defenceupdate

Publication for MDA National Members

Spring 2018

The Trouble with Testimonials

Social Media - Not Just a Social Platform

The One Ingredient for a Meaningful Career

Medico-legal Feature: The Impaired Doctor

Noteworthy Outcomes of a Medical Record-Keeping Workshop

Take Care with Medicare

MDA National Casebook

Editor's Note

This edition focuses on the importance of doctors' health – looking after ourselves and our colleagues. It still surprises me that many doctors don't have their own GP. A question often asked in the course of Medical Board proceedings is: *Do you have a GP?* This is reinforced by the Code of Conduct which states good medical practice involves having a GP.

Dr Sarah Newman discusses why it's difficult for some doctors to find and see a GP, and why it's so important to have one (page 3). Dr Jonathan Ramachenderan writes about his journey to practising self-reflection and being a 'good enough doctor' (page 8). And in our medico-legal feature, Dr Jane Deacon explains the Medical Board's Health Program and how you can assist a colleague who may be suffering from an impairment (pages 9-12).

There is an increasing recognition of the positive impact of social media in medical practice. Dr Nikki Stamp discusses how the use of social media benefits doctors in their professional lives (page 6). CrazySocks4Docs, a campaign to support doctors' health, is a good example of the use of social media to directly benefit doctors.

A key part of MDA National's role is to ensure lessons from our medico-legal cases are shared with Members and the profession. During the past year, our Education Services team delivered more than 60 face-to-face sessions on a range of medico-legal topics. You can read about the key changes our Members plan to make to their medical record-keeping after attending our Noteworthy workshop (page 13) and consider if there are changes you need to implement.

Thank you to the Members and colleagues who have contributed their knowledge and shared their experiences in *Defence Update* this year. Your input is invaluable. On behalf of MDA National, I wish you and your family a safe and enjoyable festive season and New Year.

Dr Sara Bird
Executive Manager, Professional Services
MDA National

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Doctors for Doctors

Consider taking a dose of your own medicine, but don't be a "fool". Find a GP today.

A Dose of Our Own Medicine: The Doctor-Patient

What is the most common advice given to patients leaving hospital, attending ED, or with that niggling health issue? "Go see your General Practitioner (GP)." And having a regular GP is associated with better health outcomes.

As Osler said, "A physician who treats himself has a fool for a patient" – yet only 70% of doctors have a regular GP. So what about the rest of us? Are some of us too proud to see a GP? Does our training imply we should be able to manage our own health?

Doctors often use a 'blended care' approach combining self-treatment with care provided by another medical professional. Who hasn't provided medical assistance for themselves or friends? But the ethical, legal and safety issues become questionable. The independence of an external review is essential in appropriate care and triage. The 'corridor consult' with a friend or colleague is not a full and objective assessment.

GPs act as generalists with a holistic approach to investigation and management of presentations as well as practising preventative care. The care of doctor-patients is not special, but rather different. A good GP recognises the special knowledge of a doctor-patient, but makes no assumptions and encourages shared decision-making.

Confidentiality concerns are often an issue. The stigma associated with being a patient can be a major barrier to seeking help. Even being seen in a waiting room can induce fear. Actions from treating doctors to proactively acknowledge and pay special attention to confidentiality issues can reduce the anxiety and increase the trust of doctor-patients.

Many doctor-patients refrain from seeking help due to fear of mandatory reporting by treating doctors. This is not just because of the law, which is poorly understood by health professionals, but also the fear that this law generates. In Western Australia (WA) where I practise, treating doctors are exempt from mandatory reporting of doctor-patients.

Difficulties with finding the right GP are common issues raised with the Doctors' Health Advisory Service of WA (DHASWA). GP access can be limited by time, work pressures, availability of after-hours appointments, and finding a comfortable therapeutic relationship. In response to this issue, DHASWA has created a 'Doctors for Doctors' list of practitioners in WA who have an interest in doctors' health and are willing to prioritise doctor-patients. There are similar lists in South Australia and the Northern Territory. We hope this will help our doctors and medical students to find a GP who fits their needs.

Dr Sarah Newman (MDA National Member)
Assistant Director
Doctors' Health Advisory Service WA (DHASWA)

DHASWA is an independent service supported through funding from the Medical Board of Australia.

Notice Board

TGA Restrictions on Stem Cell Therapy

Autologous blood and human cell and tissue treatments, such as stem cells and platelet rich plasma, are now regulated by the Therapeutic Goods Administration (TGA). Concerns about patient safety and the advertising of unproven interventions led to the new regulations, which will bring Australia in line with the United States and the European Union.

Products manufactured and used in an accredited hospital are excluded from regulation. Requirements include complying with standards, not advertising to consumers, and reporting adverse events to the TGA.

Further information is available on the TGA website: **tga.gov.au/publication/australian-regulatory-guidelines-biologicals-argb**.

What Constitutes Notifiable Conduct in Mandatory Reporting?

Deborah Jackson, MDA National Claims and Advisory Counsel, discusses some of the mandatory reporting issues in this video available at: **mdanational.com.au/Resources?c=videos**.

Don't miss our medico-legal feature, **The Impaired Doctor** (pages 9-12), which explores mandatory reporting, health assessments, and the role of the Medical Board.

Advice to GP Registrars – Am I Covered?

Some of our Members have raised this question: "Am I covered for advice to a GP Registrar, even if I am not their formal supervisor?"

The answer is yes, this advice would be covered under the definition of 'healthcare service' under one of the following sub-paragraphs in our Professional Indemnity Insurance Policy brochure (v.12, page 47; accessible from the Downloads section on our website):

Healthcare service means:

(a) If you are a medical practitioner, the following services that you personally provide:

- (i) healthcare treatment, services or advice or a report of those things provided to a patient or in relation to a patient in a professional capacity; or …
- (v) a healthcare report or opinion not for the purpose of treatment.

Are You Protected Against Cyber-Attack?

Explore key cyber-attack defence and mitigation measures in this recording of a webinar featuring leading digital health systems expert, Prof Trish Williams and MDA National Medico-legal Adviser, Dr Jane Deacon. The webinar is ideal for those working in private practice.

