WINTER 2022

Defenceupdate

Managing challenging interactions during COVID-19

- Disability is not inability
- Is it time for a second opinion?
- Medico-legal case book
- First Defence for junior doctors

Medico-legal content

FOR MEDICAL PRACTITIONERS

MDA National
Support Protect Promote

Welcome to our Winter 2022 edition of *Defence Update*.

As we work our way through our third year of the COVID-19 pandemic, it's timely to consider the effect that this prolonged period of change, uncertainty and challenges has had for everyone – doctors and patients alike. Unfortunately, this can be reflected in challenging or unacceptable behaviour from patients. Our Medico-legal Feature (pages 13-16) delves into this, outlining ways to avoid or minimise conflict, with a reminder that sometimes it may be best to end the doctor–patient relationship.

On pages 4-5, Dr Palipana shares his experience as a medical practitioner with a disability, and his views on how we're managing this in Australia – there's progress, but still much to be done in this space.

In our Case Book section, we describe a case where the referral process did not go to plan, highlighting the role of the referring doctor (pages 18-19). And on pages 22-23, we discuss how to deal with fake medical certificates.

Do you have your own doctor? Do you write your own scripts or arrange your own referrals? Managing your own medical care risks your patient care being less than ideal, and it can lead to an investigation by Ahpra. Dr Walter discusses this situation and the Medical Board's Code of Conduct on pages 20-21.

Patient discharge and the handover from hospital to community care is a risky time for patients and for our junior doctors. A/Prof Anna Holdgate provides some practical advice to manage this safely (pages 24-25).

If you're thinking of launching into private practice, we have a brief guide (pages 26-27) to help you get started.

I hope you enjoy this edition of *Defence Update*.

Dr Jane Deacon
Manager, Medico-legal Advisory Services

In this issue

It's renewal time!

Continue your journey with a doctor-owned mutual that supports you in the moments that matter.

Renew your policy and membership by **30 June 2022.**

Our Member Services team is here to help you:

1800 011 255

peaceofmind@mdanational.com.au

Want more medico-legal updates?

Receive our medico-legal blogs direct to your inbox to stay on top of the latest industry news. Subscribe at **mdanational.com.au**.

Stay connected!

Follow us on social media where we share medico-legal updates, articles and case studies. Search for **@MDA National**.

CONTRIBUTING AUTHORS

The articles in *Defence Update* contain topical, practical and expert insight to support you in providing safe patient care.

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

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

A/Prof Anna Holdgate
Senior Staff Specialist, Emergency Medicine

Dr Dinesh Palipana
Doctor, Lawyer & 2021 QLD Australian of the Year

Tanith Chippendale
Medico-legal Adviser

Dr Jane Deacon
Manager, Medico-legal Advisory Services

Nerissa Ferrie
Medico-legal Adviser

Deborah Jackson
Medico-legal Advisory Counsel

Dr Kiely Kim
Medico-legal Adviser

Karen Stephens
Risk Adviser

Dr Sarah Taylor
Medico-legal Adviser

Dr Julian Walter
Medico-legal Adviser

FROM THE PRESIDENT
A message to our Members

While it continues to be a challenging time for MDA National, at least our working environment has returned to some semblance of normality. I was delighted to attend the opening of our new office in Melbourne in March. Now that interstate travel restrictions have been lifted, the Board can finally have those deeper strategic conversations that can often only occur face to face, over a sandwich or sausage roll.

The World Health Organisation's announcement of a new variant of clinical significance had us all checking our Greek alphabets last year. In many respects, the evolution of the Omicron variant appears to have presented a way out of the most restrictive elements of the pandemic. But people around the world continue to suffer the consequences of SARS-CoV-2 infection, and the reality is that vulnerable cohorts in Australia still remain at risk.

The catastrophic floods that affected communities in New South Wales and Queensland will have an enduring impact on reinsurance markets. The disaster that is the Russian invasion of Ukraine will be a source of volatility and uncertainty for our investments. These are very real human tragedies that affect us all in different ways.

Last year my colleagues and I communicated the need to increase premiums to match the increased costs of an adverse claims environment. There was some good news on claims last year, but sadly it came on the back of reduced elective surgical activity for our Members across Australia. We guard Members' funds very carefully and we have enjoyed several wins in the courts in recent months defending the actions of Members.

There's no question that some of the drivers of the increased claim costs are plaintiff–lawyer activity and the increasing generosity of the courts. Equally, there are far too many cases where our Members have failed to deliver the requisite level of care. In other cases, they may have shown the appropriate forethought, skill and care, yet failed to document their management plan in a way that would allow us to offer an appropriately vigorous defence.

We cannot simply assert that social inflation is the root of all our problems. In the year ahead, I look forward to meeting Members around Australia and overseeing the work we do on education and support in practice. In striving to help enhance the safety and quality of medical practice in Australia, we seek to reap the double dividend inherent in reducing negligence claims, for the benefit of our organisation, our Members, and the patients they serve.

Dr Michael Gannon
President, MDA National

Disability does not mean inability

Dr Dinesh Palipana OAM (MDA National Member)
Doctor, Lawyer & 2021 Queensland Australian of the Year

We have an incredible opportunity – a privilege to do good in our world that reaches far beyond the practice of medicine alone. However, to draw from Thomas Jefferson, we must be eternally vigilant about protecting and using that privilege for the greater good.

Halfway through medical school, a catastrophic car accident left Dinesh with a cervical spinal cord injury. Despite the hardship, he persevered with his medical studies and became the first quadriplegic doctor to begin work in Queensland.

The journey through the profession isn't easy for someone with a disability. That's not because of inability, but rather because of our preconceived notions about what someone can and cannot do. Even worse, it might be based on our prejudices of what someone should and should not do.

But people with disabilities across the world are overcoming these barriers and misconceptions. There is, for example, an emergency physician with quadriplegia; an orthopaedic surgeon using a wheelchair; and even a director of nephrology who is paralysed from the chest down. There is a deaf general practitioner; a blind rehabilitation physician; and a paediatric neurologist with cerebral palsy. Yet, these doctors are few and far between.

According to the Australian Bureau of Statistics, 4.4 million Australians or 17.7 per cent of the population had a disability in 2018. That's one in five people. However, on many of the tables I've sat on, I've been the only doctor with a visible disability.

Immediately after that statistic was generated, the COVID-19 pandemic hit. It was a difficult time for the world, but especially challenging for people with disabilities who faced life threats like healthcare rationing apart from the social problems.

In Australia, there are still significant attitudinal – but rarely logistical – challenges for accepting doctors with disabilities into our medical profession. Over the years, I've heard comments like, *"What if they fall from the wheelchair?"* or *"Will the patients take them seriously?"*.

We need to remember that the field of medicine encompasses a wide range of specialties, each requiring different skill sets and physical requirements. And just like any other doctor wishing to specialise, a person with a disability will seek a specialty that best suits their capabilities.

> *"The barriers and separations we create are just social structures. We have to take these away to create utopia.*

> *Why do we always wait for tomorrow? Let's just do things and make it happen. Action is what is necessary. Action today."*

It's not enough to just pay lip service

Our country has invested significant amounts of money into the National Disability Insurance Scheme, the National Injury Insurance Scheme, and JobAccess – programs designed to enable people to live life to the fullest while contributing to our community. These schemes send a powerful message – that Australians take disability inclusion seriously.

