defenceupdate

Publication for MDA National Members

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MDA National
Support Protect Promote

Editor's Note

An increasing number of MDA National's case files involve disputes between colleagues, rather than complaints and claims from patients. Assistance under your policy is available for employment, credentialing and medical college disputes. Aside from the stress for the individual doctors, there is growing evidence that inter-professional disputes can have a detrimental impact on patient safety. Therefore, any strategies to minimise these disputes are worthwhile.

In this edition, we have tips on accepting and providing constructive feedback (pages 14 to 15), and the issues to consider when entering into an employment contract or leaving a practice (pages 9 to 12). Dev Pillay, employment and regulatory lawyer, outlines a recent Fair Work Ombudsman case (page 18) which provides a salutary lesson for employers about dealing with an employee or independent contractor who makes a complaint.

In 2017 we are likely to see legislation being introduced concerning end-of-life care, with plans for legislation to be drafted in NSW and Victoria. This follows the defeat by one vote of a euthanasia bill in SA in November 2016. The legal principles underlying the provision of end-of-life care are discussed on pages 6 and 7. We will keep you informed of any legislative changes via our Medico-legal Blog.

I hope you enjoy this edition of *Defence Update*. And we'd love to hear from you if you have any comments, or topics you would like us to cover.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

Defence Update **Online**

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

In This Issue

Doctors for Doctors

Be not the first to try the new, nor yet...

Two stories, a generation apart

My father died in 1955 at the age of 42. He had chest pain. Our GP – whose partner I became in 1971 – made a home call and diagnosed a heart attack. He called in a Cardiologist – who also made a home call. He confirmed the diagnosis with an ECG. The machine looked the size of a small truck to me. He told Dad to rest in bed – the standard treatment for infarcts at that time. Dad died suddenly overnight, presumably of a ventricular arrhythmia.

Graeme Sloman opened Australia's first coronary care unit in Melbourne in 1963. If Dad's heart attack had happened ten years later than it did, with CPR and defibrillation, he may have had another thirty or so years of life.

In 2002, I self-diagnosed angina when attending a conference in Denver, Colorado. I did two sensible things. I did not see a doctor there, but saw my own GP in Melbourne when I returned home a week later. A coronary angiogram was performed soon after and it showed a 90% block of the left main coronary artery, too close to the bifurcation to be stented. I was perfectly well, but as that lesion is known as the Widow Maker, coronary artery surgery followed quickly. Fourteen years on, I remain in good health.

Separating the chaff from the wheat

We can easily lose track, in the hurly burly of day-to-day practice, of the enormous and accelerating advances in medicine. I graduated in 1968. What has happened in medicine since then was literally unimaginable at that time. A lot of what I was taught as an undergraduate seems "quaint" now.

We were taught a lot then about the various types of surgery for peptic ulcers. At that time, who would have envisaged treating them with antibiotics? What medical care could deliver in the next fifty years is literally unimaginable today. Indeed, with the rapid pace of change, can we predict what we will be doing – and not doing – in just twenty years' time?

These thoughts are not particularly original. What I want to emphasise is the increasingly heavy burden of keeping abreast of what is happening, and having the discernment to separate the nonsense chaff from the valuable wheat.

Robotic prostate surgery was introduced in the early 1990s. Do we really know, conclusively, whether it is better than open surgery? Are these flash new joint prostheses really better than the ones we know a lot more about?

We go to conferences and hear about lots of "gee whiz" stuff. We jump on the latest drugs; surgeons dive into the latest surgical toys. Deciding when to shift to new developments is a bit like picking the perfect time to drink a cellared red. It's easy to fall into a routine of established practice, but that could deny our patients the benefits of real advance.

Reading widely, attending conferences and critically assessing what we read and hear are key, but so is humility – having the honesty and insight to ensure we know what we don't know, and the determination to do something about it.

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

Notice Board

Starting Strong in the New Year

The past year has been very rewarding, and we are proud to be supporting over 50,000 Members and insureds across Australia. MDA National remains strong with a secure financial position. We continue to adapt to meet the evolving needs of the profession, and to deliver more of what really matters to our Members. Thank you for your loyalty which has contributed to our ongoing success.

Some highlights from our Annual Report 2016:

Retained 98% of our practising doctor Members

First Australian MDO to launch a medico-legal blog

Grew Membership and insureds by 10%

Grew our net assets to $174m
as at 30 June 2016

Achieved a $3.4m surplus
as at 30 June 2016

New Education Activities

We are excited to bring you two new learning opportunities:

The Challenging Emotions of Difficult News: an **online education activity** exploring how to communicate difficult news in ways that benefit patient outcomes and your own wellbeing. Complete it at your own pace, place and time from a PC or tablet. Visit the online learning activities in the Resources section of our website to find out more.

Noteworthy: The How, What, Where and Why of Medical Documentation: a **face-to-face** workshop on issues highlighted from Member queries, and recent court and Medical Board findings. Includes case scenarios and quizzes to help you create quality medical records and equip you to handle issues with medical record access. View the enclosed *Your Membership, Your Education* insert for sessions currently available across Australia.

Government Changes to Medical Indemnity Contributions

The Federal Government is reducing its contribution to high cost claims via the High Cost Claims Scheme (HCCS) from 1 July 2018, which will result in cost increases for all medical indemnity insurers. This change will not affect this year's premiums; however it will impact on premium prices for our Members in 2018.

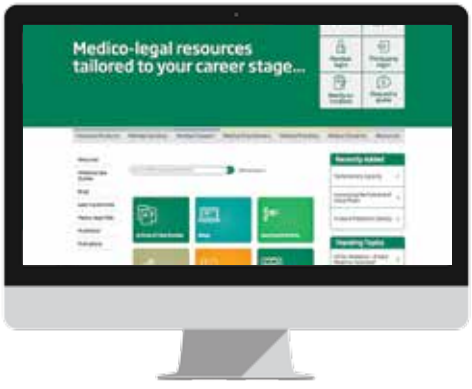
MDA National is advocating on behalf of Members with the government on their reviews of government schemes supporting the medical indemnity industry.

