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Publication for Doctor in Training Members

Winter 2017

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

Why attend?

- Hear from expert speakers with insightful perspectives on medical liability.
- Learn practical ideas to implement in everyday practice.
- Contribute to the debate surrounding new technology and risk.
- Be informed on the future direction of medical and healthcare liability.
- Network with colleagues from across the globe.

Renewal Time

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

Here are some steps to guide you.

Renew your Membership and Policy by 30 June 2017

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

For your convenience, your Renewal Notice includes:

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

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

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

Ensure you tell us about any matters arising from your practice

Early notification enables us to support you better and can help prevent matters from escalating. Ensure you have informed us of all claims, complaints, investigations, employment disputes, or any incidents you are aware of that may lead to a claim for indemnity under your Policy. This is a requirement under your Policy.

Review the risk category changes

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

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

Review the Policy changes

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

Our Member Services team is here to help.

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

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

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

I've learnt that my hospital indemnity may not always provide the broad cover I need, and having my own MDO has become indispensable. As a junior doctor, I've made a few mistakes, but thankfully during these times I felt reassured having MDA National as a safety net. There have been times when I've needed medico-legal guidance that could only be found through MDA National.

Dr Ghassan Zammar, Perth, WA

Do I Really Need an MDO?

As a doctor, I'm astounded to hear there are practitioners out there who don't have medical indemnity insurance. Particularly junior doctors, where the cost of the insurance (if there is one at all) is less than two movie tickets and a takeaway meal.

As a solicitor, I shudder to think of the legal costs that would be personally incurred by these uninsured doctors, if a matter did arise. The gnawing fear, not able to pick up the phone for advice through fear of costs – at a moment which may be one of the most harrowing points of their professional career.

As a medico-legal adviser, I'm distressed by calls we receive from uninsured doctors involved in a matter and with nowhere to turn. So let's depart on a journey to see why medical indemnity insurance really does matter. It starts with a patient, a doctor who cared, and a healthcare roulette that sometimes doesn't spin your way.

So what could go wrong?

Our patient, septic with pneumonia and pleurisy, had a central line placed earlier today. For the third time this afternoon the nurses seek review of the patient's recurrent chest pain, reassuringly noting "obs are ok". They missed that elusive respiratory rate, now 35, suggesting all is not well. It has been a long day. Losing your cool down the phone seems oddly cathartic. "I'm busy, I'll be there when I can". After all, pleurisy is why the patient is here.

The staff go quiet. So when the MET call comes, it's a surprise. Resuscitation doesn't go so well, taking longer than it should to diagnose the tension pneumothorax in the face of a new arrhythmia. Possibly the amiodarone you gave contributed to the death. Before you know it, you're completing the coronial referral, the family are threatening to sue, and the nurses are busy completing a risk notification about your delay in attending and unprofessional tone. A really long day…

What kind of insurance is required?

AHPRA registered health practitioners require professional indemnity insurance. A breach of this legal requirement[1] can result in action by AHPRA against the practitioner.

The Medical Board of Australia Registration Standard[2] importantly tells us that compulsory insurance only refers to cover for claims – *insurance against civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner*. What we doctors would term "being sued".

Generally, hospital employed doctors will have this simple level of cover provided by their employer – making them "employer indemnified". If sued, their employer would pay the costs of legal representation and any damages payable to the plaintiff resulting from the claim.

Importantly, such doctors need to ensure they're still covered by their employer outside of their place of employment, e.g. rotation to a private hospital, GP practice or locum work. If not, they may foot the bill for a claim and breach their registration indemnity requirements.

For a full list of references visit **firstdefence.mdanational.com.au/articles/do-i-really-need-an-mdo**.

Medical systems are complex. The beat of fate's butterfly wings can fan a seemingly minor task into a subsequent vortex of disaster and shame, causing irreparable damage to your future career and reputation.

So why do I need a medical defence organisation?

While being sued might be the most expensive medico-legal matter you could face as a doctor, it's certainly not the only risk.

Coronial matters

The death of a patient can be related to something you did as a doctor. Employees might receive assistance under the hospital's legal representation at an inquest. Yet your interests may not coincide with the hospital, and legal costs for a typical four-day inquest reach many tens of thousands of dollars. And what if you need separate legal representation?