Despite all this, it takes continuing effort to maintain progress.

For example, I received a letter in 2022 from a particular medical fraternity declining a request to join them. It stated, *"Please note that the decision outlined above in no way detracts from the admiration that the ... or its individual members or staff have for you and your achievements in the profession of medicine to this time."* In other words, no matter how far you've come, we still don't want you as a part of our tribe, even though we talk about valuing diversity and inclusion.

Are we doing our part as doctors?

We, in the Australian medical profession, can be a beacon for the rest of the world. Our responsibilities not only span direct patient care, but the betterment of our society as well. That's because we have the honour of a credible voice.

Indeed, historically doctors have been a voice for many important social matters. Professional associations of physicians fought the Bulgarian government when they were trying to hurt the Jewish people in World War II. Doctors were voices in the American Civil Rights Movement. The Physicians for Human Rights organisation in the United States even shared the 1997 Nobel Peace Prize for their work.

In addition to my work as a doctor in an emergency department, I'm proud to have co-founded Doctors with Disabilities Australia. I'm proud to work with the Disability Royal Commission as Senior Advisor; to be an Ambassador for the IncludeAbility program at the Human Rights Commission; and to do a range of work that will hopefully make a meaningful contribution – at least in a small way – to ensure a brighter future for Australia.

Is it time for a second opinion?

Dr Kiely Kim
Medico-legal Adviser,
MDA National

As with making any major life decision, when facing a significant health issue, many patients will want to consider their options carefully. This may also involve seeking a second opinion.

Whilst dependent on the clinical situation, there may be benefits to this – particularly when there is diagnostic uncertainty. This was shown in a retrospective study by the Mayo Clinic in 2017 finding that in one in five cases, the final diagnoses were distinctly different than referral diagnoses.[1]

Doctor-initiated second opinions

The term 'second opinion' has traditionally been considered to mean when a doctor seeks the opinion of a colleague to assist in a patient's management.

This may occur in the context of a complex, poorly defined or uncommon case. Asking a colleague to see and review a patient may help reassure you to continue the current plan or consider other options in managing the patient.

Occasionally, you may need to stop and consider if you are the right person to provide the care. For example, there may be treatments or procedures you feel comfortable in providing. However, you may be unsure whether the plan is best for you or best for the patient's specific circumstances. This situation can sometimes occur when there has been a complication after a procedure. Are there options outside your area of expertise where the opinion of a colleague can assist?

There are times when you may be concerned about a breakdown in communication with the patient, or you feel the patient is not accepting of your recommendations. In these situations, it can be helpful to suggest a second opinion to show you've taken steps to seek advice on the most appropriate treatment options and allow the patient an opportunity to obtain further advice.

High-risk surgeries and experimental procedures are other instances where a second opinion would be worthwhile.

Patient-initiated second opinions

There may be several factors that could motivate a patient to seek a second opinion – including confirming a diagnosis or treatment plan, dissatisfaction with previous advice, a desire for more information, treatment complications, and consideration of treatment costs.[2,3]

Patients have the right to seek a second opinion if they wish[4] and this is supported by the Medical Board's Code of Conduct[5] which states:

Good medical practice involves …

3.2.10
Supporting the patient's right to seek a second opinion.

3.3
Shared decision-making: Making decisions about healthcare is the shared responsibility of the doctor and the patient.

View the references online: **mdanational.com.au/time-for-second-opinion**

Communication and privacy

Problems may arise when a patient seeks a second opinion from you, but is not aware that you might be contacting the initial treating doctor for further information.

While most patients would reasonably expect[6] you to communicate with the initial treating doctor, it's good practice to obtain the patient's express consent before doing so. It may be a red flag if the patient is unwilling to provide consent.

Remember to document the patient's consent, the second opinion, and all relevant information in the patient's medical record.

Respecting colleagues

If you're asked to provide a second opinion, it's important to respect not only the patient but also the initial treating doctor. Disparaging and off-the-cuff comments can lead to a complaint or claim against the initial treating doctor, even though the care provided was entirely appropriate.

Remember – the patient may be providing a history that isn't completely accurate and further clinical information may need to be obtained where possible.

Second opinions can be helpful to both patients and doctors to provide reassurance or a fresh perspective on a complex or difficult clinical situation. It's important to keep the patient's best interests in mind, be clear with expectations, and communicate clearly and courteously with both patients and colleagues.

Think before you talk

Your obligations with third-party information

Dr Sarah Taylor
Medico-legal Adviser,
MDA National

It's a common scenario. Your receptionist calls you to say, "*Doctor, before you see the next patient can you please take this phone call from ...?*" But the caller is not a patient. The person on the phone might be your patient's partner, parent, adult child, or even a nosy neighbour.

Before you know it, the caller is giving you unsolicited information, quickly followed by, "*You cannot tell the patient that I told you this.*" Such information can also come in uninvited, in the form of a 'private and confidential' email or letter, similarly refusing consent for disclosure to the patient.

These scenarios have the potential to cause a medico-legal headache and serious consequences for all involved.

Patient confidentiality

According to *Good Medical Practice: A Code of Conduct for Doctors in Australia*, patients have a right to expect that doctors and their staff will hold their information in confidence. This is unless the patient provides consent; the information is compelled by law; or public interest considerations prevail.

While it's not a breach of confidentiality to listen, breaches of confidentiality can occur inadvertently during discussions with a third party. Your obligations in relation to confidentiality should be made clear, presuming the discussion needs to occur at all.

Damage to the therapeutic relationship

If the patient subsequently finds out about the discussion, they may understandably feel their trust in your therapeutic relationship is lost. Patients are rightfully suspicious of information provided (or discussed) about them, without their involvement.

It may put you in an awkward position if the patient should confront you directly, seeking to know if you engaged in a discussion about their health with a third party.

Privacy obligations to the third party

The caller may have refused to allow you to reveal to the patient what it was you discussed, or even their identity. Yet, they expect you to magically act on this information.

Privacy laws may restrict what you're able to do with the information without the consent of the caller. When receiving unsolicited information, your obligations under Commonwealth privacy law require you to *"decide whether or not (you) could have collected the information"* [4.2]. If you *could not* have legitimately collected the information, you need to decide whether there is an overarching obligation to act on it.

There are circumstances where the information (and source) might need to be revealed – such as serious risk to life, health, or public safety (e.g., firearm or driver safety) or where mandatory reporting obligations are involved (e.g., child safety).

Where there is no consent to inform the patient, consider whether the information should be destroyed, returned or ignored.

A decision to disclose the information should be made after obtaining advice about the specific circumstances, carefully considering the balance of risks.

How to store this information

Presuming the information cannot be discarded, deciding where to store it is often the trickiest part.

Any information stored in the file will likely be available to the patient, given their right of record access under privacy law. If you decide to destroy the information and not store it in the patient record, you may still need to retain a copy of what was provided so you can later demonstrate why it was not placed in the records. Your medical defence organisation may be the best place to store such a document.