For more information, see our Latest News page at **mdanational.com.au**.

More Online Resources

The Resources section at **mdanational.com.au** is your one-stop shop for access to all these items and more:

- **Medico-legal blog** – subscribe to receive breaking news on medico-legal issues, recent cases, court judgments and legislative updates.
- **Articles and case studies** – type in a keyword for medico-legal articles and information, search by topic or search under your specialty.
- **Medico-legal FAQs** – answers to questions about medical records, subpoenas, ending the doctor–patient relationship and other popular topics Members call us about.



Releasing Medical Records – Take Note

Processing a request for medical records can be time-consuming for doctors, and particularly onerous when dealing with requests from third parties such as insurance companies or their lawyers.

Under the privacy legislation, patients are entitled to access their medical records and also extend this authority to a range of third parties, including insurance companies. If a patient makes a claim under an insurance policy, you will likely be asked to provide medical records.

A request from the patient's lawyers

If this request does not relate to concerns about your clinical care, the process is simple. You can provide a copy of the medical records if the request is accompanied by a current authority, signed by the patient, which refers to a release of medical records and noting who has been given authority to make the request.

Requests from the insurance company and/or their lawyers

This is a little more complicated. You might have received a letter from an insurer or their lawyer along the following lines: *We enclose a copy of an authority from the patient and request that you provide a complete copy of the patient's medical record.*

Often the authority is not recent (older than six months) or is non-specific and signed upon submission of the claim. Electronic or unsigned authorities are not acceptable forms of consent. Patient authorities can vary between insurers and jurisdictions, and can be difficult to interpret.

Does a signed authority give you carte blanche to release patient notes?

The short answer is no. When a patient signs a claim form which includes a broad consent, they may not have anticipated their *entire* medical record would be requested. Sometimes the authority is straightforward and the patient's wishes are clear – but if uncertain, you should contact the patient to seek verbal consent. Alternatively, you should ask the insurer to provide you with a specific and up-to-date authority signed by your patient, authorising release of the requested medical records.

A patient may sign an authority for release of their medical information, but they also have the power to revoke this.

Responding to the request

The patient should be made aware that non-compliance with a request for medical records may affect the insurer's ability to assess the claim. The patient should also know that if the matter progresses, the records could be subpoenaed and you will be obliged to comply regardless of whether the patient consents.

If a patient does not provide consent for the entire record to be released, you should respect their wishes in this regard. A dispute over consent to release records is ultimately between the insurer and the patient, not the doctor.

From a practical perspective, you may be asked to remove a specific consultation or the patient might consent to the release of records from a specific date. In this case, you must make it clear when you respond to the requesting party what you have or have not included, and that you are acting under the patient's instructions.

Am I obliged to write a report?

You are not legally obliged to write detailed reports for insurers, although it may be necessary for the patient to advance their claim. A report will not satisfy your obligations under the privacy legislation unless the requesting party accepts a report or summary in lieu of the notes.

Can I charge for providing copies of medical records?

Yes. In accordance with the privacy legislation:

An organisation may, however, impose a charge for giving access to requested personal information, provided the charge is not excessive. (APP 12.8)[1]

If you need guidance on appropriate charges, we recommend you consult the schedule published by the AMA NSW and the Law Society NSW.[2]

Nerissa Ferrie
Medico-legal Adviser, MDA National

For a full list of references visit **defenceupdate.mdanational.com.au/articles/releasing-medical-records**.

Unauthorised release of medical records could result in an AHPRA or privacy complaint. If you are ever in doubt, or your medical records include documents marked "privileged", contact our Medico-legal Advisory Service on 1800 011 255.

Consent: End-of-Life Care

Decisions to withhold or withdraw life-sustaining treatment are ethically, professionally and legally complex, especially when the patient has lost decision-making capacity. This article discusses some of the legal principles associated with the provision of end-of-life care and outlines the consent process which underpins these decisions.

Legal principles

Doctors are not under a legal duty to provide "futile" care, even if this is requested by the patient and/or their family. In end-of-life care, medically futile treatment can be considered to be treatment that gives no, or an extremely small, chance of meaningful prolongation of survival and, at best, can only briefly delay the inevitable death of the patient.[1] That is, where the treatment is of no medical benefit to the patient, or the burdens of the therapy are out of all proportion to any potential benefits.

Futile treatment may include life-sustaining treatment. The determination of futility must be appropriately made and, ideally, there should be consensus with the patient and/or their substitute decision-maker with respect to the assessment of futility. A patient, their family or substitute decision-maker can challenge a decision not to provide futile treatment in the courts.

It is a crime to deliberately take another person's life or to assist another person to commit suicide. A doctor should never provide treatment with the intention to end a patient's life, or to assist the patient in doing so. However, a doctor can administer medication to a patient with the sole intention of relieving pain and suffering ("good effect"), even though this may hasten their death ("bad effect").

This is commonly referred to as the "doctrine of double effect" and is an exception to the general rule that taking active steps to end a person's life is unlawful. In this situation, administering medication to the patient should not achieve pain relief by hastening their death, and the need to relieve the pain and suffering must be such that it outweighs the consequences of hastening death.

