cannabis.

I'm delighted that three of our Members have contributed articles in this edition of *Defence Update*. On page 3, Dr Rachel Collings outlines the importance of mentorship and, on page 8, Dr Lily Vrtik discusses the links between learning music and her role as a plastic and reconstructive surgeon. On page 13, Dr Joel Wight challenges us on how we can develop doctors-in-training into highly competent, resilient and compassionate practitioners, with high levels of career satisfaction and work-life balance. Now that's something for us all to aspire to!

And finally, it is time to renew your MDA National Membership – on page 5 we outline the steps involved in completing your renewal.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

Defence Update **Online**

Visit **defenceupdate.mdanational.com.au**

In This Issue

Doctors for Doctors

As doctors, we don't receive formal education or specific training on what it really means to be an effective mentor, even though mentoring plays such an integral role in the success and wellbeing of our junior colleagues.

What does mentoring mean to you? Do you have a mentor or are you a mentor yourself?

Our medical students are guided by clear directives, deadlines for projects, outlined goals and close supervision. However, the story changes when they become junior doctors. They can find themselves in the long, cold corridors of the hospital as medical professionals – where that student support is no longer something they can turn to.

The transition from medical student to professional is a challenge, to say the least, and we're now seeing alarming rates of emotional exhaustion and burnout in our young doctors. The health, wellbeing and support of junior doctors are issues that require investment from all levels of the medical profession.

Personally, I was in a fortunate position to have family, friends and a strong network of support around me during stressful times – people with whom I could discuss issues and have a much needed "debrief". Sadly, not all junior doctors enjoy this luxury. In fact, many face the isolation of limited networks to call on for support when they need it most during those first years in the profession.

I recall an occasion when I encountered a clearly distressed intern in the hospital tearoom. The intern had been involved with an emotional case that had been very confronting – and this, coupled with a high patient load, had made for a demanding and stressful day. I asked if there was anyone at home or work they could talk to about their day – there was no one. Nobody to have a chat over coffee with and, most importantly, no relationships that could offer those pearls of wisdom and advice that come from someone who has been in a similar situation before.

This was the conversation which sparked an idea that led to the development and implementation of a hospital-based junior doctor mentoring scheme – a doctors for doctors mentoring program. This initiative focuses on the training of mentors, and matching interns with more senior medical officers, to create a network of support, advice and collegiality.

I'm not suggesting that being a junior doctor is all doom and gloom – it isn't. Every day is interesting, varied and stimulating; and it's the path to a rewarding career for the majority. No doubt, this profession comes with responsibility and often confronting decision-making on a daily basis. Junior doctors simply don't have years of experience to fall back on when things get tough. Mentoring in medicine is uniquely positioned to provide the necessary support which can encompass professional development advice, mental wellbeing, career guidance and, importantly, an assurance that things will be okay.

The support and wellbeing of junior doctors is a responsibility that falls on all of us. So I urge you to look out for mentoring opportunities – and keep a look out for that intern in the tearoom who's having a tough day.

Dr Rachel Collings (MDA National Member)
Obstetrics & Gynaecology Registrar, Victoria

Notice Board

More Support with Defamation Cover

Medical practitioners can be the subject of defamation claims in their provision of healthcare services – which includes supervision; training and mentoring other healthcare professionals; providing a healthcare report or opinion; writing for healthcare journals; and providing advice on a person's fitness to carry out certain duties. We are committed to supporting our Members in these additional scenarios.

Effective 1 July 2017, the cover under our Professional Indemnity Insurance Policy has been expanded to civil liability claims including legal costs arising from defamation by medical practitioners in the course of providing healthcare services, subject to certain terms and conditions. The Policy will also cover legal costs for pursuing a defamation allegation against another person who is not a healthcare professional, if it arises from defamation of you as a medical practitioner or directly in relation to healthcare services you provide.

For further details, please refer to the *Supplementary Financial Services Guide (FSG) & Product Disclosure Statement (PDS) including Endorsement to the Policy Wording V.11* enclosed with your Renewal Notice, or contact Member Services on **1800 011 255** or **peaceofmind@mdanational.com.au**.

Chaperone Review

On 11 April 2017, AHPRA released a report that recommends abandoning the use of mandated chaperones as an interim restriction in response to allegations of sexual misconduct.

Find out more about the report, allegations of indecent assault and chaperone conditions at **mdanational.com.au/resources/blogs/sexual-misconduct-and-chaperones**.

AHPRA Advertising Focus

AHPRA has just released the *Advertising Compliance and Enforcement Strategy* which outlines their approach to ensuring the responsible advertising of health services. In a recent medico-legal blog article, Dr Sara Bird outlines AHPRA's powers under the National Law, describes high-risk and lower-risk advertising breaches, and provides links to other resources to assist in ensuring your advertising is compliant.

Read more at **mdanational.com.au/resources/blogs/increased-ahpra-focus-on-advertising**.

Physician Insurers Association of America (PIAA)

The 2017 PIAA International Conference, themed "Change and Disruption", will focus on strategies for managing the evolution of medical liability. More than 250 global healthcare insurance and risk professionals will come together to share key developments and insights on the day-to-day issues facing medical and healthcare professional liability.

Early bird discounts close 30 June 2017.
Visit **piaa2017.com** for more information.

Why attend?

- Hear from a diverse range of expert speakers with insightful perspectives on medical liability.
- Learn practical and relevant ideas which can be implemented in everyday practice to improve changing healthcare systems.
- Get the opportunity to contribute to the debate surrounding new technology and risk.
- Be fully informed on the future direction of medical and healthcare liability.
- Have the opportunity to network with colleagues from across the globe.

Renewal Time

You should have recently received your 2017 Renewal Notice in the mail. If you have not received your notice or any details are incorrect, please contact our Member Services team prior to the expiry of your Membership and Policy on 30 June 2017.

Here are some steps to guide you.

Renew your Membership and Policy by 30 June 2017

If the information on your Renewal Notice is correct, you can make your payment by phone, or online via our Member Online Services. Your Renewal Notice outlines the payment options available to you. If you have set up a direct debit arrangement, we will debit your nominated account on the scheduled dates listed on your Renewal Notice.

For your convenience, your Renewal Notice includes:

- your tax invoice/receipt which is valid upon payment. A receipt will only be sent if you specifically request one
- your *Certificate of Insurance* which can be used as proof of indemnity upon payment – please keep this safe as it forms part of your Policy documentation.

Once we receive your payment, we will automatically post you a Certificate of Currency. If you renew online, you can print it out immediately after payment.

Please ensure you read and understand the *Declaration* on the Renewal Notice and the *Important Information* section of your renewal documentation.

Ensure you tell us about any matters arising from your practice

Early notification enables us to support you better and can help prevent matters from escalating. Ensure you have informed us of all claims, complaints, investigations, employment disputes, or any incidents you are 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

Please read the ***Risk Category Guide 2017/18*** and the ***Significant Changes to the Risk Category Guide*** (accessible from the Downloads section at **mdanational.com.au**) to ensure you have selected the most appropriate risk category and estimated the most accurate Gross Annual Billings for your practice.