How to avoid the pitfalls

- If possible, you should make the information provider aware at the outset of the conversation that any collateral information they disclose, including their identity, will be revealed to the patient. This discussion should occur before they disclose anything to you. If they do not consent, then you can refuse to proceed.
- Consider the impact on your therapeutic relationship with the patient before engaging in any discussion about unsolicited information.
- Any information received from a third party following their consent to release to the patient should be disclosed and verified with the patient at the earliest opportunity. If you need to store the information in the records before talking to the patient, ensure its unverified nature is also documented.
- If information is inappropriately stored in the records, these matters can be exceedingly complex to manage successfully, given the patient's right of access.
- If the unsolicited information raises concerns regarding serious risk to life, health, or personal and/or public safety, then it may need to be acted on without the discloser's consent.
- Please feel free to contact our Medico-legal Advisory Services team about how to handle unsolicited information. Ideally this advice should be sought *before* you store the information.

Misconceptions about shared decision-making

Deborah Jackson
Medico-legal Advisory Counsel,
MDA National

Shared decision-making (SDM) has many benefits and is widely accepted internationally. Despite this, the extent to which it is implemented can vary depending on the consultation, patient's preferences, and the clinician's misconceptions.

SDM — the barriers and misconceptions

1.

Time constraint – the most frequent concern and barrier to adopting SDM[1]

Three systematic reviews on intervention to implement SDM and the impact of decision aids on processes of care and patient outcomes indicate there is no systematic increase in consultation duration when SDM is implemented, or decision aids are used.[2]

2.

Patients will be unsupported when making healthcare decisions

There can be a fear that SDM will make patients feel abandoned during difficult decisions, which is a misinterpretation of its intent. SDM is not about insisting every patient make the decision – rather, it helps to ensure patients are informed about their options and are offered the opportunity to participate in the process.[3]

3.

Not every patient wants to share the decision-making process with their clinician

An Australian survey found more than 90 per cent of women preferred a shared role with their doctor in making decisions about screening and diagnostic tests.[4] A European survey of more than 8,000 people reported a high desire for SDM which was greater than 70 per cent of the sample.[5]

A systematic review of 14 studies that examined the match between patient preferences about information and decision-making with clinician–patient communication found that a substantial number of patients (52 per cent) were dissatisfied with the information given and would have preferred a more active role in decisions concerning their health, especially when they understood the expectations attached to this role.[6]

Interestingly, of studies conducted in 2000 and later, most respondents preferred a role in sharing decisions compared to 50 per cent of studies conducted before 2000.[7] This no doubt correlates to an increased level of health literacy in the community.

4.

Most people are not able to participate in SDM

Critics assert that it's too complex.[8] Clinicians who regularly adopt this process maintain SDM is comprised of a set of behaviours that can be learnt, and patients and carers can also learn this process.[9]

5.

SDM cannot be used with vulnerable people

SDM is too complex for all patients to acquire, and vulnerable people may never be able to share decisions with their clinicians.[10]

Most surveys show that vulnerable people are less willing to participate.[11] We need to be careful not to increase health inequities by offering SDM solely to the most privileged patients.

View the references online: **mdanational.com.au/shared-decision-making-misconceptions**

Individuals with low health literacy want to be involved in health decisions, but often lack the knowledge, skills and confidence to communicate with clinicians, navigate the health system, and engage in SDM.[12] They receive less information, ask fewer questions, and are less satisfied with the clinician's communication; and what we see is they are the ones more likely to complain or make a claim.[13]

In order to decrease health inequities, more needs to be done to engage the most vulnerable patients to make informed decisions.[14]

6.

I already do this

Most clinicians feel they already successfully engage their patients in SDM – a belief that may arise from not really understanding what it is and how to do it.[15]

7.

Fear of raising patients' anxiety levels

Some clinicians are afraid SDM will raise patients' anxiety levels as they become aware of the inherent uncertainty of evidence.[16]

A Cochrane review of decision aids refutes this misconception, finding no effect on anxiety – noting anxiety should not be confused with the decisional conflict individuals can experience when comparing the pros and cons of different options.

Are decision aids crucial?

This is a frequently asked question regarding SDM.

The short answer is, they are valuable but not necessarily essential. They are very useful for patients with a low level of health literacy, and further enhance a patient's understanding even with a high level of health literacy.

Decision aids including option grids are tools designed to facilitate patient participation in healthcare decisions. Practitioners can use a simple graphic to supplement (but not replace) the discussion with the patient, carer, or family.

Research supports the view that patients who are given decision aids are more knowledgeable, feel better informed, are clear about their values, and generally have a more active role in decision-making (which is one of the objectives of SDM). They also have a better understanding of the risks and may achieve decisions consistent with their informed values.[18]

Decision aids can reduce the use of discretionary surgery without apparent adverse effects on health outcomes or satisfaction.[19] They can be very effective when there is more than one medically reasonable option to diagnose or treat a health problem.

Decision aids prepare a patient for decision-making, provide facts about a person's condition and the options. They help the patient clarify and share their values with the health practitioner so that a course can be planned that matches their values.[20]

The Australian Commission on Safety and Quality in Health Care has extensive education on decision aids – ranging from videos, webinars, support tools, and links to the Ottawa Hospital Research Institute (a leader in SDM).

When doctors sell products

Karen Stephens
Risk Adviser, MDA National

A Queensland GP was reprimanded and had conditions imposed on her registration in 2019 after she failed to disclose a conflict of interest for recommending a particular product and involving a patient in a marketing scheme.

The legal separation between prescribing and dispensing of medicine was designed to prevent conflicts of interest.[1] We now see cosmetic doctors selling skincare products; integrative medicine practitioners selling supplements; and doctors being approached to endorse products.

These situations blur the boundaries between a therapeutic relationship and a commercial relationship. A patient may feel pressured to purchase; financial gain may distort a doctor's judgement of the patient's best interests; and the trust between doctor and patient may be undermined.

Honesty and transparency

The Medical Board's Code of Conduct covers conflicts of interest (10.12) and financial and commercial dealings (10.13), including:

> *A conflict of interest in medical practice arises 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… They require identification, careful consideration, appropriate disclosure and accountability.*
>
> …
>
> *Doctors must be honest and transparent in financial arrangements with patients. Good medical practice involves:*
>
> … ***declaring to your patients your professional and financial interest in any product you might endorse or sell from your practice, and not making an unjustifiable profit from the sale or endorsement.***

It would be reasonable to inform patients of your profit verbally if discussing a product, and in writing as part of an online product listing. An unjustifiable profit might involve a price above the recommended retail price, if one exists. Also, inform the patient where else they can purchase the product. If the product is part of a patient's clinical treatment, document this in the medical records.

Safety and efficacy

Before selling products to patients:

- satisfy yourself that any scientific claims are authoritative (e.g., from peer-reviewed journals)
- consult the literature independently rather than rely on the manufacturer's claims
- inform the patient if there is little scientific evidence for the product, and document this in the medical records
- be alert to potential drug interactions
- stay up to date with the product's scheduling status with the Therapeutic Goods Administration (TGA).