Adult patients who *have* capacity to make their own treatment decisions

By law, all patients who are 18 years or over are assumed to have capacity to make decisions, but that presumption can be rebutted where the need and evidence arises. Generally, a person with capacity will be able to:

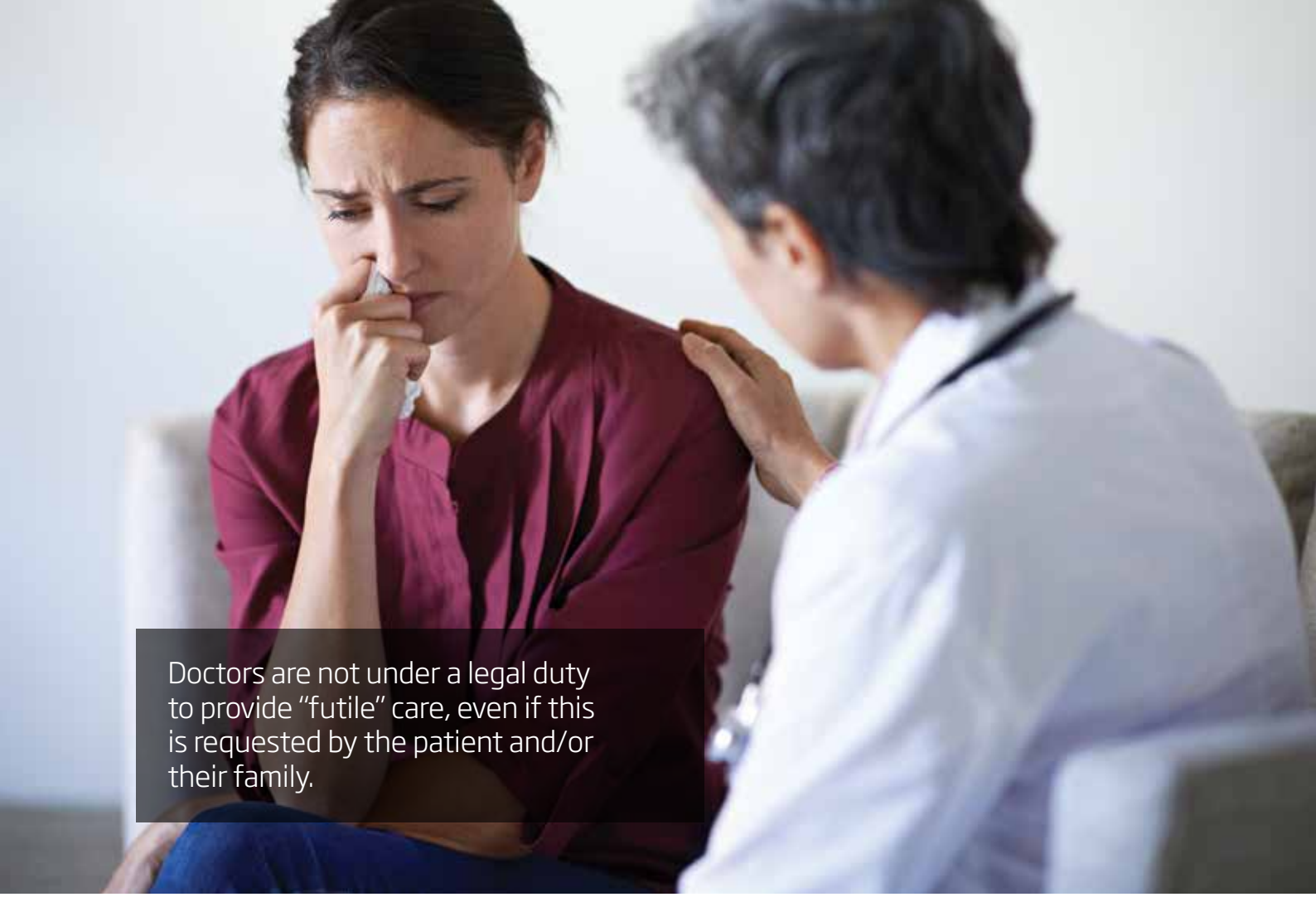
- understand the facts of the situation
- understand the main choices available
- weigh up those choices, including benefits and risks
- make and communicate their decision
- understand the ramifications of the decision.[2]

An adult patient who has capacity can refuse any medical treatment, even if this refusal will result in their death.[3]

Advance care directive (ACD)

Life-sustaining medical treatment can also be refused through an ACD. An ACD is generally a written document, intended to apply to future periods of impaired decision-making capacity, which provides a legal means for an adult to record preferences for future health and personal care and/or to appoint and instruct a substitute decision-maker.[4] ACDs are not clinical care or treatment plans, but clinical care and treatment plans can and should be informed by ACDs.

The common law recognises, as part of the right to self-determination, that an individual can complete an ACD that will bind a health practitioner who is treating that person, even if the directive refuses life-sustaining treatment. A 2009 NSW Supreme Court judgment confirmed that if an ACD is made by a competent adult, is clear and unambiguous, and extends to the situation at hand, it must be respected.[5]



Legislation governing ACDs has also been enacted in every state and territory, except NSW and Tasmania, although the legislation varies from state to state and is subject to change.[6,7] In some states, the legislation places limits on the application of an ACD – for example, in some states the ACD may only operate if the patient is suffering from a terminal illness or has no reasonable prospect of regaining capacity.

Adult patients who *lack* capacity to make their own treatment decisions

As outlined above, where a patient lacks capacity to make their own decisions, priority must be given to a valid ACD, if it exists. In the absence of an ACD, consent should be obtained from a substitute decision-maker.

Every state and territory has guardianship legislation which regulates, to varying degrees, medical treatment decisions for adult patients who lack decision-making capacity. The legislation outlines a hierarchy of decision-makers. This may include an enduring guardian who was appointed by the patient when they still had capacity; or a spouse, other family member or unpaid carer. These substitute decision-makers must act in accordance with the patient's wishes (if known) or in the patient's best interests. Where there is no available substitute decision-maker, an application can be made to the relevant Guardianship Tribunal for the appointment of a guardian.

