WINTER 2023

Defenceupdate

Recalls and reminders – closing the loop

- Practice challenges in a rural town
- Dealing with the stress of litigation and complaints
- More than just advice
- Medico-legal Case Book
- First Defence for junior doctors

Medico-legal content

FOR MEDICAL PRACTITIONERS

MDA National
Support Protect Promote

Nerissa Ferrie
Medico-legal Adviser, MDA National

Welcome to our Winter 2023 edition of *Defence Update*.

As the seasons change and we move into the winter months, it's time to take stock and catch up on all things medico-legal.

Doctors provide excellent care when patients are in need, but where can doctors turn when they need support? Dr Helen Wilcox talks about the vitally important and confidential assistance provided by Doctors' Health Advisory Services across the country (page 4).

In this edition we show some love to our rural Members, as Dr Brittney Wicksteed (President, RDAWA) reveals some of the challenges of working in rural practice (page 6) and we examine the medico-legal complexities of finding love in a small town (page 7).

Many doctors are confused about their obligation to assist in an emergency. We shed some light on this interesting issue, as we examine the legal and ethical considerations you should be aware of (page 8).

The feelings associated with a medico-legal matter can be difficult to navigate. Enore Panetta from Panetta McGrath Lawyers provides us with his best advice for dealing with the stress of litigation and complaints (page 10).

In our medico-legal feature (page 13-16), Dr Julian Walter tackles the perennial but vitally important issue of recalls and reminders. Are you closing the loop in your practice? Maybe it's time to touch base with our friendly Support in Practice team.

We know how much you value case studies, and in this edition of Case Book we take a look at privacy disclaimers (page 18), violence in the workplace (page 20) and revisit consent (page 22).

You will also find some practical information in our regular Medicare Update (page 12), advice on how to respond to a request for a character reference (page 9) and information on our complimentary Member education (page 17 and 28).

First Defence showcases two junior doctors who have come through vastly different career paths – yet both have identified the importance of camaraderie and resilience in a high-stress environment such as medicine (page 24-27).

We are a doctor-owned mutual organisation, so if you have a burning medico-legal topic you'd like to see in a future edition of *Defence Update*, please get in touch. We would love to hear from you!

In this issue

It's renewal time!

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

Renew your policy and membership by **30 June 2023.**

Our Member Services team is here to help you:

1800 011 255

peaceofmind@mdanational.com.au

Have an editorial enquiry? Interested in contributing an article?

Contact our Marketing team at **marketing@mdanational.com.au**.

Want more medico-legal updates?

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

Stay connected!

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

CONTRIBUTING AUTHORS

Dr Doug Brazil
Resident Medical Officer,
East Metropolitan Health Service, WA

Dr Joseph Curran
House Medical Officer,
Royal Melbourne Hospital

Niranjala Hillyard
(Freelance Writer, Editor & Designer)
Creative & Editorial Director,
Inkpot & Pixel

Enore Panetta
Director, Panetta McGrath
Lawyers

Dr Brittney Wicksteed
President, Rural Doctors Association
of Western Australia

Dr Helen Wilcox
Medical Director
Doctors' Health Advisory Service WA

Nerissa Ferrie
Medico-legal Adviser

Dr Elizabeth Harris
Medico-legal Adviser

Janet Harry
Medico-legal Adviser

Gae Nuttall
Risk Adviser

Daniel Spencer
Medico-legal Adviser

Dr Sarah Taylor
Medico-legal Adviser

Dr Julian Walter
National Manager, Advisory Services

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

FROM THE PRESIDENT
A message to our Members

Dr Michael Gannon
President, MDA National

While the pressures on our general practitioner (GP) Members are not new, they seem to ever increase. I regularly talk to our GP Members, specifically on how the demands placed upon them add to their medico-legal risk.

I understand the sincerity of the responsibility GPs collectively feel in trying to look after their patients. They know better than anyone, far better than any politician or bureaucrat, the extent to which the public hospital system regularly lets their patients down. They frequently feel powerless.

GPs also have to help their patients navigate the complexities of the private healthcare system, which is frequently inflexible and too often unfair when it comes to substantial out-of-pocket costs.

I know how hard it is when GPs have mental health patients to deal with and the manifest inadequacy of that system. If a patient has chest pain, they get a Priority 1 ambulance and prompt clinical attention. Our current system too often lacks the kindness and the capability to treat an equally grave mental health emergency with the same urgency.

Bulk billing, and the determination of successive governments on both sides to promote it at all costs as a right of the Australian people, continues to eat at the viability of general practices. It has come to be seen as a less attractive career path for many medical graduates. Government now seeks to impose payroll tax on these small businesses to further diminish their capability.

What is our role at MDA National? We will do whatever we can to support our individual Members. Unfortunately, we also work in an unforgiving society whose courts demand perfection from GPs. There is pressure on us to increase premiums for GPs because of the increased cost of their claims.

The reality of our legal system is that there is little contributory negligence on behalf of plaintiffs. We regularly manage cases where, for example, an overweight smoker might refuse to attend for BP checks, manage their diabetes, attempt weight loss or smoking cessation, and remain non-compliant with their statin – who then has a heart attack or stroke. Left unable to provide for their family, we then face claims for loss of income, dependency and 'nervous shock' from the wider family. Unless our Member has been judicious in carefully, contemporaneously and accurately documenting their warnings on compliance and prevention, we may have to settle the case.

MDA National has strong representation from GPs on our Board, our Clinical Underwriting Committee, and our Cases Committees. We maintain close relationships with state AMAs across the country.

Wherever we can, we will continue to try to find ways to support and protect our GP Members and, wherever possible, promote this important area of medical practice.

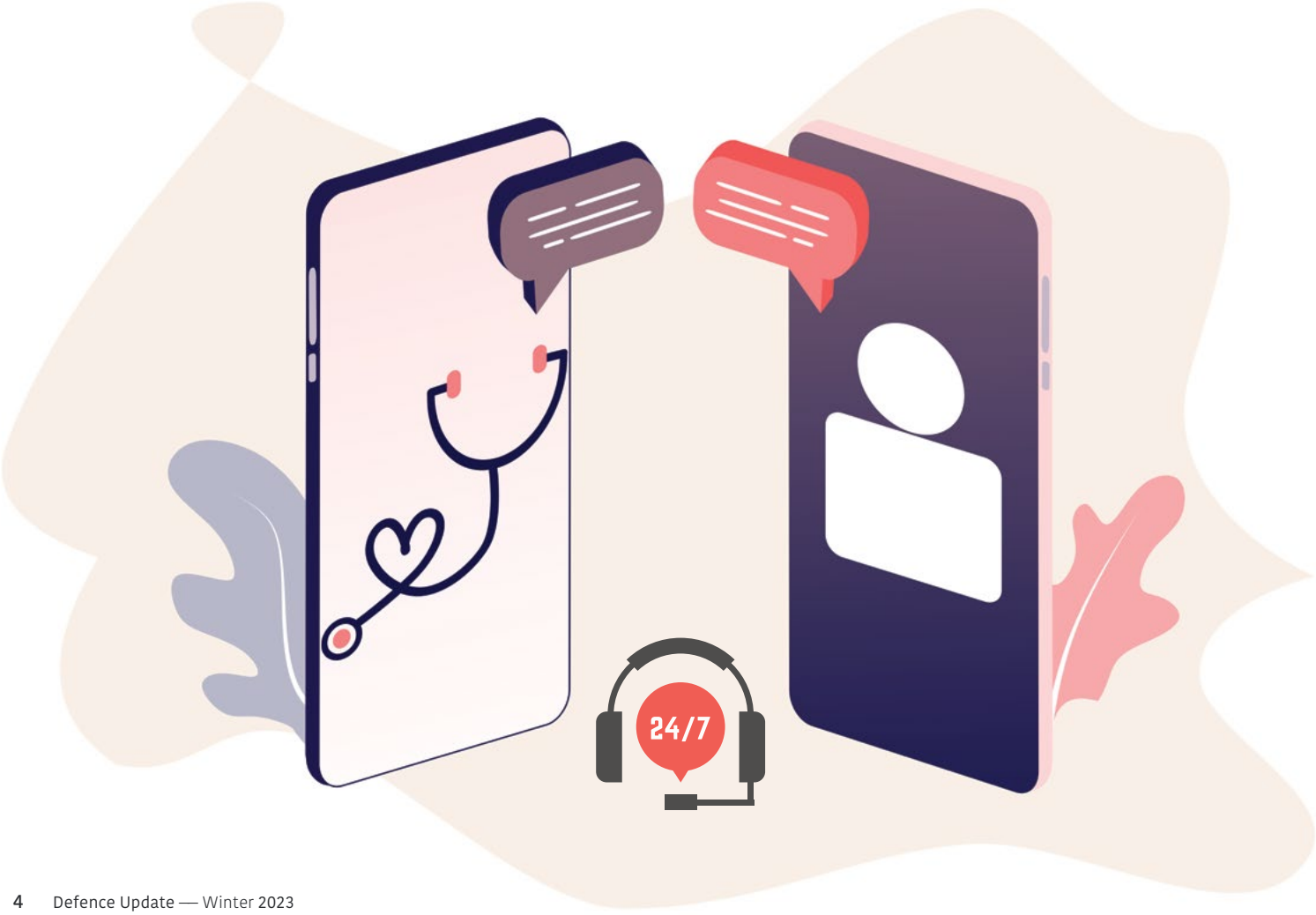
More than just advice

Dr Helen Wilcox
(MDA National Member)
Medical Director, Doctors' Health Advisory Service WA

Doctors' health phone lines. A simple name for a service.