This may affect your premium and cover under your Policy. If a change is required to the level of cover you require, we will re-issue you with a revised Renewal Notice.

Review the Policy changes

We have introduced additional covers for 2017/18 and enhanced the wording to provide greater clarity. Please read the documents included in your renewal pack prior to renewing for 2017/18.

Our Member Services team is here to help

Any queries about your Membership or Policy? Need changes to your Renewal Notice?

Please contact us on **1800 011 255** from Monday to Friday between 8.30am and 8.00pm (AEST) or email **peaceofmind@mdanational.com.au**.

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

I've been an MDA National Member from the beginning of my career and continue to stay with them. I strongly believe that MDA National is not just about providing expert 24/7 medico-legal advice, but is also an organisation that has its Members' best interests at heart. The health and wellbeing of doctors is paramount to them. My experiences, both as a Member and Ambassador for MDA National, have given me great insight into how much support they truly provide for their Members.

Dr Ghassan Zammar, Perth, WA

Prescribing Medicinal Cannabis

On 1 November 2016, following a decision by the Therapeutic Goods Administration (TGA), medicinal cannabis became a controlled drug (Schedule 8) in the Poisons Standard. As a result, medicinal cannabis can be prescribed. However, the reality is that prescribing cannabis is no easy feat, and medical practitioners will need to be guided by legislative requirements at a state or territory and federal level.

All states and territories have adopted the national scheduling changes, except for the Northern Territory which remains silent on the issue. At a federal level, medical practitioners will need to obtain TGA approval before prescribing medicinal cannabis in addition to complying with the prescribing requirements of their state or territory.

Medical practitioners will have to present clinical evidence in support of their applications to prescribe medicinal cannabis. Queensland's clinical guidelines shed some light on possible clinical indications for use that might be approved.[1] These include drug-resistant epilepsy, symptom control in palliative care, symptoms associated with multiple sclerosis, chemotherapy-induced nausea, and vomiting and pain management.

Here is a step by step guide to apply for approval to prescribe medicinal cannabis.

Step 1: Determine your state or territory prescribing requirements

See the table on the right.

Step 2: Apply for TGA approval

Australian registered medical practitioners can apply to the TGA to access cannabis products in the following ways:[2]

- Access for individual patients through either the:
  - Authorised Prescriber Scheme
  - Special Access Scheme (category B)
- Access as part of a clinical trial.

Authorised Prescriber Scheme

To be an Authorised Prescriber, the medical practitioner must:

- have the training and expertise appropriate for the condition being treated and the proposed use of the product;
- be able to best determine the needs of the patient; and
- be able to monitor the outcome of therapy.

An Authorised Prescriber is allowed to supply the product directly to specified patients under their immediate care and not to other practitioners who prescribe or administer the product. Once a medical practitioner becomes an Authorised Prescriber, they do not need to notify the TGA when prescribing the unapproved product. However, they must report to the TGA the number of patients treated on a six-monthly basis.

Special Access Scheme (SAS)

The SAS refers to arrangements which provide for the import and/or supply of an unapproved therapeutic good for a single patient, on a case-by-case basis. Patients are grouped into two categories under the scheme:

- Category A patients are defined as "persons who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment".
- Category B patients are all other patients who do not fit the Category A definition.

Clinical trial

The state or territory legislation and the TGA Act apply to clinical trials of medicinal cannabis. If you wish to conduct a clinical trial using medicinal cannabis:

- make sure that medicinal cannabis is not a prohibited substance in your state or territory
- obtain approval from a Human Research Ethical Committee
- notify the TGA (clinical trial notification scheme) or apply for approval (clinical trial exemption scheme).

Step 3: Apply for a licence and permission to import, if necessary

At present, legally produced medicinal cannabis products are not readily available for use in Australia and must be imported. Once an Australian registered medical practitioner has obtained approval (under the applicable state or territory laws) to prescribe a medicinal cannabis product to a particular patient, the medical practitioner can apply on the patient's behalf for approval to import and supply these products through the SAS. Alternatively, the medical practitioner can apply to the TGA to become an Authorised Prescriber, and approval or authorisation is granted on a case-by-case basis.

Once approved, the medical practitioner wishing to import the product will then need to obtain import permits from the Office of Drug Control.

Step 4: Comply with conditions of approval or authorisation and ongoing regulatory requirements

Each state and territory has its own ongoing prescribing requirements. Members can contact our Medico-legal Advisory Service for further information regarding ongoing regulatory requirements.

John Vijayaraj
Medico-legal Adviser
MDA National

Medicinal cannabis – state and territory prescribing requirements

New South Wales *health.nsw.gov.au*	To prescribe medicinal cannabis, the medical practitioner must hold an authority issued by both the Secretary NSW Health to prescribe that product for that particular patient and the Secretary, Commonwealth Department of Health to import and/or supply that particular product under the Commonwealth's Special Access Scheme, Authorised Prescriber Scheme or Clinical Trial Scheme.
Queensland *health.qld.gov.au*	The pathways by which a medical practitioner may access medicinal cannabis to facilitate treatment include the following: • clinical trials – a medical practitioner can be an investigator on a clinical trial using a specific medicinal cannabis product • a single-patient prescriber, on a case-by-case basis – the medical specialist applies to Queensland Health for approval to prescribe • a patient-class prescriber pathway is still being developed – a specific class of specialist medical practitioners authorised to prescribe a specified medicinal cannabis product. In addition to the state pathways, TGA approval is required to authorise the supply of a specific medicinal cannabis product to be used for treatment. This is actioned through the Special Access Scheme (Category B) or the Authorised Prescriber Scheme administered by the TGA.
Victoria *health.vic.gov.au*	Children with severe intractable epilepsy will be the first group of eligible patients in Victoria. Eligible patient groups may be expanded in the future on the advice of the Independent Medical Advisory Committee which will consider all available evidence when advising on eligible conditions, symptoms, and medicinal cannabis products appropriate for their treatment. Alternative pathways for treatment are those enabled by the TGA.
Australian Capital Territory *health.act.gov.au*	In order to prescribe cannabis as a controlled medicine, medical practitioners should obtain authority from the ACT Chief Health Officer (CHO) under the same process which currently applies for other controlled medicines, such as opiates and amphetamines. Only registered medical practitioners can apply for an authority to prescribe a controlled medicine for one of their patients. Prescribers should also obtain approval from the TGA before applying to the CHO for authority to prescribe medicinal cannabis.
Northern Territory	No information is available.
Western Australia *health.wa.gov.au*	The Schedule 8 Medicines Prescribing Code governs the prescribing of Schedule 8 medicines in WA. To prescribe medicinal cannabis, a practitioner must apply to the WA Department of Health to become an approved prescriber. Prescribers authorised for cannabis-based products may prescribe without seeking individual authorisation as long as prescribing is in accordance with the Code. Prescribing authorised within the Code includes: • products registered with the TGA • prescribing for the approved TGA indication • prescribing by a specialist in the relevant field.
South Australia *sahealth.sa.gov.au*	Authorised medical practitioners can legally prescribe medicinal cannabis products with Commonwealth approval. State approval is only required for treatment longer than two months, or before commencing treatment where the patient is already prescribed a Schedule 8 drug (for a period exceeding two months) and for any patient the medical practitioner reasonably believes to be drug dependent. A specialist medical practitioner may apply for approval to prescribe medicinal cannabis when the patient has tried conventional treatments and these have failed, and there is some clinical evidence that the benefits of using medicinal cannabis outweigh the risks.
Tasmania *dhhs.tas.gov.au*	The Controlled Access Scheme (CAS) will allow authorised medical specialists to prescribe medicinal cannabis products to their patients in certain circumstances. The CAS will impose conditions to ensure safety, including review of applications by a skilled panel of specialist medical practitioners.