Decisions to withhold or withdraw life-sustaining medical treatment are complex and serious, especially in view of the gravity of the outcome. In some states and territories, the legal authority of a substitute decision-maker to decide to withhold or withdraw a patient's life-sustaining medical treatment is not clear. There are also differences in the definitions of life-sustaining treatment or measures. This is a complex area of the law and you should contact MDA National for advice in a particular case if you are uncertain how to proceed.

Further Reading

End of Life Law in Australia.
Available at: **end-of-life.qut.edu.au**

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

For a full list of references visit **defenceupdate.mdanational.com.au/articles/consent-end-of-life**.

Cloud Storage of Medical Records

Storing data in the cloud is becoming increasingly popular. Cloud storage involves storing data online, rather than storing it locally on a device such as a hard drive. The data files are stored on a server owned by a cloud service provider such as Google Drive or Dropbox.

You must have connection to the internet to access the stored information. Benefits for businesses can include cost savings, access by multiple users, and data compatibility across different machines and browsers.

Security risk

Security is the big risk of handing over control of your data to an external vendor.

Medical records contain data that is sensitive and subject to strict legal requirements. They are also extremely vulnerable to theft, because the information they contain has "street value" – it could be used for identity theft, to falsify drug prescriptions, claim false health benefit payments, and even enable stalking.[1]

Loss of security of your medical records could breach privacy law, harm patients, damage your practice's reputation, or affect the practice's ability to function. Under Australian privacy law, a practice must take reasonable steps to protect personal information it holds from misuse, interference or loss; and from unauthorised access, modification or disclosure.[2]

Each practice's circumstances must be taken into account. A cloud-based system may offer better security than a self-hosted system in a practice without security processes or qualified maintenance staff. In a well-publicised case in 2012, Russian hackers demanded a ransom after encrypting and disabling a Gold Coast GP clinic's medical records.[3]

The fast pace of cloud development and the technical nature of data security may be daunting for doctors without extensive IT knowledge. External assistance is recommended.

A useful document is the Defence Department's *Cloud Computing Security for Tenants*[4] which aims to help a cloud user's cyber security team, cloud architects and business representatives to work together to perform a risk assessment and use cloud services securely. Risk mitigations detailed include:

- using a cloud service with particular accreditation (some providers may abide by the international standard for cloud privacy – ISO27018)
- annually testing an incident response plan
- encrypting data sent to the cloud
- multifactor authentication
- encrypted backup stored off-line or with another cloud provider
- having adequate bandwidth for reliable network connectivity
- contractually retaining legal ownership of your data.

Your contract with a cloud provider must address mitigations to security risks, persons who can access your data, and the security measures used to protect your data.

Server location

The location of servers is a vital consideration in choosing a cloud service provider – servers in Australia are recommended. Some well-known cloud services have servers located overseas. Australian privacy law requires that before personal information is disclosed overseas, a practice must take reasonable steps to ensure that the overseas recipient does not breach the Australian Privacy Principles.[5]

If you believe the country where the servers are located has similar privacy laws to Australia, you should obtain documentation such as independent legal advice to support this. If not, your options are to:

- not use that cloud service provider
- enter into a contract with the cloud service provider requiring them not to breach the APPs
- get consent from patients to disclose their information to the cloud service provider.

Seek further information and legal advice before embarking on any of these options.

Karen Stephens
Risk Adviser, MDA National

Useful information on information security

- Office of the Australian Information Commissioner
  ***Guide to Information Security*: oaic.gov.au/privacy/privacy-resources/privacy-guides/guide-to-information-security**
- Royal Australian College of General Practitioners
  ***Computer and Information Security Standards*: racgp.org.au/your-practice/standards/computer-and-information-security-standards/**

For a full list of references visit **defenceupdate.mdanational.com.au/articles/cloud-storage-medical-records**.

Contracts – What You Need To Know

The days should be long gone when a doctor joins a practice on a mutual understanding and a simple handshake. Contracts are now commonplace, and becoming more complex and difficult to navigate. We tackle some of the issues doctors encounter when joining or leaving a practice.

Do you really need to read the fine print?

You've been offered a great job. Well, if you've got some fine print to read that's a good start. We occasionally come across doctors who have accepted positions without a written contract. Although contracts can be formed through verbal agreements, this results in a lack of written evidence as to the contractual terms. We strongly recommend that you do not enter into an employment contract or an independent contracting arrangement solely on the basis of a verbal agreement.

A clearly worded contract benefits both parties

A well written contract is a benefit to both parties, as written evidence of terms and conditions significantly reduces the risk of later disputes. Provided that the contract terms are lawful, as a general rule, once it is signed both you and the other contracting party will be obliged to abide by the contractual terms – so make sure you understand what you are signing.

Is this an employment contract?

Not all contractual arrangements are employment relationships.

- Does your contract provide that you are an employee or an independent contractor?
- If you are an independent contractor, what provision is there for you to take time off for holidays or if you are sick?
- Who owns the medical records if you are an independent contractor working from a serviced practice?
- Regardless of whether you are a contractor or an employee, is the contract for a finite length of time?

If the contract is of limited duration, be aware that when that time comes to an end there may be no obligation to renew the contract – and unless it is expressed in the contract, there may be no obligation to notify you that the contract is not being renewed.

How are you remunerated?

- Are you paid by the hour or by the session?
- Are you paid a salary or based on a percentage of your billings? If you are paid a percentage of your billings, does the practice have the patient numbers that will give you a reasonable remuneration?
- If you are building up patient numbers, is there an agreed safety net below which your income will not fall?
- If you are paid a bonus, is it discretionary or is it based on clear key performance indicators?

The larger employers are likely to have industrial agreements in place that set out terms and conditions of employment, and in particular the scale of pay rates. These terms and conditions operate in addition to the basic terms in the employment contract. It is wise to get a copy of the industrial agreement before commencing employment.

When will you be working and what are the benefits?

