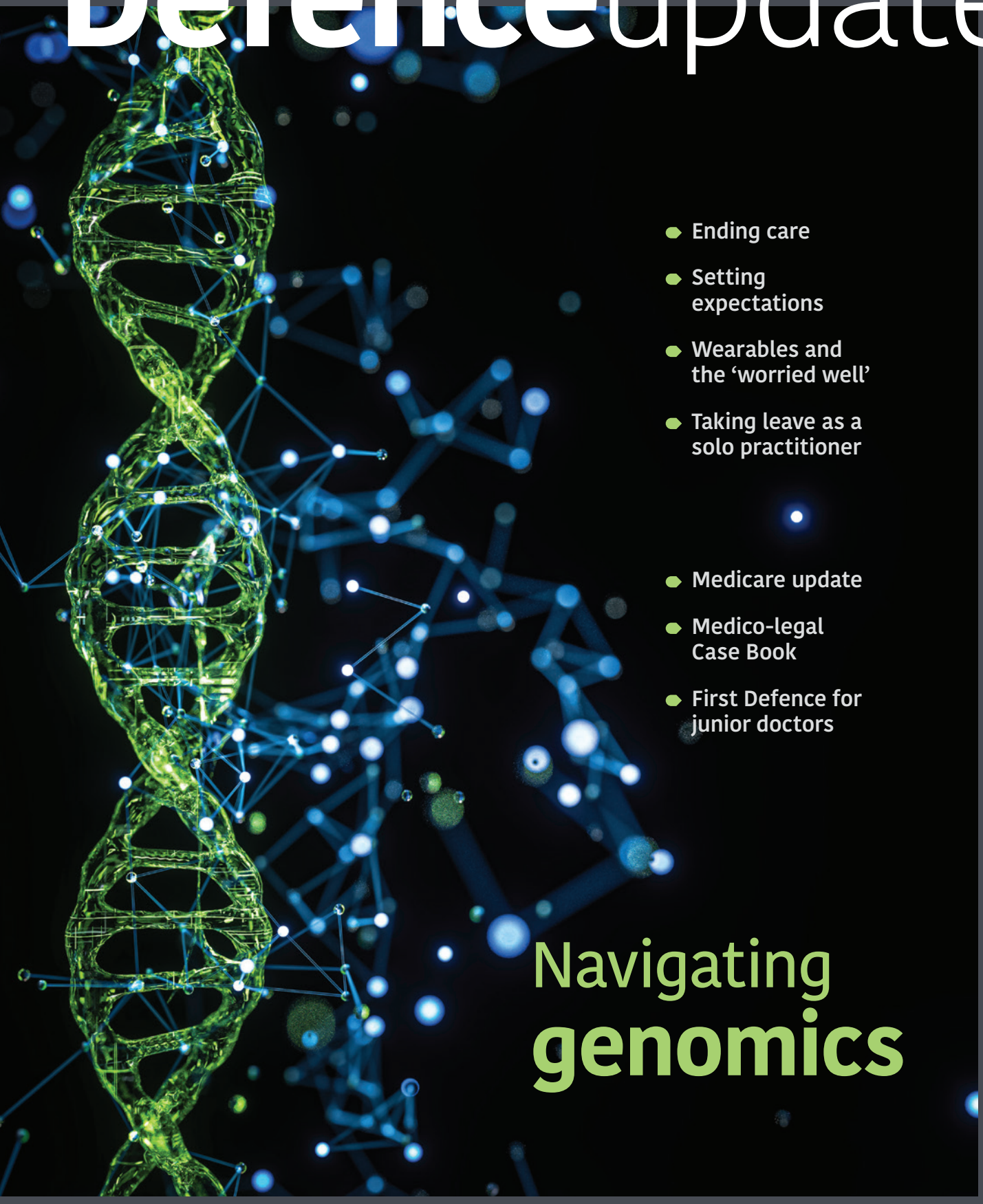
WINTER 2025

# Defenceupdate



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## Navigating genomics

Medico-legal content
**FOR MEDICAL PRACTITIONERS**

MDA National
*Trusted for Generations*
100 YEARS

**Nerissa Ferrie**
Manager, Advisory Services
MDA National

## Welcome to our Winter 2025 edition of *Defence Update*.

When I think about how much the medico-legal landscape has changed since I joined MDA National almost 17 years ago, it amazes me that 100 years ago our esteemed predecessors had the foresight to recognise the fundamental importance of protecting the medical profession. Our President, Dr Michael Gannon, welcomes our new CEO, Tim Plant, to the MDA National family – as they both reflect on this significant milestone (page 3-5).

I wonder what doctors a century ago would make of the challenges currently facing the profession, as technology outpaces our ability to prepare for unexpected and often unforeseen consequences. In this edition, I examine the positive and negative effects of wearable technology (page 8) while Dr Sarah Taylor navigates the minefield of genomics (page 18).

Not all therapeutic relationships are successful, and many stressed and worried Members call us for advice on how to best extract themselves from the doctor–patient relationship, and end care safely and appropriately. Our Medico-legal Feature (page 13) provides a snapshot for doctors and practices on why, when and how to end care.

Claims and complaints can arise when an entirely acceptable clinical outcome doesn't correspond with the patient's expectations. We provide some useful tips for setting realistic expectations (page 10) and explain how a well-timed gesture of goodwill can salvage the relationship with a disgruntled patient (page 22).

We love catching up with our Members, and I recently had the pleasure of interviewing Dr Bruce Willett, the 2024 recipient of the Rose-Hunt Award. A most deserved winner, Bruce has worn many hats throughout his medical career, and he has generously shared his thoughts on primary care and practice ownership (page 6).

In First Defence, we profile Dr Alecia Martin (page 24) who shares her views on the importance of humanitarian work and rural medicine, and the positive impact this has not only on the patients, but also on the doctors who are making a difference. Dr Marny Lishman tells us how to identify the early signs of burnout, and provides her expert advice for keeping burnout at bay (page 26).

We hope you enjoy our Winter 2025 edition of *Defence Update*, as we celebrate 100 years of MDA National with you – our valued Members.

# In this edition



### Membership queries?

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**1800 011 255**

**peaceofmind@mdanational.com.au**

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**We thank all our in-house experts and guest authors for their valuable contributions to this edition.**



# FROM THE PRESIDENT
## A message to our Members

**Dr Michael Gannon**
President, MDA National

Dear Members,

MDA National is celebrating 100 years of continuous service to Members. Our organisation has a lot to be proud of.

We are proud of our Members who continue to provide their patients with the highest levels of care and service. We stand behind those doctors who practise in a way that promotes evidence-based and patient-centred care. No matter how careful or diligent doctors are, many will eventually require our support and protection if dealing with a claim or investigation.

We are proud of our staff who have worked hand in hand with Members over the years, to build an organisation that now takes care of doctors throughout Australia.

It has been a great pleasure in recent months to work with Tim Plant, our highly respected CEO, who has brought all his insights and experience from the general insurance industry to MDA National. Tim has quickly built an understanding of the huge complexities of the healthcare system and medical care.

We are proud of our directors who came before us. I feel especially indebted to my colleagues at the old MDA WA who, in looking at the global trends and seeing the potential threats in and around our industry, became Australia's first claims-made medical defence organisation in 1997. This meant they started provisioning for matters that had occurred but not yet been reported, laying the groundwork for what has blossomed into a truly national organisation.

It was once elegantly put to me by my board colleague, A/Professor Michael Hollands, that when the indemnity crisis hit in 2000, MDA National was in a position to give doctors like him in New South Wales a choice of provider. That same crisis led to some other medical indemnity providers making a 'call' on their members equal to a full year's premium. Our younger Members should consider what it must have been like to pay double your premium – a potentially crippling expense for a solo private practice in some specialties.

We are proud of our greater contribution to the medical and wider community. We truly understand the two-way relationship between doctors' health and the stress of a medico-legal claim or investigation. We are proud to partner with Doctors' Health Advisory Services across Australia and sponsor Crazy Socks for Docs Day; and proud to sponsor BINAR Futures, an organisation creating a brighter future for Indigenous youth, recognising the relationship between playing sport and staying healthy.

Finally, I am proud of the forward-looking nature of our organisation. We are working on delivering the Connect Program, a business transformation and information technology project that will revolutionise the way we deal with our Members, making any interaction they have with the business more seamless. Doctors with expertise or experience in this area will know that no such project ever moves seamlessly – but the prudence of our previous boards and management have made us financially capable to undertake this important work.

On a personal level, I am extremely proud that this year I not only mark 30 years of continuous medical practice, but 30 years of MDA National membership. It is a huge honour to lead an organisation that has protected me throughout the highs and lows of my career.