Members can access the full 45-minute recording by logging into Member Online Services – just click on the **MyResources** tab and choose **Webinars.**

The first 15 minutes of the webinar is available for all to view at: **mdanational.com.au/Resources?c=videos**.

Best wishes for a safe and joyous festive season!

The Trouble with Testimonials

A chiropractor was found to have used false and misleading advertising about being able to cure cancer and to have used testimonials in website advertising. He was given a criminal conviction, fined $29,500 and deregistered for two years. Although the claims about curing cancer were more serious than the use of testimonials, the findings in one of the hearings[1] included the following:

The two testimonial offences demonstrate that the practitioner took no steps to stay up to date with current professional laws and standards on advertising, and failed to understand why such material may be dangerously misleading to patients.

The Law

Section 133(1)(c) of the Health Practitioner Regulation National Law states that a person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that uses testimonials or purported testimonials about the service or business.

What is a testimonial?

A testimonial is a statement, review, view or feedback about a service. AHPRA advises[2] that in the context of the National Law, a testimonial involves recommendations or positive statements about clinical aspects of a regulated health service.

Testimonials may be found:

- under a tab or heading 'Testimonials' on a practice website or information brochure
- in the Reviews tab on a practice's or doctor's Facebook page
- in comments on a practice's or doctor's Instagram feed.

Why are testimonials banned?

- They are not objective or scientific.
- One person's outcome may not be relevant to others.
- They can be misleading.
- Patients cannot assess the validity of the claims.

Which testimonials am I responsible for?

You are responsible for reviews or testimonials which appear in advertising that you control. For example, if you are the practice owner, you control your practice's Facebook page.

You are not responsible for removing (or trying to have removed) testimonials published on a website or in social media over which you do not have control, e.g. ratemds.com.

However, a breach of the National Law may occur if you use such a review to advertise, respond to the review or re-publish it on your website.

Google reviews are not considered by AHPRA to be within your control, whether or not you have verified your Google listing. You are therefore not required to try and remove Google reviews. However, if you respond to a Google review, this could be considered a testimonial if, for example, the response includes clinical aspects of care.

How do I decide if a particular review is allowed?

You can access AHPRA's testimonial tool[2] which helps advertisers understand which reviews can and can't be published. Clinical aspects cannot be referred to, e.g. symptoms, diagnosis, treatment, outcome, or the skills or experience of the practitioner.

Can I edit reviews?

Editing reviews or testimonials to meet the National Law advertising requirements could be misleading or deceptive. Recent publicity about HealthEngine,[3] an online appointment booking service, altering negative patient reviews and publishing them as "positive customer feedback" led AHPRA to issue guidance[4] that selectively editing reviews or testimonials may break the law.

What might happen if my advertising contains testimonials?

AHPRA's current process, if they become aware that advertising contains testimonials, is to write to the responsible practitioner asking them to check their advertising and correct the content to comply with the National Law. Usually a practitioner is given 60 days to do this, after which AHPRA may conduct an audit to see if the necessary changes have been made. If an audit finds the advertising still doesn't comply with the National Law, AHPRA can take further action such as imposing conditions on a doctor's registration that restrict how and what they can advertise. Fines may also be imposed by a court, and the Medical Board can take disciplinary action.

Why can't I use testimonials if my colleagues and competitors are using them?

This is like saying: "Why can't I speed when other cars are speeding?"

Karen Stephens
Risk Adviser, MDA National

View the list of references at **defenceupdate.mdanational.com.au/articles/trouble-with-testimonials.**

Social Media
Not Just a Social Platform

Social media had humble beginnings, starting as a brain child of technology's brightest minds. From the days of Mark Zuckerberg creating Facebook as an online yearbook at Harvard, social media (Twitter, Facebook, LinkedIn and many others) has grown to now encompass billions of users across multiple platforms worldwide. What started as a truly social enterprise, a way to connect with friends and family, has grown to become much more than that.

Traditionally, doctors have been cautioned away from using social media with concerns over professionalism, privacy (of doctors and patients) and standards such as those relating to advertising.[1] In recent years though, doctors have taken up social media with great fervour as they see it as much more than social. Rather, it is becoming an increasingly important tool in the modern doctors' armamentarium. Personally, joining social media in a professional fashion is one of my smartest career moves.

How social media (SoMe) stands to benefit doctors

In the past few years, SoMe has grown as an important networking and education tool. This is particularly evident on Twitter, where users send out 'tweets' of 280 characters of less, tagging other users or using hashtags as a kind of online cataloguing system. Linked by common interests or topics, doctors, healthcare professionals and even patients can have structured and unstructured interactions that serve an important role in networking, mentoring, education and collaboration.

In 2015, American general surgical resident Dr Heather Logghe MD first used the hashtag #ILookLikeASurgeon as a way to showcase the diversity in the surgical workforce. The hashtag, tweet and subsequent SoMe campaigns aimed to highlight the oft-heard "you don't look like a surgeon" often directed at young female surgeons.

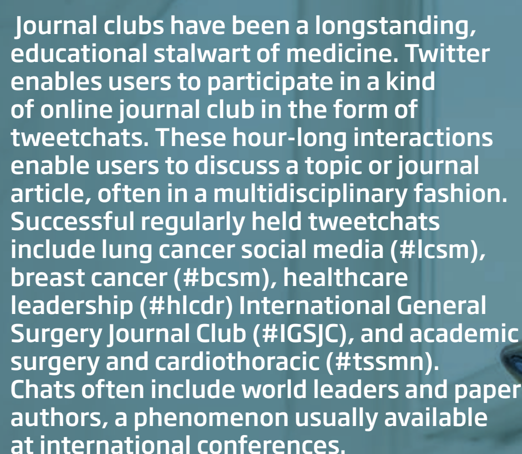
This tweet started a strong international and multidisciplinary network of predominantly female surgeons, interested in all the aspects of a surgical career but also social justice, by promoting diversity in our profession. Since that time, over 64 academic journal articles have been published on #ILookLikeASurgeon and countless more on the utility of SoMe. Analysis of data and dedicated study into SoMe shows a few noted benefits.