- What hours are you expected to work in this role, and is there any flexibility?
- Are you expected to cover for other doctors in the practice or the health facility, and to what degree?
- What are the on-call demands and remuneration for on-call work?
- What leave is provided? If you are an employee, you should be provided with a minimum of four weeks annual leave.
- Is professional development leave provided, and what about study leave or conference leave?

What happens at the end?

Consider what happens at the end of employment and afterwards. Why is this important? Well, the three most common disputes we come across are the:

- meaning and effect of the termination provisions
- termination notice and termination periods
- restraints of trade post-employment.

Review the termination provisions

Can you be terminated for any reason with the giving of notice, or is it termination "for cause"? What are those "causes" you must be aware of that can be used by the employer to bring an end to your employment?

Review the notice periods

A notice period is an important term which provides time for the parties to organise their affairs before the end of the contract. For an employer, this gives them some time to find a replacement for the departing employee. For the employee, this gives forewarning of the end of employment and time to find a new position.

A longer notice period may make it more difficult to move to another job. For example, if you had a notice period of three months, another employer may not want to wait three months for you to finalise your existing job before starting with them.

Review the restraints of trade

Restraints of trade could apply during your employment and after the employment ends. Consider whether you are restricted from doing any other work during your engagement. The contract may prohibit you from working for a competitor during employment or may require you to seek the permission of the employer before obtaining a second job. If your contract is part-time this could be problematic.

Consider whether you will be able to live with the contractual restraints after the end of the contract, as these terms are often the subject of legal disputes. The contract may include a restraint clause which prevents you from working in or setting up a medical practice in the same locality for a period of time.

Any room to negotiate?

Consider the contract terms and whether you wish to attempt to negotiate changes.

Consider what you want, what is typical in the market, and think about added benefits such as time off during school holidays. Approach the negotiations carefully and professionally, as an employer can withdraw an offer of employment if you appear difficult or unrealistic.

Bear in mind that employers with industrial agreements in place may be less inclined to negotiate more favourable terms, as these were negotiated when the industrial agreement was entered into. Ultimately, if you are unable to negotiate changes, you will need to consider whether you are prepared to decline the offer of employment or live with what is offered.

Finally, before you sign on the dotted line, consider the contract terms carefully. If you don't understand the meaning and effect of the terms, seek advice from an employment lawyer.

Jenny Edinger
Senior Associate
Employment & Workplace Relations Team
Panetta McGrath Lawyers

Contemplating Change

Doctors in private practice may move practices several times during their career. Whether you are working as an independent contractor or an employee, there are some important things to consider when contemplating a move. This article highlights some common challenges.

Case study

Dr Smith works in a small practice located in a busy beachside community. There are approximately five general practices in the area.

Dr Smith is an independent contractor, with no written contract. She works six sessions a week and is paid in accordance with normal practice rates. She is a very popular local doctor, with a large and loyal patient list. She has worked at the practice for a number of years and is aware that patients travel from surrounding towns to see her.

A year ago the ownership of the practice changed, and Dr Smith is not entirely comfortable with some of the new practice protocols being introduced. She feels confident that many of her patients would wish to transfer with her if she sets up her own practice. She identifies some suitable rooms a short distance from her current practice. She obtains accounting advice, enters into a lease, and makes plans to set up a new practice.

When the time is right, Dr Smith approaches the owner of her current practice to inform him of the decision to leave. Although she has no written contract, Dr Smith is not anticipating any problems with her decision.

Dr Smith is extremely surprised when the new owner of the current practice becomes angry and upset about the news of Dr Smith's departure, and demands to know why she was leaving. Dr Smith takes the opportunity to describe all the problems she had with the new practice protocols introduced, including criticism of the owner. The owner tells Dr Smith she should finish up at the end of that day's session, and not return to the practice.

Dr Smith had intended to make arrangements for her patients' records to be transferred to the new practice. When Dr Smith raises this with the owner, she is told that the records remain the property of the current practice and she is not entitled to them.

Aside from matters directly related to indemnity arrangements, MDA National does not provide advice on individual employment contracts. If you are unsure what a proposed contract means or how you may be bound by it, we recommend you seek independent legal advice or contact your state medical association.

She is also informed that the practice intends to recruit a new doctor to replace her and will be able to accommodate all of her patients.

Dr Smith was not expecting to leave so quickly, and she also faced a period of reduced income as she was not due to move into her new premises for another month.

Medico-legal issues

- Unless specifically contracted or with patient consent, an employee or independent contractor is not entitled to take/access patient records.
- The practice owner would be entitled to contact the patients with advance bookings and offer to transfer them to another doctor within the practice.
- Exit interviews should be conducted in a professional way and it is generally not the appropriate time to criticise the practice (or individuals).
- It is prudent to plan for your exit on the basis that discussions might not go well and you may be asked to leave immediately.

Dr Smith rang MDA National and received general advice on negotiating with her former practice.

Janet Harry
Medico-legal Adviser
MDA National

Checklist for leaving a practice

- ☐ Review your contract
  - › Notice period
  - › Restraint of trade
- ☐ Identify your personal property
- ☐ Medical records
  - › Who owns the records and patient contact details?
- ☐ Consider
  - › What can you tell your patients?
  - › Management of your patients after your departure
- ☐ Medicare provider number
  - › Cancel
  - › Organise new provider number (if applicable)
- ☐ Computer
  - › Manage inbox, emails, recalls and reminders
  - › Cancel password

Registration Standards – Are You Complying?

The Medical Board of Australia's Registration Standards set out the requirements that doctors need to meet in order to be registered. With the exception of medical students and non-practising registrants, the following standards apply to all doctors:

- Recency of Practice
- Continuing Professional Development
- Criminal History
- English Language Skills
- Professional Indemnity Insurance Arrangements.[1]

On 1 October 2016, the revised standards for Recency of Practice, Continuing Professional Development and Professional Indemnity Insurance standards came into effect.