You're providing a statement to the coroner now for an inquest years down the track – when lawyers will debate the meaning of words in your statement and examine issues you had no idea would arise. So details do matter. As both doctor and solicitor, I cannot emphasise enough the importance of getting this statement right.

MDA National assists in the preparation of statements, identifying and addressing potential issues. Where needed, we also arrange your legal representation at inquests.

AHPRA health complaint investigations and disciplinary matters

Many hospitals don't assist or have much expertise with health complaints. A poor quality response provided on your behalf can cause the complaint to escalate, bringing it closer to an adverse finding against you. It is critical that you obtain early advice and experienced assistance from MDA National, as this may save you months to years of worry.

Employment matters

With an employment dispute, you find yourself at odds with colleagues and the hospital itself. Your income provider becomes judge and executioner. Where do you turn? Who should be your support person? Employment matters can have an irreparable impact on your career. Seek advice early from MDA National. We work hand in hand with organisations such as the AMA.

Medico-legal advice

Not every call we receive reflects a disaster. Help with preparing a police statement? Patient wants to write their will? Can you date that patient you met in the ED 12 months ago?

No matter how simple or challenging the query, with MDA National you have at your fingertips a team of medico-legal experts ready to give you timely advice, so you can achieve the best possible outcomes in medico-legal matters.

We are relentless. We love what we do. We hope you will too. Give us a call on 1800 011 255.

Dr Julian Walter
Medico-legal Adviser
MDA National

WHAT I LOVE ABOUT
Sports Medicine

What do I love about Sport and Exercise Medicine (SEM)? I'm sure most people assume it's the front-row and behind-the-scenes access to sporting events. But that's not what it's all about.

Dr Gary Couanis

Recently I had my first experience interviewing prospective registrars for the Australasian College of Sport and Exercise Physicians. Perhaps unsurprisingly, many candidates described being drawn to the field by their love of sport. No doubt a healthy love of sport goes a long way to enjoying a career as a SEM physician, but it doesn't take long for your all-access sports-event pass to lose its novelty.

Don't get me wrong. A front-row seat to some diverse and amazing experiences is a major job perk. In my first two years as a registrar, I was pitch-side for victories in a WAFL grand final; an NBL championship; a South East Asian Soccer Cup; an under-18 div 2 AFL championship; and a Men's Hockey Champions Trophy. I'd flown on a private jet with the Australian Boomers and been backstage with acrobats of the Cirque du Soleil. I'd even been medical consultant for an arctic adventurer!

But not all those experiences were as glamorous as they might sound. There are the mundane bus trips, the difficult interactions with coaching staff, and some of the unrealistic expectations and external pressures. A low point was watching a player I'd cleared to play just days earlier suffer a high-grade Achilles tear in front of a massive live audience in the first game of an NBL grand final series.

Inspiring patients

The key is to keep company only with people who uplift you, whose presence calls for your best. (Epictetus c80AD)

The company you keep, over time, subtly influences the person you become. In my life, I've encountered no other field, personal or professional, that has led to more interactions with people who inspire me. On a daily basis I get to meet "dream-chasers". I see people with personal goals and private battles as diverse as the diabetic trying to run their first marathon, the 60-year-old cyclist embarking on a masters world record attempt, and the middle-aged dad challenging himself with ultramarathons.

My patients regularly raise the bar on what I expect of myself. I won't be making world record attempts anytime soon, but I love being challenged by the concept of what can be achieved, how much can be squeezed into a life, and what amount of difficulty can be overcome.

A deeper appreciation

Sports media is understandably biased towards success stories. It's hard to develop a true appreciation of how many athletes train, strive and sacrifice, but still fall short of their goals.

"My patients regularly raise the bar on what I expect of myself. I won't be making world record attempts anytime soon, but I love being challenged by the concept of what can be achieved, how much can be squeezed into a life, and what amount of difficulty can be overcome."

Dr Couanis treating a player during the 2017 Azlan Shah Hockey Tournament.

For every winner, there are hundreds, if not thousands, of "also-rans". There are stories of injury and misfortune; modest personal goals and quiet achievements. There are those that eventually do triumph with their backstories of hardship never told. SEM physicians are uniquely privy to the unpolished "warts-and-all" side of elite sport uncensored by the news media, and I feel privileged to be a part of it.