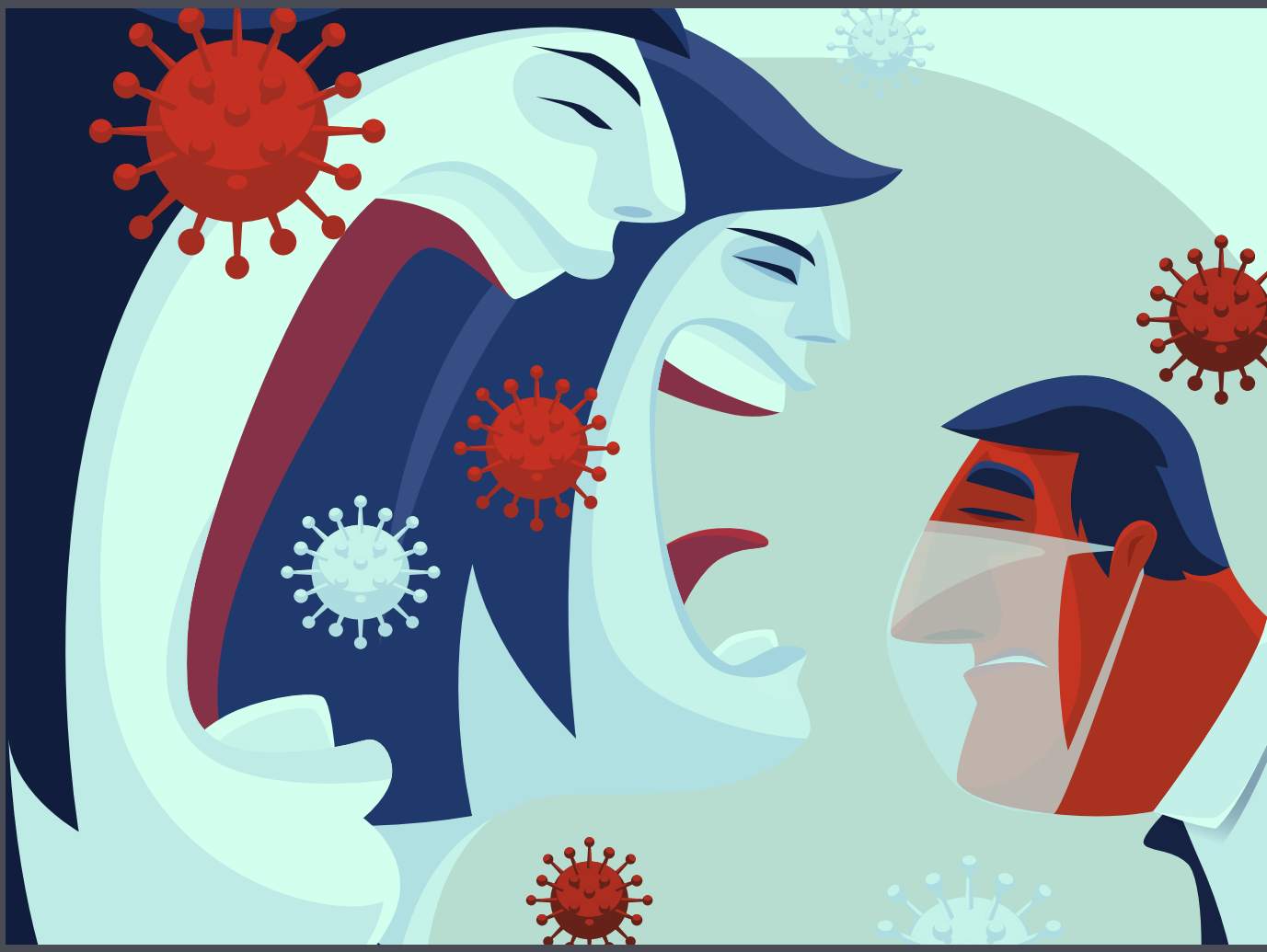
Advertising

- Making claims of a scientific nature must be accompanied by appropriate evidence for such claims – see Ahpra's *Acceptable evidence in health advertising*.
- If a product you're selling is a 'therapeutic good' (as opposed to cosmetic) or is advertised using claims of a therapeutic nature, advertising must comply with therapeutic goods regulation – see the TGA's Advertising hub.
- You should be familiar with the Australian Competition and Consumer Commission's information for medical professionals about the Competition and Consumer Act.

Insurance coverage

Seek advice as to whether you need product liability insurance. Your Professional Indemnity or Practice Indemnity Policy may have an exclusion in relation to indemnity for matters arising out of supply of goods and products.

View the references online: **mdanational.com.au/when-doctors-sell-products**



MANAGING CHALLENGING INTERACTIONS DURING COVID-19

Doctors and practice staff have always seen their fair share of challenging behaviour, but never has this become more apparent than during the COVID-19 pandemic. All staff are entitled to a safe working environment, and there are steps you can take to minimise the risks to those on the front line.

The COVID effect on patient interactions

Nerissa Ferrie
Medico-legal Adviser, MDA National

Does this sound familiar?

These are examples of comments heard in medical practices across Australia throughout the COVID-19 pandemic.

When should I end the doctor–patient relationship?

Thresholds for ending the doctor–patient relationship differ significantly across medical practices, but Ahpra and other health complaint bodies recognise that part of good medical practice is acknowledging when the doctor–patient relationship has broken down.

A good therapeutic relationship is one built on trust, communication, and mutual respect – and this often extends beyond the doctor and the patient. It's not a good therapeutic relationship if the patient is polite to the doctor, but constantly rude to practice staff. And similarly, the doctor may have an excellent relationship with the patient but be subjected to constant abuse from a carer or family member(s). It's not good for the doctor or the patient if the relationship has become dysfunctional.

Keep your cool

It's often tempting to respond in kind when faced with a rude or abusive patient. Unfortunately, there's nowhere to report rude patients, but plenty of places for patients to report doctors and practice staff. Keep your cool. This doesn't mean you should do nothing, but it takes two people to argue. Sometimes the best way to take the heat out of the conflict is to simply remove yourself from the situation as soon as possible.

If someone becomes abusive on the phone, you can calmly advise the caller that you will be terminating the call and invite them to put their concerns in writing. If the patient becomes abusive in person, you can ask the patient to leave the practice and contact the local police if they refuse to do so.

Fear can be a powerful emotion

COVID-19 has changed our world, and a fear of the unknown can provoke enormous stress in the most unlikely people. There have been so many changes over the past two years that everyone in the community is feeling the stress, as evidenced by the increase in demand for crisis and mental health support services during the pandemic.

Practices have struggled to keep up with a multitude of rule changes, so it makes sense that patients will often be a step behind. A calm and reassuring approach is often best when faced with a patient who may be struggling to understand public health orders – but it's also important to know when to back off. For every patient who genuinely wants to understand why they're required to wear a mask in the practice waiting room, there may be another who is filming the encounter so they can accuse you of breaching their human rights and post it on TikTok.

All vaccinators will go on trial for war crimes for breaching the Nuremburg code!