Luc et al[2] published a study on how SoMe has tremendous potential in mentoring. Mentoring is a vital part of career development, a fact the business world has long known. This study demonstrated that particularly for women in surgery, SoMe could connect mentees to mentors with similar interests as well as background, including gender. This is a vital part of the career path of someone who may be a minority in their field. Being able to instantaneously connect with a suitable, matched and engaged mentor, especially if that is not available locally, is a significant strength of SoMe.

Collaboration on research or academia lends itself well to social media.[3] Using SoMe can enable international, multi-centred collaboration in academic circles. With the initial connections made online, coupled with near-instantaneous information exchange, creating and writing projects is far easier than old styles of sending contributions, corrections and revisions back and forth between authors. The ability to connect with collaborators who are world leaders, and perhaps even recruit study participants in the future, will benefit strongly from the instant and broad connectivity that SoMe offers.

During the inception of #ILookLikeASurgeon, it was evident that I had 'met' online many more women surgeons than I had ever done in my career – these acquaintances have gone on to become supports in my life. They have also given us access to a network of surgeons and other healthcare professionals to whom we can pose a clinical question at any time. To have the equivalent of a noted conference's expert panel at your fingertips is irreplaceable by other means.

As doctors, we have a duty to contribute to public health through prevention and education of the public. In an age where anyone with a smartphone can declare themselves a health expert, it is incumbent upon us to disseminate high quality information. Since patients will inevitably follow doctors on SoMe, this is not a danger but an opportunity to contribute in a positive fashion to public health.



Journal clubs have been a longstanding, educational stalwart of medicine. Twitter enables users to participate in a kind of online journal club in the form of tweetchats. These hour-long interactions enable users to discuss a topic or journal article, often in a multidisciplinary fashion. Successful regularly held tweetchats include lung cancer social media (#lcsm), breast cancer (#bcsm), healthcare leadership (#hlcdr) International General Surgery Journal Club (#IGSJC), and academic surgery and cardiothoracic (#tssmn). Chats often include world leaders and paper authors, a phenomenon usually available at international conferences.

Using social media responsibly

It goes without saying that if we choose to use social media, either professionally or personally, we still remain doctors. As such, our behaviour is open for scrutiny as it should be with a public that trusts us to maintain standards. Unfortunately, despite common sense, guidelines on usage of SoMe for doctors, and even policies (such as regarding advertising), doctors can be caught behaving in an unprofessional way.

Of the utmost importance is to maintain patient confidentiality at all times. No identifying information should ever be divulged in a way that may allow identification of the patient. The protection of the patient includes avoiding engaging online with your patients or providing medical advice via any electronic means. Social media, while a great tool for health promotion, is never a substitute for the true doctor–patient relationship.

Professional behaviour also extends to the way we talk about and to our colleagues and our employers online. Using social media – even in private groups or chats – to denigrate colleagues, employers or patients is absolutely unacceptable. It's prudent to remember that once online, your comments are permanent even if they are deleted, and there are significant consequences to yourself and the people you've commented on.

The upside

Social media is not going away. And used responsibly, the benefits of social media far outweigh concerns. Like any change or advancement in our profession, we can either take charge of social media and use it well, or be consumed by it. We should use social media because that is where our colleagues are, the knowledge is, and most importantly where our patients are. The adage of old was to 'publish or perish' – but not too long in the future, this could become 'tweet or perish'.

Social media is easily accessible and easily learned for doctors of all ages, backgrounds and specialties, and is an enriching part of our jobs. Social media has enriched my clinical practice, my empathy for patients, and my commitment to public health and social justice.

I would encourage all doctors to join in this communication revolution.

Dr Nikki Stamp (MDA National Member)
Cardiothoracic Surgeon, WA

Read Nikki's blog:
drnikkistamp.com/dr-nikki-stamp-1

1 Barlow CJ, Morrison S, Stephens HO, Jenkins E, Bailey MJ, Pilcher D. Unprofessional Behaviour on Social Media by Medical Students. *Med J Aust.* 2015 Dec 14;203(11):439.

2 Luc J, Stamp N, Antonoff M. Social Media in the Mentorship and Networking of Physicians: Important role for women in surgical specialties. *American Journal of Surgery.* 215(4): 752-760. DOI: 10.1016/j.amjsurg.2018.02.011

3 Logghe HJ, Selby LV2, Boeck MA, Stamp NL, Chuen J, Jones C. The Academic Tweet: Twitter as a Tool to Advance Academic Surgery. *Journal of Surgical Research.* 2018 Jun;226:viii-xii. DOI: 10.1016/j.jss.2018.03.049

The One Ingredient for a **Meaningful Career**

Do you remember being a wide-eyed and impressionable medical student? Do you remember looking up to certain doctors who had the right touch? They stood out because of their deep compassion for their patients, balanced with sharp clinical skills and approachability.

Contrast that with the frustrated, angry and burnt-out doctor who didn't acknowledge your existence. Who snarled impossible questions at you and didn't even bother to ask for your name. Your hair stood on end when they approached, nothing ever seemed to be right, and patients were often confused and unhappy with their interactions.

Did you know that both these doctors have played a part in shaping the type of doctor you are today?

Whether good or bad, we are the composite of our teachers and clinical experiences. We mirror the best and sometimes the worst of what we've seen and learnt from those who had a direct hand in our clinical career. So the question is, how do we steer our careers and lives towards being doctors who truly make a difference?

I believe the one thing that will allow you to have a long and meaningful career is using the power of self-reflection.

The ability to self-reflect allows us to sharpen our best skills, and stop self-sabotage and elements of our behaviour which keep us from progressing. If you want to be the type of doctor who attracts opportunities, you need to be the type of doctor whom others want to be around – it is that simple.

If we are honest, we've all seen brilliance wasted and lives broken due to the relentless pursuit of power and prestige, and the failure to stop, reflect and self-care.