1 Vijayaraj, John. Queensland Releases Australia's First Medicinal Cannabis Guidelines. Available at: mdanational.com.au/resources/blogs/medicinal-cannabis-guidelines-qld.

2 Medicinal Cannabis Products: Overview of Regulation. Available at: tga.gov.au/medicinal-cannabis-products-overview-regulation.

The Queensland Medical Orchestra

What I Learnt from Music

I remember feeling confused as a 17-year-old when my parents told me to apply for medicine and to forget about my beloved music scholarship. So now, recalling the tears, tantrums and sacrifices I had made for music during my childhood, I recently asked my mother, "So why did you spend all that money and effort on my musical education?" She simply smiled and said, "Where would you be today, if you hadn't learnt music?"

Practice, theory and more practice

It all began when I started on the piano at the age of six. Practice was the last thing I wanted to do. But after multiple tantrums and spending half of my piano lessons in the naughty corner, I learnt that sometimes there were things I had to do even if I didn't feel like it.

Before my fourth grade flute exam, I was told to learn my music theory about the pieces I was presenting. With the conceit of a nine-year-old, I decided my playing would speak for itself and demonstrate my immense musical talent! Needless to say, the report taught me that the difference between a distinction and a credit was in knowing the musical principles and basic foundations.

A lesson in humility

The biggest catastrophe happened when I was 12 and invited to play in a recital. As I had performed these pieces many times by memory, I left my music book at home. Midway through my performance, I looked down at the keyboard and, suddenly, I just could not recall what notes came next. The music came to a dead stop. I paid for my arrogance that day, as I stood up in the middle of a Bach Fugue, bowed to a silent audience and walked off the stage.

To make matters worse, I was also due to perform in the second half of the concert. My piano teacher found me curled up in a corner backstage, willing myself to be invisible. She gave me the option of leaving the concert. She also told me that if I didn't have the courage to stand up in front of those people again, I might as well retire from my performance career at the grand old age of 12. So I walked back on stage and played a complete Mozart Sonata from start to finish, without music. It was my first standing ovation.

Learning to accept criticism

As a belligerent 14-year-old, I was introduced to a public piano masterclass with a world-renowned pianist from Europe who was infamous for his bad temper. I was frustrated with him stopping me every few notes to correct what I considered to be minor points. The masterclass ended with me slamming the piano lid, and Albert announcing to the observers that he had never heard anyone massacre Chopin as brutally as I did. Two weeks later, I learnt that my piano teacher had called in favours to get me into the masterclass, and my shameful behaviour reflected badly on her as a teacher. Also, listening to my mother's recording of the session, I realised all the little changes he made me do completely transformed my performance.

Nothing beats hard work

At 16, as part of a national competition, I had to perform music by Rachmaninov – a composer famous for his abnormally large hands. For my size 6 surgical-glove hands, playing his music was physically impossible. That's when I discovered that "impossible" could be overcome by finding alternative ways to play eight notes concurrently over four octaves. And that the only way to perfect a technique was with hours of practice. In the end, nothing else but hard work, determination and tenacity got me the dream scholarship I thought was out of my reach.

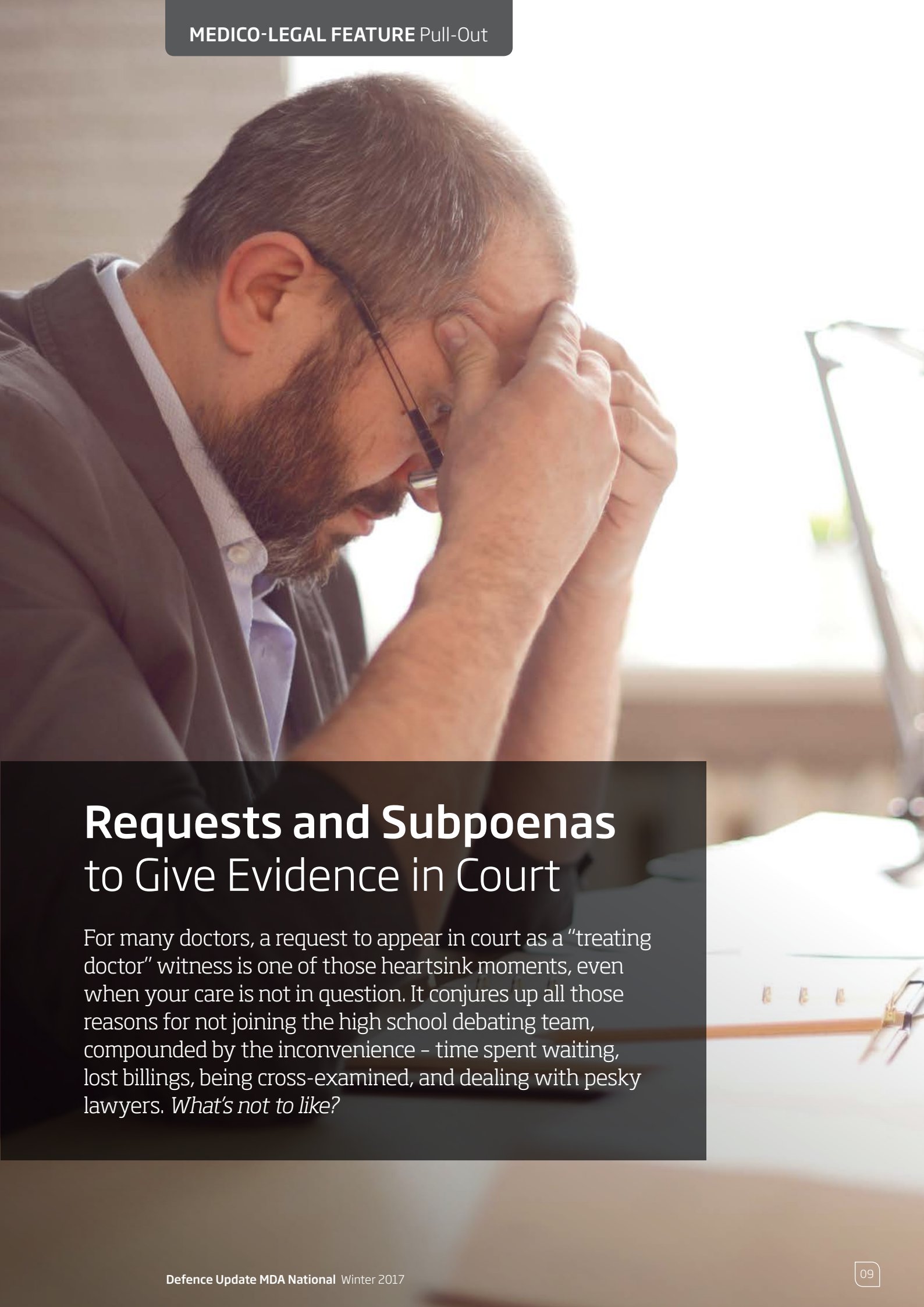
Connecting the dots between music and medicine