In our experience, if a patient has a fixed view on mandates, masks or vaccination, there is little point in entering into a dispute with them. You may not agree with the patient's point of view, but they are entitled to an opinion provided they do so in a respectful way. While you can provide your clinical advice and document the discussion in the notes, it's pointless to get into a one-on-one argument with someone proferring an 87-page dissertation on why COVID-19 is a global conspiracy.

Make sure your policies are clear

Ahpra has issued guidance on facilitating care during the pandemic, and this has led to many practices putting in place interim policies to ensure they can continue to treat patients while keeping their doctors and practice staff safe.

For example, if you're introducing an initial telehealth consult for patients who have respiratory symptoms, make sure your policies are clear and easy to locate. Some practices don't advise patients about additional requirements until the appointment has been booked. This can lead to anger and frustration for the patient who may take it out on frontline practice staff.

If you have policies in place during COVID-19, ensure the policies are clearly explained anywhere patients may go for information – including your booking page, practice website, social media, or a sign on the front door. There's no guarantee that a current or prospective patient will agree with your policy, but it will make everyone's life easier if the policy is transparent. As long as your policies are not discriminatory and are written in accordance with the Ahpra guidelines, you can usually defend a complaint made as a result of your COVID-19 policy.

Where to get help

Sadly, we have seen some appalling behaviour towards the medical profession over the last two years. Doctors and their staff are doing their best to provide quality care under very difficult circumstances, and receiving unwarranted abuse can be a little soul-destroying for even the most robust health professionals.

MDA National has a dedicated COVID-19 webpage with some really useful FAQs and links. But for those tricky ethical dilemmas or for some reassurance and guidance, you can always contact our helpful Medico-legal Advisory Services team for prompt and personalised advice and support.

Case study

The COVID effect

Jennifer had been a patient of the practice for almost two decades, and she had always been polite and respectful to the doctors and practice staff. This was why Dr Jones was so shocked at the change in Jennifer's behaviour at the start of the COVID-19 pandemic in 2020.

Jennifer complained loudly when she was advised that all patients attending the practice would be required to wear a mask. She said she had a history of anxiety which made it difficult to wear a mask, and she demanded Dr Jones provide her with a medical exemption. He checked her history and advised he couldn't give her a mask exemption when his clinical records didn't support a diagnosis of anxiety.

Jennifer asked for a transfer of her records to another local practice in the area, "because they said they would give me a mask exemption."

The practice didn't hear from Jennifer again until she booked an online telehealth appointment in late 2021. The practice contacted Jennifer and advised her that Dr Jones couldn't do a telehealth appointment – because it had been more than 12 months since her last face-to-face appointment, and she didn't meet the requirements for an "established relationship". She abused the receptionist and slammed the phone down in her ear.

Jennifer booked a face-to-face appointment two weeks later. Dr Jones greeted her politely and asked what he could do to help her.

"I need a COVID vaccination exemption," she said aggressively.

Dr Jones said he would consider an exemption if she met the requirements under the ATAGI guidelines.

"I am a teacher, and if I don't get a COVID exemption I won't be able to keep working," she said.

Dr Jones sympathised with her situation but asked her on what medical basis she was seeking an exemption.

"What do you mean? COVID vaccinations are experimental, and I'm not a lab rat. My Facebook group said my doctor will give me an exemption on the basis that the vaccine mandate is affecting my mental health."

Dr Jones explained the ATAGI guidelines and said that stress from a COVID-19 mandate did not trigger an exemption.

"THEN MAKE SOMETHING UP! You're just like all the other doctors in bed with big pharma. When my children starve it will be your fault because you won't bend the stupid rules and give me an exemption!"

Jennifer stormed out of the practice, refused to pay for the consultation, and swept everything off the reception desk on her way out.

Dr Jones and the practice staff were really shaken after Jennifer's departure. A medico-legal adviser assisted Dr Jones with a letter ending the therapeutic relationship, and Jennifer was advised that no further appointments would be booked for her at the practice.

Keep on excelling with complimentary education

We provide a diverse suite of education activities, complimentary for MDA National Members. All programs have been developed in consultation with our Members, and many of the activities attract CPD recognition to help you fulfil your CPD obligations.

Face-to-face learning

With an extensive range of programs available, Members can access education events throughout the year.

Popular programs include:

- *Practical solutions to patient boundaries*
- *Making teams work: through culture, collaboration and conduct*
- *Win-win: conflict resolution*
- *Achieving valid informed consent*

View what's coming up in your state at: **mdanational.com.au/member-benefits/events**

Workplace-based sessions

Looking to upskill and develop your team at a date and time that suits your organisation?

Our programs are available to be run in-house for our Members.

View available programs and request a session at: **mdanational.com.au/member-benefits/education/face-to-face-education-sessions/request-a-face-to-face-session**

e-Learning

Undertake learning when it suits you. Our comprehensive e-learning activities are available 24/7 to complete on your own device and in your own time.

Activities include:

- *Informed consent challenges*
- *Noteworthy: the how, what, where and why of medical documentation*
- *Challenging emotions of difficult news*

Access these and more at: **mdanational.com.au/member-benefits/education/online-activities**

On-demand webinars

Members can access a range of recordings of live webinars on demand.

Topics include:

- prescribing opioids
- risk hotspots for hospital specialists
- privacy
- avoiding medical marketing mistakes
- resolving conflict with a senior
- intimate examinations

Access the full catalogue at: **mdanational.com.au/member-benefits/education/webinar-recordings**

The lost referral

A doctor's duty of care

A doctor's duty of care does not end with issuing a referral. Mr P was successful in his medical negligence claim[1] against his GP, Dr Z, in relation to the treatment and management of hyperkeratosis (a corn) on his foot which eventually required surgery.

Dr Jane Deacon
Manager, Medico-legal Advisory Services, MDA National

Case history

July 2013: Mr P first consulted Dr Z regarding pain in his right foot. Dr Z diagnosed it as hyperkeratosis and gave general advice regarding footwear.

September 2013: Mr P returned as the lesion was tender. Antibiotics were prescribed.

February 2014: Mr P attended again, and Dr Z noted a tender and infected nodule.

March 2014: Mr P's foot was still painful. Dr Z referred him for an ultrasound which showed there was a cyst. Dr Z referred Mr P to the Canberra Hospital for further management. The hospital received the referral, but Dr Z did not receive any correspondence from the hospital.

May 2014: Mr P advised Dr Z that he had not heard from the hospital, and Dr Z sent a further referral. The hospital noted this as a duplicate referral and cancelled it.

It is unclear what happened to the referral at the hospital, and the action against the hospital was resolved prior to the court hearing.

Throughout the remainder of 2014, 2015 and the early part of 2016, Mr P presented to Dr Z on numerous occasions with considerable pain from his foot – so much so that he was unable to walk or work and required regular Panadeine Forte.

Mr P also advised Dr Z that he had still not heard from the hospital following the second referral.

In August 2016, Mr P presented to another hospital as his foot was increasingly painful. He was referred back to Dr Z with a note requesting Dr Z to "chase surgical referral attended one year ago," and to see a podiatrist in the interim to assist in management.

Mr P saw a podiatrist who described a large, complicated hyperkeratotic lesion on the plantar surface of his foot with a central crevice. The podiatrist rang Dr Z, and according to notes taken by the podiatrist, they discussed that the patient required a general surgical review, and that Dr Z would see to that.