Every state and territory in Australia has a 24/7 doctor-to-doctor telephone support service for doctors and medical students, as part of their Doctors' Health Advisory Service (DHAS). Callers speak directly with experienced GPs who have interest and expertise in doctors' health. Broadly, we provide "confidential health-related triage, advice and referral services for doctors and medical students".

But what does that actually look like?



Nationally, our services take over 900 calls per year. Some of our callers choose to remain anonymous. Perhaps it's worry about reputational risk or the spectre of mandatory reporting to Ahpra – even for states in which helpline doctors have an exemption, such as treating practitioners in WA.

Whatever the reason, we preserve this anonymity, with the only identifying detail required being the caller's phone number. We ask to obtain some demographic details for internal monitoring, and keep our own confidential notes as we would for any clinical consultation.

Our calls can be quite simple

Students or doctors who are new to a region and for whom we can provide guidance on how to find the right GP; how to access timely, affordable psychological therapy; and how to navigate mental health services under their reciprocal agreement or insurance. Or someone who is on a new roster, or in a new town without access to their usual healthcare team. We can refer them to the 'Drs for Drs' list in each state and territory managed by their DHAS; or to services provided by their employer or medical school; or telehealth-only services for doctors; or to clinicians with after-hours availability.

Our calls can be complex

A personal relationship at work which has soured; a doctor who is under an investigation and in financial difficulty; or a student with multiple financial, personal and academic stressors. Often, we will seek advice, with permission, from our fellow helpline GPs and psychiatrist or occupational health advisers, and work with these callers over the subsequent days to address the modifiable factors.

Rarely, we will have an acute caller – where there is evident risk of harm for the caller. Some may have an established relationship with a GP, but their need for support is outside their existing doctor's availability. We determine the urgency of response required based on an assessment of risk and distress, and we can trigger an immediate intervention until the caller has other care and support available.

Sometimes it's more about listening and validating, rather than advice

It may be the intern who has just completed another shift with an overwhelming workload and wants to ventilate in order to sleep. Or a trainee who feels a sense of responsibility for a failed resuscitation, who was debriefed after the episode and now seeks a further opportunity to reflect.

Sometimes we offer advice to those who are concerned about doctors

Our caller may be a GP calling about a doctor-patient with emerging symptoms of severe mental illness, seeking advice on how to fast track psychiatrist review. Or a partner of a doctor, who is concerned about their delay in seeking help for depression. Or a student concerned about a fellow student's behaviour and cannot contact their medical school services after hours. We also speak to those with professional responsibility for junior and senior doctors, who want to ensure their approach to managing a doctor in distress is appropriate for that doctor, their patients, and their health service.

All the above scenarios are frequent enough to be non-identifiable, and to build experience within the helpline doctors of the range of circumstances that face our profession. Hearing from our colleagues in difficulty helps shape our services across Australia, and it sets our priorities for service and advocacy.

We are here, around the clock, for whatever is needed.

There is nothing too complex, and there is always something that can be done.

MDA National has a dedicated health and wellbeing online page where you can find the contact information for Doctors' Health Advisory Services in each state and territory, along with other useful resources:

mdanational.com.au/member-benefits/health-and-well-being

Have you ever considered the medico-legal and ethical dilemmas we face, as rural clinicians, that may be unique or more common in the bush?

Practice challenges in a rural town

Dr Brittney Wicksteed
(MDA National Member)
President, Rural Doctors Association of Western Australia

According to the Australian Bureau of Statistics, around seven million people live outside of metropolitan centres – and they are more likely to smoke, drink dangerous amounts of alcohol, sustain serious injuries, and be hospitalised. Overall, health outcomes are worse in the bush. Fortunately, there are incredible doctors who choose to provide their services to our rural and remote population – but these doctors can find themselves in situations which might never cross the mind of their colleagues in metropolitan areas.

Patient confidentiality & boundaries

The first (and probably most obvious) issue our rural colleagues face is confidentiality for their patients – who might also be friends, neighbours, grocers, or teachers at their kid's school.

The lines between professional behaviour at work and being able to exist as a fellow human in a community may be blurred, especially when Doris wants to (loudly) talk to you in the supermarket about her unresolved health issues, or when Mark wants to question his treatment plan over a couple of beers at the bowls club.

It can also be difficult to maintain social relationships with people you have a professional relationship with, and boundary setting is an essential component of this.

Ad-hoc calls for assistance

Some of you may have come across the ethical dilemma of providing care when one might be compromised. In a small town with a very limited workforce, some mass casualty event may require the assistance of every available person – even those who aren't on call or working. Where does the responsibility lie for a practitioner who (while not at work or on call) has had a few alcoholic drinks and receives a phone call begging for help in a life-or-death situation? How does knowing those involved in the incident and their families change the lens through which the decision is made? What happens if, despite best efforts, the outcome is a bad one?

Cultural complexities

Navigating cultures different from yours can be challenging without some help and guidance, particularly for those new to an area. Those of you who've worked with our First Nations Australians may be aware of the complex kinship and family structures that are an essential part of their culture. These don't always align with the western ideas of parents and next-of-kin. This can make it challenging to determine who the adult accompanying your paediatric patient is; what their relationship is to the child; and how that relationship relates to the medico-legal frameworks.

While it can be difficult at times, navigating life in smaller communities is also enormously rewarding. If you come across any situation that makes you wonder if it would pass the pub test, or stand up in court, please get in touch with your medical defence organisation.

Love in a small town

Dr Sarah Taylor
Medico-legal Adviser, MDA National

Dr Patel's dilemma

Dr Patel has been working in a small rural town for three years. She loves hiking, belongs to a local book club, and enjoys playing hockey for the region. She's single, and keen to meet someone who shares her interests. But everyone she meets seems to be a patient of the only local GP practice where she works. Tim plays in her hockey team, but she saw him regularly as a patient after a motorbike accident and subsequently treated his PTSD. Brian loves hiking and attends a practice out of town, but he regularly brings his two children in for care following an acrimonious divorce. More recently she got chatting to Xavier, who is not a patient of the practice, but attends the practice's flu clinic each year.

The code of conduct

According to *Good Medical Practice: a code of conduct for doctors in Australia*, good medical practice includes "... never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient, such as their carer, guardian, spouse, or the parent of a child patient."

The Medical Board has developed guidelines, *Sexual boundaries in the doctor–patient relationship*, which indicate that breaching these boundaries can be harmful, given the inherent power imbalance that exists in the doctor–patient relationship. When these boundaries are broken, it can lead to issues with patient safety and the quality of care provided, as well as public confidence in the medical profession.

There's no place for a consensual relationship with current patients (including with those close to the patient) and it's the doctor's responsibility to maintain the professional boundaries. It may also be unethical for a doctor to engage in a relationship with a former patient, depending on the circumstances.

When these matters come to the attention of the Medical Board, as they often do after the demise of a relationship, the Board considers a number of factors in determining whether the doctor has breached the code of conduct – such as the duration, frequency and type of care a doctor has provided in the past; the vulnerability of the patient; the time since the professional relationship ended; and the context of the start and end of the relationship.

So, what does this mean for Dr Patel?

She contacted MDA National for advice, and felt more confident in her choices after reading the guidelines and exercising her personal judgement. She ran into Xavier at the local bakery, they caught up for a coffee, and are now happily dating.