Growing up with music was more than just reading black dots on lines. It has taught me discipline, humility, diligence, insight, initiative, integrity, and perspective – to name just a few. These are qualities that have guided me throughout my surgical training and career, and I'm sure it's no coincidence that I was drawn to plastic and reconstructive surgery, a creative and artistic specialty.

Mother was right. I would not be where I am today, if I hadn't learnt music.

Dr Lily Vrtik (MDA National Member)
Plastic & Reconstructive Surgeon
Brisbane, Queensland

Dr Lily Vrtik is a flautist in the Queensland Medical Orchestra (QMO). She is also QMO's Marketing Manager.



Requests and Subpoenas to Give Evidence in Court

For many doctors, a request to appear in court as a "treating doctor" witness is one of those heartsink moments, even when your care is not in question. It conjures up all those reasons for not joining the high school debating team, compounded by the inconvenience – time spent waiting, lost billings, being cross-examined, and dealing with pesky lawyers. *What's not to like?*

Requests and Subpoenas to Give Evidence in Court

You can minimise lost costs and precious time by properly managing requests to appear in court. Understanding the process can make it more likely that you won't have to appear, and less stressful if you do. Seeking early advice is important.

Request versus subpoena

Our general recommendation is for a doctor to attend by way of subpoena* to give evidence rather than a voluntary request. In civil matters this may assist in recovering the costs of appearing.

A request to appear in court is voluntary. It does not compel you to attend, and you can decline. It will be up to the lawyer to consider whether they will issue a subpoena. However, if you fail to appear after you have voluntarily agreed to do so, the lawyer may lodge a complaint with the Medical Board or you may be subject to an adverse court order (e.g. for costs). You might then be subpoenaed to give evidence in any event.

Doctors should carefully consider issues such as availability and fees for appearance before they voluntarily agree to appear (see below). If you are attending voluntarily at the request of a party other than your patient, you must not breach your legal and professional duty of confidentiality, and should not agree to give evidence without prior patient consent.

Subpoenas compel attendance. When giving evidence in court, a subpoena overrides your duty of confidentiality. If you fail to comply with a subpoena, a bench warrant can be issued, and you can be arrested and taken into court.

A request or subpoena does not mean you will need to appear

Many court matters are settled or withdrawn prior to a hearing. Dates may be moved because of delay, necessitating another subpoena. The need for a specific witness or a particular line of questioning may change. So while lawyers attempt to "lock in" all potential witnesses in advance, not all will be called. Our anecdotal experience is that only a small number of doctors who receive subpoenas to appear are eventually required to give evidence in court, but it is impossible to predict this in advance. The courts will generally try to accommodate a doctor's availability within the hearing dates.

* subpoena is used in this article to refer to any order to attend court, such as a summons.

How can I improve my chances of not appearing?

Generally, this is outside your control. However, a poorly drafted police statement or report may create an issue that needs to be determined in court. Seeking MDA National's assistance with drafting police statements or reports may reduce your likelihood of appearing in court. If you are able to identify what information is going to be sought from you, an offer to clarify this by way of statement may reduce the need for you to appear.

I have received a request to appear - what do I do?

Most importantly, do not ignore the request and do contact the requesting party. Given that the latter may be negotiating appearance dates and times with you, it pays to remain civil and keep communication lines open. Lawyers are only trying to do their job, and most are mindful of the disruption and inconvenience caused.

You may need to seek advice from MDA National, if appearing in court is something you are not familiar with.

Consider the following

- Note the least convenient dates and times, e.g. procedural days may incur greater income loss. A range of available dates will make scheduling easier.
- Narrow down the timeframe of your appearance (morning, afternoon or a specific time) and see if you can give evidence by phone, video-link or on standby (if you are located close enough to the court to attend at short notice).
- Provide the requesting party with a contact number to reach you if the matter is delayed or resolved.
- Find out what else you should bring with you (e.g. clinical notes; any reports you have provided; a CV; anything else?) and what documents will be available to you.
- Enquire about the relevant issues and what you are likely to be asked in court. Remember that discussing patient care outside of court is limited by confidentiality. Consider whether you might be able to resolve these issues in advance by provision of a report.
- Contact the subpoenaing party a few days before the hearing to check on any last minute changes.

Sample letter

Responding to a request to appear in court

Dear [ ]

Re: [details about the request to appear]

I write in response to the above request indicating that I may be called to give evidence [when].

It is my practice to only attend court pursuant to a subpoena. The least inconvenient days to appear are my practice days (Monday to Thursday). I would prefer not to be called on theatre days (Fridays). I am overseas from 1-21 April 2017 inclusive.

My appearance in court will mean that I am incurring costs and/or forgoing earnings in complying with the subpoena, which I am otherwise unable to recoup. These costs will not be covered by the conduct money provided. Therefore it will be necessary for me to charge for my time and these costs vary depending on the day.

My cost estimates (based on my average patient billings) are as follows:

My half daily [or hourly] rate for practice days is	$ amount
My half daily [or hourly] rate for theatre days is	$ amount

[You may have to provide objective evidence in support of the basis of this rate, e.g. average net hourly rate after costs; AMA guide; WorkCover guide]

My limited ability to rebook patients or work at short notice means that I would also require reimbursement for cancellation to appear at short notice (less than five business days). My cancellation fees (per half days of expected appearance) are:

Cancellation fee less than 3 business days prior, per half day	$ amount
Cancellation fee 3-5 business days prior, per half day	$ amount

Appearance in court results in a significant disruption to my practice, colleagues and patients, particularly because of the need to cancel or postpone consultations and the inconvenience to those who have to take over my patient care arrangements.

Could you kindly keep me up to date with any developments regarding my appearance so I can make the necessary arrangements to help minimise costs for your client.

I await further correspondence regarding confirmation of my court attendance.