We look forward to further sharing the story of our 100 years and celebrating with Members at functions around Australia later in the year.

Introducing MDA National CEO, Tim Plant

# Sowing the seed for the future

**A CENTURY OF SUPPORT.**
**A FUTURE DRIVEN BY PURPOSE.**
**TRUSTED FOR GENERATIONS.**

In 2025, MDA National proudly celebrates a rare and significant milestone: 100 years of supporting and protecting Australia's medical professionals.

From our beginnings in Western Australia in 1925 to our current position as a national organisation with over 46,000 Members and Insureds, we have always remained anchored to our purpose – to support and protect our Members, and promote good medical practice.

Now, as we look to the future, we're thrilled to welcome Tim Plant as our new CEO – a leader with deep roots in the insurance sector and a clear vision for the next chapter of our journey.

**Kylie Philippzig**
National Manager,
Corporate Affairs & Communications

With a strong track record in purpose-driven leadership and a passion for people, Tim sat down with us to share his vision for the future; what excites him about MDA National; and why our next 100 years is set to be just as extraordinary as our first!

> *This role felt like the right intersection of purpose and experience – and a chance to lead an organisation that is doing meaningful work every day. It's an opportunity to celebrate a century of care and to set the course for our future.*



> ***It's a privilege to lead this organisation into its next chapter and to ensure the legacy we've built only grows stronger with time.***

**Tim, welcome to MDA National! What inspired you to take on this role?**

Thank you, I'm really pleased to be here. MDA National is a unique organisation. We're a financially strong, reputable, service-led organisation – but more than that, we're purpose-driven. It's not just about providing insurance; it's about supporting our Members through prevention, education and timely advice, often long before a claim ever arises. That's meaningful work.

After spending decades in senior executive roles at companies like IAG, QBE, Zurich and Elders, I saw this as a special opportunity to lead a values-driven organisation that is genuinely focused on service and impact.

**What does it mean to you to be leading MDA National in its 100th year?**

I feel genuinely privileged to be joining MDA National at such a pivotal moment. It's a wonderful milestone for the business, and certainly worthy of celebration and reflection.

It's an opportunity to celebrate our past – our legacy of never making a call on our Members – while also setting the stage for the next century.

We're not just marking time; we're building something enduring.

**How has your past experience shaped your approach to leading MDA National?**

Having worked across several leading insurance and risk organisations, I understand both the technical and human side of our sector. I've led large teams, navigated complex regulatory environments, and focused on customer-centric transformation. At the heart of it all, though, is relationships – with Members, colleagues and partners.

My career has been about connecting people, purpose and performance – and that aligns perfectly with MDA National's values.

**What do you see as MDA National's greatest strength?**

Without question – our people. We have a team with an incredible depth of expertise, from medico-legal professionals and case managers to underwriting specialists and our enablement teams. Many have been with the organisation for 10, 20 years or more.

That continuity builds trust and understanding with our Members. There's a unique combination of care, competence and continuity that really sets MDA National apart.

**What does "more than" insurance mean to you in the context of MDA National?**

It means we're partners, not just providers. Doctors rely on us to support them not only when a claim arises, but to offer advice, education and proactive guidance throughout their career journey.

That responsibility drives everything we do – and we take it very seriously. We understand how critical medical indemnity is to a doctor's confidence and peace of mind.

**What excites you most about the future of the organisation?**

It's the potential. Even in my first few months here, I've seen how adaptable and forward-thinking the team is. We've welcomed new talent from a variety of backgrounds – medical, legal, general insurance – and that diversity creates an energy which is exciting to build on. We're in a position of strength – and we're ready to grow, evolve, and continue delivering exceptional support to our Members.

**Lastly, what would you like to say to MDA National's Members during this centenary year?**

Simply, thank you. Our Members are the reason we exist. Everything we've achieved over the last 100 years – and everything we plan to achieve in the future – is grounded in supporting them.

As we mark 100 years, we remain committed to standing with you, and providing personalised, expert support that helps you focus on what you do best – delivering outstanding care to your patients.

**100 YEARS STRONG**
**— AND JUST GETTING STARTED**

As MDA National celebrates its centenary, we reflect back with pride and look forward with purpose. With Tim at the helm, we continue to evolve while staying true to what has always defined us: our purpose, and our values of courage, care and commitment.

**Here's to the next 100 years.**

# We celebrate
# Dr Bruce Willett

**Nerissa Ferrie**
Manager, Advisory Services
MDA National

A dedicated general practitioner and longstanding MDA National Member, Dr Bruce Willett has seen it all during his extensive medical career. I caught up with Bruce, who generously shared his thoughts about his life as a GP with his trademark wit and humility.

> *Take more risks and back your judgement.*


**What does it mean to be recognised by your peers when you received the Rose-Hunt Award at GP24?**

One wonderful thing about being a GP is the extraordinary insight into people's lives. We see people at their best (and perhaps their worst).

I have had the privilege to know many fabulous people and patients over the decades. I have witnessed their unheralded self-sacrificing and caring lives dedicated to the benefit of others. I have always been struck by the fact that their quiet achievements deserve more awards than ex-judges, celebrities and politicians who have already been rewarded, and yet receive these additional awards.

So, most of all, I feel lucky. I know so many GPs doing amazing things that are not recognised half as much as they should be. Nevertheless, I am absolutely shallow enough to have accepted the award.

**How has primary care changed from when you started your career in general practice?**

Computers and IT dominate our day now. We have a love-hate relationship with our computers that comes with co-dependency. Nevertheless, I can't imagine trying to find a pathology result now from a pile of printed results haphazardly stapled to one another like a terrible homemade Christmas decoration.

There is so much red tape and documentation, and it is a wonder we find any time to treat patients. Regulators need to fully appreciate the cost they add to the healthcare system and the burden on patients.

I regret that we, as GPs, have surrendered too much of what we do – for example, emergency and procedural medicine. When I started in general practice almost four decades ago, we routinely managed broken bones, fractured bodies, eyes and sutures. It was part of our everyday life; patients expected and appreciated it. We have given up this stuff at our cost. I am now principally a chronic disease manager. And although I enjoy it, I miss the other stuff.

I would love to see the next generation of GPs capturing this back. The government would get more bang for their buck by encouraging young GPs to provide these services, rather than funding extraordinarily expensive urgent care centres.

**Technology in medicine is advancing at a rapid rate – does this make you nervous or excited?**

The rapid development of technology, especially AI, is exciting and terrifying. If we know one thing about new technology, it's that we never understand all the flow-on implications. We know to expect the unexpected, and the unknown is always scary.

Every country in the world is struggling with the spiralling cost of healthcare. Over the last 50 years, technology has driven much of that cost increase; the hope is that AI will reverse the trend and make healthcare more affordable. AI will bestow an additional level of expertise that will allow everyone to extend their capabilities and work to a higher level of practice.

For now, I feel like I am a long way off from allowing my car to drive me or a robot to treat me. The challenge will be maintaining the art of medicine, humanity and empathy in what we do.

**Being a practice owner has its challenges. What advice do you have for GPs who might be thinking about running their own practice?**

Practice ownership is challenging; it has become increasingly more complex and bureaucratic since I began my practice. It is now much more difficult to start a practice. However, I would strongly urge all young doctors to consider practice ownership.

I have no doubt that clinician-led teams provide the best patient care. While sometimes frustrating, practice ownership is incredibly rewarding and satisfying. It is a wonderful, creative endeavour. You start with a blank page and create something new that is a reflection of yourself and your values.

**You've contributed significantly to advocacy for GPs through various roles within the RACGP and GPSA. What would you say to junior doctors who are considering a career in general practice?**

Don't believe everything that is said about GPs and general practice in the hospital. It is worth remembering that GPs and hospitals see the worst of each other. We each see when things have potentially gone wrong in the other space.

I love being a GP; it is a rewarding career, with variety and the flexibility to practise in all different ways and all different spaces.

**COVID-19 feels like a fever dream now – but what was your best moment, your worst moment, and the one thing you will take away from the pandemic?**

It is hard to remember now, but there were moments of genuine fear in the early days of COVID-19. In our practice meetings, we frankly discussed the fact that we may well be putting our lives at risk by coming to work.

I am honoured to work with such a dedicated group that continued to provide face-to-face services the entire time, despite the unknowable risk.

My lesson: in future, make sure I have the courage to make the space needed to make the best decisions.

I was scheduled to take holidays at the time COVID hit, so I had no patients booked. I was able to sit in the practice, support everyone, and respond to the seemingly hourly changes in recommendations and protocols. I would not have had the sense to take the time out to do this, had I not already booked the holidays.