When duty calls
Responding in an emergency

Nerissa Ferrie
Medico-legal Adviser, MDA National

Dr Julian Walter
National Manager, Advisory Services
MDA National

As a medical practitioner in Australia, you have a duty to respond in an emergency situation. This duty arises from your professional obligations as a healthcare provider, as well as the community's expectations that you will provide assistance in times of need. Members often ask about the nature of this duty, and the legal and ethical considerations that apply to doctors.

A duty as a medical practitioner to respond in an emergency was established (in certain circumstances) in the 1996 NSW civil case of *Woods v Lowns*.[1] Based on now repealed legislation, an obligation was established to render urgent medical attention, even though the person was not a patient, absent reasonable cause. Under s139C of the National Law in NSW,[2] a finding of unsatisfactory professional conduct could be made in similar circumstances.

The professional obligation is now codified in *Good medical practice: a code of conduct for doctors in Australia*:

> *Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options, and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.*

Legislation, such as the Good Samaritan laws in Australia, provides legal protection to individuals who provide assistance in good faith, without expectation of reward or remuneration.

Practically, this may include providing first aid, calling for emergency services, or providing medical treatment if you're qualified and equipped to do so.

Responding in an emergency can be particularly onerous if your practice is located within a shopping complex, or near a sporting ground. It's important to have a good triage process in place, which may include the ability for practice nurses to respond in the first instance.

Your duty to respond in an emergency is not absolute. There may be circumstances where it's not reasonable for you to provide assistance, such as if doing so would place you or others in danger (as in the case of *Medical Board of Australia and Dekker* [2013]).[3] In addition, you're not expected to provide assistance beyond your level of training or expertise, and you should always act within the limits of your qualifications and experience.

Obtaining consent from the patient may not be possible or practical in an emergency. You should act in the patient's best interests, based on your professional judgement and available information, and make efforts to obtain informed consent as soon as possible.

View the references online: **mdanational.com.au/when-duty-calls**

Should I provide my patient with a character reference?

Janet Harry
Medico-legal Adviser, MDA National

The patient's request

You have seen Phoebe in a general practice setting eight times over the past two years, mainly for repeat scripts. She tells you she's appearing in court next week on shoplifting charges – and it isn't the first time. Her lawyer has told her that a character reference from a doctor would help her in court, as she faces the real prospect of incarceration this time.

Phoebe hands over some wording suggested by her lawyer, including that "she is a person of good character and an upright citizen". You feel sorry for her, but you're incredibly uncomfortable making a statement about her character when you hardly know her.

Phoebe also mentions that she's the main carer for her mother who suffers from a neurodegenerative condition. It will be a hardship if she isn't there to care for her mum.

Doctors hold a position of trust in the community, so it's not uncommon to receive a request to write a letter for court. Your patient's lawyer might suggest the patient obtains a character reference from you, as it may be helpful for an upcoming court case.

Knowing your limitations

You ask Phoebe to wait at reception while you put in a quick call to MDA National. Although you feel bad about saying no to Phoebe, you don't feel you can write the letter she has asked for.

The medico-legal adviser suggests a letter of support may be more appropriate than a character reference. As Phoebe's mum is also seen at the practice, you know she provides care for her at home. This factual and clinically supported information may be used by Phoebe's lawyers to persuade the court that a period of incarceration may be unnecessarily harsh in the circumstances.

A difficult discussion

It's not easy to tell Phoebe that you simply don't know her well enough to provide a character reference. You stress this isn't a reflection on her, or a judgement of her current situation. You offer to refer her to a psychologist to address the issues around her repeated offending.

Phoebe is grateful for the letter of support which covers how long you've been treating her, a summary of care, the recent referral to a psychologist, and the role she plays in caring for her mum with Parkinson's disease. You also note that Phoebe is polite and respectful during her visits to the practice – and this is a personal observation you feel entirely comfortable with.

If you're unsure whether you should provide a patient with a letter for court, please contact our Medico-legal Advisory Services team for prompt and personalised advice.

Dealing with the stress of litigation and complaints

Enore Panetta
Director, Panetta McGrath Lawyers

The emotional cost

Seeing your name on the initial claim or complaint associated with alarming legal terms like negligence, below standard of care, or unprofessional may cause a rollercoaster of emotions: shock, anger, fear and anxiety, guilt, shame, defensiveness, wanting to give up practice, and increased stress.

You may feel like you've been kicked in the gut, lose sleep, get angry with staff and family, feel distracted, second-guess yourself, or have self-doubt. Unfortunately, those feelings can be re-experienced with every new document or communication from your lawyer about the legal matter.

A defendant health practitioner may often harbour visions of disastrous personal consequences – such as loss of reputation, desertion by patients, suspension or deregistration. They also dread the possibility of media coverage.

Some health practitioners cope reasonably well and are able to address the issues, leaving their medical defence organisation to handle the matter. However, others go into a shell and don't want to face reality – as a result, the issues only get worse for them.

To complicate matters, often claims and complaint resolution times and processes can be frustratingly slow (even when there is little substance to the allegations). The delays can cause more stress.

The legal process and procedures can also be difficult to understand for someone not familiar with the rules, as well as being unpredictable.

Added to this is the uncertainty at any stage that a case will proceed to the next step; and if so, when; and what the outcome might be. Fear of the unknown causes the health practitioner further stress and can make them feel like they have no control over the events or process being faced.

The effect on the conduct of the defence

In my experience, health practitioners who don't cope well with their litigation-caused stress tend to make less than optimal defendants.

Often, due to their feelings, a defendant health practitioner will withdraw or go into isolation. They may lose perspective about the litigation. This usually then impedes the health practitioner's ability to effectively assist in the defence of the claim or complaint during the legal process. Increased stress may also trigger dysfunctional or irrational behaviour.

For example, the health practitioner might lie, conceal things, or even alter the clinical records. They may contact the plaintiff or complainant, despite having been warned not to do so. Sometimes a defendant health practitioner may abuse alcohol or drugs in an attempt to self-medicate to alleviate stress. These sorts of behaviours can result in additional lawsuits and complaints to the Medical Board.

The stress of being sued or complained about sometimes also directly contributes to physical illness of the health practitioner. Tragically, if their reaction is extreme, depression may lead to suicide.

Being the subject of a claim or complaint can have significant professional and personal impacts. Doing their best and practising to high standards is ingrained in health practitioners – so those who are sued or have a complaint against them usually perceive it as an assault on their own integrity.

Coping with the stress

Being named in a claim or complaint is a difficult process, but there are ways to successfully manoeuvre through this minefield. Here are some coping strategies that can be used to counteract the stressful characteristics of litigation and complaints:

- Seek professional help if you need support, perhaps from your own general practitioner. Individual professional counselling can also be of great benefit.
- Do not self-medicate, or use substances or alcohol to alleviate stress.
- Look after yourself, including exercise, eating well, and getting adequate sleep.
- Participate actively in your own defence. Educate your solicitor about the clinical matters involved in the case, and assist with identifying expert witnesses and relevant literature. Working closely with your solicitor in this way can reduce feelings of helplessness and restore feelings of self-esteem, confidence and control. Most solicitors will welcome the assistance and knowledge you can provide.
- Ask questions and stay informed about the legal process and procedure. This can be helpful in educating yourself about the legal system, and addressing your fears and concerns about the litigation. Knowing what to expect will allow you to prepare and feel more in control, which usually diminishes anxiety.
- Talk openly about how you're feeling with your colleagues, family, friends and medico-legal advisers. Do not isolate yourself.
- Resist taking the allegations personally. The most ethical and competent health practitioners can be sued or complained about. Remind yourself frequently that the threat of a claim or complaint is a well-established occupational hazard of practising medicine.

Litigation is one of the most stressful events in the life of any health practitioner – but it is survivable and surmountable. At the end of the process, you may be able to learn from the experience and adopt risk management strategies for the future.

Medicare news for Members

Gae Nuttall
Risk Adviser, MDA National

Nerissa Ferrie
Medico-legal Adviser, MDA National

Item 10997

Many GPs will be aware of a recent targeted compliance exercise initiated by the Department of Health & Aged Care (DHAC) reviewing the co-billing of item 10997.

We have assisted a number of Members with this audit, and it certainly refocused our attention on how the item was originally intended to be used. It seems the intent may have been lost somewhere along the way, and some practitioners and practices might be using the item incorrectly.

Item 10997 is a service consistent with the scope of a care plan (already in existence) by a practice nurse or Aboriginal and Torres Strait Islander (ATSI) health practitioner *in between* reviews by the usual treating doctor. This means it would be rare to see a 10997 co-billed with a chronic disease management (CDM) item. This is not to say that practice nurses or ATSI health practitioners can't assist you with the initiation or review of a CDM plan, but the assistance is already built into these item numbers.

