WINTER 2020

Defenceupdate

FOR MEDICAL PRACTITIONERS

Frontline care in the face of fire

Take care with cryotherapy

HIV confidentiality and privacy

CASE BOOK

- Beware boundary violations
- When spinal surgery goes wrong
- A case of COVID-19 in a country town

TACKLING TELEHEALTH

FIRST DEFENCE

Feature section for doctors in training

MDA National

WELCOME

Welcome to our Winter 2020 edition of *Defence Update*.

Over the last few months, we have all faced many challenges and changes in our private and professional lives due to the COVID-19 pandemic. Who would have thought that telehealth would become such an important part of all doctors' professional lives with the arrival of this virus?

In our medico-legal pull-out feature (pages 15-18) we take a closer look at telehealth, with essential information to get you started. We also have some great tips from Dr Shannon Nott on how you can optimise telehealth.

On page 7, Dr Andrew Davies relates his inspiring account of Homeless Healthcare, a service he initiated to provide medical care to some of the most marginalised people in our community – the homeless.

Have you had to provide care during a natural disaster? On page 8, Dr Jaclyn Brown describes her experience at the frontline of the recent bushfires.

In our First Defence section, Dr Vasuki Annamalai shares her story as an IMG and the challenges along her journey to pursue her career in Australia (page 28).

Dr Jane Deacon
Manager, Medico-legal Advisory Services

Our Casebook section (pages 19-25) features a recent tribunal decision highlighting the importance of maintaining appropriate boundaries with patients. We also discuss the risks of spinal surgery and ways to minimise potential claims or complaints.

This edition also includes several articles on the importance of confidentiality in all situations, whether HIV (page 12), or COVID-19 test results (page 24) – and how it can be breached inadvertently.

I hope you enjoy reading *Defence Update*, and that you're all looking after yourselves in these unsettling times.

Have an editorial enquiry?
Interested in contributing an article?
Contact our Marketing team
marketing@mdanational.com.au

Cover photo:
Dr Andrew Davies with a patient

Photography: Cover and pages 6-7
donated by Tony McDonough
(Raw Image)

In this issue

- *Defence Update* articles can be found online on our library webpage: **mdanational.com.au/advice-and-support/library**

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The articles in *Defence Update* contain topical, practical and expert insight to support you in providing safe patient care. We thank all our authors for their valuable contributions to this edition.

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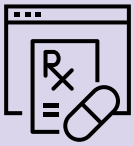


Fast-tracked ePrescribing

The Australian Government has announced that the implementation of electronic prescribing (ePrescribing) will now be fast-tracked to help protect people most at risk from exposure to COVID-19.

This will allow doctors to prepare electronic prescriptions that patients can share electronically with their pharmacy. It will also alleviate some of the practical difficulties when prescribing during a telehealth consultation.

As of 8 May 2020, Australia's first fully electronic prescription has been successfully prescribed and dispensed by a doctor and pharmacist in the Victorian town of Anglesea, using the token model developed by industry and regulators as an alternative to paper scripts.

Rollout is expected in early June 2020. It will initially be available only through some clinical software programs generally used by GPs.

More Information

Australian Digital Health Agency
digitalhealth.gov.au/get-started-with-digital-health/electronic-prescriptions/for-prescribers

It's renewal time

Here's what you need to do to renew your Membership and Policy by 30 June 2020.

- Check your Renewal Notice to ensure the information is accurate.
- Ensure you've informed us of all claims, complaints, investigations, employment disputes, or any incidents you're aware of, that may lead to a claim for indemnity under your Policy.
- Review the risk category changes to ensure you've selected the most appropriate risk category and estimated the most accurate Gross Annual Billings for your practice, as this may affect the cover under your Policy.
- Advise us of any changes to the information on your Renewal Notice by contacting our Member Services team via email: **peaceofmind@mdanational.com.au** or phone: **1800 011 255**.
- Make your payment online at **payonline.mdanational.com.au** using your reference number – or refer to your Renewal Notice for other payment options. If you're on a direct debit arrangement, your premium will be deducted on 1 July 2020.

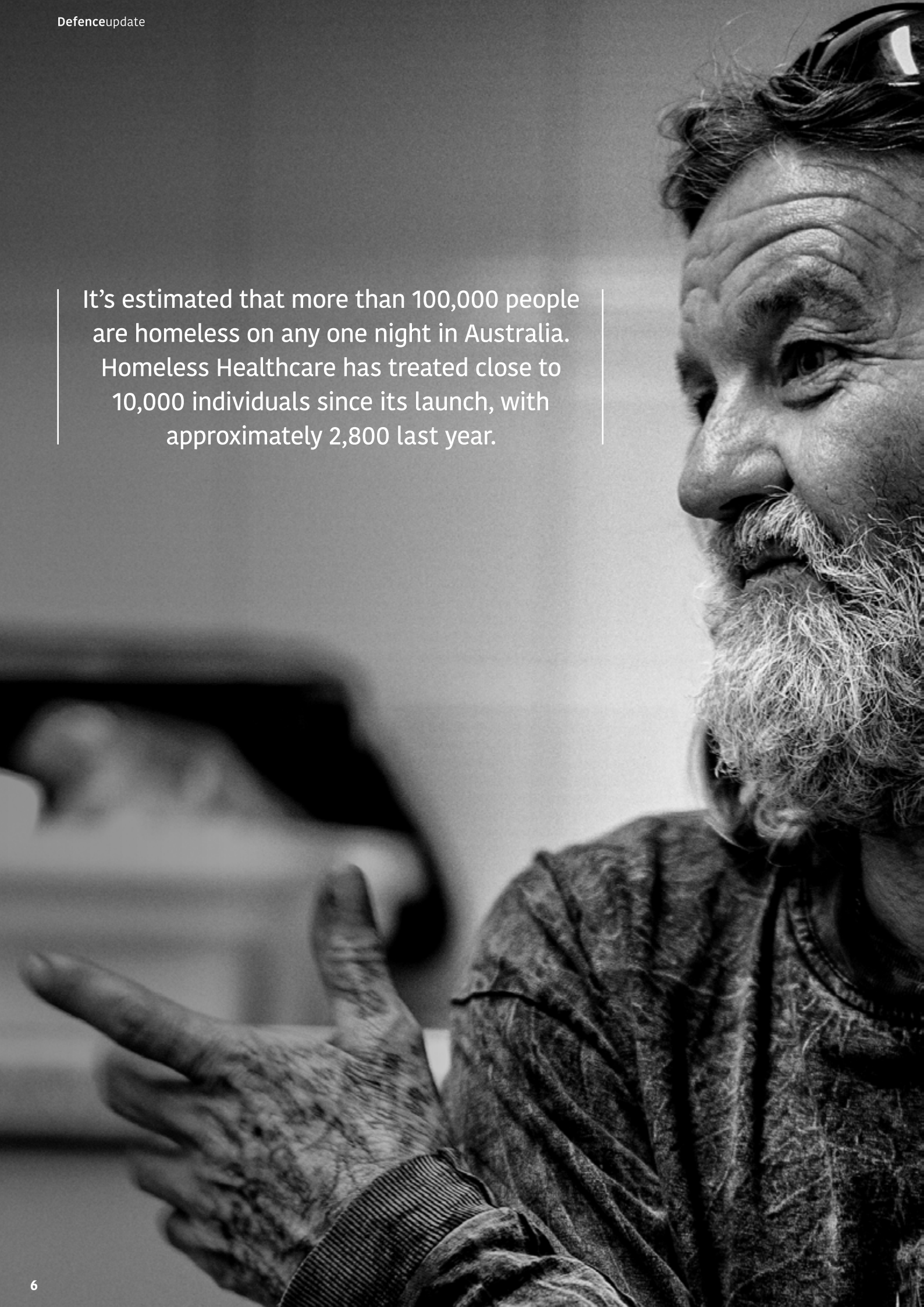
Please read the *Supplmentary FSG & PDS including Amendments to the Policy Wording V.12 2020/21* included in your renewal pack for details of all changes prior to renewing.

By your side

As a doctor-owned mutual organisation, we recognise the challenges you're facing in responding to COVID-19, and want to help ease some of the burden. That's why we've frozen premium increases for 99% of members* for the upcoming financial year, despite the rising cost of medical indemnity claims.

Our medico-legal advisers are ready to help you with any COVID-19 related concerns. We'll also keep updating our online hub – **mdanational.com.au/mda-national-coronavirus-advice** – to guide you through this difficult time.

* A very small number of Members will receive a premium increase due to their claims experience, nature of practice, level of billings or risk profile.



It's estimated that more than 100,000 people are homeless on any one night in Australia. Homeless Healthcare has treated close to 10,000 individuals since its launch, with approximately 2,800 last year.