Motivated people

Most physicians know the frustration of care compromised by poor patient compliance. SEM patients are generally very motivated and engaged with their treatment. They're usually happy to follow advice even when it may be difficult, unpalatable or onerous. Sports people are often process-driven, a useful mindset when dealing with pain and injury. Occasionally the pendulum swings too far and patients can be over-zealous in their injury management, but that tends to be much easier to address.

Diverse experience

I've learnt, through my patients, about the worlds of dance sport, underwater rugby and roller derby, just to name a few. I've treated musicians, dancers, acrobats and archers who shared interesting insights into their professions. I've seen trekkers, climbers and adventurers with stories about their travels and adventures. Every day, I learn something interesting that may be completely unrelated to medicine.

A diverse experience at the elite level of sport is actually quite a rare thing. Athletes and coaches who reach the highest levels of their sport are obviously highly specialised. The SEM physician, however, is an exception and can experience multiple elite sporting environments and cultures. Often the team doctor is a fly-on-the-wall observer during team meetings, with the unique opportunity to view differences in coaching styles and team culture across dozens of sports.

Enabling aspirations

As doctors, we all love to help people. Helping people who inspire you and value (and comply with) your advice is a bonus. Helping people overcome setbacks and achieve their goals brings added reward. Engaging with people doing interesting things across diverse fields of physical activity enhances job satisfaction. In the end, with SEM, you generally get to help facilitate aspirations more often than you have to advise against them.

Dr Gary Couanis (MDA National Member)
Sport & Exercise Medicine Physician
Perth, WA

Three Models for Shared Healthcare Decisions

It's always a good time to think about how you're going to provide patient-centred care. Patient centeredness is a fundamental component of healthcare delivery.

MDA National outlines three models of shared decision making – a consultation process where both the doctor and patient make a health decision together after talking about the benefits and risks of treatment options, and what the patient values, their preferences and life circumstances.[1]

Model 1: Five Questions

The doctor personalises the choice for the patient and ensures the patient has enough information to make a decision by asking the patient five questions (see the table on the right).

More information on this model is available at **mja.com.au/system/files/issues/201_01/hof00002.pdf**.

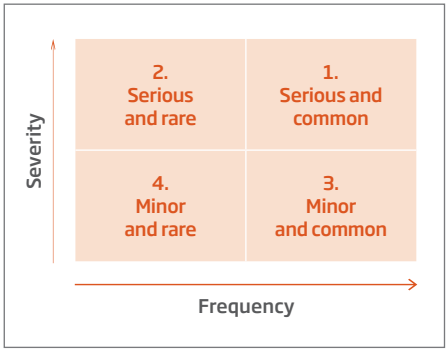


Figure 1. When considering the order in which to present risks it is recommended to spend most time on 1) serious and common risks, followed by 2) serious and rare, 3) minor and common, and 4) minor and rare.

1. **What will happen if we wait and watch?** Give information and find out the patient's expectations, previous experiences, and fears – e.g. "Most patients find that the symptoms go away by …" (p36);[1] "What have you heard about …?"; "What is concerning you about …?"
2. **What are your test or treatment options?** Explain each option in more detail, e.g. "Waiting for it to get better by itself is one option. Another option is to take antibiotics. Do you want to discuss that option?"
3. **What are the benefits and harms of these options?** Discuss side effects, cost, inconvenience, interference with daily living etc.[1] Curious about the order of presenting risks and how much time you should spend on each risk? See figure 1.
4. **How do the benefits and harms weigh up for you?** Find out what the patient's preferences are and whether you need to explain anything differently – "With all I've said, which option do you feel most comfortable with?"; "How will you explain the procedure to your family?"
5. **Do you have enough information to make a choice?** Answer any outstanding questions the patient may have and ask if they're ready to make a decision – e.g. "Is there any more you want to know?"; "Do you feel you have enough information to make a choice?"