Just under 600 doctors received a 'review and act now' for this item, but this is an ideal opportunity to read up on the explanatory notes and ensure you're complying with the item descriptor when you bill CDM items.

If you're uncertain whether your CDM billing policy complies with the MBS requirements, please contact us for further advice.

Attendance items for non-GP specialists

Another recent targeted compliance review involves the billing of initial attendance items (104/110) and subsequent attendance items (105/116/119).

DHAC is reminding specialists that initial attendance items must only be claimed for the first attendance in a single course of treatment. Any subsequent attendance that relates to the continuing management or review of the referred condition is to be claimed as a subsequent attendance item.

According to the Services Australia webpage – *Referring and requesting Medicare services for health professionals*:

> *A referral covers a single course of treatment for the referred condition. A single course of treatment is an initial attendance at the specialist or consultant physician. It includes subsequent attendances for the continuing management until the patient is referred back to the referring practitioner.*
>
> *A new referral doesn't always mean a new course of treatment.*

Further information on whether you can bill an initial attendance every time you accept a referral can be found in section 1.6 of the *AskMBS Advisory for non-GP specialist and consultant physician services.*

MDA National has a dedicated Medicare Committee that meets regularly to discuss the issues that matter to you. We keep up to date with all things Medicare, so we can provide current and practical advice when it's needed most.

If you receive any correspondence from DHAC in relation to your billing, please contact our Medico-legal Advisory Services team for support and assistance. The sooner you contact us, the sooner we can help you to navigate the process.

RECALLS & REMINDERS

The need to ensure that patients return to a practice for care is fundamental to achieving good healthcare outcomes – and this will be managed by a recall and reminder system. ‘Recalls’ and ‘reminders’ are often confused, which can generate unnecessary work.

Recalls and reminders
Closing the loop

Dr Julian Walter
National Manager, Advisory Services
MDA National

Reminders

Reminders are for routine preventative or screening care, such as a contact drive for influenza immunisation. There's no legal responsibility to follow up on reminder non-attendance, so a single communication is acceptable.

Recalls

The RACGP 5th Edition Standards (at Criterion 2.2) state a r ecall occurs "when a (doctor) decides that a patient needs to be reviewed within a specified period". Failure of patient attendance for a recall can result in patient harm and incur medico-legal liability for practices and clinicians. Timely communication is important.

There are two broad types of recall:

- **Result recall:** to inform patients of clinically significant results they are not aware of.
- **Reschedule recall:** where the patient needs to be re-seen for a clinically significant issue they are typically already aware of, but where failure to attend will likely result in significant harm to the patient. Examples include following up a clinically significant consultation or referral, or arranging to repeat an investigation to establish the progress of an abnormal condition.

Managing recalls

The following discussion is primarily relevant to result recalls, but it will assist if a patient fails to attend for matters subject to a reschedule recall.

When a patient doesn't attend, good clinical care and discharging your medico-legal responsibility requires that the patient is made aware of the recall issue, the clinical implications, and any treatment options. It's not enough to simply inform the patient that they need to make an appointment, with no further communication if they don't attend.

Think of recall as a relay, with the baton being the clinical advice the patient needs. From the initial practitioner who determines the need for a recall, the baton of responsibility is passed to the practice, to ensure the patient presents for the clinical advice (or to inform the practitioner this can't be achieved). Responsibility is then returned to the treating doctor, once discussion of the clinical issue occurs. It is a closed loop process, requiring distinct outcomes.

Clinical significance

Clinical significance does not just mean abnormal results (an INR of 1 is normal, but clinically significant for a Warfarinised patient). Clinical significance is relative, patient-specific, and will reflect the probability or severity of harm; and the timeframe in which harm might occur**.**

Informed refusal

There will be situations where a patient with capacity declines to follow clinical advice (informed refusal). This ends the recall, but careful documentation is required. You should consider whether to put an alert on file so that the failure to progress care can be reconsidered if the patient re-presents. It's different from a patient refusing to engage with a recall (who has not been clinically advised) where medico-legal responsibility for the recall has not been discharged.

Documentation

There should be documentation of a recall as it moves through the process. This includes the steps staff took to contact the patient, and any communication or advice outcomes. It can be very difficult to unravel the status of a poorly documented recall, and it may result in failure of follow-up.

It can be helpful to additionally document in the records that a result with dire clinical consequences requires discussion. Some practice software allows for a separate alert to be placed on the file, so that if the patient attended for another purpose, the next clinician is made aware of the outstanding recall.

Think of recall as a relay, with the baton being the clinical advice the patient needs. Recall is a closed loop process, requiring distinct outcomes.

Enacting the recall

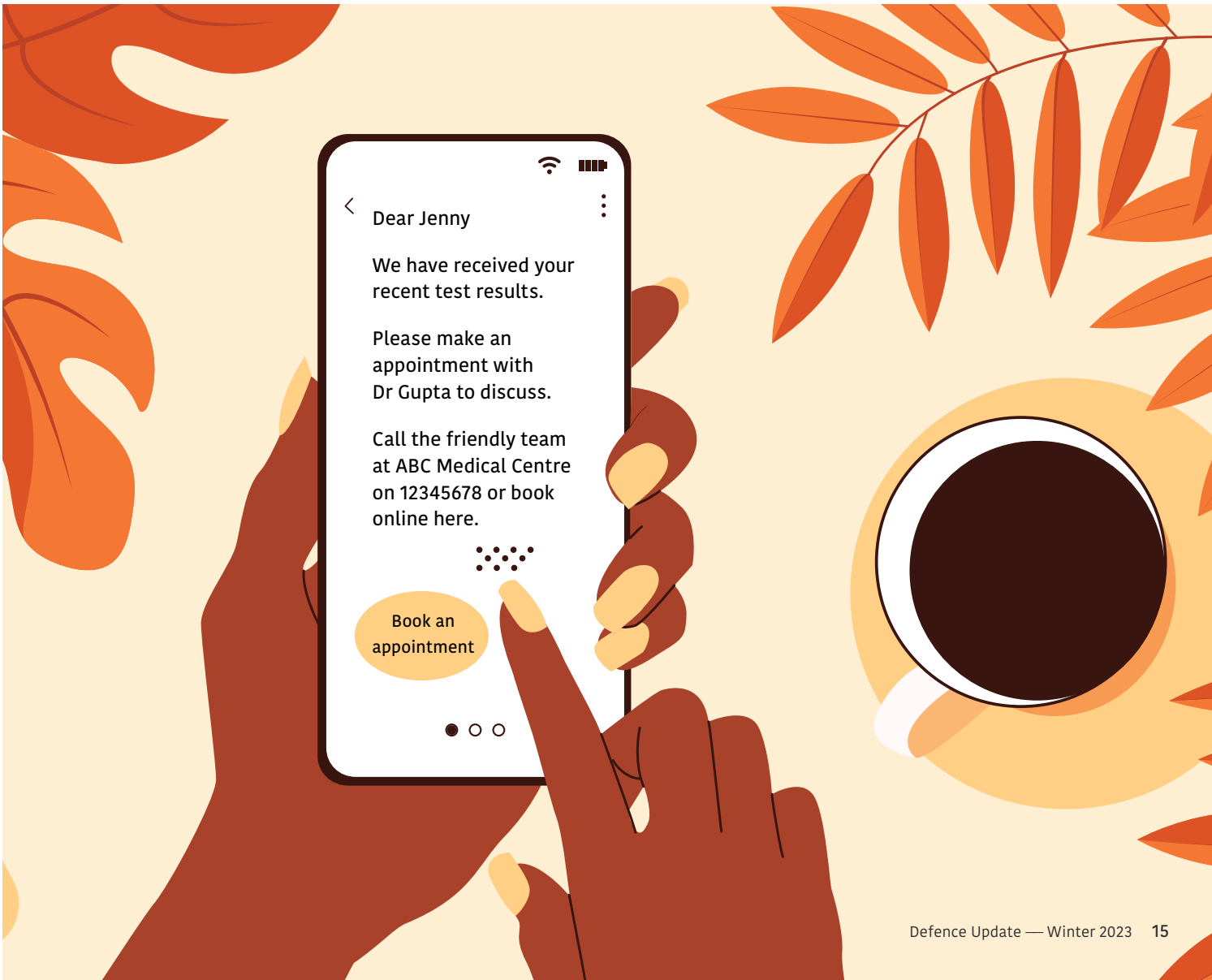
There is no specific legal requirement as to the frequency and method of patient contact. Typically, three attempts, at different times, using any of the preferred patient contact methods, is recommended. Failure to contact might necessitate use of alternative contact methods. Contact is to alert the patient that they need to make a consultation booking (so it should not typically include clinical information). For contact difficulties, consider involving the treating doctor, as they are the one with the therapeutic relationship.