**Who is Bruce Willett outside of medicine?**

I am a recovering gadget and technology addict. I love time in my garden and bushwalking.

# Wearables and the ‘worried well’

We are starting to receive calls which relate to the increasing use of Wearable Digital Health Technology (WDHT) across all age groups and patient cohorts.

**Nerissa Ferrie**
Manager, Advisory Services
MDA National

## What are wearables?

Some WDHT devices are medical grade (e.g. blood glucose monitors) but most fall into the fitness tracker or smartwatch category. There are various price points, but even low-cost devices can monitor a range of ‘health indicators’ like heart rate, sleep quality, and oxygen saturations levels.

While there are many positive aspects to patients using WDHT, there are also potential downsides – particularly for the doctors of anxious patients.

## “Doc... what does this mean?”

The ‘worried well’ has always been a challenge for doctors, but technology has heightened the level of health anxiety for many patients. Patients now have documented proof of their worst health fears, all contained in a handy app they can bring to the consultation.

Sleep anxiety is a good example of how the interpretation of sleep data captured on a phone app can lead to an exacerbation of a patient’s poor sleep. Although a lot of devices capture a vast range of health data, the data can be inaccurate or misinterpreted.

## Balance is crucial

The challenge for doctors is knowing when to reassure a patient that the reading worrying them is normal, and when to investigate further. There have been cases where WDHT has led to the discovery of a serious, underlying health condition,[1] so it’s not a one-size-fits-all approach to either discounting or investigating a patient’s concerns.

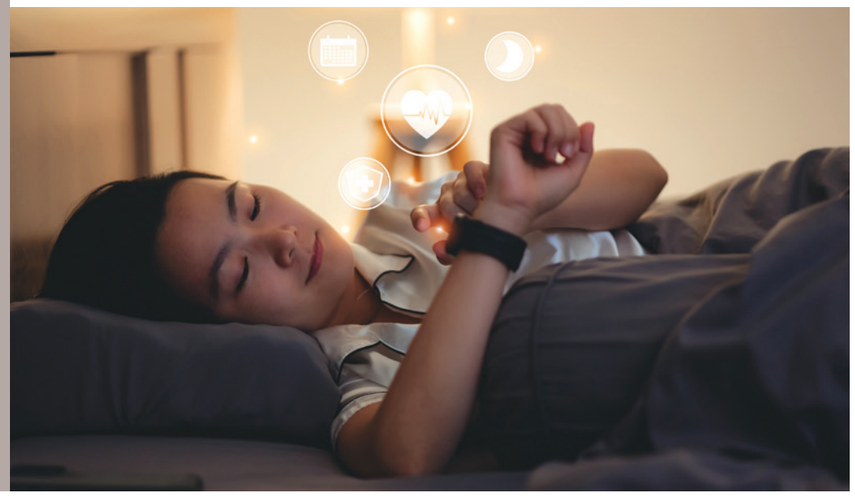
The accuracy of the data obtained from WDHT is variable, so it’s difficult to assess the validity (correct measurements) and reliability (consistent measurements) of your patient’s WDHT device.[2]

Using your clinical judgement and communicating this clearly to your patient are both paramount in striking the right balance between dismissing or over-investigating data obtained from WDHT. It’s also a good opportunity to educate patients on how to use WDHT for better effect.

## It’s not all bad news

On the plus side, WDHT can be used to encourage patients to play a greater role in their own health outcomes. “Nudging”[3] is where patients analyse and track their own WDHT data. This psychological strategy is intended to subtly guide individuals towards behavioural change.

**The research into the use of WDHT is largely positive,[4] but this technology is still relatively new. So medical practitioners should remain alert to the potential risks, as well as the known benefits, of WDHT.**



View the references online: **mdanational.com.au/wearables-and-worried-well**



# Taking leave as a solo practitioner

**Karen Stephens**
Risk Adviser, MDA National

**Doctors’ work is demanding. Long hours, a high-stress environment, emotional situations and administrative burdens can take a toll on your wellbeing over time. Solo practitioners, without traditional employment arrangements, can easily fall into the trap of overwork and burnout.**

Taking time off can feel daunting – but remember that you are the most valuable asset in your practice. Even in your early days of private practice, it’s important to start planning for regular holidays.

## Planning ahead

Good planning is key to a successful break. Think about upcoming family events, your personal goals for a holiday (rest, adventure, family time) and your work cycle. Identify quiet periods in your practice, and avoid booking time off during peak demand.

Get those potential dates in the calendar early. This helps you visualise the rhythm of the year and avoid overcommitment. Decide whether you’d rather have shorter, more frequent breaks or one longer trip – then plan accordingly.

## Financial considerations

The biggest barrier to taking leave? Lost income. As a solo practitioner, no work often means no pay. But with foresight, you can ease the financial impact:

- Set up a dedicated ‘Travel’ savings account.
- Begin automatic contributions 6-12 months ahead of your planned time off.
- Estimate your likely income loss and ensure your budget can absorb it.

## Practice coverage

Your absence shouldn’t mean disrupted care for your patients. Plan for coverage well in advance:

- Arrange a locum doctor or trusted colleague to manage your caseload. You can also try a medical recruitment agency, online job agencies such as Seek, or your professional networks.

*Just over half (52%) of retired surgeons (2,295 survey respondents) wished they had done some things differently during their career, with 24% saying they would have spent more time with family and taken better care of themselves.*

– Stolarski A, Moseley JM, O’Neal P, Whang E, Kristo G. Retired Surgeons’ Reflections on Their Careers. JAMA Surg. 2020;155(4):359–361.

*Doctors with lower self-rated health, lower self-rated life satisfaction (especially for male doctors) and those who had experienced a recent serious personal injury or illness were more likely to be sued.*

– Bradfield OM, Bismark M, Scott A, et al. Vocational and psychosocial predictors of medical negligence claims among Australian doctors: a prospective cohort analysis of the MABEL survey. BMJ Open 2022;12:e055432.

- Make a list of high-priority patients and discuss them with the covering doctor.
- Ensure the covering doctor understands your results-management system.
- Assign a staff member to handle incoming communication (mail, email, phone calls) in your absence.

Upon your return, allocate time to review what occurred while you were away, and check in on patients of concern.

## Communication is key

Letting your patients and colleagues know your plans ahead of time builds trust, and minimises confusion or anxiety about your availability.

It is helpful to also:

- inform patients about your leave dates, who they can see in your absence, and when you’ll return; and
- provide clear, thorough documentation in your patient notes. Others may need to step in and rely on your records to deliver appropriate care.

# Setting expectations

**Karen Stephens**
Risk Adviser, MDA National

Complaints from patients about their medical care can come as a surprise to the doctor who provided excellent care and achieved a good clinical outcome.

“

***I was told*** *my vision would improve in a few days.*

***It’s been three months*** *and I still can’t run.*

***He told me*** *it wouldn’t be painful.*

***I didn’t realise*** *how bad an iron stain would be.*

***She never even looked at my wrist****; didn’t even touch or feel it once to check for mobility.*

***Without asking he took two photos*** *of my back – I only realised because I heard the familiar iPhone camera sound.*

Patient dissatisfaction often stems from unmet expectations. Expectations are especially important with elective and private surgery.

A survey found that three in four patients seeking bariatric surgery would be disappointed with long-term weight loss of 20% and two-thirds would be disappointed with an excess weight loss of 50%, although these levels are considered successful outcomes clinically.[1]

Unrealistically high expectations have been linked to decreased patient satisfaction with spinal surgery, joint arthroplasty and plastic surgery.[2,3,4,5,6,7,8] Patients seeking cosmetic surgery may have underlying psychological conditions such as body dysmorphic disorder, which can prevent them from ever being satisfied with a surgical outcome.

**Expectations are formed by what patients have:**

- experienced themselves or heard from others
- read and seen on the internet or in the mass media, including TV shows such as *Grey’s Anatomy* and images created with filters and AI enhancement
- seen on practice websites or social media
- heard during the consultation and consent process.

## Communication is the key to creating realistic expectations

## Before the consultation

### *Practice information*

Give clear information about practice processes on the practice website, online booking system, waiting room signage and/or information sent to a new patient prior to their appointment. This is particularly important for things that may seem unusual to patients, such as:

- independent medical examinations where the traditional doctor–patient relationship does not exist
- long wait times for an appointment such as an ADHD assessment
- requirements for telehealth appointments to attract a Medicare rebate.