Kind regards
Dr [ ]

Recovery of your lost costs

Conduct money

The subpoena should come with conduct money, a nominal sum to cover basic travel expenses. Contact the subpoenaing party if long distance booked transport or accommodation is required. You may also be entitled to nominal daily witness appearance fees. Ensure you keep receipts.

Criminal matters

If you are subpoenaed to appear in a criminal matter, you may not be able to recover lost income (but the question is still worth asking!). It is seen as a "civic duty". Employed doctors may be able to negotiate being paid by their employer if the matter arises from their workplace. Public prosecution departments will usually book your long distance travel or transport arrangements upon request.

Civil matters

In civil matters (one party suing another), you should carefully consider and prepare for recovery of any reasonable loss or expenses incurred in complying with the subpoena, including the possibility of cancellation at short notice. You can negotiate cost arrangements with the subpoenaing party in advance, but ensure this is agreed in writing. Disputes over cost recovery may require you to submit an application to the court, including supporting evidence. This submission will usually require some evidence of your actual costs (lost opportunity or incurred), and how they have been calculated.[1]

Calculating rates

The AMA, your college, WorkCover guides and your colleagues may be able to provide a guide as to an appropriate hourly or daily rate for a court appearance. Alternatively, use a tally of the actual income you would have earned, including costs, to calculate a rate (court appearances are not generally GST exempt). Consider cancellations to appear at short notice (your unavoidable opportunity costs that you can't recover – can you take on patients at short notice?). Detail what your cancellation costs will be with the appropriate notice times.

Dr Julian Walter
Medico-legal Adviser
MDA National

1 *George v Biggs & Anor* (No. 2) [2015] NSWDC 43. Available at: caselaw.nsw.gov.au/decision/552df7b8e4b0fc828c995c33.

Your Day in Court

So this is it, your day in court.

The experience can be very stressful, especially to first-timers. The most important point to remember is that *you* are not on trial – you are just a conduit for information to be provided to the court for their decision-making.

Your duty to the court

Your overriding duty is to the court, not your patient or another party. You will be asked to swear an oath (a religious-based declaration) or affirmation (non-religious) on the truth of your testimony. Failure to tell the truth can result in perjury charges. Under subpoena,* your duty of confidentiality is overridden by your duty to the court.

You should also be familiar with the documents you have brought or are expecting to discuss. You can request a copy of documents tendered to the court to be provided to you while giving your evidence.

Responding to questions

You may be asked questions by all parties, in turn, usually put to you by the barrister representing the party. Occasionally, you will be questioned directly by self-represented parties (more commonly in family court matters). Be courteous and listen. Sarcasm, denigration and anger have no place. Barristers are skilled at what they do and provoking you may be part of their plan. If there is an objection, stop what you are saying and wait for the court's direction.

Listen carefully to the question and consider what is being asked before responding. Get the barrister to rephrase convoluted and lengthy questions. Avoid being overly helpful or wandering off the topic. The lawyers will ask more questions if you haven't provided enough information. Don't try to second guess where the questions are heading.

Cross-examination can be daunting. Your credibility may be tested. Closed ended (yes/no) questions may be asked. You can seek court direction if the question cannot be safely answered with yes or no. Just because you are repeatedly questioned on a point does not mean your position is wrong – it might just be inconvenient for that party.

Only answer what is asked and as simply as possible.

Q: "Do you have the time?"

A: "Yes" (as doctors, we may want to say, "Yes, it is quarter to four on Monday 1 December")

Giving opinions as a "fact witness"

Treating doctors are usually being called as a witness of fact which involves describing what you observed and experienced, based on your recollections and records. Try to specifically differentiate sources of information (e.g. "the patient said"; "the police officer informed me"; "the hospital discharge summary indicated") if you did not directly observe what you are discussing.

Because of their professional training and experience, doctors can offer opinions within their areas of expertise. Where you are asked for an opinion, you are not compelled to provide one, and there may be good reason not to (so don't guess). Opinion evidence may be quite contentious and lead to further cross-examination.

Consider these points before responding:

- Do you have sufficient facts on which to form an opinion – "I would need to know … before answering"
- Do you have appropriate expertise to give an opinion – "I don't have the relevant expertise to answer that"
- Has your opinion changed – "At the time my opinion was … however based on [additional facts; further consideration; further learning and development] my opinion is now that …"
- It may be that a more balanced opinion should be provided by someone objectively independent and impartial to the patient's care, particularly if it will affect ongoing care.

Dr Julian Walter
Medico-legal Adviser
MDA National

* subpoena is used in this article to refer to any order to attend court, such as a summons.

Developing Doctors of the Future

Medicine is an ancient profession with a rich history of training the next generation. The first statement in the original Hippocratic Oath deals with how the profession should be passed on. Indeed, the etymology of the word "doctor" is not carer or healer, but teacher.

In more recent times, however, our noble profession has been dogged by bullying, an under-supported junior workforce, and a growing problem with anxiety, depression and suicide amongst doctors in training. These problems, along with our modern culture and advanced, subspecialised medicine forces us to ask the question: *What is the best way to develop junior doctors into highly competent, resilient and compassionate individuals with high levels of career satisfaction and work-life balance?*

Making mentoring the norm in medical training

Perhaps I am naïve in thinking it's possible to address all aspects through one training method. And yet, I also think the failure to account for each of these aspects has become the downfall of our current training methods. Though in recent times medical training has made some important gains, becoming "competent" by being thrown in the deep end without a proper safety net is still too common.

Becoming "resilient" seems to be more about survival of the fittest – where we let the ones who "haven't got it" burn out, whilst the others become jaded and cynical. And what of career satisfaction and work-life balance? Those concepts seem diametrically opposed to each other, where career satisfaction seems to require being married to the job, too often at the expense of one's personal life.

One solution is to make mentoring a normative part of medical training. Corporate business has been doing this effectively for years. If we want to train the next generation of doctors, we must invest in them. Because mentoring is by definition personalised, it offers tailored training and advice to develop doctors in accordance with their needs.

Three pillars of mentoring in medicine

I would like to suggest three pillars that mentoring in medicine must be built upon in order to be effective.

1. **Mentoring should be *intentional***. Occasionally, two people will fall into a great mentoring partnership based upon personal chemistry and shared experience. But if we left mentoring to these chance encounters, it would not become the norm. Intentional mentoring occurs when mentoring is on the training agenda of those providing the training and those being trained. Potential mentors are seeking out mentees, and mentees seeking out mentors.
2. **Mentoring should be *goal-directed***. Too many promising mentoring partnerships do not reach their potential because there are no goals or expectations set at the beginning, or these are not followed through. This is not to say mentoring is not flexible; the personal nature of it makes it the most flexible of all doctor development methods. But a change in direction for the partnership necessitates new goals to be formed.
3. **Mentoring should be *trainee-focused***. Of course, the mentor will also derive some benefit from the partnership, but the primary focus is on the development of the trainee. The trainee must be heavily involved in identifying their needs and setting goals with the help of the mentor. The mentor is not there to make a "mini-me", but to help the mentee become the best doctor they can be.