DOCTORS FOR DOCTORS

Dr Andrew Davies (MDAN Member)
General Practitioner
Director, Homeless Healthcare

In 2008, I started Homeless Healthcare with a colleague. From an office in my house, we planned to visit drop-in centres twice a week to provide health care to people experiencing homelessness. Our biggest mistake was underestimating the demand — within three months it became a full-time job.

After years of domestic violence, John's parents separated when he was eight years old. John and his family moved to rural Western Australia with his new stepfather. At this point, John felt his life changed forever. His stepfather began hitting him – and the regular hitting soon turned into regular beatings.

To make things worse, John's stepfather sexually abused him when he was 12 years old. After this happened for the fourth time, John ran away to Perth. With no other family in Australia, he was forced to live on the streets, eating leftovers in food courts and rubbish bins.

Eventually he fell in with some older boys on the streets who introduced him to cannabis. He found it helped him relax and sleep better. Before long he became a regular user of this and other drugs.

At age 17, John had his first episode of depression. Not knowing what was going on, he didn't seek professional help. When he was 23, he went to the Emergency Department (ED) when manic and was told by the doctor that it was 'just the drugs'.

Left untreated, John continued to self-medicate with illicit drugs. He eventually caught hepatitis C from IV drug use and developed chronic obstructive airways disease from heavy smoking. Still homeless and in his early 40s, John saw a GP for the first time in 2012.

Eight years later, John continues to see our service regularly. He takes his mood-stabilising medication regularly. Now housed in a Department of Housing property, he has re-engaged with his two teenage children who enjoy coming over for sleepovers.

John's latest aim is to walk more steps each day than his doctor, and is losing weight steadily.

Tri-morbidity (coexisting mental health, drug and alcohol problems, and physical health problems) occur in more than half of the people experiencing homelessness. As a result, they have a life expectancy of approximately 47 years.

Our service recognised that the lack of safe and secure housing was at the core of a homeless person's poor health – so we would need to work closely with the agencies that help find housing.

Practitioner visits to Homeless Healthcare continue to grow (1,500 in 2011 to 14,000 in 2018).

Homeless Healthcare now employs over 40 people. We provide general practice clinics in drop-in centres, a drug and alcohol rehabilitation service, transitional accommodation services, and domestic violence shelters – all from an office in West Leederville.

In 2016, we established an in-reach program at Royal Perth Hospital five days a week for patients presenting to the ED identified as homeless, and an after-hours service to support those who've been rehoused. The program was aimed at alleviating the increasing demand homelessness places on Perth's emergency services. Since implementation, the number of patients presenting to the ED has dramatically decreased.

We're always looking for medical staff who have that extra bit of compassion. As a not-for-profit organisation, we also rely on donations to continue our work.

If you're interested in joining us on our mission, please call 08 6260 2092, email generalmail@hhc.org.au, or visit homelesshealthcare.org.au.

Frontline care in the face of fire

Dr Jaclyn Brown (MDAN Member)
General Practitioner

The bushfire crisis may seem a distant memory for some – but for those on the frontline, the experience will last a lifetime. Dr Jaclyn Brown, a GP from Merimbula, shares her story.

As a rural GP, I honestly hadn't given much thought to disaster planning. In the rural town where I grew up, I subconsciously believed geographical isolation offered some kind of buffer. I knew our clinic had talked about disaster planning during the accreditation process, but I remember discussing a mass casualty at the airport as an example, rather than a bushfire.

Throughout the festive season, the far south coast was surrounded by bushfires. We had been consulting as normal, while watching the increasing smoke outside and becoming aware of the encroaching fires. We were lucky we had 48-72 hours to prepare – a window of time when the most critical planning decisions were made.

I intended to offer my services at the rural emergency department, thinking they would be overwhelmed with burns and respiratory distress. But most people chose to present to evacuation centres where the most common presentations were anxiety, respiratory distress, and corneal foreign bodies.

I attended the ED on Friday night to find it empty and overstaffed, so I left with some hospital supplies to lend a hand in the evacuation centres that were opening closer to home. By 8pm, two private general practices were setting up a makeshift medical room in the town's main evacuation centre located at the Bowling Club. The numbers quickly swelled to 800 after mass evacuation orders were given.

GPs are well positioned to mobilise people. On Saturday, we created a WhatsApp group for local medical professional volunteers. Over the next 24 hours, the Bowling Club reached maximum capacity, spilling over to the RSL Club and the Golf Club before reaching numbers of 1,400+ local residents.

We centralised our limited resources at one venue, the Bowling Club, which proved to be an excellent decision. We arranged a basic triage through a nurse stationed at peripheral evacuation sites and organised the 'Club Courtesy Bus' to drop unwell patients from the peripheral centres to the Bowling Club.

Due to the extreme nature of the fire, with roads and airways cut off, we had to manage countless patients over three days. Other local sites used a model of St Johns Ambulance acting as triage or patients being directed to a local GP clinic, but these weren't available to us. Fortunately, NSW Ambulance was able to offer a partial service, with our local district hospital 35km away.

My reflections from this experience

GPs have many skills which are helpful in an evacuation centre. We're a familiar and trusted face for the community; we provide 'infectious calm'; we have access to medical equipment and connections; and the ability to recruit other health professionals.

If you ever find yourself in a similar situation, encourage your colleagues to work as a team, communicate early and frequently, and don't be afraid to ask people for help. Overwhelmingly the answer was 'yes', but many people felt they needed permission to say it.

I have no postgraduate qualification in disaster management, and I can only share my own experience of the situation. I suspect many medical professionals develop imposter syndrome when it comes to natural disasters. But if there's one thing I learnt during this experience, it's to offer what you can. You might surprise yourself and be amazed at just how much a team of likeminded professionals can achieve when they work together.

> If there's one thing I learnt during this experience, it's to offer what you can. You might surprise yourself and be amazed at just how much a team of likeminded professionals can achieve when they work together.

What we did well

- Used a range of health professionals and drew on their specialist knowledge
- Wore a badge to identify ourselves
- Nominated a clear leader of the group and played to the individual strengths of the medical professionals available
- Gathered stock from wherever we could – including our homes, private pharmacies, private general practices and the local district hospital – and photographed all stock with the contributor so it could be returned after the event
- Set out clinical space appropriately, including clear a space to perform CPR when necessary
- Set up a screen to offer some privacy when dealing with very personal problems in the public space
- Encouraged people with known medical morbidities to sleep or stay near the medical area for easier monitoring
- Used a mobile communication aid (e.g. WhatsApp) to manage short, rostered shifts to facilitate adequate breaks and reduce fatigue
- Ensured appropriate storage and documentation of S4 medications

What we found challenging

- The lack of a practical local disaster plan
- Establishing a chain of command during chaos and rapidly changing conditions
- Documentation and storage of notes – working out how to meet clinical obligations in strange and unfamiliar territory
- Anxiety about whether we were indemnified for volunteering in a crisis
  - MDOs are usually prepared for these questions, so make contact if you're concerned
- Transitioning back to general practice
  - As Monday arrived, we put up signs at the evacuation centre directing to the two general practice clinics for better triage, documentation and treatment
- Distress among colleagues
  - A natural disaster is a time to be tolerant and supportive of one another. Encourage debriefing and monitor your colleagues after the event
- Managing difficult patients
  - People will be extremely distressed so you must prioritise your personal safety. Keep a register of difficult patients for handover to the next shift. Ask for police presence, as this can help keep everyone calm

Take care with cryotherapy

Dr Jane Deacon
Manager, Medico-legal Advisory Services

Cryotherapy is effective, simple and inexpensive — but not without the potential for adverse outcomes.

Cryotherapy is a procedure that uses an extremely cold liquid or instrument to freeze and destroy abnormal tissue that requires elimination. It is a widely used procedure for both non-malignant and malignant skin lesions.

As with all procedures, patient selection, discussion with the patient regarding benefits and risks (consent), and careful technique are important.

The Medical Council of NSW has recently received a number of serious complaints from patients related to pain and scarring associated with the use of cryotherapy. MDA National is also aware of several cases where medical practitioners have used prolonged freezing which has resulted in unacceptable scarring, ulceration and nerve damage. In some of these cases, inadequate training and supervision of GP registrars was apparent.

Non-malignant lesions which may be suitable for cryotherapy include warts, seborrhoeic and actinic keratoses, molluscum contagiosum in adults, and spider naevi.

Cryotherapy is used for non-melanoma skin cancers, now known as keratinocyte cancers. It can be used for small basal cell carcinomas, but is not recommended for facial lesions. Small superficial and well-differentiated cutaneous squamous cell carcinomas in low-risk sites can be adequately treated with cryotherapy. The recently released *Clinical practice guidelines for keratinocyte cancer* by the Cancer Council Australia contains more detailed information.