Recency of practice

Significant changes have been made to the Recency of Practice registration standard with respect to the minimum number of practice hours required to meet the standard. To meet the revised standard, medical practitioners must practise within their scope of practice at any time for a minimum total of:

- four weeks full-time equivalent in one registration period – a total of 152 hours; or
- 12 weeks full-time equivalent over three consecutive registration periods – a total of 456 hours.

Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours. Possible consequences for not meeting this standard include imposition of conditions on registration or disciplinary proceedings.

For medical practitioners with non-practising registration or who are not registered, but have two or more years' clinical experience, and who wish to return to practice, the following requirements must be met:

1. No additional requirements are needed for those with non-practising registration or who have not been registered for a period up to and including 12 months.
2. For a period between 12 months and up to 36 months, at a minimum, before re-commencing practice, the equivalent of one year's CPD activities relevant to the intended scope of practice must be completed. The CPD activities must be designed to maintain and update knowledge and clinical judgement.
3. For a period greater than 36 months, a plan for professional development and re-entry must be submitted to the Board for consideration and approval.

For medical practitioners with less than two years' clinical experience who are returning to practice after either not having been registered for more than 12 months, or who have not practised for more than 12 months, Board approval for working under supervision in a training position needs to be sought.

The Medical Board has provided further clarification in relation to frequently asked questions on its website: **medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Recency-of-practice.aspx**.

Continuing Professional Development (CPD)

The revised standards for CPD requirements have not significantly changed, other than the requirement for international medical graduates (IMGs) to complete a minimum of 50 hours CPD per year – **including** the CPD outlined in their supervision plan and work performance report. If this totals less than 50 hours, IMGs must complete additional CPD to reach a minimum of 50 hours per year. In the past, there was no minimum hour requirement for IMGs.

The Medical Board has provided further clarification in relation to frequently asked questions on its website: **medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-for-CPD-for-IMGs.aspx**.

Professional Indemnity Insurance (PII)

All medical practitioners are now required to have appropriate retroactive PII cover for otherwise uncovered matters arising from prior practice undertaken in Australia.

If appropriate retroactive cover is not included as part of your PII policy, please contact us immediately to amend your cover and ensure you are properly covered. This requirement was effective from 1 October 2016.

We encourage you to take the opportunity to review the revised registration standards and frequently asked questions published by the Medical Board of Australia to ensure these are met, especially if an extended break from practice is being contemplated. Guidance on planning leave can also be found on the Medical Board's website: **medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Recency-of-practice.aspx#leave**.

Dr Helen Havryk
Claims Manager, MDA National

1 Medical Board of Australia. Registration Standards. Available at: **medicalboard.gov.au/registration-standards.aspx**

Constructive Feedback Supports Lifelong Learning

Being a proficient doctor entails lifelong learning which requires reflecting on performance. MDA National outlines tips for seeking, accepting and providing useful feedback.

A recent Australian study found that medical students considered "teaching by humiliation" to be part of the culture in the medical profession. These findings raise concerns regarding the:[1]

- impact on students' learning and mental health
- contrast with and subsequent undermining of the formal professionalism curriculum
- future medical teaching workforce (people tend to do what was done to them as students thus perpetuating the culture)
- possible negative impact on patients who observe such behaviour including intimidating questioning styles or abusive language from teachers.

A medical professional who does not self-regulate, reflect on their performance and ask for help risks compromising patient safety.[2] Seeking feedback from others is dependent on:[3]

- a workplace culture that encourages and normalises critique from others
- open and supportive relationships based on mutual respect and trust
- lowering individual emotional barriers (trainees who fear appearing incompetent may not seek feedback, and supervisors who are uncomfortable with the emotional reactions feedback can elicit may not readily give feedback).

Cultivating a lifelong learning ethos starts early

Encourage medical trainees to seek and accept feedback, and to reflect on their performance. To achieve this, consider the following principles for providing constructive feedback:

- **Set realistic goals and objectives** based on what the individual is expected to learn and what they want to learn. The trainee will be more likely to act on the feedback and less likely to take comments personally.[4,5]
- **Make feedback a regular occurrence**[5] and act immediately where necessary and appropriate.[4] Embed an element of reflection into all learning opportunities and set aside time for observation to enable meaningful feedback.
- **Ask the trainee for their self-assessment** to promote reflective practice.[5]
- **Be specific**.[4] Validate feedback by basing it on direct observation with specific examples of behaviour that can be modified.[5]
- **Provide reinforcing feedback**. Find reasons and take opportunities to recognise positive behaviours and excellent performance. This reinforces current desired behaviour and inspires people to want to do better.[6]
- **Use positive communication strategies**. Body language is important as well as a respectful and supportive tone. Ensure the session is a two-way conversation.[5]
- **Reflect** on your feedback skills.[5]

Use the DASR script as a template for expressing constructive feedback[7]

1. **D**escribe the behaviour you observed using factual information, sensory language (e.g. what you saw, heard, counted), and statistical information (e.g. quantity, frequency, duration).
2. **A**cknowledge your reactions to the situation or impact of their behaviour without making any judgements or assumptions about the person, e.g. "I felt…"
3. **S**pecify different desired behaviour.
4. **R**eaffirm the individual's worth and ability to correct their behaviour, e.g. "I am confident you can improve on…".

Receiving feedback continues throughout your career

Accepting advice from colleagues can be a challenge for any doctor. Here are some tips for seeking, receiving and handling feedback:[8]

- **Improve self-assessment**. Proactively identifying and being aware of your own strengths and weaknesses can make receiving feedback less abrasive. Assess performance by breaking down tasks into different components, e.g. if reflecting on how things went in a specific patient encounter, consider the steps involved such as building rapport, history taking, etc. This helps to reveal specific areas that may need attention.
- **Be open to receiving feedback**. Everyone has blind spots about their abilities. Being receptive to others' observations provides the opportunity to discover strengths and areas of improvement.
- **Proactively ask for feedback**. Medical workplaces are often busy and feedback can be overlooked.
- **Control your emotions**. Many people find receiving feedback emotionally challenging. Focusing on seeing it as an opportunity for development and thinking about it objectively can help.
- **Clarify feedback you do not understand**. Not everyone is good at providing feedback, and general comments such as "good job" are not helpful. Ask questions to discover the details and initiate a productive conversation.