With ongoing contact failure, it may be necessary to contact nominated persons on the patient file. Information should be limited to either confirming contact details (and then using these) or passing on a need for the patient to make contact.

When a patient cannot be contacted, is refusing to attend, or has not attended within a clinically safe period, a failsafe communication is required to 'hand back' responsibility for follow-up to the patient.

This will typically involve sending a letter by registered post (as receipt will be confirmed to close the communication loop). You should include the result or issue of concern, the need for a clinical plan, and advice about the risks of follow-up failure. If the patient is unable or unwilling to return to the practice, you can suggest they provide this information to another doctor for follow-up or a second opinion.

Failure to confirm contact at this point likely necessitates specific advice – which may involve welfare checks, access to other location information sources, and contacting relatives.



Managing recalls
Issues for specific parties

Initial treating doctor

Appropriate triage of clinically significant issues for follow-up is essential, including guidance as to the urgency. Consider placing a parallel alert or entry on file to inform other clinicians seeing the patient. Liability presumes that the person who orders a test (or recognises an issue) is responsible for ensuring the matter is followed up and that the patient is aware of the clinical significance. This responsibility can be delegated (e.g. to the practice by way of a recall).

It's helpful to educate patients on how they should expect to be alerted about results, or the need to attend for follow-up.

The practice

Develop a robust recall system, with clear lines of responsibility – how to enact a recall; mode and number of contact attempts; how inability to contact is escalated; documentation expectations; when a recall should be removed (after clinical communication of the issue occurs, or on clinical advice); managing urgency; and expectations where clinicians need to respond to software alerts.

In the absence of a clinical discussion with the patient, the recall should not be removed, except on advice from a clinician. Practice staff should routinely check that patient contact details are kept up to date. Regular 'sweeps' of the recall list are necessary, to pick up new recalls and those that have not resulted in clinical communication.

While patients can choose to opt out of receiving reminders and/or certain communication modes (e.g. SMS or third-party recall systems), it's not possible to opt out of receiving a recall for clinically significant results or issues unknown to the patient.

Other clinicians

Patients returning for care for other reasons can risk recall failure. The patient may fail to raise the recall issue (or be unaware) and unless the clinician is alerted, the consultation may proceed oblivious to the recall. The practice may then remove the recall, seeing that the patient 'attended'. Subsequent attendances may 'bury' the clinical recall issue in past consultations. There will be cases where the intermediate doctor has no way of knowing the pending recall, and responsibility will fall to other parties.

The patient

Courts are typically reluctant to make patients responsible for recall failure, unless there is good evidence that the patient was aware of the result and understood it's significance. Hence the importance of clearly documenting any communication that has occurred. Occasionally, patients can exhibit very challenging responses to a recall, but the courts recognise that once a patient is properly informed, further efforts to get them to comply with advice may be an exercise in futility.

What's on for Members

MDA National provides a diverse suite of education activities to help Members practise with safety and confidence. Members have access to over 20 different programs, aimed at various career stages and specialties, available in a range of learning formats.

All our programs are **complimentary for Members**. They have been developed in consultation with Members, and many of them attract CPD recognition to help you fulfil your CPD obligations.

Upcoming education activities

For more information and to register, visit:
mdanational.com.au/member-benefits/education#schedule

PROGRAM	DATE	LOCATION
Noteworthy: the how, what, where and why of medical documentation	SAT 12 August	Melbourne
Win–win conflict resolution: practice-based teams	SAT 12 August SAT 4 November	Perth Sydney
Practical solutions to patient boundaries	SAT 26 August	Brisbane
Collaboration in action	WED 30 August	Online
Webinar: Demystifying Medicare	TUE 5 September	Online
Communicating for success	WED 6 September	Online
Cultivating a positive team culture	WED 20 September	Online
Enhancing patient understanding – health literacy and communication	TUE 26 September	Online
Webinar: Employment law changes – what you need to know	October (date TBC)	Online
De-escalation of aggressive behaviour in health care	TUE 7 November SAT 18 November SAT 2 December	Adelaide Perth Brisbane

On-demand learning programs

Available 24/7 to complete on your own device, in your own time.

e-Learning

Activities include:

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

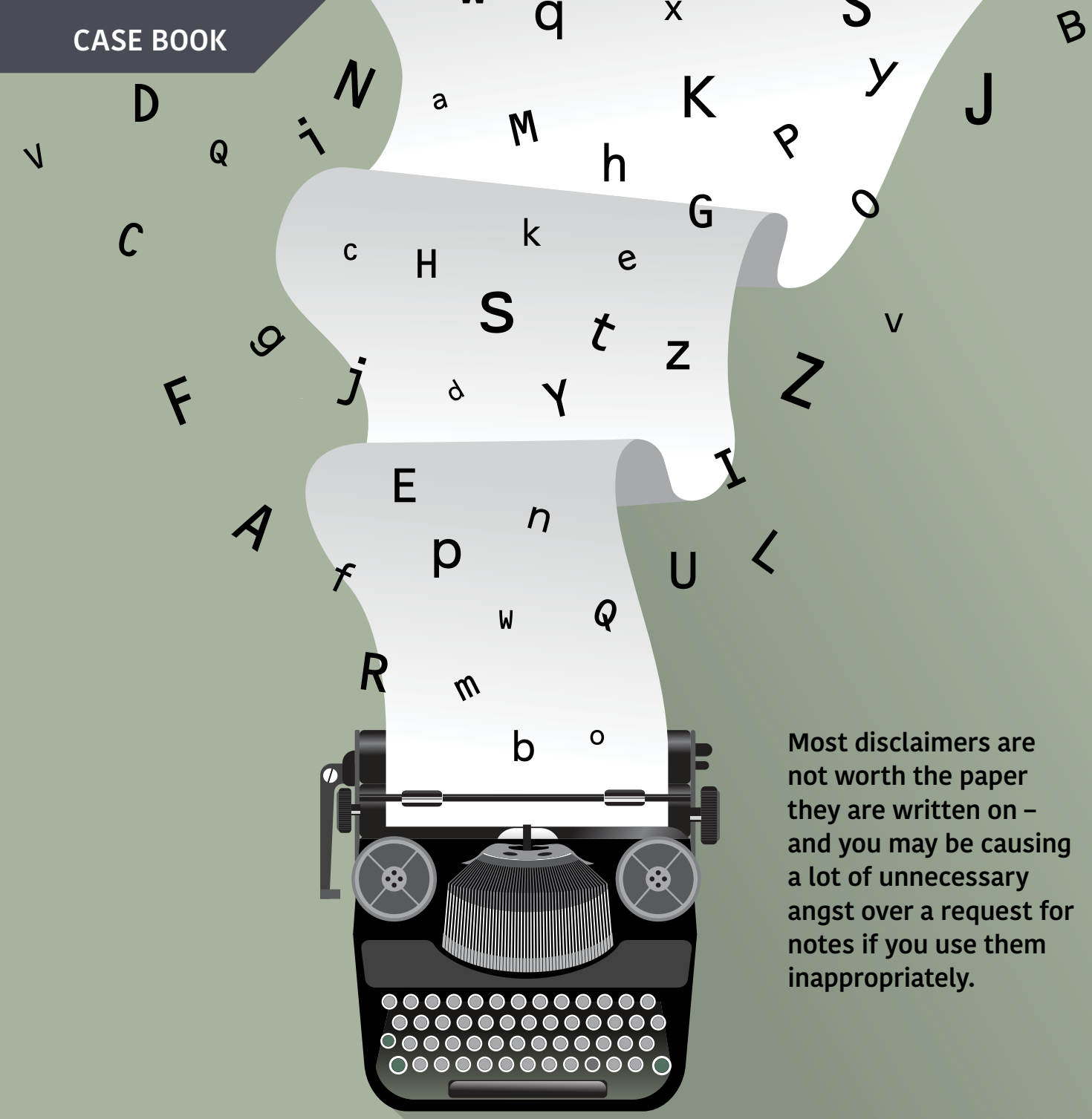
To access these and more, visit:
mdanational.com.au/member-benefits/education/online-activities

On-demand webinars

Topic include:

- Prescribing opioids
- Patient autonomy in Australian health care – **NEW**
- Understanding voluntary assisted dying laws – **COMING SOON**

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



Most disclaimers are not worth the paper they are written on – and you may be causing a lot of unnecessary angst over a request for notes if you use them inappropriately.