It is particularly important that doctors are confident in the diagnosis of the lesion, as this determines the dose and number of treatments.

Cryotherapy can be painful – so communication with the patient as to the technique, the possible outcomes and complications, as well as alternative methods of treatment, should form part of the consent process.

Contraindications to cryotherapy

- Undiagnosed skin lesions
- Patients with poor circulation
- Dark-skinned patients
- Patients unable to accept side effects

Precautions

- Some areas are not suitable: corners of eyes, fold of skin between nose and lip, skin surrounding nostrils and skin overlying nerves.
- Recurrent skin cancers after cryotherapy may be more difficult to treat.
- Care should be taken with patients who are at risk of slow healing or skin infection.
- Prolonged freezing may result in scarring.
- Cryotherapy leaves permanent white marks which may be very unsightly, especially in dark-skinned patients.
- Cryotherapy may sometimes cause nerve damage and ongoing pain in some danger areas where the nerves lie superficially (e.g. sides of the fingers).
- Patients should be informed that the treated area will first blister within a few hours. The blister then shrinks to be replaced by a scab within a few days. The area may swell, but that should settle within a few days.

Complications

- **Acute** complications include oedema and pain.
- **Delayed** complications include bleeding, local infection, ulceration and prolonged wound healing, pain and hyperpigmentation.
- **Long-term** complications can occur: e.g. nerve damage, pigmentary changes, hypertrophic scarring, recurrence of the lesion, alopecia and ectropion.

Technique

Technique is critical. It depends on the size, location of the lesion and the depth of freeze required. It is better to freeze lightly the first time and have the patient return if the response is inadequate.

More resources

DermNet NZ
Liquid nitrogen/cryotherapy guidelines
dermnetnz.org/topics/liquid-nitrogencryotherapy-guidelines/

RACGP
Optimising cryosurgery technique
racgp.org.au/afp/2017/may/optimising-cryosurgery-technique/

ACCRM

Liquid Nitrogen Cryotheraphy
youtube.com/watch?v=ojzOT_3R6bM&feature=youtube_gdata_player

HIV privacy & confidentiality

Dr Kiely Kim
Medico-legal Adviser

What should you do when a patient asks you not to include their HIV status on their medical record?

Jenny is a new patient and informs you she is HIV positive. She's anxious to know if this will be recorded and whether it will be seen by others. She tells you she made a complaint about her previous GP who had included her HIV status on a referral to her physiotherapist without her knowledge. Jenny asks you not to include her HIV status on her medical record. What should you do?

Protecting sensitive information

The protection of health-related information is of importance due to its sensitive nature.

- Privacy – the legal *right* to control access to oneself including information, is regulated in Australia by the *Privacy Act 1988* (Cth)[1] and the Australian Privacy Principles.[2]
- Confidentiality – relates to a health practitioner's ethical and legal *duty* to ensure personal health information is not disclosed inappropriately.

Patients don't have to disclose their HIV (or other BBV) status before undergoing any type of medical examination or treatment. However, this information is often helpful as it may affect decisions about health care. For example, HIV or viral hepatitis medications may interact with other medications or may have an impact on other medical conditions.

It's important to have a conversation with the patient about when it's useful to disclose this information. This is particularly important with the introduction of *My Health Record* in Australia which provides individuals' health information that is accessible to any healthcare professional involved in that person's care.

The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) has the *Guide to My Health Record: for BBV & STI healthcare providers to support their patients*[3] that provides helpful information and recommendations for healthcare workers to have discussions with patients about the benefits, and any concerns about privacy. This includes supporting patients to understand the privacy and security control options to guide their decision-making in engaging with *My Health Record*.

Multidisciplinary teams

Working in a multidisciplinary treating team is common in Australia and sharing information is often important in delivering good health care.

Healthcare providers don't always require a person's consent to disclose specific health information to another member of a multidisciplinary team if the patient would *reasonably expect* that information to be shared for a directly related secondary purpose. It would be considered that there would be a strong link between what an individual has been told (about the proposed uses and disclosures) or has consented to, and his or her 'reasonable expectations'.[4]

It would therefore be prudent for healthcare providers to let patients know how their information will be handled and to gain patient consent rather than relying on implied consent. It's helpful in a group practice to have clear policies to ensure staff are aware of their obligations, and have systems in place to protect patient privacy.

Jenny is planning to have her tonsils out and her anaesthetist is not sure whether other staff in theatre should be informed of her HIV status.

It would not be expected that theatre staff in general would need to be informed of Jenny's HIV status, as universal precautions will be in place.

If other health practitioners need to know about her illness and/or medication for her benefit, they should be informed as necessary – otherwise Jenny's confidentiality should be respected.

Exemptions to privacy and confidentiality obligations

It's important to discuss with Jenny the circumstances in which certain staff members may become aware of, or have a need to know, her HIV status.

Australian Privacy Principle 6[5] outlines principles governing the use and disclosure of health information. The ASHM also provides some guidance in relation to HIV:

> *In short, healthcare workers must not disclose a person's health information without consent except in a very limited number of circumstances. These may generally be summarised as:*
>
> - *communicating necessary information to others directly involved in the treatment of a patient during a particular episode of care*
> - *cases of needle-stick injury where a professional is aware of a patient's HIV positive status and a healthcare worker has been exposed in circumstances where there is a real risk of transmission, and it is not possible to conceal the identity of the source patient who has refused to consent to disclosure*
> - *provision of medical services in a particular instance of care where there is a need to know the infection status for treatment purposes of benefit to the patient (e.g. in an emergency or if the patient is unconscious). This should not, however, detract from the observance of standard infection-control precautions.*

In addition to obligations under privacy legislation, healthcare providers should also be aware of state and territory legislation regarding confidentiality of health information[6] and, if uncertain, should obtain medico-legal advice.

Jenny feels reassured after having a discussion on who has access to her medical records and the circumstances in which her health information may be released to others.

Discussion with patients regarding how health information will be handled is important in maintaining privacy and confidentiality obligations. It's often better to obtain patient consent directly rather than relying on implied consent. If uncertain of your obligations in a specific situation, contact MDA National for medico-legal advice.

▶ View the references at mdanational.com.au/advice-and-support/library/articles-and-case-studies/2020/06/hiv-privacy-confidentiality.

Mandatory reporting — what's new

Dr Sara Bird
Executive Manager, Professional Services

Under the National Law, health practitioners and employers must make a mandatory notification to the Australian Health Practitioner Regulation Agency (Ahpra) about the conduct of a health practitioner in circumstances where there is 'notifiable conduct'.

What types of conduct must be reported to Ahpra?

There are four concerns that constitute 'notifiable conduct' and trigger a mandatory notification: intoxication while practising, sexual misconduct, impairment, or a significant departure from accepted professional standards.

The National Law defines an impairment as 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession'.

> Mandatory notifications account for 11% of the notifications received by Ahpra.

What's new?

On 1 March 2020, the requirement for a treating practitioner to make a mandatory notification to Ahpra about a colleague changed. These changes provide different thresholds for the reporting of 'notifiable conduct' for treating health practitioners and non-treating practitioners.

The aim of these changes is to support health practitioners in seeking help about their health by limiting the circumstances that would trigger treating health practitioners to make a mandatory notification, compared to non-treating practitioners.

A mandatory notification by a treating practitioner in relation to impairment, intoxication or practice that significantly departs from accepted professional standards is required only when there is a substantial risk of harm to the public.

When considering whether a mandatory notification is required, a treating practitioner can take into account strategies put in place by the practitioner-patient and/or their employer that reduce the risk of harm to the public. While a practitioner-patient may have an impairment that causes a minor detrimental impact on their capacity to practise, it does not trigger a mandatory notification unless it poses a substantial risk of harm to patients.

Key messages

- Illness ≠ impairment. A health condition is not the same as an impairment. An illness or condition that does not, or is not likely to, have a detrimental impact on a practitioner's capacity to practise is not an impairment.
- A notification to Ahpra does not need to be made if there are effective controls to manage the impairment and to reduce the risk and severity of harm to the public. This includes the provision of treatment, modified scope of practice or ceasing work.
- In WA, treating health practitioners providing a health service to a practitioner-patient are exempt from the requirement to make a mandatory notification.
- Seek advice and support from our Medico-legal Advisory team if you receive a notification from Ahpra.
- If you believe you should make a mandatory notification about another health practitioner, please feel free to contact us to discuss the situation.