Explore the topic further

- Do you find it difficult to accept feedback from others? Review tips for effectively reflecting on your performance: **ncbi.nlm.nih.gov/pmc/articles/PMC4116619**.
- Are you a clinical mentor? Consider best practice for providing feedback: **ncbi.nlm.nih.gov/pmc/articles/PMC3399605**.
- Are you involved in General Practice training? Discover strategies and tools to minimise medico-legal risks with MDA National's **General Practice Supervision and Patient Safety** workshop. Check our website to find out about any upcoming events. You can request a session if an event is not scheduled in your area or is not at a convenient time for you.

Gemma Brudenell
MDA National Education Services

For a full list of references visit **defenceupdate.mdanational.com.au/articles/constructive-feedback**.

CaseBook

Patient Information – Third Party Disclosure

Case history

A GP, Dr Z, was found to have breached a patient's privacy and ordered to pay the patient $6,500 for injury to his feelings and distress.[1] The privacy breach occurred when the GP answered a phone call from the police asking if she thought her patient was psychotic. Dr Z knew the patient well, having seen him on 26 occasions over the previous two years, but she had not seen him for two months. The GP replied to the police that it was possible, but further assessment was needed.

Professional obligations – confidentiality and privacy

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 information about them in confidence, unless the release of information is required by law or public interest considerations.[2]

The ethical and professional duty of confidentiality dates back to Hippocrates and forms the basis of trust in the doctor–patient relationship. It encourages patients to disclose information truthfully, without fear of harm, discrimination or embarrassment that may arise from the dissemination of the information. However, the duty of confidentiality is not absolute and there are exceptions.

A doctor will occasionally face a situation where they need to weigh up their obligation to protect patient confidentiality against acting in the "public interest" in trying to protect the health or safety of the general community.

Legal obligations – privacy

In what circumstances can you disclose information about one of your patients to a third party?

Under the *Privacy Act 1988* (Cth), a patient's health information can be disclosed to a third party in certain circumstances, including when:

- the patient provides their consent for the information to be released to the third party
- it is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety, where it is unreasonable or impracticable to obtain the patient's consent:
  - › includes a threat to physical or mental health and safety
  - › may include a threat of serious harm to the patient or to any other unspecified individual
- it is required or authorised by or under an Australian law or a court/tribunal order (e.g. mandatory reporting of child abuse, a subpoena or search warrant)
- it is reasonably expected by the patient and directly related to the primary purpose of providing health care (e.g. complaints handling, audit, disclosure to a medical defence organisation)
- it is reasonably necessary for one or more enforcement-related activities conducted by, or on behalf of, an enforcement body:
  - › a written note of the disclosure must be made
  - › enforcement-related activities include the prevention, detection, investigation and prosecution or punishment of criminal offences and intelligence-gathering activities
  - › "enforcement body" includes bodies responsible for policing, criminal investigations and administering laws to protect public revenue or to impose penalties or sanctions.

Preventing a breach

What should Dr Z have done to prevent a breach of privacy when she was contacted by the police?

She could have asked the police whether any of the exceptions to her duty of confidentiality and privacy applied. Specifically, whether the patient had given his permission for the GP to discuss his health information with the police; if the information was needed to lessen or prevent a serious threat to life, health or safety; or whether the information was necessary for an enforcement-related activity by the police.

If Dr Z was not certain how to respond, she could have asked the police to put their request in writing to enable her to obtain advice from her medical defence organisation, and/or discuss the situation with the patient, if appropriate.

Summary points

- If a patient provides you with consent to release their health information or medical records to a third party, you should do so.
- In the absence of your patient's consent, there are limited circumstances in which you can release their health information or medical records to a third party.

Dr Sara Bird
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MDA National

For a full list of references visit **defenceupdate.mdanational.com.au/articles/third-party-disclosure**.

CaseBook

Writing Letters of Support – How Far is Too Far?

A recent independent research study[1] commissioned by the Medical Board of Australia confirms that doctors are the most trusted profession in the country. Patients know doctors are held in high esteem, so they often turn to their doctor for letters of support.

When should I say yes?

It is appropriate to write a letter of support when the information the patient is seeking is entirely factual and within your area of knowledge and/or expertise.

When should I say no?

If a doctor calls MDA National to seek advice about whether to write a letter of support, invariably the alarms bells have already started ringing. If it feels a step too far, it probably is.

Letters of support which require you to make a moral judgement, or interfere with an existing court order, should be considered carefully.

If you speculate or advocate without the benefit of all the facts, your own integrity may be called into question.

Case history

John is a new patient to the practice. At the first consultation, John seeks repeat scripts for Panadeine Forte and Endep. He presents a letter from his previous GP referring to chronic leg pain following a motorcycle accident three years prior.

The next time John comes in, he asks Dr Jones to write him a letter for court. He hands over a letter from his lawyer which says:

Dear Dr Jones

We understand you are treating our client for injuries suffered in a motorcycle accident in 2013.

Our client has been charged with stealing a motor vehicle, dangerous driving, and possession of methamphetamine.

He intends to mitigate his guilty plea on the basis that he has difficulty understanding the consequences of his actions since the accident.

Can you please write a letter "to whom it may concern" confirming that our client is of good character, and that his behaviour is the result of head injuries from the motorcycle accident and the medication he is taking to treat those injuries.

Yours sincerely...