Despite seeing Dr Z the next day, no further referral was arranged.

A few days later, Mr P attended the emergency department and was admitted to the Canberra Hospital. He was an inpatient for two weeks and underwent two surgeries for incision and drainage of an abscess.

The court's findings

The court determined that from May 2014, after three months without a response from the hospital, a reasonable practitioner:

- would have followed up the referral to get an approximate timeframe for a specialist consultation and the timing of any potential surgery
- should have discussed with Mr P about how to treat his condition in the meantime.

After the consultation in May 2015, a reasonable practitioner would have the knowledge that his patient's condition was not improving; that he had been on Panadeine Forte for over a year, was depressed and in significant pain, and still awaiting surgery in the public health system.

Expert medical evidence was given which supported that the delay in specialist review and treatment likely led to a substantially poorer outcome for Mr P.

The court found that the referral had not been appropriately managed by Dr Z, and that he should be liable for losses and damages that flowed from the delay.

Medico-legal discussion

A GP's duty of care is not discharged by merely issuing a referral to a specialist or hospital.

If the patient returns to the referring practitioner for ongoing treatment of the relevant condition thereafter, and no communication from the specialist or hospital to whom they were referred has been received, the referring practitioner may need to make enquiries.

Depending on the circumstances, the referring practitioner should:

- check with the patient and/or follow up with the entity or specialist to whom the referral was issued to ascertain whether the patient was on a waitlist, and obtain an approximate timing for when the treatment or surgery might be provided
- formulate a treatment plan for the patient's care until they can be seen by the entity or specialist to whom they have been referred.

This decision places the onus on GPs to continue to monitor a patient's progress through the referral; and requires them to advocate on behalf of their patients to the specialist or hospital to whom they have been referred if necessary.

View the references online: **mdanational.com.au//the-lost-referral**

Physician, heal thyself

Medice, cura te ipsum

The limits of self-care and prescribing

Dr Julian Walter
Medico-legal Adviser,
MDA National

The doctor who called us was stunned. They had been reported to Ahpra and were being investigated for self-prescribing. *"It's my business if I prescribe to myself; and anyway, these were not Schedule 8 medicines!"*

And so began a discussion of how the Medical Board views self-treatment by medical practitioners, and how this has changed over the years.

There is broad recognition that our health and wellbeing impacts on our practice, and we are extolled to accept self-care as a cornerstone of professional life.[1,2] However, there are distinct limits to the self-care we can and should provide to ourselves.

Stepping into providing ourselves care that only a registered health practitioner could deliver, likely means we are stepping outside the Medical Board's Code of Conduct[3] guidelines, with the risk of poor care outcomes or investigation. Every year, there are examples of practitioners who have registration-impacting outcomes at Tribunals resulting from inappropriate self-care and care boundaries.[4]

Section 11 of the Code, a relatively recent addition, talks about managing one's own health. This section reflects similar constraints to the provision of care to close friends, family, and those you work with, discussed in section 4 (which was also updated).

Medical practitioners should not be self-prescribing

This isn't just a reference to self-prescribing Schedule 8 drugs (which most jurisdictions restrict or prohibit) or select Schedule 4 drugs, including drugs of dependence. It refers to ALL prescriptions by a practitioner for themselves. In addition, practitioners risk breaching the specific, varying, and complex legislative restrictions on self-prescribing in each jurisdiction – ranging from full self-prescribing prohibition (Victoria) through restrictions on prescribing Schedule 8 drugs and some Schedule 4 medicines (Queensland, ACT, NSW, potentially WA/NT); or restrictions on self-prescribing Schedule 8 drugs. Such breaches may be a criminal offence.

View the references online: **mdanational.com.au/physician-heal-thyself**

Health practitioners should have their own GP

While I'm sure we all subconsciously self-diagnose at times, the value of independent objective workup, investigation and treatment cannot be overstated. This includes the importance of approaching your treating team for documents like medical certificates, and not issuing these yourself.

Seek advice

There is additional emphasis on the importance of seeking advice in relation to health issues that could impact your work, including stress, burnout and mental health.

Contact the DHAS

If you have troubles locating a GP, the Doctors Health Advisory Service (DHAS) in your jurisdiction may be able to assist in finding GPs who have identified themselves as having an interest in looking after the health of their colleagues. They can also provide confidential telephone call-back support in more acute circumstances, such as mental illness, stress, drug and alcohol dependence, and other personal issues.

Mandatory reporting reassurance

Where doctor-patients follow their treating team's advice on whether their health issue impacts on work and how they should manage this (including modifying their practice), there should be no basis for a mandatory report. Complaints are generally straightforward to deal with if the doctor has sought and followed their treating practitioner's advice. It is more common for doctors who don't have a treating team to find themselves in difficulty if a concern about health impairment is made to a health complaints body. Tragically, we are also aware of terrible outcomes arising when doctors attempt to manage their own substance misuse or significant mental health conditions.

MDA National strongly supports all doctors having their own treating team. If you are concerned about the medico-legal implications of a health issue, our medico-legal advisers are happy to assist you and provide advice.

Extracts from the Medical Board's Code of Conduct

11.2 Your health

Good medical practice involves:

- *11.2.1 Having a general practitioner.*
- *11.2.2 Seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment.*
- *11.2.3 Seeking help if you are suffering stress, burnout, anxiety or depression.*
- *11.2.4 Making sure that you are immunised against relevant communicable diseases.*
- *11.2.5 Not self-prescribing.*
- *11.2.6 Recognising the impact of fatigue on your health and your ability to care for patients, and endeavouring to work safe hours wherever possible.*
- *11.2.7 Being aware of the doctors' health program in your state or territory which provides confidential advice and support through the doctors' health advisory and referral services.*
- *11.2.8 If you know or suspect that you have a health condition or impairment that could adversely affect your judgement, performance or your patient's health:*
    - *not relying on your own assessment of the risk you pose to patients*
    - *consulting your doctor about whether, and in what ways, you may need to modify your practice, and following the doctor's advice.*

4.15 Providing care to those close to you

Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with, and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the patient and doctor. In particular, medical practitioners must not prescribe Schedule 8, psychotropic medication and/or drugs of dependence or perform elective surgery (such as cosmetic surgery) to anyone with whom they have a close personal relationship.

In some cases, providing care to those close to you is unavoidable, for example in an emergency. Whenever this is the case, good medical practice requires recognition and careful management of these issues.

How do you deal with fake medical certificates?

A GP was incensed to find that a patient had falsified a COVID-19 exemption certificate in the GP's name and presented this to their employer. A call from the patient's employer posed several dilemmas for the GP.

Can the GP speak to the employer without breaching confidentiality?

What effect will this have on the doctor–patient relationship?

Is the GP obliged to contact the police?

In an already frustrating situation, medico-legal concerns can add to the stress.

Tanith Chippendale
Medico-legal Adviser,
MDA National

General practitioners frequently come across situations where they are asked to verify whether a document was prepared by them, only to find the document has been forged. This can be a stressful and confronting circumstance for which you may need to seek advice.