### *Advertising*

Provide balanced and accurate information, and promote realistic outcomes on your website, social media and other advertising. Note that the Health Practitioner Regulation National Law prohibits advertising that is misleading or deceptive, or which creates an unreasonable expectation of beneficial treatment. Cosmetic surgery advertising has specific requirements, with one example being that single images must not be used when the use of the image is likely to give the impression that it represents the outcome of a surgery.[9]

## During the consultation

### *Understand*

Seek to understand patient expectations:

- Let patients talk and actively listen.
- Ask open questions, e.g. “What do you hope the operation will achieve?”
- Check that they’ve understood by asking questions, e.g. “From the information I’ve given today, what will you tell your family when you get home?”; “What do you think of the plan we have discussed today?”; “Is this what you thought would happen today?”

For cosmetic surgery, Medical Board guidelines[10] require the patient’s expectations to be discussed to ensure they are realistic. A validated psychological screening tool must be used to screen for body dysmorphic disorder, and the process and outcome of the assessment and screening must be documented in the patient’s record.

### *Explain*

Explain things such as why you need to do an examination and what it will involve; why tests are or aren’t necessary; what will happen if the tests are inconclusive; what the consequences will be if risks materialise; and what the patient should do if symptoms worsen.

Use plain language and avoid medical jargon. Provide written information and/or use visual aids such as before-and-after photos or diagrams to illustrate potential results.

### *Address*

Address unrealistic expectations:

- Explain what can be realistically achieved, e.g. “The pain will likely get much better, but your range of motion won’t improve enough for you to play professional basketball.”
- Explain the clinical rationale – “antibiotics don’t work for viruses”.
- Don’t be persuaded by patients who are desperate to “have something done”, especially if it’s a last resort for a longstanding problem.
- If it becomes clear that your expectations and those of your patient cannot be aligned, consider referring the patient to another practitioner.
- Ending the doctor–patient relationship is a last resort, but may be necessary.

## Consent for procedures

Inform patients about:

- their condition and its likely course
- alternative options for treatment, including the option of doing nothing
- what the result is likely to be, given their particular circumstances
- what the procedure involves
- the course of recovery and their role in it
- risks (general, specific and material risks)
- the consequences should one of these risks eventuate, e.g. further surgery or antibiotics
- what follow-up is involved
- the total cost, any rebates from Medicare, health funds, etc.

Use language the patient can understand, and check their comprehension. Provide printed material or information on your website so patients can think about it further at home. Having patients sign a procedure-specific consent form can provide evidence of what information was provided to and discussed with them.

There are specific requirements which apply to consent for patients seeking cosmetic procedures.[10]

Informed financial consent should occur prior to a procedure or treatment being performed, so that the patient knows what their out-of-pocket costs may be.

View the references online: **mdanational.com.au/setting-expectations**

# Medicare news for Members

It will be a busy year for Medicare, with election promises aplenty during the lead-up to the recent federal election.

**On the compliance front, the Department of Health, Disability and Ageing (the Department) released its priorities for 2025,[1] including the following:**

## Suspected fraud

The Department is committed to tackling illegal activity and behaviour of concern to protect the integrity of Medicare.

## Bulk billing

Charging a co-payment or membership fee is a breach of the *Health Insurance Act 1973*. Where the Department finds that a health professional has charged a co-payment or membership fee for a bulk-billed service, it will take compliance action.

## Specialist and consultant physician claiming of attendance items and management plans

Data shows specialist and consultant physician attendance items drove the growth of attendance services in financial year 2023-24.

This includes management plans such as MBS items 132 and 133. The Department's focus is on ensuring providers understand how to claim correctly to protect the sustainability of Medicare.

## Claiming MBS services while overseas

Medicare benefits are only payable where the service is performed in Australia to an eligible patient. 5,800 doctors have received either a schedule for self-audit (and possible repayment) or an education letter reminding them of the requirement for both the doctor AND the patient to be located in Australia for a Medicare item to be billed.

If you receive a schedule for self-audit, please contact MDA National for advice.

## Opportunistic billing and emerging business models

The Department is alert to the increasing risk of business models prioritising revenue generation over clinically relevant patient care. The integrity of Australian Government health program payments is impacted (and action may be taken) where:

- arrangements between an organisation and a health professional remove health provider control over their claiming; or
- a practitioner's clinical independence is undermined by corporate billing requirements.

## Duplicate payments

Medicare benefits are only payable where a service has not already been paid for through another funding arrangement. Duplicate payments breach section 19 of the *Health Insurance Act 1973*. This requirement ensures the sustainability of Australia's healthcare system.

**IN OTHER NEWS...**

## The 80/20 and 30/20 rule

In addition to the Department's compliance priorities, we have also been contacted by Members who are either very close to or already breaching the 80/20 rule and/or the 30/20 rule.

## 75% vs 85% for a service rendered as part of an episode of hospital treatment

We have also seen targeted compliance around the incorrect claiming 85% of benefits, instead of 75%, for an episode of hospital treatment or privately insured hospital-substitute treatment.

### The new Chronic Disease Management items are finally here!

The Department has released details around the long-awaited changes to the Chronic Disease Management Framework which came into effect on **1 July 2025**.

Further information can be found on the fact sheet ***Upcoming changes to the MBS Chronic Disease Management Framework*** on the MBS online webpage[2] – and keep an eye out for our **Medicare webinar** coming up later in the year where we will discuss the changes in more detail.

View the references online: **mdanational.com.au/medicare-update-july-2025**





# ENDING CARE

The decision to terminate a doctor–patient relationship can be a difficult one for a doctor to make, and it often comes later than it perhaps should. 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.

MEDICO-LEGAL FEATURE

# Ending the doctor–patient relationship

**Dr Sarah Taylor**
Medico-legal Adviser, MDA National

For many doctors, acknowledging they are no longer able, or willing, to look after a patient is not easy; and it goes against their understanding of their professional obligations as a doctor.

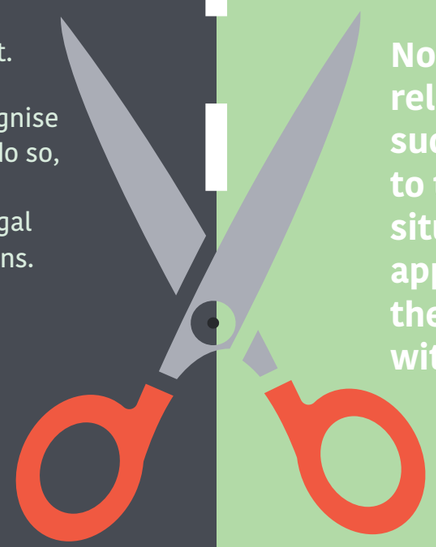
It's important to be aware that it is acceptable and, in certain circumstances, advisable to terminate a therapeutic relationship with a patient.

The key issues are to recognise when it is appropriate to do so, and to know how to do it without breaching your legal and professional obligations.

## Grounds for ending the doctor–patient relationship

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

- **Unacceptable patient behaviour** – including verbal abuse, threatened or actual violence, harassment and other boundary violations; unacceptable behaviour towards practice staff; or criminal acts by a patient, such as obtaining drugs fraudulently or forging certificates.
- **A loss of mutual trust and respect and/or a breakdown in communication** – including ongoing non-compliance with management recommendations, or a patient who tries to coerce the doctor to provide medical treatment that the doctor disagrees with.
- **The behaviour of someone close to the patient that jeopardises ongoing care** – such as the parent of a child patient, or carer of a patient without capacity.
- **A conflict of interest arises** – between you and a patient, or between two patients you currently treat (e.g. a relationship breakdown).
- **'Heartsink' patients** – not all therapeutic relationships are going to be successful. It's important to remember that one doctor's difficult patient is not necessarily another doctor's difficult patient. If you're feeling anxious, fearful, angry or emotionally wound up about a particular patient, then you're not being the best doctor you can be – and care may no longer be provided in the patient's best interests. Consider if the patient is likely to receive better and more effective care from another doctor.



**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.**



## Legal obligations

There is generally no legal obligation imposed on a doctor to see any patient, except in a genuine emergency. 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, or the patient may have a right of access to care, e.g. in an Emergency Department setting, or in a public hospital.

Concerns should be raised through the appropriate channels, including the Head of Department or the Director of Medical Services, who may be able to arrange a change of care internally.

It's also important to be aware that health practitioners must not refuse to treat patients based on unlawful discrimination, i.e. 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 must 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 break down or become compromised (e.g. because of a conflict of interest), 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 (taking into account patient safety and any clinically significant risks, such as follow-up of results, etc)
- forward relevant clinical information to the new treating doctor.