Figure 2. The five-question model helps doctors guide patients towards making an informed healthcare decision.[1]

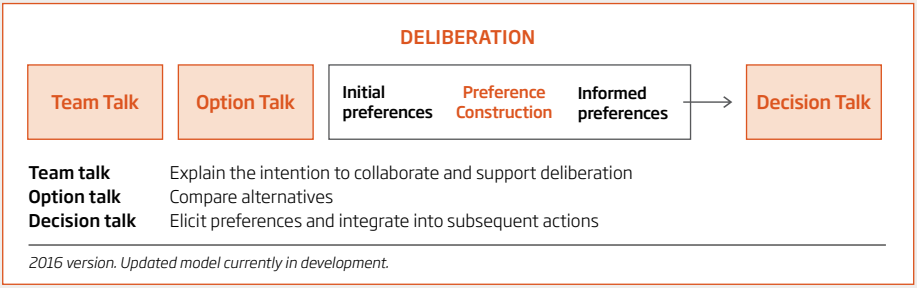
Model 2: Three steps

The doctor helps the patient improve their knowledge and form preferences to make an informed decision.

See **glynelwyn.com/blog/collaboration-talk-model-for-shared-decision-making** for more information on this model.

Figure 3. (below) The three-step model is a sequential process that encourages discussion, reflection, weighing up of options and reconsidering information.

Used with permission from Prof Glyn Elwyn 2016.[2]



Model 3: Ask, Share, Know

The patient leads the process to make a healthcare decision ("No decision about me, without me").

See **askshareknow.com.au** for more information on this approach.

1. Ask three questions

a. What are my options?
b. What are the possible benefits and harms of those options?
c. How likely is it that each of those benefits and harms could happen to me?

2. Share more information

The more information a patient shares, the more the health professional is able to give the information they need.

3. Know what is right for them

The more they ask and share, the more information they'll have, and the better equipped they'll be to make decisions that are right for them.

Figure 4. Ask, Share, Know encourages the patient to lead the decision-making process in three main ways.[3]

People are entitled to make their own decisions about their health care. Patients who are supported to truly actively participate in selecting their treatment are more likely to make decisions that are best for them.[1]

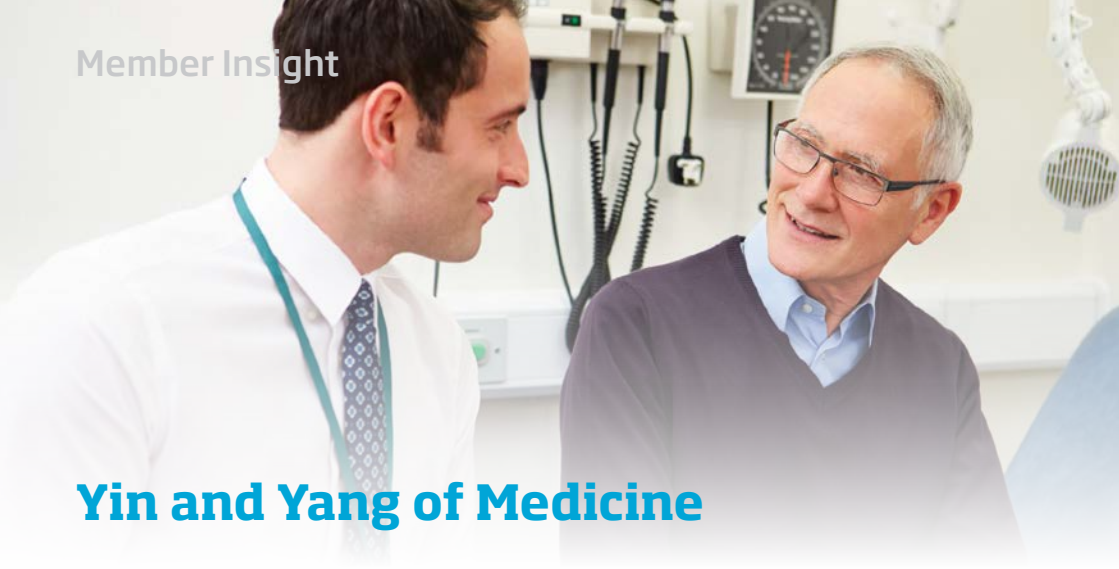
Want more information on these models and informed consent? Our online education activity **Informed Consent Challenges** is available now. Use your Member login at **mdanational.com.au** and select *Online Education Activities* from *My Education*.

MDA National Education Services

1 Hoffmann T, Legare F, Simmons M, McNamara K, McCaffery K, Trevena L, et al. Shared Decision Making: What Do Clinicians Need to Know and Why Should They Bother? Med J Aust. 2014;201(1):35-9. Available at: mja.com.au/journal/2014/201/1/shared-decision-making-what-do-clinicians-need-know-and-why-should-they-bother.