Validating documents and duty of confidentiality

You are able to validate to the requesting party which certificates you have (or have not) provided. This would also include confirming that a particular certificate was not produced by the practice or doctor on the date it was apparently prepared, or why the document appears to be a forgery.

Patient confidentiality prevents you from discussing any clinical consultation(s) or the patient's medical history with the requesting party, beyond confirming the validity of any genuine certificate(s) the patient may have presented.

A brief factual note should be made in the file to document that you have been contacted by the requesting party and how you have responded.

Should you contact the patient?

You do not have a duty to discuss the matter with the patient. Contact with the patient might be appropriate where there is a matter of patient care involved (e.g., a concern that the fraud is a manifestation of a mental health issue that needs addressing). You do not know all the facts of the matter and there may be more to it than is initially evident.

Do you have to tell the police?

No. Doctors generally have no mandatory reporting requirements in relation to alleged less serious criminal activity. The requesting party may be in a better position to do this in any case.

You are able (but not required) to disclose information regarding suspected unlawful activity to the police under the *Commonwealth Privacy Act (1988)* – Australian Privacy Principle (APP) 6. This APP recognises that a health service provider may wish (or be required by law) to report suspected unlawful activity – and this may involve the release of confidential information. The minimum disclosure possible should be made to allow the matter to progress. The police can then issue a warrant, summons or equivalent to compel the production of additional material. This may be more likely if the fraud has been perpetuated against you personally, i.e., the patient has stolen your identity beyond a fake certificate.

If you were to take such action, please liaise with our medico-legal advisers before sending out any correspondence as certain obligations may apply, e.g., keeping a written record.

Should you continue to see the patient?

There is generally no obligation to see any patient in private practice (excepting an emergency situation), although the reason for refusing care must not be discriminatory.

Ultimately, this will be a very personal clinical judgement that balances the need for a therapeutic relationship with the patient and their health needs against the significance of the apparent fraud and loss of trust. Some practitioners agree to try to assist the patient moving forward, while others prefer to terminate care.

Ending care

Many patients decide not to return to the practice, once they know the practice has confirmed the fraudulent behaviour. Continuity of outstanding significant clinical care should be considered, and steps put in place to manage this if ongoing care unexpectedly ends. This might involve forwarding records or sending the patient specific advice and/or results to take to their new practitioner.

Risk management

Fraudulent actions by patients are difficult to prevent, but you should take the time to review the circumstances in case there are any risk mitigation steps the practice can take to prevent similar occurrences.

Our medico-legal advisers are happy to assist with queries regarding fraudulent documents, including advice on the subsequent management of patient care.

Playing it safe with patient discharge

A/Prof Anna Holdgate
(MDA National Member)
Senior Staff Specialist, Emergency Medicine
Liverpool and Sutherland Hospitals

As a practising emergency physician with a side interest in medico-legal work, I've seen many situations where poor discharge practices can leave doctors vulnerable to complaints and litigation.

Being discharged from hospital is generally an experience that patients and their doctors look forward to, but it's not without risk. This is particularly so for patients discharged from the emergency department (ED) where the interaction has frequently been brief; the investigations limited; and the certainty around the diagnosis may be unclear.

Research suggests that fewer than 50 per cent of patients discharged from the ED with non-specific complaints will have a correct diagnosis at discharge.

Patients generally have faith in the diagnosis made in a hospital setting, and in the care provided. And doctors, particularly junior doctors, often feel compelled to come to a definite diagnosis prior to sending a patient home. Wanting to be right and wanting to do something are inherent traits in most doctors. It fits in with our high-achieving personalities and the desire to help. That's why many of us studied medicine.

Having the confidence and maturity to acknowledge uncertainty is an important component of practising good medicine. When a patient is determined to be well enough to be discharged home but uncertainty remains about the diagnosis, it's much safer if both the patient and the ongoing healthcare providers are aware of it. This makes it much more likely that the patient will seek review if their condition changes or doesn't improve as expected. It also gives the outpatient healthcare provider (usually the GP) an awareness that further investigation, treatment or referral might be necessary.

Reducing the risks

Some simple steps can reduce the risk of serious misadventure after a patient leaves hospital, either from the ED or following an in-patient stay.

View the references online: **mdanational.com.au/safe-discharge-practice**

Step 1
Follow-up

Make sure the patient knows with whom they should follow up, when they should follow up, and the purpose of the follow-up.

Step 2
Explain the condition and the treatment

Whether there is diagnostic certainty or not, make sure the patient understands what you think is wrong with them and how certain you are about this. In my practice, if I'm unsure about the diagnosis, I tell the patient that I'm not exactly sure about the cause of their symptoms, but I'm reasonably confident that all acute sinister causes have been excluded – but this means they do need to be alert for any change in their condition and seek review if necessary.

Make sure they understand any medications they have been prescribed including dosage, frequency, and possible side effects.

Step 3
Explain what you expect will happen

Again, this somewhat depends on your diagnostic certainty, but you should be able to provide a reasonable estimate of how their condition will progress. For instance, if you've diagnosed a community-acquired pneumonia and you're discharging them on oral antibiotics, they should understand that it will be a few days before their symptoms improve significantly, but they shouldn't get any worse.

Step 4
Tell them when to come back or get reviewed

This is probably the most important part of safe discharge planning. Give the patient both general and specific symptoms they should watch out for, and which of these should lead them back for further medical review. For instance, in the case of the pneumonia patient, general advice would include "come back if you feel too systemically unwell to manage at home due to poor oral intake, fatigue or pain". But specifically, "come back immediately if your shortness of breath worsens, you have persistent vomiting, or you feel confused".

Step 5
Write it all down

Even with the best medical care and best discharge planning, things will sometimes go wrong. Your best defence is to document ALL of the above and to also provide the patient with written discharge advice. Make sure the GP (or appropriate ongoing provider) receives a copy of the discharge information.

Finally, keep the door open for the patient to come back. Regardless of how minimal their complaint may seem and how confident you are that there's nothing serious going on, always encourage them to seek further review if they have any concerns.

A simple mnemonic to summarise safe discharge planning:

Health literacy – does the patient understand the diagnosis?

Organise follow-up

Medications – make sure the patient understands the timing and dose of new medications, and the important side effects

Expectations – what to do if symptoms get worse or are no better in the expected timeframe.

A brief guide to setting up in private practice

Karen Stephens
Risk Adviser, MDA National

Here's a brief checklist outlining the main things you may need to consider before setting up your private practice.

Business planning

- Business structure
- Financing and insurances*
- Location – demographics, nearby colleagues or referrers, nearby competitors, patient/staff access, disability access, optimal layout, buy or lease
- Equipment and supplies
- Accreditations and licensing
- IT system and support – software, hardware, phones, backup, telehealth, cybersecurity
- Marketing and advertising, including websites and social media
- Advice from a business adviser, accountant, financial adviser, lawyer and/or practice manager, preferably with experience in the medical field.

Business – government guides

See the *Starting a business checklist* from **business.gov.au** which has detailed information on key steps and a downloadable checklist.