This should be carried out in a safe way, taking particular care if the patient is in a vulnerable cohort (e.g. unstable mental health issues, concerns about cognition or capacity, or taking medications that can't be abruptly stopped).


## Ending care at a practice vs individual doctor level

It may be necessary to end the professional relationship with a patient at a practice level, not just with an individual doctor. This might occur when a patient behaves inappropriately or makes threats against you and other staff members. It might also be necessary when the usual treating doctor leaves or retires, and no other doctors in the practice are willing to take over care.

If care is ended at a practice level, the communication will generally come from the practice – whereas an individual doctor ending care will usually communicate the decision to the patient under their own signature.

Generally, if care is ended at a practice level, there is no need for individual doctors to also communicate this. There should be a discussion between the doctor and the practice to confirm at what level care is being ended and how the decision will be communicated to the patient.

Communication from the practice can simply come from 'the practice' rather than a specific individual, particularly if there is a safety concern.

## What about when the patient ends care?

If the patient ends care, then you should consider whether to follow this up in writing. If there is a chance the patient will return, and you have no issues with continuing care, then it may be best to do nothing.

If, however, the consultation ends very badly and you and/or the practice don't want to risk the patient returning once they have cooled down, it may be appropriate to acknowledge their decision to end care in writing, advise that no further appointments will be offered, and forward a copy of their medical notes to their new treating doctor upon request.

*Continued on page 16.*

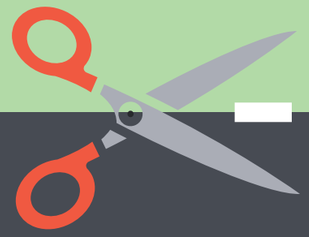
# **STEPS TO FOLLOW:** Ending the doctor–patient relationship

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 by the doctor or the practice. Written confirmation of a decision delivered verbally may also be appropriate.

- Inform the patient that the doctor–patient relationship has broken down, and it is in the patient's best interest to seek ongoing medical care from another doctor.
- This is not the time to 'get things off your chest'. It can be counter-productive and time consuming to go into too much detail about why you are ending care. Maintaining your own position (e.g. "It is no longer possible for me to provide your ongoing care") makes it difficult for the patient to argue about the reason care has been ended.
- It is appropriate to seek medico-legal advice about any outstanding issues, and to obtain a review of any written communication you intend to send.
- You may also need to inform the referring practitioner or specialist colleagues involved in the patient's care, and/or the local hospital, that you are no longer involved in the patient's care. You are not required to find a new treating doctor for the patient.
- 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. It may be necessary to include relevant clinical results or guidance with the written communication about ending care.
- It may be appropriate to supply a prescription for a small quantity of regular medication to bridge care until the patient can find a new doctor. A month should be sufficient, and the script(s) can also be sent to a nominated pharmacy with prescribing limits if needed (e.g. daily pickup).
- The patient can request their notes be transferred to their new treating doctor for continuity of care. This can be requested by the patient, or upon receipt of a signed transfer-of-medical-records form. We recommend you waive your usual fee for the transfer of the records.
- If ending care at an individual level, 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 aim is to communicate the termination of the therapeutic relationship in clear and unambiguous terms, and to ensure you have done everything you can to ensure the patient can receive ongoing care with a new doctor.

Ending care with vulnerable patients requires careful consideration. Addressing any potential risks and ensuring you are meeting your legal and ethical obligations is not only good for the patient, but it may also assist you if the patient makes a regulatory complaint about the breakdown in therapeutic rapport.



If you find yourself in the difficult situation of having to end care, we encourage you to contact our Medico-legal Advisory Services team for advice and support.

View the references online: **mdanational.com.au/ending-care**





# Do you need to top up your CPD by the end of the year?

Make the most of the resources available through your MDA National membership to assist in meeting your CPD obligations for the year. On-demand webinars and eLearning modules are available 24/7 and attract CPD hours for 'education activity' and 'reviewing performance'.

## On-demand webinars

- *A Health Practitioner's Guide to Social Media*
- *AI in Record Management for Doctor Consultations*
- *Avoiding Medical Marketing Mistakes*

## eLearning modules

- *Introduction to Open Disclosure*
- *Prescribing Opioids*
- *Informed Consent Challenges*
- *Noteworthy: The How, What, Where and Why of Medical Documentation*

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### WORKSHOPS

- ***De-escalation of Aggressive Behaviour in Healthcare***
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- ***Achieving Valid Informed Consent***
  Melbourne — 6 September 2025
- ***Win Win — Conflict Resolution***
  Perth — 6 September 2025
- ***Practical Solutions to Patient Boundaries***
  Brisbane — 13 September 2025
- ***Noteworthy: The Why, What and How of Medical Documentation***
  Online — 11 October
- ***Win Win — Conflict Resolution***
  Sydney — 1 November 2025
- ***AI in Record Management for Doctor Consultations***
  Perth — 20 November 2025
- ***Open Disclosure: Practical Steps for Everyday Clinicians***
  Online — 22 November 2025

### WEBINARS

- ***Practical & Medico-legal Challenges of the Safe Prescribing of Medicinal Cannabis***
  Online — 2 September 2025
- ***Medicare Updates: What You Need to Know***
  Online — 25 September 2025

### For more information and to enrol:

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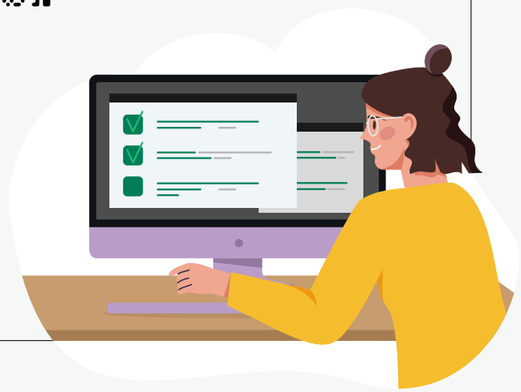


# Navigating the minefield of genomics

Dr Sarah Taylor
Medico-legal Adviser, MDA National

The National Health Genomics Policy Framework defines the term ‘genomics’ to refer to both the study of single genes (genetics) and the study of an individual’s entire genetic makeup (genome) and how it interacts with environmental or non-genetic factors.

## Case study

Carolyn is a fit and well 55-year-old woman. She doesn’t like seeing doctors, but she has heard about a test she can get to see if she will develop cancer in the future.

She has no medical diagnoses, but smokes 15 cigarettes a day and her BP is elevated at 148/92.

She hands over a pamphlet from a local pathology company and points to the test she wants – which tests for genes for breast, ovarian, colorectal and pancreatic cancer.

Her mother had breast cancer in her 50s, and she has no other family history.

What do you do?

Genomics is a rapidly advancing area of medicine with increasing clinical application. While some tests are standard practice (e.g. offering preconception carrier screening) others are not (e.g. screening low-risk patients for cancer-causing genes). Many tests lack concrete clinical application; can produce results of unknown significance; and can cause unnecessary stress and uncertainty for the patient.

There can be unexpected consequences including barriers to obtaining insurance, implications for other family members, and psychological harm. Patients may need to think carefully about irreversible decisions (such as surgical resections) based on the findings of a genetic test; not to mention the potential for increased interventions for the ‘worried well’.[1]

A good example of the unexpected fallout from genomic testing is Australian actor Chris Hemsworth who became aware of his increased risk of developing Alzheimer’s disease after he was found to be carrying two copies of the gene APOE e4 during filming of the National Geographic documentary series, *Limitless*. Hemsworth chose to not edit the unexpected finding from the program, but he has instead focused on preventative measures he can take now to reduce his overall risk of developing Alzheimer’s disease.

## What genomic tests are available?

**The utility of genomic testing is broad, and examples include:**

- preconception carrier screening – a standard test looking for SMA, CF and Fragile X (now Medicare-funded). An extended screen is also available
- antenatal Non-invasive Prenatal Testing
- preimplantation genetic diagnosis testing as part of assisted reproductive treatment
- paternity testing
- cancer genetics – looking at genes that increase the risk of developing particular cancers (e.g. BRCA) and also testing existing cancers to tailor treatments or determine prognosis
- risk testing (as part of a diagnostic workup) for specific medical conditions including familial hypercholesterolemia, coeliac disease and haemochromatosis
- diagnosis of rare and inherited diseases.

**Other areas with emerging clinical application include:**

- pharmacogenomics[3] – which describes how common gene variants influence drug metabolism and clinical response.[4] Theoretically, this can assist in minimising adverse effects, choosing efficacious medications, and informing speed of dose titrations. There are only two items on the Medicare Benefits Schedule that inform individualised prescribing: tests for abacavir hypersensitivity and one to guide dosing with thiopurines. Other testing is ‘user pays’ and has variable supportive evidence – some medications have higher level evidence than others
- nutrigenomics, ancestry, risk/susceptibility testing for a wide range of diseases using polygenic risk scores.