Medico-legal issues

There are a number of reasons why Dr Jones should **not** comply with the lawyer's request:

- He has only met John twice and therefore cannot comment on his character, either before or after the motorcycle accident.
- The patient has been treated by other doctors in the period between the accident and the move to Dr Jones' practice, so Dr Jones has no clinical information about an alleged head injury.
- There is no clinical evidence to suggest that Panadeine Forte or Endep would influence the patient's behaviour to the extent alleged.
- He avoids writing letters "to whom it may concern" as he has no way of knowing how the letter will be used.

Dr Jones is not obliged to provide the letter requested, and instead writes:

Dear Sirs

I have consulted John Smith on two occasions – 21 October and 1 November 2016.

On 21 October 2016, John provided me with a letter from his previous GP noting ongoing leg pain from a motorcycle accident in 2013.

John advised me his leg symptoms remain unchanged and I provided repeat scripts for the following medication:

- *Panadeine Forte*
- *Endep.*

Yours sincerely...

If you receive a request for a letter of support and you are unsure how to respond, contact our Medico-legal Advisory Service for guidance.

Nerissa Ferrie
Medico-legal Adviser
MDA National

1 Medical Board of Australia. Doctors the Most Trusted Professions: Board Research. Available at: medicalboard.gov.au/News/2016-11-10-media-statement.aspx

CaseBook

Navigating Workplace Rights – Employers Beware

A medical practice and its directors have been fined more than $51,000 for threatening a doctor for complaining to the workplace regulator about how the surgery had treated him.[1]

The case highlights the often unappreciated legal risks to medical practices arising from adverse treatment of workers, due to the general protections provisions of the *Fair Work Act 2009* (Cth). In short, those provisions mean prosecution and litigation can flow from a wide variety of treatment of employees or independent contractors – the risk does not only arise in the context of dismissal.

Case history

The Windaroo Medical Surgery Pty Ltd engaged an overseas-trained GP who had migrated to Australia with his family. The medical practice provided the GP with a "letter of appointment" which the trial judge later described as "confused and confusing" as it did not clearly set out all relevant matters.

The conflict between the GP and the medical practice began because the GP was not paid for his services. The GP complained to a number of people about this, and also lodged a formal written complaint with the Fair Work Ombudsman (the workplace regulator). Following this, a director of the medical practice threatened the GP in what seemed to be an attempt to force him to withdraw his complaint.

The GP said these included threats to:

- not pay him for work he had performed
- reclaim money spent by the medical practice in recruiting him
- provide the Medical Board with patient complaints against him.

Medico-legal issues

Under the general protections of the Fair Work Act, it is unlawful for an employer to take "adverse action" against an employee or independent contractor because that person has exercised (or has proposed to exercise) a "workplace right". Both "adverse action" and "workplace right" are defined flexibly, which means a variety of workplace scenarios can fall within the scope of the general protections (in contrast to the unfair dismissal provisions which only apply to the dismissal of an employee).

Importantly, the court can order a variety of remedies when it finds a person has breached the general protections, including awarding unlimited compensation or imposing pecuniary penalties. In a recent decision, a court awarded an employee $1,272,109 for past and future loss of wages (plus $24,626 in interest) and also required the employer to pay a pecuniary penalty of $50,000.[2]

In this case, the court found the GP had exercised a workplace right by making a formal written complaint to the Fair Work Ombudsman and that the medical practice had taken adverse action against him in threatening not to pay him if he did not withdraw the complaint. Consequently, the medical practice and the directors had contravened the Fair Work Act.

The medical practice was penalised $39,600 and two of the directors fined $11,800 in total as individuals. Additionally, the medical practice and the directors were ordered to pay the practitioner $24,724 in compensation for economic loss and distress suffered.

Discussion

This case should warn any persons operating a medical practice that there is a variety of behaviour that could be "adverse action" that contravenes the Fair Work Act – including:

- reducing an employee's status and level of responsibility
- altering an employee's roster
- investigating an employee's conduct.

It could be unlawful if any of the above actions are taken because the employee has exercised a workplace right. The following actions have been found to be "workplace rights":

- making a claim for workers' compensation
- taking personal or carer's leave
- making a complaint about a supervisor (either internal or external).

Medical practices should tread carefully when managing or dealing with a worker who has exercised a workplace right, and ensure they are in a position to prove that any "adverse actions" were not taken because of a relevant "workplace right". Seeking a second opinion before proceeding with any adverse action can be effective in preventing claims.

The decision also highlights how the lack of clarity in contracts about critical matters, such as payment, can lead to acrimonious workplace disputes.

Care should be taken in drafting relevant documents to provide a clear understanding of how such critical matters will work in practice.

Dev Pillay
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For a full list of references visit **defenceupdate.mdanational.com.au/articles/employers-beware**.

What's On?

Medical Conferences

At MDA National, we are actively involved in various conferences of Australian Medical Colleges and Associations in order to support our collective Members. Our friendly business development specialists and other professional experts will be on hand at the MDA National booth and involved in many presentations. Come and say hello and meet your MDA National team members. Here are a few of the upcoming conferences we will be present at:

7–14 Feb	Australasian College of Sport and Exercise Physicians Scientific Symposium **Gold Coast, QLD**
24–26 Feb	AMA VIC Congress **Melbourne, VIC**
8–9 Apr	Rural Health West **Perth, WA**
26–29 Apr	14th National Rural Health Conference **Cairns, QLD**
30 Apr –4 May	RANZCP Congress 2017 **Adelaide, SA**
2–4 Jun	Business for Doctors **Melbourne, VIC**
16–18 Jun	ANZCA Country Conference **Broome, WA**

At the MDA National booth for the February, April and May conferences, we will have complimentary massages on offer – and the chance to win a $500 travel voucher by completing a survey.

For more information, visit our **Upcoming Events** page at **mdanational.com.au**.

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Head for the IMGs page under the Medical Practitioners tab at **mdanational.com.au**.

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