As medical leaders, we must begin to ask: *What is the one thing that others would say I need to change about myself to be the type of doctor who enriches others?*

A year ago, I left general practice to undertake the Clinical Diploma of Palliative Care, balancing this with my anaesthetic practice. I knew this work would be challenging, and due to my history of burnout I organised a monthly Clinical Supervision session with a senior colleague.

To my surprise, the conversations in our sessions did not focus on palliative care, but rather upon the most glaring and distressing aspect of my personality – perfectionism.

Every clinical story that we dissected and reflected upon almost always came back to my insistence on perfection. While I had *perfectly* placed over 200 epidurals and spinals in six years, I couldn't let go of having two failed spinals. While I had *perfectly* tried to help several severely depressed patients, I couldn't let go of those few who had harmed themselves.

Further from my clinical life, my perfectionism was hurting my family, affecting the way I was raising my sons with rigid rules and unfair expectations. But most of all, it was hurting my wellbeing, leaving me more anxious and incapable of self-compassion.

The blue sky we found in our sessions was the concept of being a 'good enough doctor'. This was first observed and written about by British Paediatrician, Donald Winnicott in his observation of thousands of mothers and babies, when he described the 'good enough mother'.[1]

Good enough wasn't about being mediocre or above average, but about continual improvement and excellence rather than the illusion of perfection or 'being the best'.[2,3]

This one thought brought freedom to my clinical work and personal life. It allowed me to practise self-compassion inwardly, and outwardly offer it to those in my world because I was indeed a 'good enough doctor'.

The most important thing that doctors can do to have a long and meaningful career is stop and practise self-reflection. It is the one thing that allows great doctors to leave an even greater lasting legacy.

Live intentionally.

Dr Jonathan Ramachenderan (MDA National Member)
General Practitioner Anaesthetist, Albany, WA

Read Jonathan's blog: thehealthygp.com
Follow Jonathan on Twitter **@thehealthyGP**

1 Winnicott DW. The Theory of the Parent-Infant Relationship. *Int J Psychoanal.* 1960;41:585-95.

2 Smith R. Thoughts for New Medical Students at a New Medical School. *BMJ.* 2003;327(7429):1430-3

3 Ratnapalan S, Batty H. To Be Good Enough. *Can Fam Physician.* 2009;55(3):239-42.

The Impaired Doctor

What happens when a doctor has an impairment? What does it mean for their career? How can a colleague assist a doctor who appears to have an impairment?

This feature addresses some common concerns from doctors about health assessments, the role of the Medical Board, and mandatory reporting.

Dr A phoned MDA National to seek assistance with a notification made about him to AHPRA.

Dr A was an Anaesthetist. He had recently broken up with his wife and not seen his children for some time. Distressed about his personal situation, he had unfortunately turned to alcohol. Theatre staff smelt alcohol on his breath during an afternoon list. As a result, the hospital staff made a mandatory report to AHPRA.

The Medical Board has asked me to go for a health assessment – what does this mean for my career?

The Medical Board (the Board) may become aware of a doctor's possible health impairment when a notification is made. Under the National Law, the Board may require a doctor (or any registered health practitioner) to undergo a health assessment if it reasonably believes, because of information received, that a doctor may have an impairment that detrimentally affects, or is likely to detrimentally affect, the doctor's capacity to practise.

Why does the Board require an independent assessment? My treating doctor could supply a report.

A health assessment is carried out by an experienced and suitably qualified independent medical practitioner or psychologist. The health assessor is not a member of the Board. The consultation is booked by AHPRA staff, and there is generally no cost to the doctor undergoing the assessment.

The doctor will be asked whether any conflict of interest exists which would preclude the assessor from carrying out the report. If that is the case, another assessor can be arranged.

The Board considers that an independent assessor can take an objective view because they lack prior knowledge of the doctor and have no ongoing responsibility for continuing care. A treating doctor may be reluctant to provide a report which could result in restrictions on their patient's ability to practise. That situation could disrupt an effective therapeutic relationship.

Treating doctors who believe their doctor-patients can practise safely can and do provide supportive reports which assist the Board.

What happens next?

After the health assessment, the assessor will prepare a report for the Board. This report is usually very comprehensive, and may address specific questions from the Board regarding fitness to practise, and also whether any restrictions or conditions should be in place when the doctor returns to work. The report will also include a copy of any results from pathology testing performed as part of the health assessment process.

The doctor who has been assessed will then receive a copy of the report. This is usually provided directly to the doctor. However, if it contains information which may be prejudicial to their health or wellbeing, it will be provided to the medical practitioner or psychologist nominated by the doctor.

After the doctor has received the report, a meeting is arranged with the doctor and a person nominated by the Board. This is usually a Board member, and AHPRA staff are present at the meeting. The purpose of the meeting is to discuss the report, and ways of dealing with the findings of the report if it is necessary to alter the way the practitioner is working.

The Board reviews the outcome of this discussion at its next meeting and will decide if any restriction on the doctor's registration is needed to protect the public. The doctor is then advised of the Board's decision.

What decisions are available to the Board?

As a result of a health assessment, the Board may decide to:

- take no further action
- progress to further investigation
- refer the matter to a health panel
- impose conditions or accept an undertaking from the doctor
- refer the matter to a panel or tribunal hearing.

It can be difficult for doctors to be assessed in this way, and many doctors find it a very stressful experience. Doctors can take a support person along on the day of the assessment, but they will not be allowed into the room when the assessment is taking place.

It is very important that doctors are open and honest with the health assessor.

How can MDA National help?

During this very stressful process, MDA National staff can provide valuable support including information about how the process works and the steps that AHPRA will take. Unfortunately, the process takes some time. We provide peer-to-peer support (Doctors for Doctors Program) by a member of our in-house medical team for doctors who are distressed by this process.

When Dr A contacted MDA National, he was provided with assistance. Dr A was deeply remorseful and, on advice from MDA National, he made an appointment to see his GP as well as a Psychiatrist who specialised in drug and alcohol issues. The Board asked him to undergo a health assessment.