## Consent

Pre-test consent must be approached very carefully, and doctors have a duty to ensure the patient has capacity to consent and an understanding of the complex issues that might arise once the results are provided.

The patient should be encouraged to ask themselves:

- *What will I do with this result?*
- *What could be the consequences of having this information?*

The patient should be aware of the risks of receiving unexpected findings, or of information where medicine does not yet fully understand the implications of the results.

More information on gaining appropriate consent for different types of genomic testing and with different patient populations can be found in the NHMRC publication, *Medical genetic testing: information for health professionals*.[2]

## Case study – conclusion

You had a long discussion with Carolyn about the limitations of the test and explained that sometimes the results can be unclear or provide no benefit in terms of clinical significance.

You explained this could result in a lot of uncertainty and may end up making her more concerned about her risk of cancer than providing the reassurance she is seeking. You advised her that her family history did not put her at high risk for an obvious genetic risk of cancer.

You spoke about genetics being only one risk factor for the development of cancer, and that there were other more reliable risk factors to consider – such as smoking, regular exercise, and alcohol use.

You explained the importance of screening tests like mammograms and the cervical screening test (CST), and that she could now self-collect her CST as a first step.

Carolyn was grateful for the thorough explanation, and she realised there was a lot more to genetic cancer tests than she had initially thought.

She agreed to go away and think about it, and that in the meantime she would self-collect her CST, monitor her blood pressure, and do some baseline blood tests. She acknowledged that she should give up smoking, and this was something she would also think about.

View the references online: **mdanational.com.au/navigating-genomics**

# Separated families & other conflicts of interest

**Nerissa Ferrie**
Manager, Advisory Services
MDA National

## Case study 1

You've been treating Andrea for many years. You knew her when she met and married Ben, and you've gone on to treat the whole family.

Andrea asks for a referral to a psychologist. She says things are not going well in the marriage and she's going to ask Ben to move out.

Ben comes to see you and asks you to document a small bruise on his left cheek. He says he and Andrea were having an argument, when she hit him with a saucepan.

Andrea comes in the next day and asks you to document the dark bruises around her left wrist, which she says occurred during an argument in the kitchen. Ben had become angry and tried to physically restrain her, so she had lashed out with the saucepan in her hand to make him let go.

Both Andrea and Ben intend to report the alleged assault to the police.

## Case study 2

You're a GP in a small rural community. You are alerted by raised voices and find two of your older male patients squaring up to each other in your practice reception. Bob had left your consultation room minutes earlier, and John is the next patient on your list.

You call John in an attempt to diffuse the tension, and he follows you into the room.

John apologises and tells you there are legal proceedings afoot between the two men. John is an organic farmer. Bob, his nearest neighbour, has used pesticides on his crop which threatened John's organic status. The lawsuit is worth millions, and John indicates that he intends to add psychological damage to his existing claim, and he asks you to provide a medico-legal report in support of his claim.

Long before a family dispute results in court orders that guide decisions about access to notes and consent for treatment, doctors may find themselves in a position of conflict when the relationship initially breaks down.

## What is a conflict of interest?

*Good medical practice: a code of conduct for doctors in Australia*[1] describes a conflict of interest (COI) as a situation when:

*… a doctor, entrusted with acting in the interests of a patient, also has financial, professional or personal interests, or relationships with third parties, which may affect their care of the patient…*

*and*

*these interests compromise, or might reasonably be perceived by an independent observer to compromise, the doctor's primary duty to the patient.*

This is extremely difficult to navigate when the third party who may be compromising the doctor's ability to provide care to a patient is also a patient.

This situation is not uncommon when relationships break down, and it's really important to recognise the potential COI early and take steps to remedy the situation.

## What are the risks if I continue seeing both parties?

The risks are not always obvious at first, but they can include:

- both patients requesting a supportive report and/or issuing you with a subpoena to give evidence in court
- the temptation to challenge one patient's version of the same event which has been disclosed to you by the other patient
- inadvertently disclosing something to one party that was disclosed in confidence by the other party, because you don't recall which patient made the disclosure.

## How do I choose?

You are often forced to choose one patient over another. This is easier when you have a long-established relationship with one patient, and not so much with the other. But what if both patients are valued patients and you don't want to appear to be taking sides?

This is a moral and ethical dilemma which can lead to doctors seeing both parties for much longer than they should.

## How do I manage this practically?

When both patients know that you see the other patient, it's best to be upfront and explain that the conflict between them puts you in a difficult position. It may be obvious to you which patient you need to move on to another doctor, and it can be helpful to explain your reasoning (e.g. Mum usually brings the kids for appointments, so it's less disruptive to transfer the care of one patient rather than three).

Bear in mind that patients in the middle of a dispute are already feeling vulnerable, and it's important to ensure the patient you are moving on knows it's in their best interest to have a doctor who is not otherwise aware of the dispute; and that it's not intended to be a punishment.

## What are my options?

- It may be enough to move one patient on to a colleague in the practice. This won't be an option if there is a family violence order in place against one patient.
- Make it clear that you've made no judgement in relation to the dispute that is creating the COI, and explain your decision to the patient with whom you are ending care.
- If you become aware of a serious COI and neither patient is aware that you see the other, this requires very careful handling – as you will need to move one patient on without breaching the confidentiality of the other patient.

### Seek advice

Situations like this can involve a lot of emotion and present really challenging circumstances which require creative thinking. If you find yourself in this situation, contact our Medico-legal Advisory Services team for prompt and tailored advice.

View the references online: **mdanational.com.au/separated-families-conflict-of-interest**

# A gesture of goodwill

Patient complaints are an inevitable aspect of modern clinical practice. A gesture of goodwill, such as a refund of out-of-pocket consultation fees, can be a pragmatic way to resolve dissatisfaction early and amicably.

**Daniel Spencer**
Case Manager (Solicitor), MDA National

## Case study

A private GP in New South Wales consults with Lisa, a 33-year-old woman who presents with a recent history of mild intermittent abdominal pain. During the 10-minute consultation, Dr Malik takes a detailed history and advises symptomatic treatment with over-the-counter pain medication. Lisa leaves the appointment feeling dismissed and unclear about the next steps.

That evening, Lisa submits a written complaint to Dr Malik's practice, stating she felt "rushed"; that "no examination was performed"; and that she had "wasted her money" on a consultation that only left her more confused. She doesn't use the word "negligence" but is clearly dissatisfied with the service she received.

Following receipt of the complaint, the practice manager and Dr Malik discuss the matter and review the consultation notes. They agree that:

- a detailed history was obtained and well documented
- no examination was performed due to the patient's report of recent mild symptoms
- Dr Malik's communication about next steps could have been clearer.

Dr Malik sought advice from MDA National on how to respond to the complaint, and he mentioned that the practice manager felt a refund of the patient's out-of-pocket expenses, as a gesture of goodwill, might be appropriate in the circumstances.

Dr Malik proceeded accordingly, and Lisa received a well-worded response to her concerns, together with confirmation of the refund.



## Am I admitting I've done something wrong?

Patient complaints are an inevitable aspect of modern clinical practice. While most grievances can be resolved informally, a small number escalate into formal claims for compensation or complaints to a regulatory body. In this landscape, a gesture of goodwill – such as a refund of out-of-pocket consultation fees – can be a pragmatic way to resolve dissatisfaction early and amicably.

Doctors and practices may feel deterred from making a goodwill payment on the basis that it may be seen as an admission of liability. Provided it is carefully worded, a well-timed gesture of goodwill can be an effective, non-litigious resolution tool.

When used judiciously, such payments can help preserve doctor–patient relationships, prevent legal escalation, and reduce the emotional toll on doctors.

## When is a refund appropriate?

While consideration may be given to a gesture of goodwill payment in any circumstance, it may be most appropriate when:

- there has been a delay or miscommunication
- patient dissatisfaction has occurred due to system-level issues or administrative shortcomings outside of your control
- there has been an error associated with a minor adverse outcome, a treatment complication, or patient dissatisfaction with a treatment outcome.

At the heart of many complaints lies a sense of disappointment, misunderstanding or unmet expectations, rather than true clinical negligence. For these patients, a prompt and empathetic response can offer a sense of validation and closure.

Refunding the cost of the consultation, particularly when a patient feels they received little value or clarity from the interaction, can provide a meaningful acknowledgement of their disappointment. It may defuse tension, signal that the patient's concerns have been taken seriously, and avoid the adversarial tone that can accompany formal complaint processes or legal proceedings.