2 Elwyn G. Collaboration Talk Model for Shared Decision Making. 21 July 2015 [cited 29 June 2016]; Available at: glynelwyn.com/blog/collaboration-talk-model-for-shared-decision-making.

3 Ask Share Know. [cited 6 January 2016]; Available at: askshareknow.com.au/index.html.



Yin and Yang of Medicine

My wife asked me recently what I would have done if I hadn't got into medicine. She said my face turned ashen. I had no Plan B! From a very young age, I knew I wanted to be a doctor. Fortunately, I did get into medicine. I was a pretty lazy student, but did well enough to get an internship at the Royal Melbourne Hospital. It was then I discovered why I had a vocational call so early in my life. I really enjoy caring for people.

That's what medicine is about – people – not just diseases and their treatment. We're not passive observers of the passing parade, we're in it up to our eyeballs. Of course we have to know our trade. But that's the *Yin*. The *Yang* is our people skills – the communication and empathy needed to create effective relationships with the people we see. And you note I say "people" not "patients". They are people first, patients second.

The question we ask whenever we see a patient – "Why has this patient come to see ME, HERE, NOW?" – is not just a clinical question. We need to understand the patient's personality, their "backstory", belief system, expectations, past experience with the medical system, and so on before we can properly answer that question.

So, here is some advice.

Don't jump to conclusions about your patients' expectations

Two examples from my experience (both true):

- A young woman who had a very large nose asked for a referral to a plastic surgeon. I started talking about rhinoplasties. She then pulled back her long black hair and pointed to her bat ears.
- A middle-aged woman came in and said she wanted to get a load off her chest. I settled back for a counselling session. But she wanted a referral for a reduction mammoplasty.

OK – silly examples. But I still had to find out what the young woman thought having flat ears would do for her. She thought they would remove a barrier to an international modelling career. The older woman wanted the operation, but was worried about her husband's reaction.

Beware confirmation bias

When we first see a patient, we tend to make intuitive diagnostic leaps – and then find reasons to discard information that does not fit our preconceptions. The medical equivalent of surgical "time out" is to stop, just before shutting down the diagnostic process, to think, "Am I missing something here?"

Be kind to (almost) all of your patients

You will have patients that you just don't like. They're usually people with expectations that you can't meet or aren't prepared to meet. Gently point them elsewhere. "*I don't think I can be the sort of doctor you're looking for. Might I suggest you …*". But make sure the rest of your patients know that you're genuinely concerned for their wellbeing; that they're not just an abstract, interesting clinical problem.

Humility must trump hubris

This above all, to thine own self be true.
(Hamlet Act 1, scene 3, 78-82)

There is one person you must always be honest with – yourself.

Dr Paul Nisselle AM
General Practitioner
Mutual Board Member, MDA National

Medico-legal Post Box

In this edition, Dr Sara Bird answers questions from a Member about prescribing for family and friends.

Q I was wondering if there are any legal implications of writing scripts or ordering imaging for family members or friends, if appropriately indicated. For example, a simple repeat script for my mother for a non-restricted medication, or a hip ultrasound for a nephew?

A There is no legislation that prevents you from prescribing for family and friends, except in SA where the law prohibits the prescription of Schedule 8 drugs of dependence to family members unless it is a verifiable emergency.

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

For advice or further information, call **1800 011 255** or email **advice@mdanational.com.au**.

Our Medico-legal Advisory Service operates on weekdays from 8.30am to 8.00pm (AEST), with access to emergency advice 24 hours a day.

However, just because the law allows you to write prescriptions for family and friends, doesn't mean you should. In the circumstances you have outlined, your professional obligations as a doctor clearly state this should be avoided.

Your professional obligations as a doctor are outlined in *Good Medical Practice: A Code of Conduct for Doctors in Australia*. Section 3.14 of the Code addresses the issue of treating family and friends:

Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient. In some cases, providing care to those close to you is unavoidable. Whenever this is the case, good medical practice requires recognition and careful management of these issues.

It's important to be aware that as soon as you write a prescription or provide a referral for diagnostic imaging, you have entered into a doctor–patient relationship. As such, you need to have appropriate medical records for any patient interactions, conduct an appropriate assessment of the patient, and ensure you have medical indemnity insurance for all your clinical work.