Mentoring is not a panacea for medical training

When done correctly, mentoring is intensive and time consuming. However, in most hospitals and practices in Australia, we already have the infrastructure present to implement it properly. Institutionally, this can take the form of either formal mentoring programs at the commencement of the training year or, alternatively, leveraging the existing educational supervisor roles that exist in most training programs.

I strongly believe that making mentoring the norm in medical culture and training would do much to address the challenges we face, both now and into the future.

Dr Joel Wight (MDA National Member)
Haematology Research Fellow
Melbourne, Victoria

Dr Joel Wight has recently co-authored ***The Intentional Mentor in Medicine***, a toolkit for mentoring doctors, with Dianne Salvador (a medical education officer with a background in psychology).

MDA National Members are eligible for a 30% discount on individual purchases of the book, using the discount code available at **https://www.intentional-mentor.com/mda-national-member-order-form**. Further discounts are also available on bulk purchases of 10 or more.

Hydromorphone is approximately 5-7 times more potent than morphine. Care needs to be taken to ensure that prescribing and administration risks are minimised.

Hydromorphone – The Subject of Safety Alerts

What is hydromorphone and why has it been the subject of three safety alerts in the last seven years? The discussion below is relevant to all clinicians who are involved in the care of patients who are prescribed hydromorphone.

A fatal iatrogenic overdose

On 26 October 2016, the NSW Deputy State Coroner handed down findings in a matter involving the opioid drug hydromorphone and the tragic death of a patient following an iatrogenic overdose.[1]

Unfamiliarity with the drug and inadvertent calculation and administration led to nurses substituting morphine for hydromorphone on one occasion, then a nursing drug calculation error on another. The patient died following the administration of a dose of hydromorphone that was ten times the prescribed dose.

Similar circumstances were explored in an inquest in 2011 into the death of Rishi Deo Maharaj (2011/388777) and also in overseas cases. Following the release of findings, on 10 January 2017, NSW Health released their first Safety Alert for 2017 concerning the use of hydromorphone (SA001/17).[2]

This follows a similar alert in 2011 (SA004/11)[3] and 2010 (SN011/10).[4] NSW Health classifies hydromorphone as a High Risk Medicine, subject to a specific policy.[5] The NSW Clinical Excellence Commission had also previously released recommendations.[6]

What is hydromorphone?

Hydromorphone[7] (trade name Dilaudid, long-acting tablet Jurnista[8]) is a semi-synthetic opioid narcotic that comes in both long and short acting tablets and injectable forms.

Importantly, hydromorphone ampoules come in "normal" and "high potency" concentrations:

- Normal – Dilaudid **2mg/ml** as 1ml ampoule
- High Potency (HP) – Dilaudid-HP **10mg/ml** as 1ml, 5ml, or 50ml ampoule.

Hydromorphone is approximately 5-7 times more potent than morphine. It has a similar risk profile to other opioids, although there is some preference for use in patients with renal failure.[9]

Why the recurrent safety alerts and safety standards?

Hydromorphone has a number of features that mean fatal errors are more likely than other opioids.

Confusion over the name

US (2007)[10] and Canadian (2013)[11] data suggests that morphine/hydromorphone was the most commonly reported drug pair error (look alike, sound alike pairs). This is presumably because of an incorrect assumption that the similar names indicate hydromorphone is a trade name for morphine. There is also risk in verbal orders where the recipient incorrectly transcribes the wrong drug.

Substitution errors

Substitution errors involving hydromorphone and morphine are well recognised.[12] Because morphine is 5-7 times less potent, substitution with hydromorphone at the same dose may result in a fatal overdose.

Conversely, morphine substitution for hydromorphone may falsely suggest that analgesia is insufficient, or opioid toxicity (respiratory depression) is not an issue, leading to an increase in the drug dose – potentially fatal when the correct drug is subsequently administered.

Potency errors

Hydromorphone ampoules come in high potency (10mg/ml) and normal (2mg/ml) concentrations. The differing concentrations can lead to fatal errors.

Conversion errors

When performing the conversion between hydromorphone and other opioids,[13] it is easy to make an error.

Calculation and administration errors

When calculating volumes of hydromorphone to be administered, care needs to be taken to identify which concentration of the ampoules are to be used – HP (10mg/ml) or normal (2mg/ml). Confusion between the two concentrations results in a fivefold increase or decrease in dose.

The HP preparations (typically used for infusions) should be avoided for intermittent patient injections, given the inherently tiny volumes that will be required – for example, 0.5 mg hydromorphone (bio-equivalent to 2.5 mg morphine) will require drawing up a tiny 1/20th (0.05) ml if using the HP preparation.

Unfamiliarity

Hydromorphone's unfamiliarity among prescribers and those dispensing and administering the drug compounds the risk of error.

Avoiding errors

As noted in the NSW Health alerts and other advice,[11] in addition to education to increase familiarity with the drug,[14] specific steps are recommended to reduce errors:

- Label prescriptions with the trade name (Dilaudid; Jurnista).
- Emphasise that it is hydromorphone with tall man lettering (HYDROmorphone).
- Where possible, avoid stocking the HP ampoules on wards and ensure it is not mixed with the lower concentration ampoules.
- Indicate the parenteral concentration where possible (2mg/ml or 10mg/ml). If the HP version is intended, indicate this (HYDROmorphone HP (10mg/ml)).
- Have clear policies and calculation guidelines specifically for HYDROmorphone (e.g. standard volume/prescription charts).
- Consider limiting starting doses of HYDROmorphone to 0.5mg or less (especially for opiate-naïve patients or those with concomitant risk factors).
- Consider limiting access to prescribing to certain clinical specialties or level of seniority.

Conclusion

Tragically, the findings demonstrated that almost every one of the possible hydromorphone systemic risks, as discussed above, occurred in the 2016 NSW case. It is a salient reminder that if things can go wrong, they almost certainly will – with potentially fatal outcomes for patients, tragic impact on their families, and serious consequences for hospitals and staff.

Hydromorphone does have a place in clinical medicine, but care needs to be taken to ensure that prescribing and administration risks are minimised.

Dr Julian Walter
Medico-legal Adviser
MDA National

For a full list of references visit **defenceupdate.mdanational.com.au/hydromorphone-safety**.

CaseBook

Termination of Pregnancy – A Question of Capacity

Case history

Fay, 19 years of age, was suffering from severe pre-eclampsia, with associated renal failure requiring haemodialysis. She was 22 weeks pregnant and, despite six anti-hypertensive agents at high dosage, Fay's blood pressure could not be controlled and her condition was deteriorating.

The treating team believed that Fay was at high risk of suffering a stroke or seizures, and there was a 10% chance of death if her pregnancy continued. They recommended a termination of pregnancy to enable effective control of her pre-eclampsia. Although her foetus had been progressing relatively normally, it would not survive birth.