Dr A saw a Psychiatrist for his health assessment. The health assessor's opinion was that Dr A's use of alcohol was related to his acute distress. Now that he was receiving appropriate treatment for his depression, the assessor considered he was fit to start a return to work program, provided he underwent regular alcohol testing.

Dr A's employers accommodated the conditions, and Dr A returned to work.

There were **3,726 notifications** received about medical practitioners in 2017/18.

There were **97 outcomes** from health assessments during the financial year.

Outcome of health assessment	Number completed
The Board decided to close the notification with no further action	29
Progressed to further investigation	16
Progressed to Panel Hearing	2
Progressed to Tribunal Hearing	2
The Board cautioned a practitioner	1
The Board accepted an undertaking from the practitioner	15
The Board imposed conditions on the practitioner's registration	32
Total	**97**

Note: This data does not include NSW where matters are managed by coregulatory bodies. The data for Queensland only includes those matters that were referred to AHPRA and the Medical Board of Australia by the Office of the Health Ombudsman.

Source: Data obtained from the Australian Health Practitioner Regulation Agency (AHPRA); October 2018

Dr Jane Deacon
Medico-legal Adviser, MDA National

I'm Worried About My Work Colleague

In general, doctors enjoy good physical health, but have higher rates of depression, burnout and stress-related problems. They are also more susceptible to substance abuse and have a higher suicide rate than the general population.

> Dear MDA National medico-legal adviser,
>
> Help! I'm very worried about my work colleague. There appears to be something wrong with him. He's no longer his normal chatty self and is irritable with his colleagues and staff. He seems to be taking longer to do his usual work and other people have noticed this too. What could this mean? What should I do?
>
> Dr W

Warning signs of potential impairment that colleagues (such as Dr W) might notice include:

- out of character behaviour, e.g. social withdrawal, poor focus and concentration, irritability
- decreased empathy for patient's problems
- unexplained work absences
- spending increased hours at work
- making errors
- declining quality of work
- changing appearance, e.g. weight loss, appearing tired, less attention to grooming and appearance.

While Dr W is concerned about his colleague, he is also worried about patient safety and his mandatory reporting requirements.

Depending on the circumstances, it can help if a concerned colleague sat down with the doctor and discussed what has been noticed. Dr W may be a suitable person to talk to the doctor, or he may be able to identify another colleague better suited for this discussion.

Such conversations are often difficult for both parties, and it's important to explore the underlying cause and assess their insight. In setting up such a discussion, it is advisable to:

- ensure privacy and adequate time
- show care, not judgement
- be open and direct with communication
- demonstrate respect for the other person.

One technique is to use the 'Four Cs' to initiate constructive discussion: Caring, Curious, Concerned and Confused.

- *You seem very distressed. I* ***care*** *about you and want to help.*
- *I'm* ***curious*** *about what you said just now – can you tell me more about that?*
- *I'm really* ***concerned*** *about what might be going on for you at the moment.*
- *I'm* ***confused*** *by you saying you're fine while you don't seem your usual self. I really want to try to understand what's happening.*

Depending on the conversation, Dr W's level of concern, and the doctor's level of insight, the doctor could be encouraged to seek medical attention, have some time off work, seek assistance from his MDO, or even make a self-report to AHPRA.

What about mandatory reporting?

Mandatory reporting of AHPRA registered practitioners was introduced in the National Law in 2010. The threshold for mandatory reporting to AHPRA is high. All registered health practitioners are required to report to AHPRA any other registered health practitioner who has behaved in a manner that constitutes 'notifiable conduct'.

Notifiable conduct is defined in the National Law and means the practitioner has:

a. practised the practitioner's profession while intoxicated by alcohol or drugs; or
b. engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
c. placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
d. placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Impairment is defined as a person who has 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession'.

When deciding whether or not to make a mandatory report about a health practitioner's impairment, two things must be satisfied – the practitioner must place the public at risk of substantial harm in their practice of the profession and that must arise because of the practitioner's impairment. A practitioner may have an impairment, but if it is not affecting their practice of medicine then a mandatory report is not required.

When deciding whether or not to report, a reasonable belief about the impairment must be formed. This requires direct knowledge and observation of the behaviour – not speculation, rumours or gossip. However conclusive proof is not needed.

A practitioner who fails to make a notification when required to do so under mandatory reporting legislation may be subject to action by the Medical Board. There are some exceptions to this requirement, including treating doctors in WA.[1]

These situations can be very difficult and distressing. We encourage you to seek advice before reporting.

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1 AHPRA. Guidelines for Mandatory Notifications. March 2014.

Noteworthy Outcomes of a **Medical Record-Keeping Workshop**

Do you document effectively to support continuity of patient care? And are you confidently managing access to records? Participants at MDA National's education workshops are planning to change the way they manage medical records.

Our *Noteworthy: The How, What, Where and Why of Medical Documentation activity* focuses on areas that have been identified as being problematic for doctors in recent court and Medical Board findings, and in MDA National Members' queries.

An average of 80% of respondents in the first 11 sessions delivered across Australia said they were considering doing something differently because of the activity.

Here are the main areas in which participants intended to make changes:

1. Obtain consent before releasing information to others:

- Ensure there is a signed authority from the patient. Exceptions to this include a court order to produce documents. Contact the patient if unsure whether they understood what they were consenting to.
- A patient's right to confidentiality does not cease when they die. Seek consent from the executor or administrator of the deceased patient's estate.[1]
- Correspondence from third parties forms part of the medical record, which means you do not need permission from the author. When releasing a specialist's letter to a third party you can let the author know out of professional courtesy, if you wish to do so.