More information

Ahpra and National Boards
Guidelines: Mandatory notifications about registered health practitioners. March 2020
ahpra.gov.au/notifications/mandatory notifications/revised-guidelines.aspx

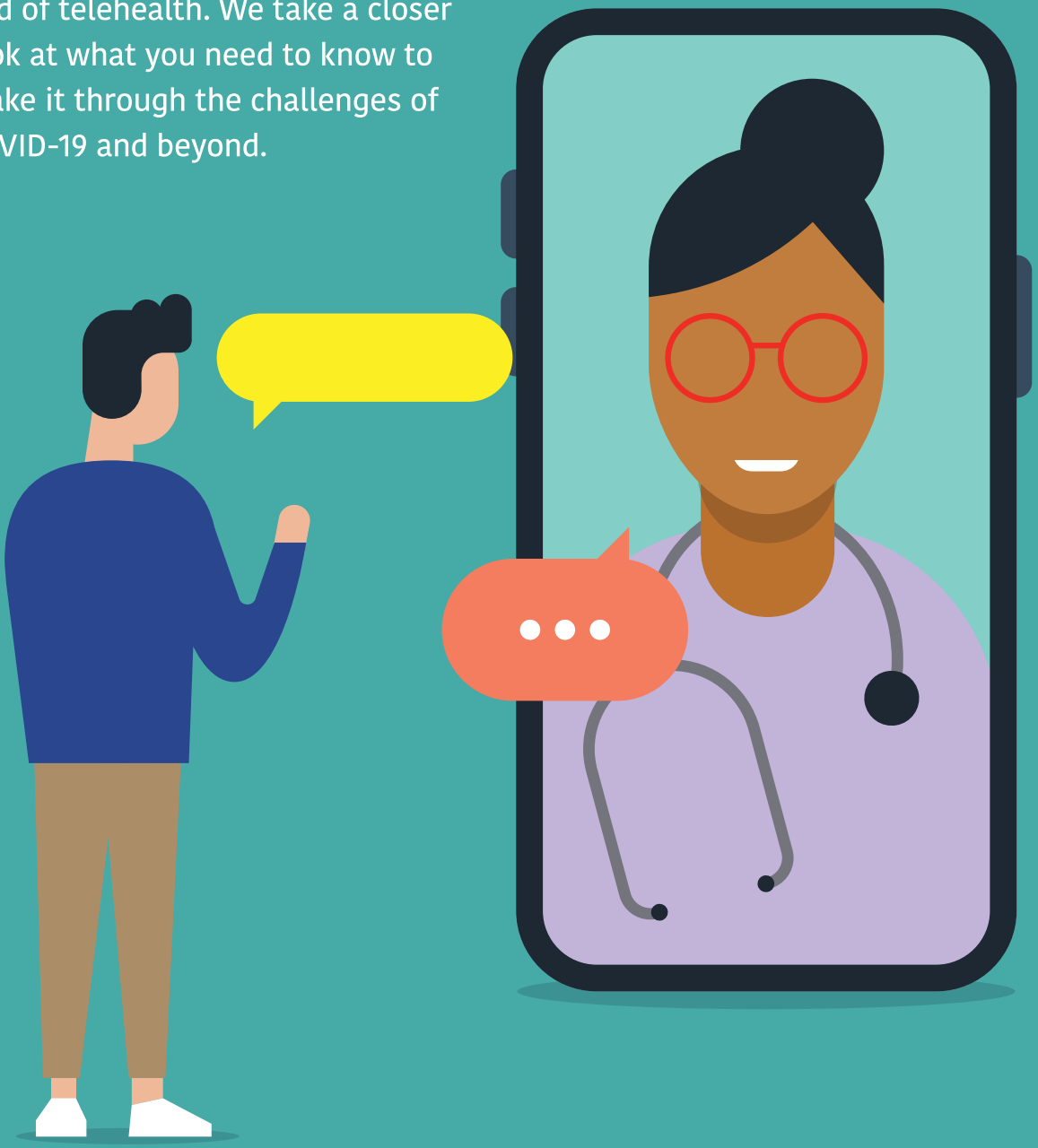
Mandatory notifications – a video for treating health practitioners
ahpra.gov.au/notifications/mandatorynotifications/resources-to-help-you/watch-our-videos.aspx

Resources – helping you understand mandatory notifications
ahpra.gov.au/notifications/mandatorynotifications/resources-to-help-you/resources.aspx

MEDICO-LEGAL FEATURE

Telehealth

In recent times, many doctors have been thrown into the deep end of telehealth. We take a closer look at what you need to know to make it through the challenges of COVID-19 and beyond.



Tackling telehealth

Nerissa Ferrie, Medico-legal Adviser
& Karen Stephens, Risk Adviser

When we refer to telehealth, we're talking about patient consultations that use any form of technology as an alternative to face-to-face consultations[1] — including, but not limited to, videoconferencing, internet and telephone. You might also see telehealth referred to by other terms such as telemedicine and eHealth.

Planning a video-based telehealth service

1. Match your patient to the service

If the patient is known to you, you should consider whether a telehealth consultation is appropriate or if a face-to-face consultation may be needed. Patients who are deaf, have limited English, live in a noisy or chaotic household,[2] or have poor IT access may find telehealth challenging.

Remember that not all patients or types of consultations and presentations will be amenable to telehealth.

2. Your location

An appropriate location is one that is quiet, situated where you won't be overheard or disturbed, well-lit, and with a neutral background colour.

3. Get your setup right

Getting your office space telehealth-ready is one of the basics many people overlook when starting out with telehealth consults. Like setting up the flow of your clinic room for optimal patient interaction, investing in the right setup will make you more efficient and improve both your patient's and your own experience.

Here's what we recommend:

- Dual screens – a minimum requirement to allow for the patient on screen and your electronic health record on another
- Webcam – don't rely on built-in cameras; buy one that's enabled for high definition (minimum 1080P)
- Headset – these provide better audio clarity. Built-in laptop microphones may decrease your audio quality and make it harder for patients to hear what you're saying
- Internet provider – invest in speed
- Lighting – try to avoid light projecting from behind you as cameras will struggle to project your face.

Remember that adequate care requires reasonable quality of sound and images, so you also need to consider the equipment the patient will have available. Telephone will be good enough for some consultations – block your number from the communication if using a personal mobile phone.

4. Software

The RACGP supports the use of some free apps for telehealth provided on an ad-hoc basis, but for an ongoing telehealth service a professional platform will provide greater quality and sustainability. Dr Shannon Nott has provided some excellent advice on platform choice on page 18.

5. Administration

Consider workflow, bookings, allocation of extra time for technical aspects, and staff training.[3] This may take longer than normal until staff are familiarised with the new process. You'll need read-write access to the practice's record system if working remotely.

6. Consent

Consent can be verbal or written, but the patient should be aware and understand:

- the reasons and benefits
- the process
- it's not the same as face-to-face, limited examination
- the possibility of technical problems
- that reasonable steps will be taken to protect privacy, but can't be guaranteed
- security features of transmission (e.g. encryption)
- additional costs and the assignment of benefit.

If you intend to record the consultations, seek written consent including the reason for recording, where it will be stored, and for how long.

View a sample consent form at: ehealth.acrrm.org.au/sites/default/files/content/informed%20consent%20form.pdf

7. Documentation

Documenting telehealth consultations requires the same level of detail as face-to-face, and your notes should include the type of consultation and patient's location. The RACGP also recommends documenting information such as:

- the rationale for a telehealth consultation vs a physical consultation
- responsibility for any follow-up actions
- the presence of other parties and the patient's consent for their involvement
- any technical malfunctions that may have compromised the consultation.

8. Follow-up

Advise the patient if a physical examination is required or urgent care is needed. Ensure good documentation, clear communication, and your usual follow-up of results or referrals.

Billing and Medicare

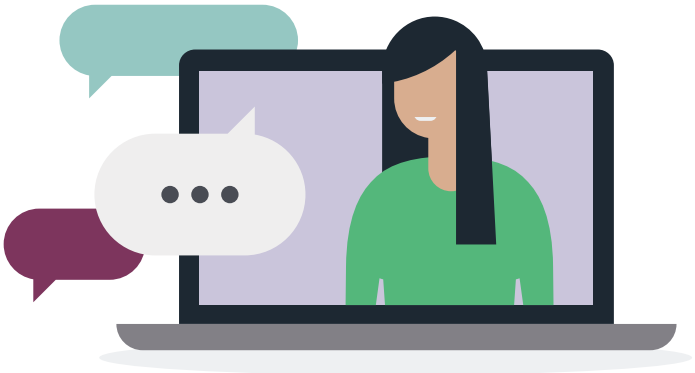
Prior to COVID-19, Medicare rebates were available for specialist video consultations in eligible (remote, rural and regional) areas and facilities, and for GP video consultations with eligible rural and remote patients.