Fay refused to accept the advice, and her mother agreed with this decision. Fay had an intellectual disability and the treating team were of the opinion that she did not have the requisite capacity to reject the termination of pregnancy.

Medico-legal issues

The hospital initially made an application to the Guardianship Division of the NSW Civil and Administrative Tribunal (NCAT) which could have permitted the termination of pregnancy to be performed. The treating Obstetrician and Renal Physician provided supporting evidence, along with a report by a Psychiatrist which concluded that Fay was unable to understand her medical condition and weigh up the various treatment choices. NCAT dismissed this application.

The hospital then made an application to the Supreme Court, under its *parens patriae* jurisdiction,[1] that the termination of pregnancy could lawfully be performed by the hospital's staff. The judge conducted an urgent hearing at Fay's bedside on a Saturday morning. Evidence was given by Fay and her mother, who opposed the proposed treatment. Independent expert reports by an Obstetrician, Renal Physician and Psychiatrist were considered, in addition to reports by the treating Obstetrician and Renal Physician.

The judge concluded that Fay did not adequately understand, nor was she capable of balancing or making an informed decision to refuse the recommended termination of pregnancy. He also expressed concern about the influence of Fay's mother on her decision-making. The decision was handed down late on the Saturday evening, when Fay's condition worsened, allowing the termination of pregnancy.[2]

Discussion

An adult is presumed to have the capacity to consent to, or refuse, any medical treatment unless or until that presumption is rebutted.

To demonstrate decision-making capacity, a person will be able to:

- **understand the facts of the situation**
- **understand the main choices available**
- **weigh up those choices, including benefits and risks**
- **make and communicate the decision**
- **understand the ramifications of the decision.**

The "flip side" of the expectation that patients will provide consent for medical treatment is that there is no obligation on capable adult patients to undergo recommended treatment, even if that decision ultimately results in their death.

A question about capacity may arise when a patient refuses treatment which the treating team believes is in the patient's best interests. Indeed, it is worth considering in this case whether the issue of Fay's capacity would have arisen if she had consented to the termination of pregnancy.

Some commentators have suggested that the capacity to refuse a particular treatment may differ from that needed to consent to it, particularly where refusal involves a high risk and a low benefit, but the risks of treatment are low with a high probability of benefit.[3]

For more information on how to assess capacity, see the medico-legal pull-out feature "**Assessment of Capacity**" in MDA National's *Defence Update* Spring/Summer 2015 (pages 9-12). Available at: **defenceupdate.mdanational.com.au/articles/assessment-of-capacity**.

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

1 The *parens patriae* jurisdiction is protective in nature and requires the Court to act in the manner of a wise, affectionate and careful parent for the welfare of those persons who cannot look after themselves.

2 Application of a Local Health District: *Re a Patient Fay* [2016] NSWSC 624.

3 Collier B, Coyne C, Sullivan K. Mental Capacity: Powers of Attorney and Advance Health Directives. Sydney: The Federation Press, 2005.

CaseBook

Prescribing for Self and Family – What Could Go Wrong?

A recent decision in the NSW Tribunal[1] found a doctor guilty of professional misconduct, reprimanded and ordered to undergo medical ethics education and mentoring by a Psychiatrist because she treated her family members.

Case history

The doctor provided prescriptions to her two adult children and husband. She also self-prescribed by issuing scripts in her husband's name for medications which she consumed. The prescribing spanned five years. The doctor failed to maintain records of the prescriptions, or records of any kind.

The doctor attributed her conduct to the chaos and stress that existed in her home life during the time of her misconduct, and a misplaced sense of duty as a mother to meet the needs of her family. She felt obligated to assist her children and her husband in whatever way she could under very stressful circumstances.

One of her daughters had received treatment for a variety of addiction, mental health and other problems. Although the Tribunal found that the prescriptions to family members were issued in quantities and frequencies that fell within normal parameters, it was considered improper for a doctor to treat and prescribe medicines to family members, other than within narrow limits such as emergency or necessity.

Discussion

The Medical Board of Australia's Code of Conduct for Doctors in Australia states:

Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient.

Difficulties may arise for both parties in traversing sensitive matters, or for the patient in making frank disclosures in relation to intimate matters such as private behaviour, giving rise to special risks. The doctor who treats a family member may be affected by subjective emotions and views which hamper his or her ability to undertake a full investigation and give the best and most appropriate treatment. The doctor may be influenced by a desire to please the family member, and not upset that person.

Research suggests that it is common for doctors to be asked for medical advice by family members, and it may be useful to discuss the reasons why this is not advisable with your family.[2,3]

Summary points

- It is not advisable to treat family members, or yourself.
- If you need to provide care to a family member in an emergency, hand over your care to another doctor as soon as possible, and document your treatment.
- MDA National's Professional Indemnity Insurance Policy excludes cover for claims arising from elective medical treatment provided by a Member to their immediate family.
- State and territory legislation regarding prescribing for self and family varies significantly. However, S8 self-prescription is not generally permitted. In Victoria, S4 or S8 self-prescribing is NOT allowed under any circumstances.

Dr Jane Deacon
Medico-legal Adviser
MDA National

1 *Health Care Complaints Commission v BXD* (No. 1) [2015] NSWCATOD 134 (7 December 2015).

2 La Puma J, Stocking CB, La Voie D, Darling CA. When Physicians Treat Members of Their Own Families. Practices in a Community Hospital. *N Engl J Med* 1991;325(18):1290-4. Epub 1991/10/31.

3 Evans RW, Lipton RB, Ritz KA. A Survey of Neurologists on Self-treatment and Treatment of Their Families. *Headache* 2007;47(1):58-64. Epub 2007/03/16.

See the detailed prescribing table online at

defenceupdate.mdanational.com.au/prescribing-self-and-family

CaseBook

Allegation of Defamation

Case history

A number of concerns had recently been raised by staff about the conduct of the Head of Department (HOD). There had been questions about whether some of the procedures he performed were clinically indicated, and there had been difficult interactions with registrars and theatre staff.

A meeting was held between the other Visiting Medical Officers (VMOs) where the concerns were discussed with a view to deciding what action should be taken.

Two days after this meeting, one of the VMOs received a letter from solicitors acting on behalf of the HOD. The letter stated that the HOD had been informed that the VMO had made a number of false and defamatory statements about him at the meeting. The letter concluded:

We require you to:

- *immediately cease and desist from making false statements about our client*
- *inform each VMO at the meeting, in writing, that the statements you made about the HOD were false, and provide copies and proof of service of those letters to us*
- *offer an unreserved written apology to the HOD within two days.*

We inform you that if you do not undertake these steps, or you continue to make false and defamatory statements about our client, he will take legal action against you to protect his reputation and seek compensation for damages he has suffered due to your conduct.

Medico-legal issues

The VMO sought advice and support from MDA National. Following the discussion with our Member, a response was sent to the solicitors as follows:

We refer to your correspondence and please ensure any further correspondence is directed to the writer.