2. Review storage security:

- Store paper records in an area that can be locked.
- Regularly change passwords and do not share them.
- Maintain appropriate levels of access, e.g. do not allow support staff to log on as a doctor.
- Perform regular backups of the database and test the backup system. The interval period between backups will dictate the minimum amount of data that cannot be recovered in the event of data loss.[2]

3. Be more thorough:

- Use SOAP to structure consultation notes:[3]
  - **Subjective** – presenting complaint and history
  - **Objective** – examination findings and investigation results
  - **Assessment** – diagnoses, differential diagnoses and problem lists
  - **Plan** – all aspects of management discussed during the consultation and follow-up instructions.
- Document the essential elements of phone calls including who, when, and what was discussed with the patient, other doctors and allied health professionals. Note that the discussion occurred over the phone, not face-to-face. If phone contact was attempted but not successful, that should also be recorded.
- There is no 'universal' right or wrong information that needs to be recorded for an informed consent conversation. It is generally agreed that you should note the patient's decision, details of the health care to be provided, the benefits and risks discussed, and the date and time.

For further and specific advice on medical records, contact MDA National.

MDA National Education Services

Want to experience the Noteworthy activity for yourself?

Go to **mdanational.com.au/Member-Services/Education** to find upcoming events on the calendar or to request a session.

You can also do an online version whenever convenient. Find out more and access it at: **bit.ly/2nQ6yGM**

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1 MDA National. *Defence Update*. Access to Deceased Patients' Records. Available at: defenceupdate.mdanational.com.au/articles/access-deceased-patient-records

2 MDA National. *Defence Update*. Security of Electronic Records. Available at: defenceupdate.mdanational.com.au/articles/security-of-electronic-records.

3 Physician SOAP Notes. [cited 20 August 2018]; Available at: physiciansoapnotes.com.

Take Care with Medicare

Medicare is one of my main areas of interest at MDA National. With a recent increase in the number of investigations and audits, it seems an ideal time to provide some guidance on what you should do if you receive correspondence from the Department of Health about your billing.

Doctors are often confused and concerned about why they have come to Medicare's attention. Some doctors feel they have been unfairly targeted by the Department of Health (DOH). In my experience, Medicare investigations tend to be one of the most black and white jurisdictions doctors are subject to.

Put simply, most doctors receive a tap on the shoulder from Medicare because they are statistical outliers. Medicare runs a series of computer algorithms which measures each doctor against every other doctor in Australia. If you are above the 90th percentile for a specific item number, your profile may be reviewed under the Practitioner Review Program.[1] Other statistical triggers could be daily billing which exceeds the number of hours in a day, or ratios which are vastly different from your peers, e.g. Level B: Level D. If the anomalies are not readily explained by your practice profile, you may be asked to participate in an interview with a DOH medical adviser. You are more likely to come to Medicare's attention if you are a specialist with an unusual sub-specialty, or a GP with a special interest which alters your patient demographics.

Certain item numbers may be on Medicare's radar, and we see some items numbers more regularly than others, including Chronic Disease Management and GP Mental Health Treatment Plans. Each investigation is unique to the individual doctor on the basis of their practice profile.

If you receive a letter from the DOH asking you to participate in an interview, you should contact us immediately.

Once we have reviewed your documentation, an experienced medico-legal adviser will take you through your practice profile, discuss the concerns raised, go through each of the relevant item descriptors, and generally assist you to prepare for your interview. After the interview, the DOH medical adviser may recommend no further action, a six-month review period, or a referral to Professional Services Review (PSR).[2]

Some of the more common criticisms we see from the DOH include poor documentation, and billing for services which are not clinically relevant. One of the most significant failures is not understanding the item descriptor, or believing that "near enough is good enough." We hear a lot of reasons, which simply don't cut it with Medicare – *I work 90 hours a week; the practice does all my billing; no other item number fits the service; I didn't know those items couldn't be billed together; I have never read the MBS.* And one to really avoid – *but all my colleagues do it.*

If the DOH makes contact with you, it doesn't mean you are doing something wrong. It means you are a statistical outlier and you need to satisfy the DOH that your billing is appropriate.

MDA National provides a range of support to Members, from assisting with a simple self-audit through to full PSR Hearings. We are assisted in this process by external lawyers who are experts in this area. The sooner you contact us, the sooner we can put your mind at ease and start working towards a resolution.

Nerissa Ferrie
Medico-legal Adviser, MDA National

View the list of references at **defenceupdate.mdanational.com.au/articles/take-care-with-medicare.**

'Tis the Season for Giving and Receiving

"Hi Doc, I've brought a present for you."

Everyone loves receiving gifts. Gifts for doctors come in all shapes and sizes, and not just during the festive season. Nearly all doctors will receive at least one gift during their career. Traditional gifts from patients include smaller consumable items such as chocolates, bottles of wine or home-made goods. But how much is too much when it comes to gifts from patients?

Would you accept bottles of wine every couple of months from a patient? Or a $200 gift voucher for a meal? What about an envelope containing $1,000 in cash?

A recent disciplinary hearing[1] involving a GP considered these issues.

Case study

The GP had been seeing an elderly patient every fortnight for more than a decade. The GP acknowledged receiving a couple of bottles of wine every two to three months from the patient. In 2013, the patient delivered a $200 gift voucher for the GP and his wife (also a GP) to enjoy a meal at a local restaurant.

In 2014, the patient offered the GP an envelope which contained $1,000 in cash. The GP denied accepting the money.

Medico-legal issues

At the Professional Standards Committee hearing, the patient's daughter gave evidence that she was aware her father had prepared the cash gift, and she wanted to find out if the GP would take the money. The daughter went with her father to the practice and waited in the reception area while her father consulted the GP. The envelope was in the patient's shirt pocket. She asserted that when the patient came out of the consultation room, the envelope was not there. When she asked her father if the GP had taken the money, he had said, "Yes, and he thanked me profusely!" Although the daughter was concerned about the GP accepting the $1,000, she did not raise the matter at that time or later. Based on the evidence at the hearing, the Committee accepted the GP's evidence that he did not accept the $1,000.

The Committee ultimately made no finding of unsatisfactory professional conduct against the GP.

When is it improper or unethical to receive gifts from patients?

The Committee concluded that the decision to accept a gift was based on self-reflection, discussion with peers and, most importantly, talking to the patient and underscoring that the medical treatment would be just as good whether gifts are given or not.