Not worth the paper it's written on

Nerissa Ferrie
Medico-legal Adviser, MDA National

Case study

Helen, the practice manager at a small suburban GP clinic, calls the medico-legal team at MDA National.

We've received a really formal looking letter from the Office of the Information Commissioner. It says we may be investigated if we don't provide the medical records to one of our patients.

The matter arose because a long-term patient of the practice had an ongoing claim against the local council for a slip and trip on the library steps. One of the concrete steps broke, and it hadn't been repaired despite numerous requests.

Mrs Jones, a 78-year-old widow, fractured her ankle coming out of the library and she was still experiencing ongoing pain and difficulties walking.

Mrs Jones engaged lawyers who wrote to the practice and asked them for a copy of their client's medical record. The practice took their time, but eventually obliged and sent all the consultation notes and test results they had on file. The lawyers wrote again and asked why the reports from the orthopaedic surgeon were not included in the notes.

I told them the letters from the surgeon were marked private and confidential – not to be released to a third party – and therefore they were not entitled to them. They would have to ask the surgeon.

The lawyers wrote back and advised Helen that the orthopaedic surgeon had closed his practice and was now living overseas. They further explained that under the privacy legislation, medical records in their keeping should be released to the patient, upon request, unless one of the privacy exceptions applies. The lawyers had tried, unsuccessfully, to obtain a complete set of notes for over a year, and said they would take the matter further if the practice didn't comply with their client's request.

The doctor completely agreed with me. If the correspondence is marked private and confidential, we can't release the reports without the surgeon's permission. Now we've received this letter!

Patients are entitled to access the health information you hold about them regardless of who authored particular documents, or who 'owns' the record. This means that, unless an exception applies, you must give a patient access to information you hold that you received from other health service providers, such as specialist reports.

Source: Guide to Health Privacy,
Office of the Information Commissioner (OAIC)

Disclaimers

Most disclaimers have no practical application. Doctors gather medical records from a number of sources. In addition to the progress notes they generate themselves, we often see pathology results, radiology reports, letters from specialists and allied health providers, or notes transferred from past practices. If the information relates to the patient's personal health information, it then forms part of the medical record you hold for that patient.

Under the privacy principles, patients are entitled to access their personal health information (with limited exceptions). Writing "private and confidential" or "not to be released to a third party" has no standing, and it potentially puts other doctors in breach of the privacy legislation when they follow the disclaimer on the report and unlawfully refuse the patient access to their records.

Exceptions to a release of notes

If a patient has provided consent to release their records, there are very few grounds on which release can be refused. One exception is where you reasonably believe giving access would pose a serious threat to the life, health or safety of any individual, or to public health or public safety.

It's up to each doctor or practice to determine whether a request for notes should be actioned, or whether a legitimate exception applies. If you're treating a vulnerable patient and concerned that a release of a psychiatric report without appropriate boundaries (i.e. the use of an intermediary) could result in serious harm to the patient, you could consider contacting the author for further information.

Legal professional privilege (LPP)

LPP can only be claimed by lawyers – yet we still see a number of specialist reports with "legal professional privilege" or "privileged" written across the top.

LPP is a rule of law that protects the confidentiality of communications made between a lawyer and their client. The privilege belongs to the client, and may only be waived by the client. It's not a privilege that can be claimed by a doctor on a medical report – unless the report is written in direct response to a request made by a lawyer under LPP.

If you're ever unsure whether the document in question is subject to LPP legitimately claimed by a lawyer – or another doctor has claimed LPP erroneously – we recommend that you contact our Medico-legal Advisory Services team for advice.

Violence in the workplace

Dr Elizabeth Harris
Medico-legal Adviser, MDA National

Becoming the victim of an assault by an aggressive patient can be a frightening and traumatic experience for a doctor.

Case study

You've been treating Mr Smith, a 38-year-old man who reports ongoing back pain following an injury at work the previous year. You're running over time, and reception staff send a message advising you that Mr Smith is becoming increasingly agitated in the waiting room.

Without warning, he storms into your consulting room and stands over you, berating you for keeping him waiting. He demands a prescription for Panadeine Forte, "with plenty of repeats because I don't want to see you again anytime soon!".

You attempt to remain calm, but he proceeds to kick over a chair and starts yelling loudly. You reach underneath the desk to press the duress alarm button just as he hauls you out of your chair and presses you up against the wall, threatening to kill you. Other staff members rush into your office to restrain the patient while a receptionist calls the police.

The doctor as a victim

Becoming the victim of an assault can be frightening and traumatic. Everyone should have the right to feel safe in their workplace, but Australian studies have shown that almost three-quarters of surveyed doctors have been faced with aggression at some point during their careers.[1]

These episodes can have a lasting impact leading to reduced hours, lower job satisfaction, and an intention to leave the profession.[2,3] Patient violence can appear in a wide spectrum of behaviours and actions including verbal aggression, sexual harassment, intimidation, property damage, assault, stalking or online trolling.[4]

Healthcare workers often have a high tolerance for, or even normalise, unacceptable behaviour. When we encounter patients unable to behave appropriately, we often don't want to punish them or worsen their situation. Staff may need to be reassured that sometimes police involvement is necessary, and there are good reasons to report these incidents to police.

However, choosing to pursue criminal charges against a patient (the police can elect to prosecute based solely on the evidence) can be a difficult decision with ramifications that may stretch over months, or even years. Health professionals train in a culture of caregiving, so the idea of prosecuting patients can be uncomfortable and accompanied by a great deal of guilt – or concerns that the conduct arose out of a failure of clinical care.

The aftermath

The initial stage of what may be a life-altering event can affect each person in different and unforeseen ways. It may take some time for the full extent of the physical and emotional impact to set in, so it's important to get support as early as possible. You may require time to identify what outcome you desire, and why. This is a very personal decision. Seek help, either through your own GP (ideally separate to the practice), or other supports such as employment assistance programmes or doctors' health advisory services.

The criminal process

Pursuing a criminal prosecution will likely result in you making a statement, and potentially giving evidence in court. Giving evidence may be re-traumatising, particularly under cross-examination. It can take some time for a matter to progress to court, and you may be disappointed by the outcome.

Confidentiality obligations

Seeking medico-legal advice prior to making a police statement is essential. You still have professional and legal obligations of confidentiality to maintain. While there may be exceptions under privacy legislation which allow limited disclosure of patient information, these need to be carefully considered. The focus of any verbal or written statement should be on the inappropriate conduct and behaviour you experienced, rather than revealing information about the assailant – such as past medical history or the reason for presentation.

Discontinuing patient care

Depending on the severity of events and ongoing risk posed by the patient, a decision will likely need to be made about whether care is ended at either an individual doctor or a practice level. Where the behaviour is less serious, it may be appropriate to give the patient a formal warning or place the patient on an acceptable behaviour agreement. You may need to consider a restraining order, if threats are ongoing.

Follow-up

Debriefing with the practice team is critical after any violent or threatening event. This ensures everyone is given the opportunity to discuss the event and identify any triggers or possible future safeguards. Abuse of healthcare workers is one of many factors contributing to burnout.[5] Tackling the problem through violence prevention is key, meaning clinicians don't have to endure these kinds of assaults or face tough decisions over whether to press criminal charges against their patients.

Warning signs of escalating aggression

- veiled and overt threats
- violent gestures such as swearing or slamming objects
- intense staring or avoiding eye contact
- irritability, restlessness or inability to sit still
- refusal to communicate
- past history of violence

View the references online: **mdanational.com.au/workplace-violence**

Consent revisited

When the little things *are* the big things

Daniel Spencer
Medico-legal Adviser, MDA National

Case study

Mr White is a right-hand dominant 25-year-old who worked FIFO as a driller's offsider. He consulted a surgeon, Dr Jenkins, who obtained a history and clinical examination consistent with right-sided carpal tunnel syndrome.

Dr Jenkins advised that a trial of conservative treatment could be considered, including wrist splinting and steroid injection. He further indicated that surgery would be definitive management, where symptoms persisted or progressed, and may eventually be required regardless. Dr Jenkins handed Mr White a brochure on the procedure so he could "read up on it at home".

Mr White informed Dr Jenkins that he wanted to proceed to surgery, because he was struggling to maintain his duties at work and couldn't afford to take time off. Dr Jenkins said it was a simple procedure and he would be "as good as new".