This proactive approach can often prevent complaints from escalating further – especially when combined with a thoughtful explanation and an invitation to continue dialogue.

In addition to placating a dissatisfied patient, a goodwill payment may decrease the risk of escalation to a regulatory body. Offering a goodwill payment in line with open disclosure principles is likely to support, not hinder, compliance with professional standards.

If a patient complaint was made to a regulatory body following a goodwill payment, the earlier conciliatory response provided by a doctor to a patient is likely to be looked upon favourably by the regulator.

Offering a goodwill payment does not mean compromising a doctor's clinical judgement or professional standards. On the contrary, it can reflect a patient-centred approach that values transparency and compassion. It also demonstrates a willingness to engage constructively with feedback, which is increasingly seen as a marker of quality in healthcare.

## Is it just about the money?

While a goodwill payment may be made to a patient in the absence of a written explanation, personalised apologies and acknowledgements may hold more value than the money being refunded. They serve as an expression of empathy and commitment to patient-centred care, and can make a patient feel heard.

Goodwill gestures need not be financial. While they are often in the form of a reimbursement, other examples include offering a free follow-up consultation and patient liaison support.

A copy of the response should be retained on the patient's file, as well as a note kept on the doctor's medico-legal file summarising the patient's complaint or issue, the reason for the goodwill gesture, and confirmation that no liability was admitted.

The circumstances leading to a gesture of goodwill may point to deeper operational issues that need addressing by the doctor and/or the practice. As a part of risk management, a review of how and why an adverse event may have occurred should take place to prevent similar outcomes in the future.

### Seek advice

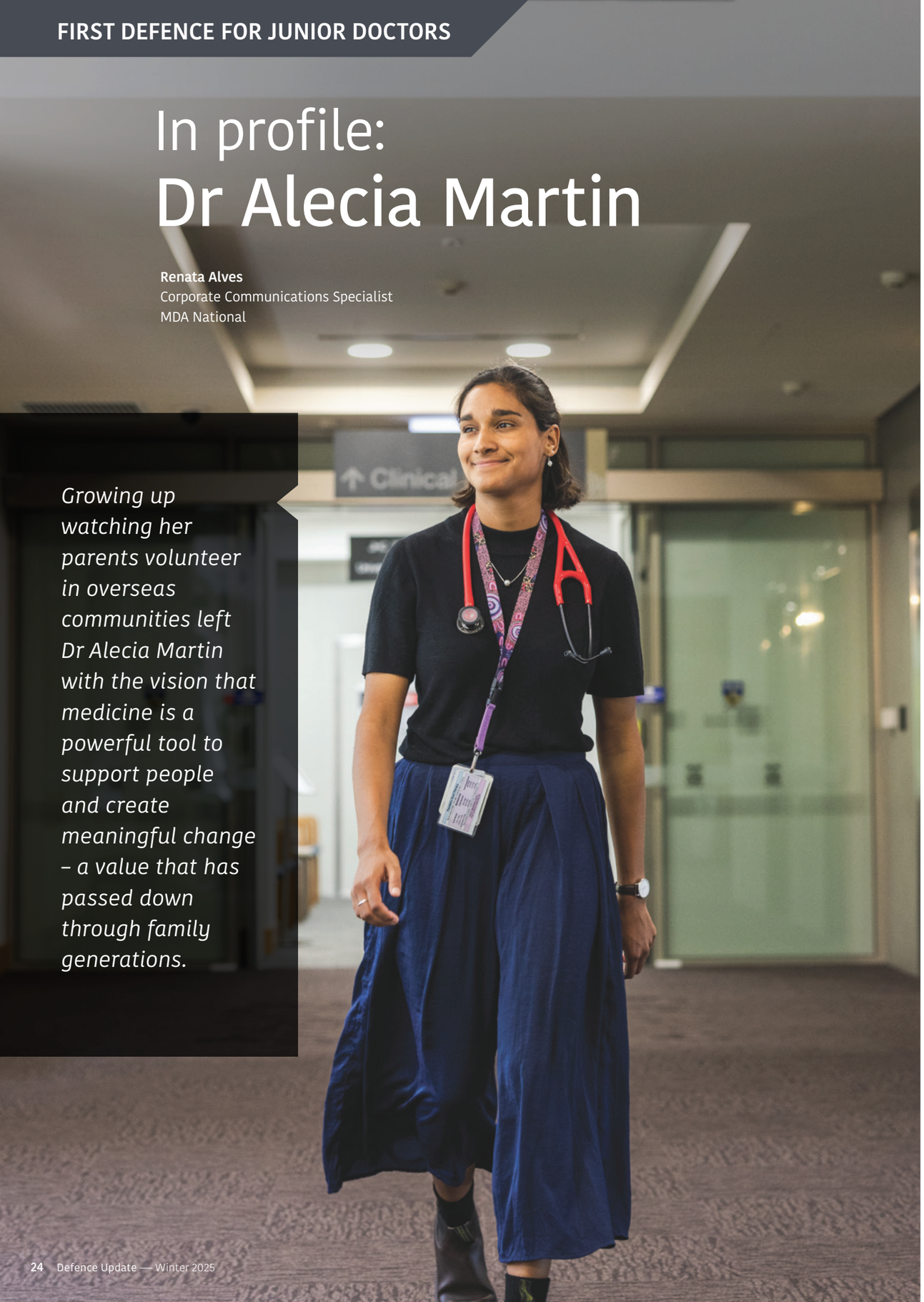
While the benefits of goodwill gestures are compelling, doctors must be cautious as to how such offers are framed.

The correspondence accompanying any refund should be meticulously worded to express empathy and a desire to maintain professional trust, without implying clinical fault or negligence.

It's always advisable to seek advice from MDA National before offering a gesture of goodwill.

# In profile: Dr Alecia Martin

**Renata Alves**
Corporate Communications Specialist
MDA National




*Growing up watching her parents volunteer in overseas communities left Dr Alecia Martin with the vision that medicine is a powerful tool to support people and create meaningful change – a value that has passed down through family generations.*

Whether working in regional Western Australia or participating in not-for-profit initiatives, Alecia is committed to using her medical skills to reach those most in need. Inspired by her parents – both general practitioners (GPs) – and her own experiences in the field, Alecia is now building a career anchored in social responsibility, always with an eye to giving back. I caught up with Alecia to find out a bit more about her medical journey.

**What inspired you to pursue a career in medicine?**

For as long as I can remember, I wanted to be a doctor. This originated from a positive experience of my family in medicine. My parents are both GPs (and MDA National Members) and they spent nine years working as volunteer doctors in Nepal during my primary school years. I think growing up in that context helped me to see medicine as an opportunity to contribute meaningfully to individuals and communities, especially in under-resourced settings.

Throughout my school years I was interested in the sciences and human biology. I also enjoy interacting with people. It was a combination of all these things that led me to pursue a career in medicine. My younger sister is also doing medicine, which has been a great experience to share together.

**How did your parents come to do humanitarian work in Nepal?**

Both my parents decided to pursue careers in medicine, with the goal of doing humanitarian work overseas. They met each other somewhere along the way, and were able to pursue those goals together.

When they were looking into where to go overseas, Nepal had established mission hospitals where volunteer doctors could teach and work, so it seemed like a good opportunity. We didn't have prior connections with Nepal, but now we have many connections and relationships after our time there.

**What are your most common career challenges, and how do you address them?**

I think my biggest ongoing challenge is finding work-life balance. I consistently find that medicine becomes a less enjoyable space when I don't make regular time to recharge with activities that are energising to me.

Medicine is busy, with long working hours and significant emotional investment. There are also the interpersonal challenges of working in a team setting and managing different people's expectations, preferences and personalities. Medicine also brings me in proximity with a lot of suffering and unfairness in our world.

I often struggle with the fact that some people have horrible diagnoses, live shorter lives than they should, or are limited in both small and very significant ways. I'm challenging myself to cultivate compassion in the face of frailty, rather than become immune or indifferent to the lives and suffering of others.

**How would you describe your passion for not-for-profit projects?**

I think that comes from my own story and upbringing. My Mum is from Sri Lanka, and she came to Australia as a refugee when she was sixteen. I grew up in one of the poorest countries in the world, and moved back to Australia when I was eleven. Those experiences remind me that I've been given immense privilege and opportunities in being able to live and study in Australia, and to pursue a career in medicine.

I want to leverage my privilege to benefit others, particularly those who haven't had the same opportunities that came my way. I think, at some level, we all want to do something good and meaningful in the world – and for me, giving back through non-profit work seems like a great way to do that.