The receipt of a gift without the doctor reflecting on how the gift might affect the doctor-patient relationship could amount to unethical conduct. It would be improper if the gift giving and receiving were to somehow influence the doctor-patient relationship. It is not enough for a doctor to simply conclude they had not encouraged the gift-giving.

Issues for doctors to consider include:

- motivation in the gift-giving
- the monetary value of the gift
- whether the gift was given during current treatment
- any vulnerability of the patient
- the type of gift – personal or generic
- the frequency of gifts
- attempts by the doctor to encourage, or to discourage and return the gift.

Dr Sara Bird
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MDA National

1 Professional Standards Committee Inquiry: Dr Richard Grant Wood. Available at: mcnsw.org.au/sites/default/files/decision_-_wood_richard_grant_-_psc_-_18_january.pdf

CaseBook

A Case of **Compartment Syndrome**

Acute Compartment Syndrome (ACS) remains a challenging diagnostic problem. It is important to seek early clinical assistance in making the diagnosis in problematic cases, and work towards an early surgical consensus as to how the condition should be managed.

Case study

A 30-year-old motorbike rider was brought to the ED following a collision with a pole. Injuries included extensive soft tissue thigh abrasions and a proximal fracture of his tibia on the same side with significant leg pain. The patient went to theatre for fixation of the tibial fracture and debridement of the thigh contusion that evening. An epidural was placed. The patient was monitored in ICU for other injuries.

The following day, a junior ICU doctor was asked to review the patient's severe pain below his knee. A patchy epidural block was thought to be the cause. Following phone discussions with the Anaesthetist, further doses of the epidural (using a mix of local anaesthetic and opiate) were administered with good relief. That evening the pain returned. The epidural was turned off to allow proper assessment. The patient continued to experience uncharacteristically severe knee pain. Distal limb sensory loss was noted, initially attributed to the epidural, but eventually diagnosed as an acute compartment syndrome. The patient underwent fasciotomies.

The outcome was a permanent foot drop and sensory loss. Litigation was commenced two years later against the hospital (junior ICU doctor), Orthopaedic Surgeon, Intensive Care Specialist and Anaesthetist.

What is acute compartment syndrome (ACS)?

ACS typically results from the build-up of pressure within a muscle bundle encased in an inelastic fascial sheath. While there are physiological causes, e.g. exertional compartment syndrome, this discussion concentrates on ACS arising from injury or procedural interventions.

Causes are diverse, including trauma (both accidental, typically involving an underlying fracture, and iatrogenic, such as surgical intervention), spontaneous haemorrhage, venous or arterial circulatory obstruction, envenomation, local infection and external compression. While the lower limb is typically affected, other sites such as the abdomen and upper limb are also at risk.

Once compartment pressures exceed capillary filling pressures, a positive feedback mechanism develops, with ischaemia resulting in further increased compartment pressures, eventually impairing venous filling and then arterial perfusion. Without intervention, tissue necrosis of the compartment contents results. Occasionally external causes of increased pressure may contribute, such as splinting, plasters, dressings, circumferential burns or tourniquets.[1]

Long-term effects can include permanent loss of sensory and/or motor function, scarring and contractures, chronic wounds and infection (osteomyelitis), amputation and significant disfigurement. Surgical decompression (fasciotomy) to reduce the pressure in the compartments may release toxic by-products into the blood stream, impacting on other organs, causing renal failure, hyperkalaemia or even death.

Diagnosis

ACS should be treated as a surgical emergency. Diagnosis is primarily clinical and may be challenging, even for experts. Given the difficulties involved, early escalation and consultation should occur. Severe pain out of keeping with the underlying diagnosis, worsened with passive movement, is often the first sign. Many of the clinical 'red flags' have poor sensitivity, present late and have poor positive predictive value (often already present in many of the underlying injuries that create the risk). The appearance of 'red flag' symptoms may also herald that irreversible damage has already occurred. Intervention after 12 hours from symptom onset has been found to significantly reduce the chance of acceptable outcome to just 15%.[2]

Proper exposure and careful examination is critical including removal of anything which impedes review, e.g. casts, dressings or minimisation of regional nerve blockade.

If a clinical diagnosis cannot be made, pressure monitoring should be considered[3] to exclude the diagnosis. However this may induce delays (and is considered to have low specificity[4]). Expertise in procedural setup may be lacking. A pressure gradient of <30mmHg between the diastolic blood pressure and compartment pressure is frequently cited as significant,[5] but exact numbers vary.

Indirect supportive tests, e.g. creatinine kinase suggesting muscle breakdown, may be of assistance – but they typically indicate a late diagnosis and poor prognosis.

'Time is muscle' is the critical consideration, and delays in diagnosis of greater than 12 hours are associated with very poor outcomes.

Certain scenarios should increase clinical suspicion. Tibial shaft fractures are well associated with ACS (ranging from 46-77% of such fractures and resulting in about 30[8]-70[9] % of ACS cases). Carefully consider scenarios involving concomitant anticoagulation or platelet inhibition.

There is recognition that once fulminant irreversible necrosis is inevitable, fasciotomy may increase the risk to the patient (by opening necrotic compartment, increasing the risk of deep infection, metabolic impacts) with little benefit. Our experience is that it is difficult to obtain peer support for failure to offer surgical decompression within the first 24 hours.

Medico-legal issues

These matters can be difficult to defend, particularly when they arise from failure to consider the diagnosis in the first place. A US 2004 review of 19 ACS claims found that fasciotomy performed within eight hours of symptom presentation uniformly resulted in successful defence.[10] Data from a 2012 US review indicated 6% of all malpractice claims against Orthopaedic Surgeons were related to ACS.[11] In the same review, the number of red flags present at the time of diagnosis correlates with increasing settlement value.

Exposure can occur for a wide range of treating clinicians, including ED doctors, hospital ward staff (nurses and doctors in training), Surgeons and Anaesthetists. Care should be taken to consider the appropriateness of regional anaesthesia in high risk cases.[12] Early clinical consultation should be sought if the diagnosis is suspected.