In March 2020, temporary item numbers were created to allow telehealth items to be billed under Medicare in response to COVID-19. These item numbers and their requirements were expanded through March and April, with regular updates posted to MBS Online and MDA National's dedicated COVID-19 advice page. These item numbers will be available until at least 30 September 2020 and their continuing availability will be reviewed prior to this date.

Telehealth consultations may also be privately billed, without any Medicare contribution or rebate, with sound informed financial consent.

Is telehealth covered under my policy?

Telehealth is covered under MDA National's Professional Indemnity Insurance Policy, provided both you and the patient are in Australia and the practice is in accordance with the guidelines of the Medical Board, the relevant College and Medicare.



View the references at mdanational.com.au/advice-and-support/library/articles-and-case-studies/2020/06/tackling-telehealth

Tips for telehealth

- If you've called the patient, you should verify their identity by confirming name, address and date of birth.
- All participants should introduce themselves (including a support person).
- Adjust the camera, lighting or chair position if needed.
- Avoid rustling papers near the microphone, enunciate clearly, and ask the patient to repeat your instructions if you have any concerns about being heard and understood.
- Be prepared for technical issues.
- Assess the patient's condition based on the history and clinical signs to justify any proposed investigation or treatment.

More resources

Medical Board of Australia
Guidelines for technology-based patient consultations
Inter-jurisdictional technology-based patient consultations
RACGP
Guide to providing telephone and video consultations in general practice
Telehealth video consultations guide
mHealth in general practice
RACP
Telehealth guidelines and practical tips
ACCRM
Telehealth guidelines
Telehealth tool kit
RANZCP
Professional Practice Standards and Guides for Telepsychiatry
AMA
Position Statement: technology-based patient consultations
University of Queensland, Centre for Online Health
Quick guides for telehealth

Optimising telehealth for you and your patients

Dr Shannon Nott (MDAN Member)
Rural Director of Medical Services
Western NSW Local Health District

Are you transitioning your practice to working in telehealth? Our guest author and telehealth expert, Dr Shannon Nott, provides some practical information to get you started.

Selecting your platform

The market is full of options for videoconferencing (VC) and it can be confusing to figure out which one to use. Long story short is that you should invest in one that suits your needs. Here are some considerations for purchasing a platform:

- **Support**: Can you get tech support when you need it? Are there additional costs? What education/advice will your provider give you?
- **Broadband speed**: What's the optimal speed for your platform? Do a speed test and pay attention to download and upload speeds (most providers are optimal at a minimum of 2mbps up and down). Remember that high ping = increased lag time.
- **Waiting rooms**: Will your provider provide a virtual waiting room? This will significantly help you to manage patients and allow people to be 'placed' in the virtual waiting room until you're ready for them.
- **Browsers**: Some platforms work better on different browsers. Ask your provider for their recommended browser and use that. Make sure you advise your patients too!
- **Security**: Most providers have encrypted end-to-end transfer of data; make sure yours has this as a minimum. Ensure that any data stored on a personal device is deleted or encrypted using a commercial application.
- **Usability**: Is it simple? Odds are that if you're struggling with it, your patients are too! Also, ask your practice provider if there are VC providers compatible with your practice scheduling systems (e.g. can your practice software schedule for telehealth?).

Patient engagement

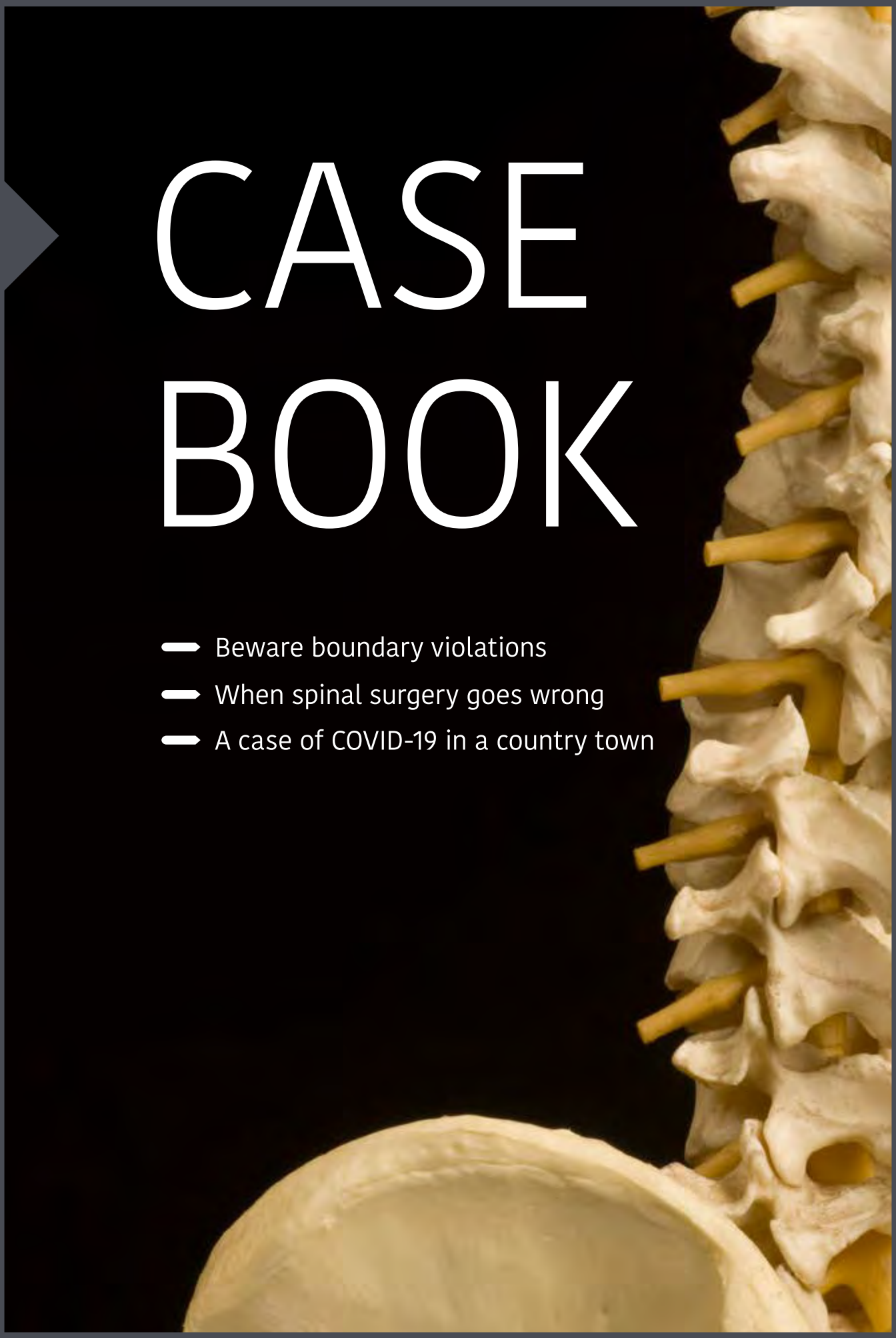
Remember that if you're new to telehealth, it's likely your patients are too. As with all aspects of medicine, good communication is key to making telehealth work:

- **Patient information:** Provide either patient information sheets or information on your website about telehealth. It's important to advise patients on what to expect, what your limitations are and how to access telehealth.
- **Practice staff:** Ensure your staff are familiar with your VC platform and can offer first timers support in logging in and/or do a practice run prior to their first consultation
- **Feedback:** Ensure you've developed systems to seek feedback (good and bad) from patients.

It's important to think through some of these areas as you get started with telehealth. Spending a bit of time upfront will save you a lot of time (and potential heartache) as you move forward.

CASE BOOK

- Beware boundary violations
- When spinal surgery goes wrong
- A case of COVID-19 in a country town



CASE BOOK

Beware boundary violations

Marika Davies
Medico-legal Adviser

A recent Tribunal decision[1] highlighted the importance of maintaining professional boundaries and respecting the dignity of patients.

The complaint

Dr A agreed to prepare a medico-legal report on a patient to assist with the assessment of her workers' compensation claim. The consultation, which was his first since returning to work after major abdominal surgery three months earlier, took approximately two hours following which he submitted a report to the insurer.

The patient subsequently made a complaint to the Health Care Complaints Commission alleging that the doctor had made inappropriate personal disclosures to her about himself and his family; had brushed against her back and breasts while examining her arms and shoulders; and that he hadn't left the room while she was undressing or given her a gown to cover herself.