As Dr Jenkins had a surgical waitlist of six to eight weeks, Mr White agreed to trial conservative treatment in the meantime. Dr Jenkins said they could discuss the risks and benefits in more detail prior to surgery.

Two days following the consultation, Dr Jenkins' assistant telephoned Mr White advising him that a surgical patient had cancelled at the last minute, and Dr Jenkins was happy to slot him in if he was keen to proceed with a carpal tunnel release. Keen to get back to full strength, Mr White agreed to be booked in for the following afternoon.

Dr Jenkins performed the procedure uneventfully, but Mr White still hadn't recovered sufficient hand strength to return to full duties several months after the procedure. Mr White engaged lawyers who alleged their client had not been properly consented for surgery, and was not sufficiently warned about this risk of nerve damage with due regard given to his personal work circumstances.

Consent is a process and not a form. A glossy brochure just won't cut it.

While the provision of relevant information is obvious to many, the importance of getting it right cannot be underestimated. Asking a patient to sign a consent form is important, but it's only part of the consent process.

Material risks specific to the patient are of the utmost importance, and these require a higher level of engagement and consideration. Generally, the more complex or risky the procedure, the more important it is for those details to be captured in the patient's medical record.

Checklists have their place in practice, but they can be impersonal and robotic. If relied on too heavily, they can also shift attention away from discussing with the patient risks material to *them* based on *their* clinical history and presentation.

While all doctors will have their own nuanced approach, one approach can involve having the patient repeat back to you in their own words what they understand about the procedure and its risks. This will enable you to determine whether the patient understands the procedure, and has evaluated the risks sufficiently.

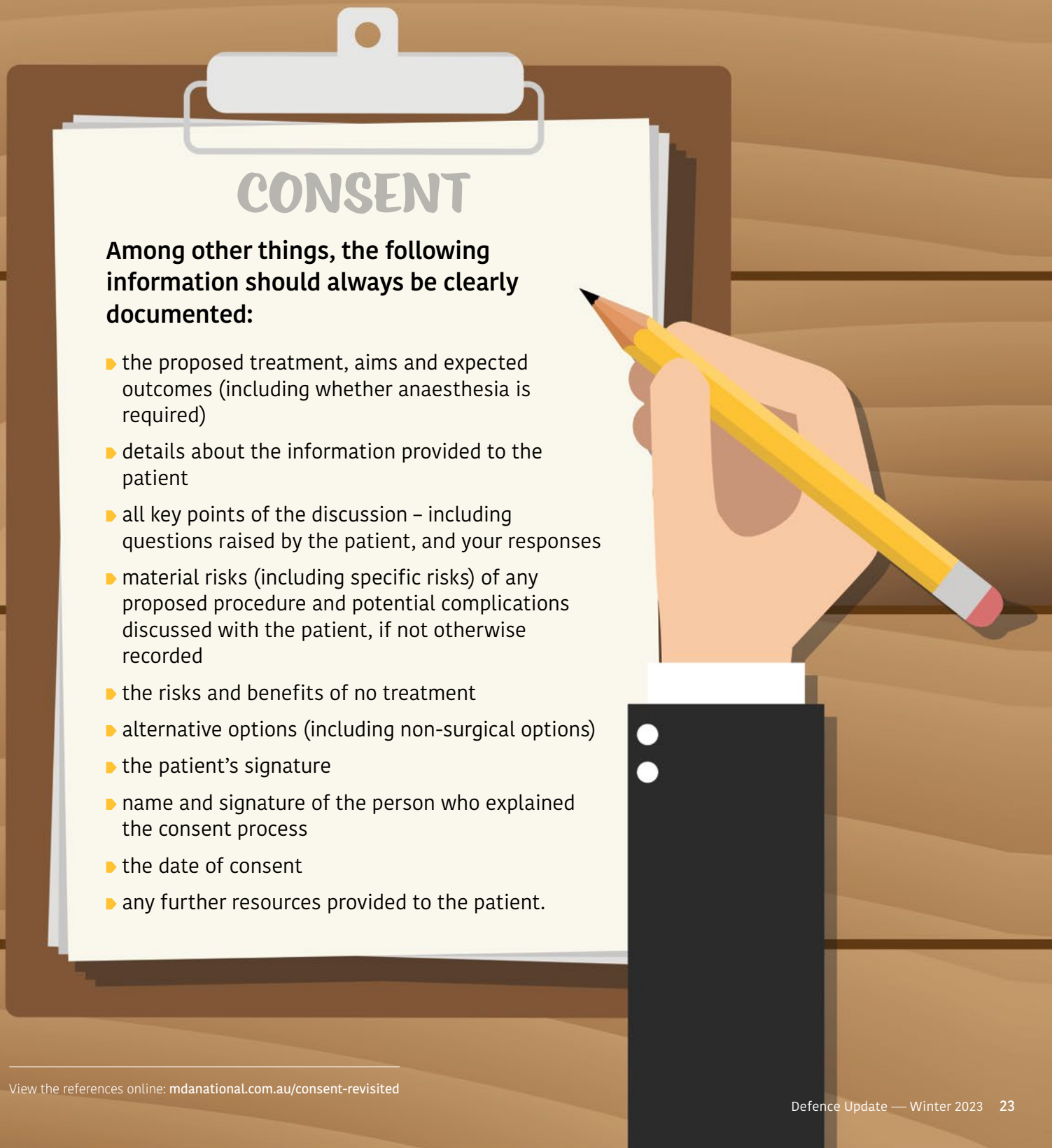
It should be remembered that consent obtained at one stage of your clinical management of a patient does not mean such consent is valid indefinitely. A change in patient circumstances will mean consent needs to be reobtained. This may occur when there is an improvement or deterioration in the patient's condition, or new treatment options have been developed.

There can be multiple barriers to obtaining and documenting informed consent. A study from the UK[1] compared the discussion of specific risks of surgery between two groups of patients: one in the trauma setting for distal radius fracture surgery, and the other in the elective setting for total knee arthroplasty.

It found specific risks of surgery were recorded more than 35 per cent less in the trauma setting. Significantly fewer risks were also recorded in that setting. It is a timely reminder that a shortage of time can lead to a rushed and sub-standard consent process.

It's a well-worn phrase in medico-legal circles – that documentation is the best defence. It sounds simple and, to borrow a sporting cliché, may be regarded by some as a 'one-percenter'. But it's not. It's incredibly important.

Ten minutes spent now can save hours, days or months defending a claim down the track.



Among other things, the following information should always be clearly documented:

- the proposed treatment, aims and expected outcomes (including whether anaesthesia is required)
- details about the information provided to the patient
- all key points of the discussion – including questions raised by the patient, and your responses
- material risks (including specific risks) of any proposed procedure and potential complications discussed with the patient, if not otherwise recorded
- the risks and benefits of no treatment
- alternative options (including non-surgical options)
- the patient's signature
- name and signature of the person who explained the consent process
- the date of consent
- any further resources provided to the patient.

View the references online: **mdanational.com.au/consent-revisited**

Livin' the dream – or not?

Dr Joseph Curran
(MDA National Member)
House Medical Officer, Royal Melbourne Hospital

"Livin' the dream…"

This is one of the most common responses I hear from junior doctors on the ward when asked how they're going. Sometimes delivered with a smirk, sometimes with a sardonic tone; but overall giving the impression that they are, in fact, not living the dream.

After a while, I began to wonder about how junior doctors handle adversity and some of the key challenges we face. I don't think junior doctors are under any illusions about how difficult working in healthcare is. However, our attitudes towards these adversities are changing.

We've certainly come a long way in how we're treated, but unfortunately the 2022 annual survey of all doctors in training in Australia, delivered by the Medical Board of Australia, found that 20 per cent of respondents were considering a future outside of medicine. The reasons are likely multifactorial, with bullying and a heavy workload being key elements cited in the report.

Some challenges in medicine have always been present, including the years of training and the anxiety over the weight of some decisions.

But, as with every industry, there are new and evolving challenges as we move into an increasingly technologically savvy and competitive environment.

Good doctors are assiduous, and this will and should never change – it strives to ensure the best outcome for patients. The difficulty comes with what's added on top of the necessary level of hard work – like the increasing competition to get on to training programs, or the pressures to publish research early as a junior doctor. And with the healthcare system under constant strain, at times it seems like having well-staffed hospitals is a pipedream, even though this would greatly help in promoting the mental health and wellbeing of junior doctors and all health professionals.

So how do we actually live the dream?

Well, on the surface it doesn't seem altogether difficult – proper pay, proper support, proper hours, to name a few things. But the answer is much more complex than that. There are intricacies and nuances I'm probably yet to understand, including those influenced by socio-political pressures.