The claims are often costly, involving permanent loss of function, cosmetic deformity, loss of limbs, and need for life-long prosthetics and rehabilitation. Given the underlying association with trauma, young patients are often involved.

Matters that are difficult to defend include:[13]

- claimant aged between 16-35 years of age
- tibial fracture
- anterior compartment affected
- three clinical features apparent at an early stage
- diagnosis not entertained, or intervention delayed
- compartment pressure monitoring not undertaken before *ruling out* the diagnosis.

Conclusion

ACS remains a challenging diagnostic problem, but must be considered as a differential diagnosis in cases of atypically severe and persistent limb pain associated with tissue trauma. Seek early clinical assistance in making the diagnosis in problematic cases.

'Time is muscle' is the critical consideration, with delays in diagnosis of greater than 12 hours being associated with very poor outcomes. Work towards an early surgical consensus as to how the condition should be managed.

Dr Julian Walter
Medico-legal Adviser, MDA National

Clinical Red Flags:	'Prominent Ps' of compartment syndrome
Pain	Increasing pain out of keeping with the underlying problem, worsened with passive muscle stretch, and not readily relieved with immobility and analgesia. However, pain is an unreliable subjective symptom, and determining an 'appropriate' level of pain can be challenging. It requires experience and may be confounded by the severity of the underlying injury from trauma or surgery, presence of analgesia and resolving nerve blocks (which can suppress pain or result in rapid increase in severity as they wear off), or reduced level of consciousness.
Paraesthesia	Loss of sensory function is related to nerve ischaemia. It can confound the ability to sense pain. It may be a late finding and progress to complete anaesthesia.
Paralysis	Loss of motor function arises from muscle infarction, neurological impairment, pain and compartment pressure. It may be a late finding and indicate irreversibility.
Pressure	Increasing firmness in the compartment, classically described as 'woody', which is a late finding.
Pallor	The increase in pressure coupled with circulatory impairment may result in skin pallor. However, superficial skin changes (including temperature) may be entirely unreflective of deep compartment changes.
Pulselessness	Beware waiting for a diminished or absent pulse to confirm the diagnosis. Distal pulses will be affected if the vessels pass through the affected compartments or the limb is threatened. It is typically a very late finding.

View the list of references at **defenceupdate.mdanational.com.au/articles/acute-compartment-syndrome.**

CaseBook

Super Gonorrhoea **Exposed on Social Media**

Most medical professionals are familiar with social media and believe they know the potential pitfalls, both privately and professionally. Every so often we come across a cautionary tale which demonstrates how far reaching social media can be, and how even the best consent process can fall at the last hurdle.

Case study

A young man presented to ED with severe burning during urination and penile discharge. He advised the ED registrar that he had recently returned from South East Asia, and was worried he had picked up a sexually transmitted infection after having unprotected sex. His symptoms were getting worse, and he was running out of excuses with his fiancé – who was unaware of the unwanted souvenir he had brought back from his holiday.

The ED registrar suspected 'super gonorrhoea' after reading about a recent case in the UK, so he called in the infectious disease team. The diagnosis of multi-drug resistant gonorrhoea was later confirmed and alternative antibiotic treatment eventually cured the patient. The registrar asked the patient if he could write up the case for a medical journal. The patient, feeling grateful and relieved, signed an authority for the registrar to publish the case on the proviso he wasn't identifiable.

The registrar wrote an article with some of the infectious disease doctors, and was really pleased when the paper was published in a well-respected medical journal eight months later. The patient signed an additional authority at the request of the medical journal, and also gave consent for the registrar to be interviewed by a media outlet who showed interest in the story – as long as he (the patient) remained anonymous.

The registrar gave the interview. Although he referred to the patient as a backpacker, he felt he had protected the patient's anonymity and hadn't released any information that would identify him. The media outlet promoted the upcoming interview on their Facebook and Instagram pages.

The patient had of course told his mates that he had super gonorrhoea, which they all thought was hilarious. So when the media outlet publicised the interview with the tagline, "Young Aussie goes backpacking in South East Asia and returns with super gonorrhoea", his mates couldn't resist and started tagging him in the comments on Facebook.

> Hey Johnno – is this what you had?
>
> I think they are talking about you bro!

By the time he became aware of the comments, his fiancé had seen the posts. She put two and two together, and gave "Johnno" his marching orders. The patient's workmates saw the posts, as did members of his immediate family.

The patient contacted the registrar saying, "You told me I would be anonymous – this article has ruined my life. Everyone knows it was me!" The registrar was understandably shocked, never having intended for the patient's identity to become public. The registrar apologised and contacted the media outlet who agreed to remove both the interview and the promo – but it was too late, the damage had been done.

In this case, it was the patient's friends who effectively 'outed' him – not the registrar. But the registrar felt terrible nonetheless and quickly realised that in the age of social media, information can take on a life of its own.

Anonymity cannot always be guaranteed, because if a third party holds information disclosed by the patient, the de-identified information may be enough to complete the whole picture and disclose the patient's identity.

Nerissa Ferrie
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Stay informed about trending medico-legal topics and test your knowledge for continuing professional development credit.

"Well delivered. Good range of topics."
– General Practitioner

Noteworthy: The How, What, Where and Why of Medical Documentation

Learn how to create good quality medical records that support continuity of patient care and explore how to deal with common issues surrounding medical documentation.

"Well put together, easy to follow and pay attention."
– Emergency Medicine Specialist

Prescribing Opioids

Enhance your skills in identifying people who are drug-seeking or drug-dependent, managing expectations, minimising harm, and lawfully prescribing opioids.

"I thoroughly enjoyed the activity and learned a great deal from it."
– General Practitioner

In 2017-18, an average of 77% of survey respondents said they would likely do something differently due to participating in an online activity we released that year.

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- cyber-attack defence and mitigation measures
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MDA National
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The case histories used have been prepared by the Claims and Advisory Services team. They are based on actual medical negligence claims or medico-legal referrals; however where necessary certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

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