The hearing

Dr A admitted having told the patient about his recent abdominal surgery for cancer and large scar, and that his son was becoming a veterinary surgeon. An expert appointed by the Tribunal was critical of the doctor's discussion of his own surgical management and family with a patient. The Tribunal accepted that the doctor hadn't made any other personal disclosures as alleged by the patient, but found he had failed to maintain appropriate professional boundaries between himself and the patient during the consultation.

The Tribunal noted that the patient was evasive and discursive when giving evidence, and that the accounts of the inadvertent 'brushing' by Dr A were different in all five of her written statements. Dr A denied this allegation and the Tribunal found he had not brushed against the patient, inadvertently or in any other way.

Dr A said he hadn't offered to leave the room while the patient was undressing because observation during this process was part of the medico-legal assessment. He admitted he hadn't offered the patient a gown. The expert said this fell significantly below the standard expected of a practitioner of an equivalent level of training or experience. The Tribunal agreed, commenting that it isn't appropriate for a medical practitioner to use disrobing by a patient as part of an assessment of mobility.

The outcome

The Tribunal took into account that Dr A was an elderly man in poor health at the time of the consultation, and that he had confined his practice to medico-legal assessments for a number of years. It also noted his favourable character references and that he had acknowledged it was good practice to provide a gown to a patient who is required to disrobe. The Tribunal considered it unlikely that Dr A would repeat these errors in any future consultation.

Dr A was cautioned in relation to unsatisfactory professional conduct for making inappropriate personal disclosures to a patient. He was also reprimanded for unsatisfactory professional conduct for failing to provide adequate privacy to a patient, and for failing to provide a gown to a patient when she was partially disrobed.

Medico-legal issues

- The professional relationship between a doctor and a patient is not a social one – it's a one-way arrangement and everything that goes on in a consultation should be about the patient and not about the doctor.
- Careful and limited self-revelation may occasionally be acceptable if it's genuinely for the benefit of the patient, e.g. as a method of establishing rapport.
- Disclosing personal matters to a patient is a warning sign that boundaries with patients may be at risk.
- Patients have the right to respectful care that promotes their dignity, privacy and safety.
- Always enable people to undress and dress in privacy, and allow them to dress as soon as possible after the examination.
- Do not assist patients in removing their clothes without checking that they need your help.
- Provide appropriate cover during the examination such as modesty gowns or sheets. There should be as little physical exposure as possible during an examination, and staged exposure whenever possible, i.e. re-cover an exposed area before uncovering the next area to be examined.
- Consider using a chaperone – a trained chaperone or a personal support person. Exploring the need for a chaperone with a patient is part of good medical practice.

Reference

1. *Health Care Complaints Commission v Wilcox* [2020]. NSWCATOD 10.

More resources

The Medical Board of Australia Guidelines
Sexual boundaries in the doctor-patient relationship
View Section 7 for information on conducting physical examinations

CASE BOOK

When spinal surgery goes wrong

Karen Stephens
Risk Adviser

While spinal surgery has successfully helped a great many patients, the outcome can be catastrophic if it goes wrong.

The Health Care Complaints Commission prosecuted a complaint against a surgeon before a Medical Professional Standards Committee concerning spinal surgery on the wrong side of the spine – contrary to the patient's consent and without adequate 'time-out' procedures to properly check the correct site for the surgery.

The Committee found the doctor's conduct amounted to unsatisfactory professional conduct and reprimanded him. It also imposed conditions on his registration that he submit to future audit of his medical records and provide evidence of his future participation in 'time-out' procedures.[1]

Claims data

- Claims against MDA National's neurosurgeons in the last 15 years show that **58%** of incidents and **78%** of incurred costs involved spinal surgery.
- **6%** of our orthopaedic surgeons who do spinal surgery account for **13%** of claims costs for all orthopaedic surgeons.

These figures are in keeping with US neurosurgeons' claims data.[2]

Negative outcomes for patients can be catastrophic – e.g. paraplegia, incontinence, and severe and/or chronic pain. Accordingly, payouts can be large. Several cases at MDA National have cost over $1 million, with some exceeding $3 million.

Surgeons have also been subject to disciplinary action, such as having conditions placed on their registration.

Procedures involved

Analysis of MDA National's cases shows that:

- procedures in the lumbar region were most involved (**>60%**)
- the wrong spinal level was operated on in approximately **10%** of cases
- procedures most often involved, in order of significance, were:
  - fusion
  - laminectomy
  - microdiscectomy
  - discectomy
  - foraminotomy.

Common themes in claims

Poor choice of patient or procedure

- Referrals to surgeons and decisions to operate should be made according to evidence-based clinical thresholds, for example:
  - there is high-quality evidence for open discectomy in patients with persistent, disabling chronic low back pain with radiculopathy due to herniated lumbar discs or spinal stenosis[3]
  - lumbar spinal fusion is not recommended for treatment of uncomplicated axial chronic low back pain, according to the Choosing Wisely campaign,[4] and MBS items for spinal fusion are not claimable for the treatment of uncomplicated axial chronic lower back pain.[5]
- Co-morbidities are associated with significant increases in complications.[6]
- Psychological components of chronic pain can complicate recovery.[7]
- A study of NSW workers' compensation patients concluded that the outcomes of spinal fusions were so poor that they were not recommended for this group.[8]

Failure to follow standard protocols

- Spinal localisation can be challenging, but there are many strategies to help ensure accurate intraoperative localisation.[13]
- Patient positioning should be afforded great care to minimise compression or traction of neurological structures.[14]
- Imaging should be checked for anatomic particularities, and high-quality imaging insisted upon.[14]
- Equipment-related failures have been implicated in surgical errors and adverse events – an equipment check is recommended as part of a pre-operative surgical safety checklist.[15,16]
- Surgeons should adhere to RACS' standards on safe working hours[17] and long elective operating lists[18] and, where possible, operate with a consistent theatre team.[19]

Problems with the consent process

- A study of patients undergoing spinal stenosis surgery revealed that patients frequently had unrealistic expectations of their surgery and consequently tended to have lower levels of satisfaction.[9]
- Failure to explain the risks and adverse effects of surgery, and failure to explain alternative treatment options were the two most common consent allegations in a retrospective cohort study of malpractice claims for spinal surgery.[10]
- Obtaining consent on the hospital ward or in the pre-operative holding area was associated with an increased risk than when consent was obtained in the rooms of the operating surgeon.[11]
- Patient understanding following their consent for orthopaedic procedures is significantly improved using procedure-specific consent forms.[12]
- Documentation of appropriate informed consent in the notes of the surgeon protects the surgeon and helps defend a claim.

Delay in recognition of complications

- Delays in the diagnosis and treatment of post-operative complications of spinal surgery may have devastating consequences and have been found to be predictive of a plaintiff victory in litigation.[20]
- Recovery room staff, other treating health professionals and patients should be informed about signs and symptoms to be concerned about and how to contact the surgeon urgently.

▶ View the references at mdanational.com.au/advice-and-support/library/articles-and-case-studies/2020/06/when-spinal-surgery-goes-wrong

CASE BOOK

A case of COVID-19 in a country town

Nerissa Ferrie
Medico-legal Adviser

Jack was self-isolating at home following his return from a two-month road trip around the US when he received a call from his local football teammate. “Hey! Just checking you’re still alive mate. I heard you’ve got coronavirus,” his friend said. “Facebook has gone right off!”

The patient

Jack was shocked. He hadn’t told anyone he had tested positive to coronavirus. Having seen some backlash on local social media about selfish travellers bringing COVID-19 back to Australia, he had decided to lay low until he recovered. As he lived in a small town in country Victoria, he was worried about his work prospects following his recovery if anyone knew about his diagnosis.

Jack told his friend he was fine and that he was self-isolating at home after his return from overseas. But Jack was concerned about how his friend knew about his diagnosis. Jack had avoided testing at his local practice and instead visited a large multi-disciplinary clinic over 30km away, where he felt he would have greater anonymity.

As the Facebook posts escalated, Jack became increasingly concerned about how his results were made public. He rang the practice and asked to speak to the doctor who had performed the test and delivered the results.

“I’m sorry, but Dr Sharma is working at another practice today,” said the practice manager.

A quick Google search revealed that Dr Sharma mainly worked at the large clinic where Jack was tested, but he also worked one day a week at the practice located in Jack’s town.

Jack called the local practice and asked Dr Sharma to explain how his privacy had been breached.

The doctor

Dr Sharma was shocked and embarrassed when the young man he had seen at another practice asked him how his COVID-19 diagnosis had been made public.