Each state or territory has specific information on starting a business:

ACT *canberra.com.au/business/set-up/start-a-business*
NSW *nsw.gov.au/topics/starting-a-business*
NT *nt.gov.au/industry/start-a-business*
QLD *business.qld.gov.au/starting-business*
SA *business.sa.gov.au/services/start-a-business*
TAS *business.tas.gov.au/starting*
VIC *business.vic.gov.au/business-information/start-a-business*
WA *smallbusiness.wa.gov.au/starting-and-growing/8-steps-to-starting-a-business*

Private practice – College guides

RACGP
Starting a medical practice
Becoming an owner of a general practice

RACS
Preparing for private practice (course, guide and checklist)

RANZCP
A guide to private psychiatric practice

Patient information systems and processes

Medical records

Appointment system

Follow-up of tests and referrals

New patient registration

Telehealth

Consent forms

Complaints handling

Clinical procedures

Infection control

Medication storage

Emergency equipment

Billing

Medicare billing requires a location-specific provider number — apply via Services Australia or PRODA/HPOS account

Compliance with item descriptors and explanatory notes in the MBS

Invoicing and records for tax purposes

Informing patients about costs upfront – see the AMA's *Informed financial consent*

Staff

Clinical and non-clinical staff:

- Recruitment, screening (e.g., Working with Children checks), employment contracts and position descriptions
- Training and performance management
- Superannuation and taxation
- Clinical supervision

Obligations as an employer:

- AMA *Guide to employment law for medical practices*
- FairWork resources for federal workplace laws and the Fair Work Act
- State-based regulation of Work Health and Safety:
  - *WorkSafe ACT*
  - *SafeWork NSW*
  - *NT WorkSafe*
  - *WorkSafe Qld*
  - *SafeWork SA*
  - *WorkSafe Tasmania*
  - *WorkSafe Victoria*
  - *WorkSafe WA*

Privacy

By law a medical practice must have a privacy policy:

- AMA *Sample privacy policy*
- OAIC *Guide to developing an APP privacy policy*

If using cloud backup or storage, it's easiest to meet Australian privacy law requirements if the server is in Australia

Confidentiality agreements for staff — see:

- OAIC *Guide to health privacy*
- ADHA *Information security guide for small healthcare businesses*
- ADHA *Cyber security*
- MDA National *Privacy know-how*
- MDA National *Email and texts to patients*

Advertising

Advertising, including a website or social media presence, must comply with Ahpra's *Guidelines for advertising a regulated health service*

Advertising therapeutic goods or medicines must comply with the TGA's advertising regulations

Direct marketing to patients requires their specific consent (under privacy law; APP7)

*MDA National offers practice indemnity policies to cover claims against the practice or an employee of the practice, for matters such as privacy breaches, loss of documents, intellectual property disputes and more.

Keep on striving with complimentary career support

MDA National junior doctor Members have access to support, advice and education tools specific to your training years.

Career development

To support you to keep on striving as you plan your career and prepare for medical officer interviews, we are hosting a Career Planning and Interview Preparation webinar series.

Unsure about your career path?

Presented by Medical Career Counsellor, Dr Ashe Coxon, the Career Planning series provides practical guidance and personality-based insights to help junior doctors identify which areas of medicine they enjoy, and to assist participants in identifying the medical specialty that suits them best.

Topics include:
Aiming for the Stars
From uncertainty to clarity – A practical session

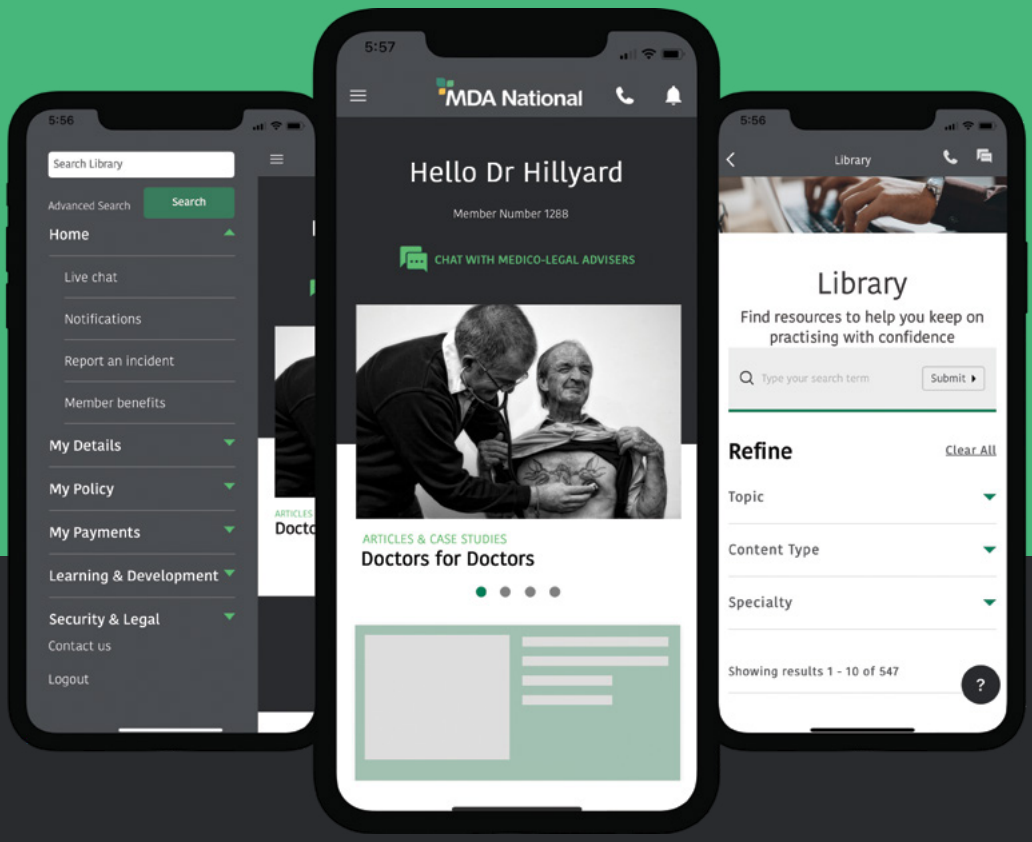
Scan the QR code to learn more about the series and register attendance.

Need help with your medical officer interviews?

Presented by Medical Interview Coach, Dr Brooke Bullock, the Interview Preparation workshop series provides education on interview techniques and training on how to tackle both standard and unexpected interview questions.

Topics include:
Interviewing for Doctors: How would you respond to the following scenario?
Interviewing for Doctors: What are your thoughts on XX?
Interviewing for Doctors: What are your best cards?
Interviewing for Doctors: Tell me about a time when?

Manage your membership and stay connected to our support services at your convenience.



As a Member, you can access the MDA National app to:

- receive notifications for the latest medico-legal updates relevant to your career stage and specialty
- read case studies and articles
- watch videos and recorded webinars
- connect directly with our medico-legal experts via LiveChat
- update your personal and Policy details
- and more!

Scan the QR code to download the MDA National app from the App Store or get it on Google Play.

Download on the App Store

GET IT ON Google Play

mdanational.com.au

1800 011 255 peaceofmind@mdanational.com.au