There have been some recent cases in Australia where doctors have been the subject of disciplinary proceedings and criticism for writing prescriptions and referrals for family members.[1,2]

Summary points

- Say "no" to requests from family and friends for prescriptions and referrals – it's only considered ethically and professionally appropriate to do so in exceptional circumstances, and there are potential risks to both you and your family member or friend if you do proceed.
- Consider in advance how you might refuse a request to provide a prescription or referral, e.g. "Professional guidelines mean that I am not able to prescribe for (or refer) family and friends."

1 Bird S. Prescribing for Relatives. Available at: mdanational.com.au/en/resources/blogs/prescribing-for-relatives

2 Bird S. The Pitfalls of Prescribing for Family and Friends. Aust Prescriber 2016;39:11-13. Available at: nps.org.au/australian-prescriber/articles/the-pitfalls-of-prescribing-for-family-and-friends

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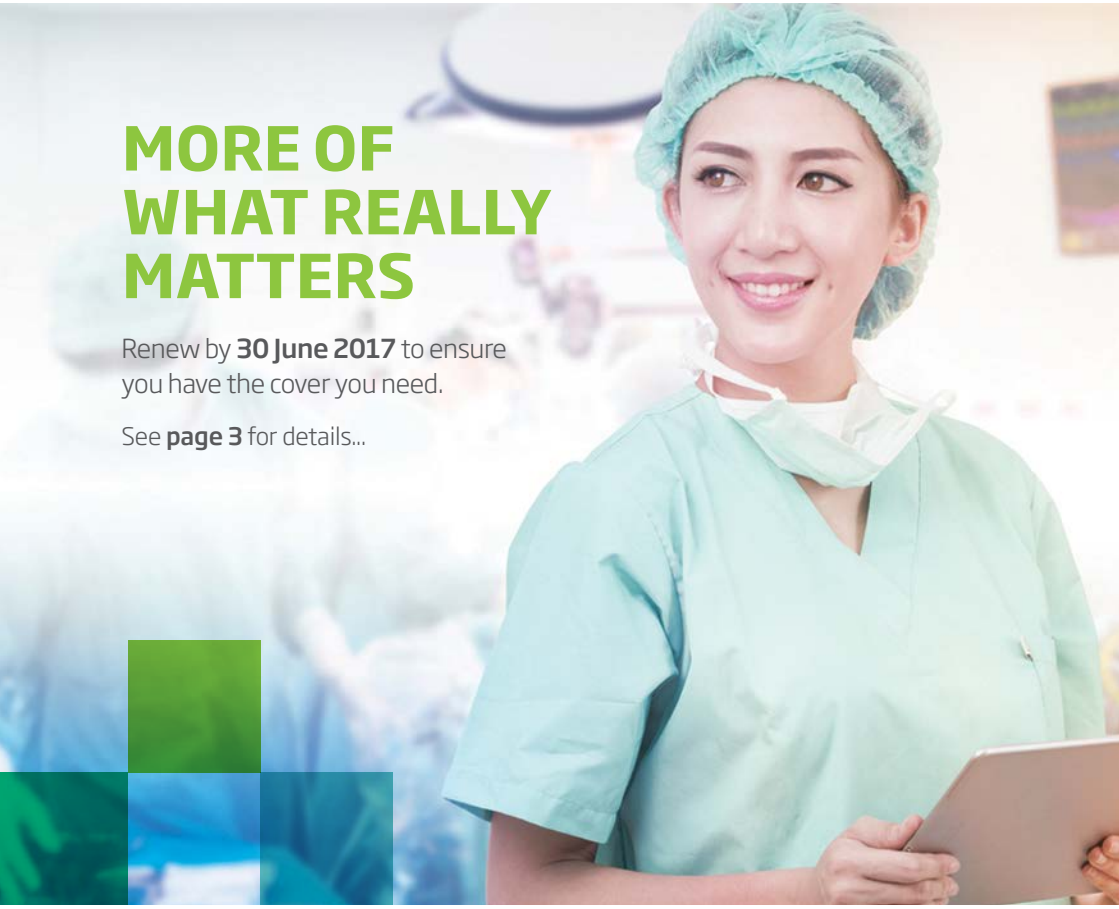

MORE OF WHAT REALLY MATTERS

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

See **page 3** for details...

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

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