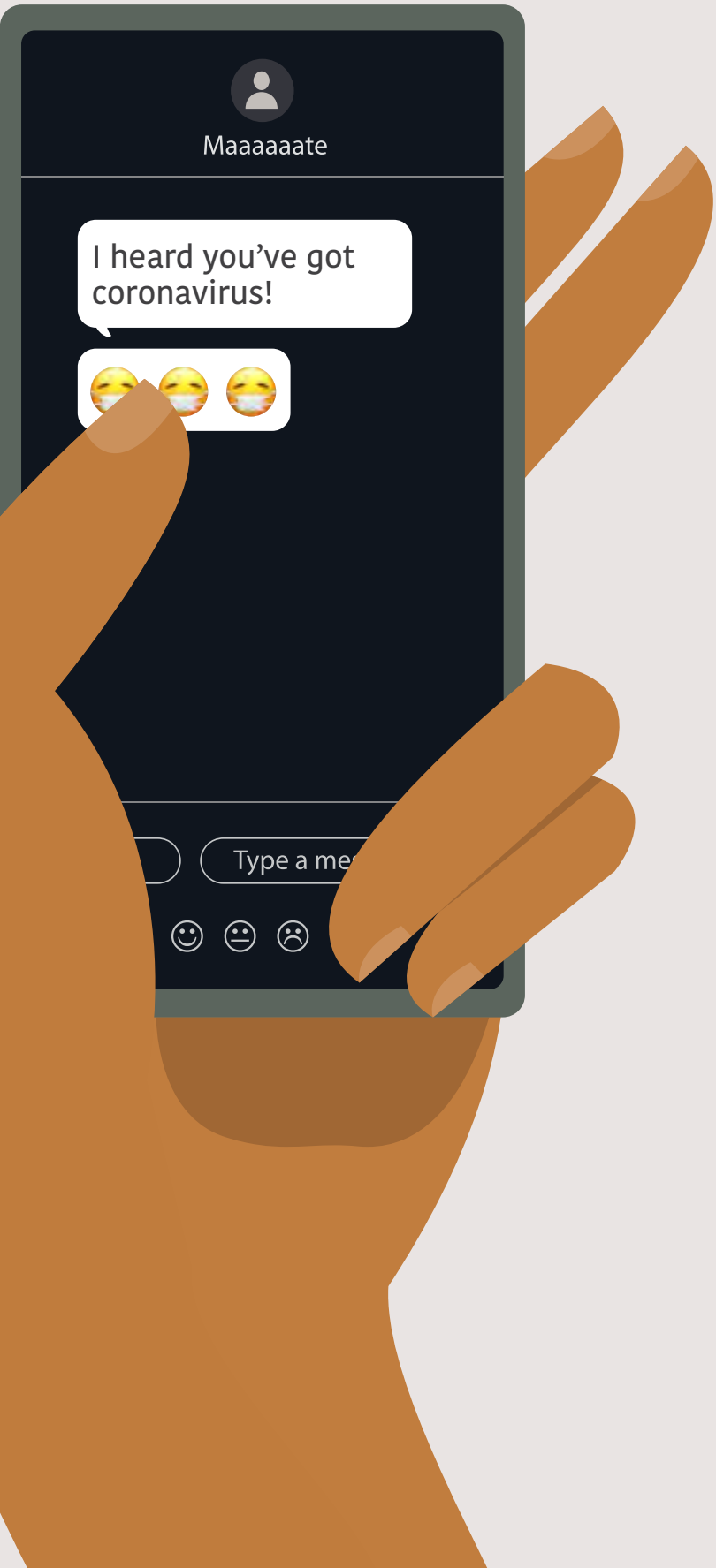
“So much for patient privacy. I told no one about my diagnosis, and now my name is all over Facebook,” Jack said.

Although Dr Sharma had tested Jack at the large multidisciplinary clinic, he received the results on the one day he worked at the local practice. Surprised at seeing the positive result as the patient had very minor symptoms, he had commented to the practice nurse that coronavirus had even reached their small town, with a young local man testing positive after recently returning from the US.

The patient was adamant on the phone that he had not disclosed his positive COVID-19 result to anyone, so Dr Sharma asked the practice nurse if she had told anyone else about the test results.

“Only my flatmate, and I didn’t look at the patient’s results or give her a name – I just told her what you told me,” she said.

On reflection, both Dr Sharma and the nurse realised that a patient in a large rural centre wouldn’t be as easily identifiable as a young man returning from the US in a town with a population of 450 people.



Medico-legal discussion

Dr Sharma called Jack and apologised for the inadvertent breach of his privacy. He explained that while he hadn't disclosed Jack's name or discussed his personal health information outside of the practice, he hadn't realised how easy it would be for the town locals to identify him by other means.

The practice considered its obligations under the Notifiable Data Breaches scheme, and determined that the breach wasn't likely to result in serious harm to the patient and therefore didn't need to be notified to the OAIC.

The importance of privacy was put on the agenda for the next practice meeting, where all staff watched and discussed the MDA National webinar: *Privacy and Info Security in Private Medical Practice*.

What can you do?

Some doctors are required to make a conscious decision to breach a patient's privacy. Others might face criticism for not disclosing a risk to public safety when they should. While system failures and cyber-attacks can lead to significant multi-patient breaches, many of the privacy breaches we come across at MDA National are completely unintentional and involve only one patient.

Health professionals are acutely aware of their obligations to keep personal health information safe, and yet patient privacy can be breached in any number of ways.

Here are some handy hints for maintaining patient privacy in your practice:

- Have a good understanding of patient confidentiality.
- Ensure your privacy policy is up to date, and that all staff receive regular privacy training.
- Include information on the appropriate use of social media and online professionalism.
- Make sure your systems are secure.
- Understand your obligations under the Notifiable Data Breaches scheme in the event of a breach.

Firstdefence

FOR DOCTORS IN TRAINING

- When curiosity kills professional conduct
- An IMG's road to GP training and fellowship
- Volunteering at events – what you need to know

When curiosity kills professional conduct

Janet Harry
Medico-legal Adviser

The case

A well-known rock band cancelled their tour and left the country with a plan to self-isolate at home. Prior to their departure, the lead singer became acutely unwell requiring hospitalisation and treatment after testing positive to COVID-19.

No one knew the singer had remained in Australia – so when the star's diagnosis was splashed across the front page of a gossip magazine, the hospital had no choice but to investigate the leak. The article included specific clinical information that could only have been known by accessing the patient's medical record.

The investigation

Several doctors at the hospital were asked to explain why they had apparently accessed the famous musician's medical records. Although the investigation was being conducted by the hospital, the doctors were advised that they could be referred to the Australian Health Practitioner Regulation Agency if they were found to have breached hospital policy in relation to privacy.

What if I accessed the record?

With so much personal health information being stored online, regular audits are conducted within hospitals to ensure there is accountability when it comes to patient privacy. At MDA National, we have assisted several doctors who have been investigated for looking at the medical records of their partners, other family members, or 'celebrity' patients.

Significant penalties can apply if you're found to have accessed medical records without clinical justification. In addition, there can be serious consequences at work – including disciplinary action, and even dismissal.

Medical practitioners working in hospitals should ensure they only access records and other health information about a patient when involved in the care of that patient, or for a purpose approved under hospital policy.

Things to think about

- Ignorance is a poor defence if you knowingly breach a patient's privacy. Ensure that you know your hospital's policy on privacy, as it's not enough to claim you were unaware of its existence.
- Make sure you log out after accessing your patient's records so that your login credentials cannot be used inappropriately by anyone else. There are many good reasons to protect your electronic footprint, and patient privacy is certainly one of them.
- If there is a universal login ID, ensure that you only access records where you're personally involved in a patient's care, or you have been directed to do so by someone senior.
- If you believe there is a genuine educational or other reason for you to access patient information, discuss this with your supervisor and document the discussion before accessing the notes.
- Remember that the bigger the celebrity, the greater the risk that their personal health will be inappropriately accessed, and an electronic audit trail examined.

An IMG's road to GP training and fellowship

Dr Vasuki Annamalai (MDAN Member)
GP Registrar - RVTS

Dr Vasuki Annamalai, a GP registrar, shares her personal insights to help IMGs heading towards general practice fellowship in Australia.

Doctors trained in countries other than Australia, whether they are Australian citizens or not, are referred to as an OTD (overseas trained doctor) or an IMG (international medical graduate).

I am an IMG in Australia.

I have a basic medical degree from the National University of Ireland and I'm a citizen of Sri Lanka, my country of birth. My road to fellowship has been a long and arduous one; but at the same time, it has given me the opportunity to become a better doctor.

Foreign-trained doctors make up a large part of the Australian medical workforce. I believe it's important for all medical practitioners to have a basic understanding of the processes involved in achieving specialist qualifications for IMGs. Some IMGs pursue the path to general registration with Ahpra before commencing specialty training. Others can enter a training program regardless of their residency or Ahpra registration status.