**A lot has been discussed about rural medicine in Australia. How would you describe your experience?**

My first exposure to Australian rural medicine was spending a year in Port Hedland during medical school. That was an eye-opening experience that made me realise how limited resources are in the country compared to metropolitan settings. I was so impressed by the doctors there. Not only did they have an incredibly broad skill set, but they were making a really positive impact on the community through longstanding relationships with their patients. I've since had the opportunity to work in Newman, Kununurra, Kalgoorlie and Broome; and each of those placements have further inspired me in the direction of rural medicine.

My plan is to do rural generalist training, which I've started this year. My goal in the shorter term is to work in rural Western Australia, particularly among Aboriginal populations. In the long term, I plan to do volunteer humanitarian work overseas in under-resourced settings.

**What advice would you give to someone considering a medical career?**

I'd say that medicine is a wonderful career! It makes me excited to think about the lifelong possibilities of learning and contribution in medicine – it's so vast and in-depth that I will be busy swimming around in it for the rest of my life!

I'd also say interacting with people is a significant part of medicine, so it's important to enjoy doing that. Undoubtedly, medicine is a significant commitment. My Mum likes to say, "you need to be married to medicine", which I often laugh at. But it constantly reminds me that medicine is a high calling – and if you are going to do it, do it with all your heart.

# Keep **burnout** at bay

**Dr Marny Lishman**
Psychologist & Keynote Speaker

In 2019, the World Health Organisation (WHO) defined burnout as an "occupational phenomenon"; a syndrome resulting from chronic, unmanaged workplace stress. In Australia, it's estimated that 30-40% of people experience burnout.

Among doctors, it's even more common – with research suggesting about 40% of the profession is affected.

Burnout is a state of physical, mental, emotional and spiritual exhaustion that stems from ongoing stress or emotional strain. For most, burnout doesn't happen overnight. It creeps up slowly, with many busy professionals not realising they are experiencing burnout until they hit breaking point.

## Are you suffering from burnout?

If you're dragging yourself to your next shift, constantly tired, disconnecting from people around you, or even questioning your decision to study medicine so early on in your career, you're certainly not alone. You might have felt that deep pull to help people, to be a doctor, to make a difference. But right now? You might mostly feel like calling in sick. Perhaps there's a possibility you are burnt out, or even close to it.

The good news is, although burnout can feel overwhelming, you can bounce back from it. And the even better news is that with the right awareness, and putting some personal and professional wellbeing strategies in place early in your career, you can prevent burnout from happening in the first place.

Burnout prevention isn't just about avoiding hitting that brick wall. It's about building a solid foundation for a long, healthy and fulfilling career in medicine. And you can start laying that foundation now.

As a junior doctor, you're particularly vulnerable. The intense study load, long hours, emotional toll, often unhealthy workplace systems, and a steep learning curve of transitioning into clinical work – this can all pile on. It can also be uniquely draining to be in a caregiving profession, where looking after others can wear you down in ways you might not expect.

Burnout isn't always just about work. It's hard to separate the whole person from their life context, so all the emotions we feel in reaction to the world – both internally and externally – can build up and wear us down.

If you're juggling emotional pressure from a demanding job alongside family responsibilities, financial concerns, relationship challenges, or caring for others, it can be hard to pinpoint where the stress is coming from. Life is complicated, and so are your emotional responses to it.

## What can you do to prevent burnout?

First, you have to recognise burnout and act on it before it takes hold.

As you move from medical school into the clinical environment, you'll face long shifts, emotional strain and heavy responsibility. To stay ahead of burnout, you need to be honest with yourself about your limits, and create space for recharging and recovery before burnout takes hold.

'Know thyself' might sound cliché, but it's one of the most important tools you have in preventing burnout. Burnout prevention involves knowing yourself and being self-aware, ritualising self-care into your otherwise busy schedule, and advocating for systems at work that protect your wellbeing as well as that of your peers.

Start by looking out for the early signs. Your brain and body are likely whispering these to you already. They are your cue to slow down, check in with yourself, seek support, and ramp up your self-care routines. Acting early on these warning signs can help you avoid more serious consequences later.

You may notice differences in your body and mind that deviate from what you're like when you're 'well'. These might include constant tiredness that doesn't improve with rest; becoming more cynical or emotionally detached from patients or colleagues; or struggling to concentrate.

Maybe you've started feeling numb or overwhelmed. You might notice you're sleeping poorly, getting irritated more easily, forgetting crucial information, experiencing decision fatigue, or losing motivation for things you once loved – both in and outside of work. Even physical symptoms like headaches, digestive issues or frequent colds can be signs that your body is under prolonged stress.

Burnout prevention involves knowing with clarity what you need in order to function at your best. For most, this involves replenishing sleep, eating nourishing food, keeping physically active, and making time for things like socialising, being in nature and spending time with family. And, of course, just taking time out to relax and do nothing!

Little daily rituals can fill the cup with positive emotions and help release some of the negative emotions. Self-care also means setting boundaries, saying no, debriefing after challenging days at work, and not being afraid to talk about how you are feeling.

## The role of your workplace in preventing burnout

Burnout prevention is not just about what you do. Your workplace has a big role to play in preventing burnout.

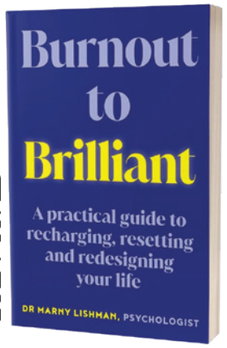
Working in a positive, empathetic culture where you feel valued, heard and supported can make a huge difference. When open communication is encouraged and trust is built, you're more likely to feel safe speaking up about what you're going through, and getting the help you need when your wellbeing is affected.

Hospitals and training programs should offer development opportunities that focus on mental fitness, because learning how to manage stress and complex emotions is just as important as clinical skills. Reducing the stigma around help-seeking is essential too.

Everyone experiences stress differently, and a one-size-fits-all approach won't work. By embedding wellbeing into workplace systems, hospitals can improve not only staff morale but also team performance and retention – creating an environment where doctors thrive. There are little things we can all do in our daily practices now that can help us move towards this in the future.

Dr Marny Lishman's latest book is a practical guide to thriving, not just surviving.

*Scan the QR code to purchase* ***Burnout to Brilliant***



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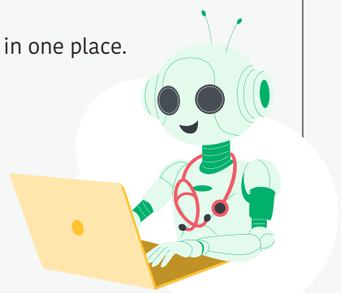

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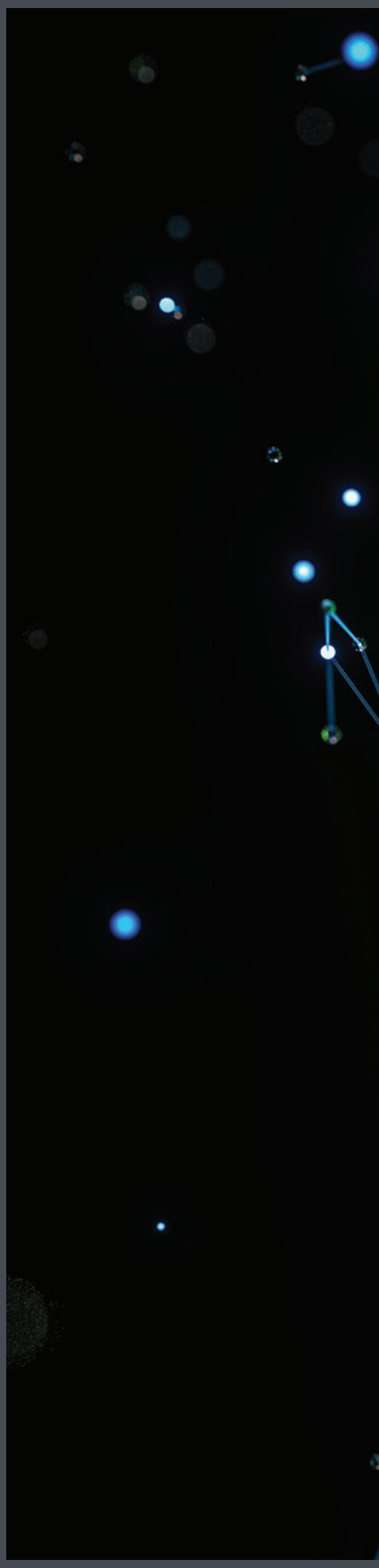

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