Dr Z has not made any false or defamatory statements about your client. Such behaviour is entirely at odds with Dr Z's interactions with his colleagues, including your client, and his commitment to patient care over many years of practice within the hospital.

Against this background, no correspondence will be sent to the VMOs who attended the meeting that contains the matters requested by your client. Nor will Dr Z provide an apology to your client, as he has not acted in a manner that requires him to do so.

The VMO received no further correspondence from the solicitors. The concerns about the HOD were provided to the Medical Director, and an investigation was commenced into his conduct.

Discussion

MDA National Insurance's Professional Indemnity Insurance Policy (PIIP) currently provides cover for defamation claims arising out of:

- Members reporting an incident or a registered healthcare professional to a hospital, area health authority or professional body, in good faith and in the public interest
- Members participating in the examination of such an incident or the registered healthcare professional.

Medical practitioners can also be the subject of defamation claims in their provision of healthcare services – which includes supervision; training and mentoring other healthcare professionals; providing a healthcare report or opinion; writing for healthcare journals; and providing advice on a person's fitness to carry out certain duties. We are committed to supporting our Members in these additional scenarios.

Effective 1 July 2017, the cover under the PIIP has been expanded to civil liability claims including legal costs arising from defamation by medical practitioners in the course of their provision of healthcare services, subject to certain terms and conditions.

The Policy will also cover legal costs for pursuing a defamation allegation against another person who is not a healthcare professional, if it arises from defamation of you as a medical practitioner or directly in relation to healthcare services you provide.

For further details about this cover, please refer to the *Supplementary Financial Services Guide (FSG) & Product Disclosure Statement (PDS) including Endorsement to the Policy Wording V.11* enclosed with your Renewal Notice, or contact our Member Services Team on **1800 011 255** or **peaceofmind@mdanational.com.au**.

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

What's On?

Educational Events – Complimentary for Members

We hope to see you at our upcoming education events. All activities below are recognised for continuing professional development with medical colleges.

24 June	Win-Win Conflict Resolution: Positive Communication in Hospital-based Clinical Teams **Perth, WA**
27 June	Complexities of Informed Consent Conversations **North Sydney, NSW**
22 Jul	Noteworthy: The How, What, Where and Why of Medical Documentation **Brisbane, QLD**
5 Aug	Practical Solutions to Patient Boundaries **Glen Waverley, VIC**
12 Aug	Practical Solutions to Patient Boundaries **Mandurah, WA**
26 Aug	*Broome Education Day* Noteworthy: The How, What, Where and Why of Medical Documentation Challenging Emotions of Difficult News **Broome, WA**
9 Sep	Practical Solutions to Patient Boundaries **Brisbane, QLD**
7 Oct	Anaesthetists' Think Tank **Sydney, NSW**
14 Oct	Anaesthetists' Think Tank **Perth, WA**

For more information or to register, visit **mdanational.com.au**, call us on **1800 011 255** or email **events@mdanational.com.au**.

We continually add education sessions to our events calendar. Avoid missing out – keep an eye on **Upcoming Events** at **mdanational.com.au**.

MDA National
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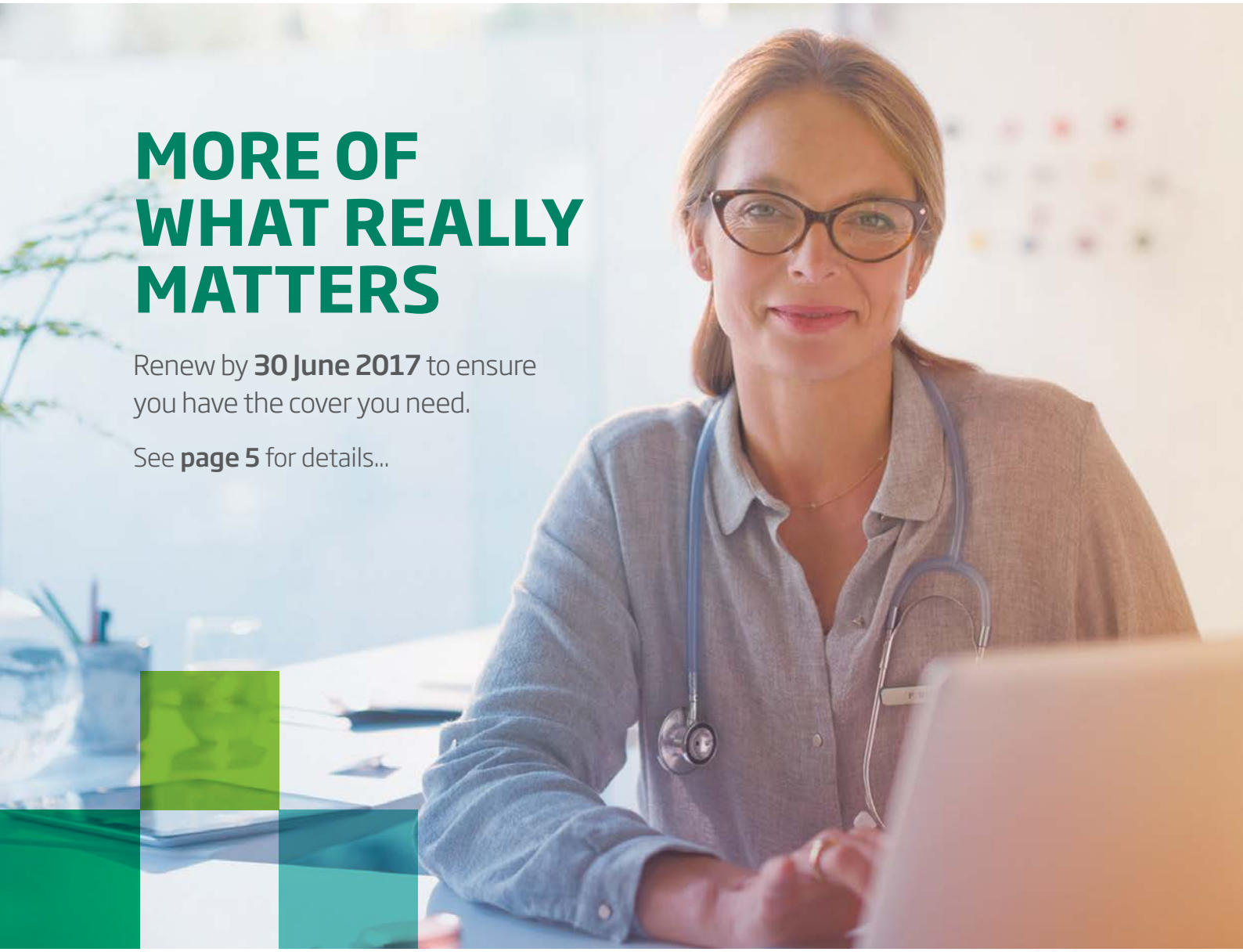

MORE OF WHAT REALLY MATTERS

Renew by **30 June 2017** to ensure you have the cover you need.

See **page 5** for details...

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