It took me a long time to figure out which specialty I wanted to pursue. When I was at PGY4 as an obstetrics and gynaecology RMO in New Zealand, a patient died during a night shift. Although it was no fault of mine, I still lost sleep over it. It was then that I decided to leave the hospital system. I felt general practice would keep me out of the hospital shift-work roster and give me the routine I needed, with more regular work hours.

I hope to finish up specialist general practice training next year and then pursue further training in palliative care. I do love general practice and the chance to practise all my skills including minor surgery, gynaecology, general medicine, mental health, obstetrics and paediatrics.

GP training and fellowship providers

Focusing on general practice in Australia, there are two providers of GP training:

- **Australian General Practice Training (AGPT)** – who recruit and fund the program, while the actual training is provided by Regional Training Organisations [RTOs]
- **Remote Vocational Training Scheme (RVTS)** – who recruit and provide their own training.

There are two colleges who award fellowship, which recognises the holder as a specialist general practitioner. Both colleges also offer an independent pathway to fellowship for experienced GP IMGs:

- **The Royal Australian College of General Practitioners (RACGP)**
- **Australian College of Rural and Remote Medicine (ACRRM)**

I was lucky enough to secure a training position with RVTS for the 2018 cohort. There were 22 funded spots and 91 applicants – a very popular program. RVTS aims to encourage GPs to work in a rural setting as they train towards achieving fellowship. Webinars, clinical teaching visits, and workshops twice a year are a regular occurrence.

I've had two lots of maternity leave in the last two years and RVTS have been very supportive of my family. I was able to get through the first part of the RACGP exams in February 2020 and I aim to complete the rest of the assessments by 2021.

Some things to consider when starting work as an IMG GP in Australia

- Fulfilling the conditions of the visa – work hours, pay rate, employer sponsorship, income tax
- Fulfilling the conditions imposed by Ahpra – supervision requirements, CPD requirements, evidence of progress towards fellowship
- Fulfilling conditions imposed by the specialist college – supervision, logbooks, face-to-face training, annual leave allowances, assessments. Keep in mind that regional training organisations that facilitate training for AGPT have their own set of rules – e.g. the requirement for the RTO in Tasmania is different to other states
- Considering the requirements for permanent residency and citizenship if you want to stay in Australia long-term – and what this means for the current citizenship held, dual citizenship, etc

I hope I've been able to shed some light for IMGs heading towards fellowship in general practice in Australia.

Here are some useful website links:

- Remote Vocational Training Scheme (RVTS): **rvts.org.au**
- The Royal Australian College of General Practitioners (RACGP): **racgp.org.au**
- Australian College of Rural and Remote Medicine (ACRRM): **acrrm.org.au**

Volunteering at events — what you need to know

Dr Kiely Kim
Medico-legal Adviser

Your daughter's football team is travelling interstate and the coach has asked whether you can act as their team doctor. What should you consider before you agree?

Doctors are often asked to help at events which could be for small local community clubs and organisations, or on a larger scale. Whether you're undertaking a paid or volunteer role, it's important to consider whether you have the qualifications, skills and experience for the health care you'll be expected to provide.

Consider potential medical problems that could arise

Depending on the type of event, you'll need to consider the range of medical problems you may be faced with. This may differ depending on the type of event – for example, at a sporting event you may need to be prepared to manage a wide range of conditions from traumatic injuries to a cardiac arrest. At a music festival, you might see heat-related illness and possible drug overdoses.

Whatever the role, it's important to recognise and work within the limits of your competence and scope of practice.[1]

Ensure you have equipment and support available

As well as having the appropriate skills and experience, you'll want to check that you have suitable equipment and support available. This may involve finding out what facilities and equipment will be provided by organisers, and the policies and procedures that will be in place. It will help to be aware of and familiarise yourself with local health services and support, including ambulance services.

Maintain your professional responsibilities

If you're involved in managing a medical problem at an event, your professional responsibilities of obtaining consent and maintaining confidentiality continue. Ensure you keep medical records of the health care you provide in case you're asked to provide information on this later.

- **Volunteering at an event is different to a Good Samaritan act[2] where a doctor is called to provide medical care in an emergency and there was no prior expectation to provide healthcare services. In either situation, you should consider your own safety and skills, and work within the limits of your competence in providing care.[3]**
- **Before agreeing to help at an event, check whether indemnity cover will be provided by the event organisers. If not, please contact MDA National to check whether your current membership will indemnify you for this.**

▶ View the references at mdanational.com.au/advice-and-support/library/articles-and-case-studies/2020/06/volunteering-at-events

Keep on learning...

Complimentary for Members

Webinars

Watch recordings of live webinars including responses to Members' questions. Topics include:

- pandemic practicalities
- Medicare, protecting your provider number
- common causes of claims for hospital-based specialists
- privacy and information security
- intimate examinations
- teamwork lessons from the 'Jack and Dr Bawa-Garba' case.

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

Participants' feedback

For the three live webinars delivered February-April 2020, evaluation responses averaged across the sessions:

- **84**% selected 8, 9 or 10 out of 10 when saying whether they would recommend the webinar
- **83**% said they would do something differently as a result of participating.

e-Learning

Online CPD activities are available 24/7 from your computer or tablet. Topics include:

- prescribing opioids
- medical record-keeping
- informed consent.

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

Members' feedback

From surveys averaged for these three on-demand e-learning activities in 2019:

- **93**% selected 8, 9 or 10 out of 10 when saying whether they would recommend the online activity
- **96**% said they would do something differently as a result of participating.

Podcasts

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

Listen to them on Apple Podcasts or Spotify, and find them under 'podcasts' on our library webpage:
mdanational.com.au/advice-and-support/library

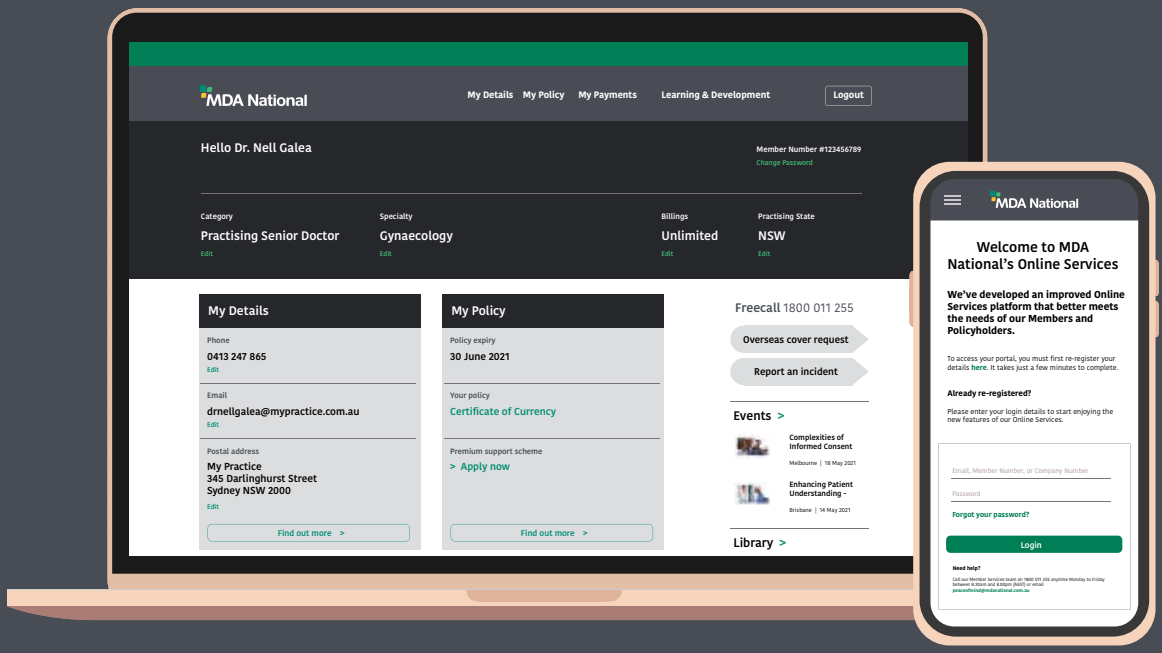
- More invitations to live education sessions arriving in your inbox soon!
- Ideas for education resources warmly welcomed - send an email to education@mdanational.com.au

MDA National has launched a new and improved Member Online Services platform to make it easier to view your policy information and update your contact details on the go — quickly and hassle-free.

There are many other benefits including:

- access to our latest stream of podcasts, articles, blogs, case studies and webinars
- live-chat with our medico-legal advisers for real-time online support with any issue you're facing.

➡ To access Online Services visit **members.mdanational.com.au** and re-register your details.



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  Level 3
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  Southbank VIC
  3006
- PERTH
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  6005
- SYDNEY
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