We should feel lucky in many respects though, when hearing some of the horror stories from our senior colleagues in medicine. We have our predecessors to thank for speaking up for change in those times. Such tales include having an entire 12-week rotation on nights, with zero nights off; or that while overtime was commonplace, overtime pay barely existed. I can hardly imagine enjoying these rotations, not to mention the exhaustion and questionable patient safety involved. Moreover, hearing of the prominence of the hierarchy in medicine makes me feel fortunate that medicine has changed for the better, and still continues to change.

There are, of course, so many positive aspects about the job. Too many to name, in fact. Atop the list is the strong sense of camaraderie between junior doctors, which is perhaps one of my favourite aspects of medicine so far. Not only do we look after each other, but we relish doing so. When we say, "livin' the dream", we know our colleagues are aware of exactly how we're doing. More often than not, this response entails an offer for help, because we know that part of the fabric of being a doctor is helping one another.

There are few things more comforting than being taken under the wing of a registrar who acutely recognises the challenges of being a junior doctor. Moreover, aspects of mindfulness and reflection are well established in medical school training, which altogether help promote resilience in the formative years of being a doctor.

Junior doctors will always strive for appropriate working conditions. This isn't a controversial notion. We have come a long way, and the job will always have its challenges. But the notion of being in a supported and caring environment is as important as it has ever been.

So let's aim to actually "live the dream", and make the most of the myriad of opportunities we have every day to really engage with and help our patients, and become the best doctors we can be.

From ship to shore

Doug Brazil's childhood dream was to become a marine medic, and he was fortunate in being able to follow his dream. From an early start with the Australian Air Force, his career took him sailing across the seas as a medic with the Royal Australian Navy. After a successful 22-year stint, feeling he had more to offer, Doug drifted back to shore and found himself anchored in medicine. Doug was a delightful person to interview, with many valuable insights and life experiences that will no doubt steer him wisely through his journey as a doctor.

Niranjala Hillyard
Creative & Editorial Director, Inkpot & Pixel
(Freelance Writer & Designer, *Defence Update*)

Q1. How did you get started with the Australian Air Force?

I always wanted to be in the defence forces. The distant lands, amazing equipment, and doing something to change the course of history. A far cry from my home in suburban WA. I joined the Army cadets at 12, and was a shaved-head little military fan boy throughout my high-school years. I started off with the Airfield Defence Guards (Air Force infantry) and was by far the youngest.

I joined the RAAFSFS (a unit that trained my job, dog handlers, firefighters and police) and spent the next few years walking through bush looking for an imaginary enemy; blowing things up in military style; training in weapon systems; digging holes and refilling them; and generally had an average but not exciting time.

Q2. What initiated your career shift into the medical pathway, and how did you cope with the change?

My friend was badly injured during an air-training exercise, with bone exposed and screaming in agony. I was helpless. All I had was a torn triangular bandage and bits of band-aid. Then a camouflaged F150 careened over, and people with red crosses on their shoulders expertly secured their equipment, speaking medical lingo I barely understood. The way they stabilised his leg and took charge of the situation really impressed me. They were medics and doctors – and that was what I wanted to be.

That week I put in my transfer to join the Navy, as the Air Force wasn't hiring medics. I was finally transferred in 2005 and never looked back. I served on various warships in multiple zones (conflict, humanitarian, border protection and counter-piracy) and sub-specialised in hyperbaric medicine, working with submariners, clearance divers, commandos, and the SAS.

> *"Don't hurry to reach the end goal... take time to breathe and enjoy the journey."*

At age 30, I was almost at the top of the sailor ranks, with a chest full of medals and a drawer full of commendations. I loved my career, but I was bored and felt I had more to offer. That's when I applied for medicine. I got my first preference, and the Navy sponsored me – this meant I was able to have my two children and live a comfortable life while studying.

It took time to adjust as a mature-age medical student. My peers were at different life stages to me, with no kids, and more time for study and social activities. I felt I had stepped into a new era, a stark contrast to the military. I was slower on the technological side, but made up for this in other ways – such as being able to empathise, read between the lines, and not just recite a book. And while being respectful to peers and supervisors, I was able to call out inappropriate behaviour in a mature and constructive way.

Q3. How do you manage to balance work and family life, as a husband and a father?

Like any medication, the better the efficacy of the drug (usually) the worse the side effects. Clozapine is great for mental health where other tablets don't work, but so damaging to the body you have to be on a surveillance program to ensure you don't fall off the edge.

I don't have my work-life balance perfectly sorted out, but I do have boundaries though. Birthdays, weddings, mental health days, sick days – I prioritise these without remorse or apology. I support my wife's career completely, and I'm conscious of being around for my kids as they're only young once. I politely decline to participate in anything I don't have the capacity for.

Q4. What would you consider to be the highlights of your medical career?

When a patient comes into hospital at death's door, and I see them walk out in good health, knowing I played a part in their recovery or even saved their life – it makes all the effort worthwhile. People are my highlight, and I have a long list of those who inspire me – the ED team, trauma surgeons, doctors, registrars, nursing staff, and many others.

I don't consider myself talented, but I take every opportunity to learn and improve. I'm dedicated to my personal growth because I have a clear vision of the type of doctor I want to be.

My parents weren't wealthy, and university wasn't an option when I was growing up. So, being awarded '2022 Intern of the Year' at Royal Perth Hospital was really gratifying, and I was humbled by the words of recognition that I received.

Q5. Can you share some learnings from your multiple careers to help your fellow interns?

A wise person once said, "it takes a village to raise a child". A more modern military term captures that ethos with, "bullets don't fly without supply".

I've learnt that discipline, perseverance and hard work are far more powerful and rewarding than talent. I watched soldiers on special forces selection courses who weren't the quickest learners. But even when their bodies were on the verge of shutting down in the middle of the night, they would practise the scenarios in their heads. They were the ones who made it and got their beret.

Make your own luck and never give up. Read the criteria, identify the key stakeholders, and do everything you can to succeed. Arrive early and participate in discussions; be the person who replaces the printer paper and knows where the stash of scripts are; pay for courses and do research projects.

Your rifle will never jam if you're diligent and consistent with your learning and preparation. Observe your official and unofficial mentors; see the good and reject the bad. Listen to criticism, but be wary of the staff who give it. Don't be afraid to admit when you're wrong or just don't know the answer to something.

Diligence and discipline outweigh talent and spontaneity. There's no magic formula to being a good doctor. Just be honest, consistent, ask questions, use the MDT staff, and accept that you can feel stupid and challenged at times – but always strive to have one small win a day. Remind your colleagues you have a privileged job; remind patients that they matter.

It's never truly satisfying if you do things just for praise. I've stayed back late helping RMOs master cannulation. I worked hard to study the local mental health and support services. I'd start work half an hour early, printing and checking blood results, and reviewing patients' notes to try and formulate a plan while awaiting the consultant – not for accolades or to be noticed, but to become a better doctor.

Every sailor on a ship has a special job that is vital for the cog to run. But you never step over a pile of trash on the flight deck because you think it's someone else's job. You will meet all kinds of people – polite, helpful, rude or disrespectful. But YOU have the choice to be a supportive and kind human. Never forget that.

Dr Doug Brazil is currently a Resident Medical Officer at the East Metropolitan Health Service in Western Australia. He was the recipient of the Royal Perth Hospital 2022 Intern of the Year Award.

Elevate your career with industry-leading education programs tailored to your needs and career stage

As junior doctor Members of MDA National, you can access complimentary education resources to help you navigate intern, resident, and registrar-specific challenges with confidence while you plan your future career path.

Empowering our junior doctors

Whether you're facing bullying and micro-aggressions as an intern, struggling to maintain a healthy work-life balance as a resident, or juggling exam preparation and the supervision of junior staff as a registrar, this series will equip you with the skills and information you need – so you can keep on progressing through your early career with confidence.

Topics include:
How to manage anxiety when responding to MET calls and code blues
Imposter syndrome and managing career transitions
Perfectionism and medical errors
Setting healthy boundaries and assertive communication
Exam stress and study procrastination
Supervision and teaching of JMOs

Led by Dr Amy Imms from **The Burnout Project**, this webinar series is scheduled to begin in August 2023.

Unsure about your career path?

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

Topics include:
Your medical career: what to do when you don't know what to do!
Understanding individual personality traits and how these impact work satisfaction and career choices
Skills and strengths: the importance of identifying yours in your career planning, and for applying for your desired role

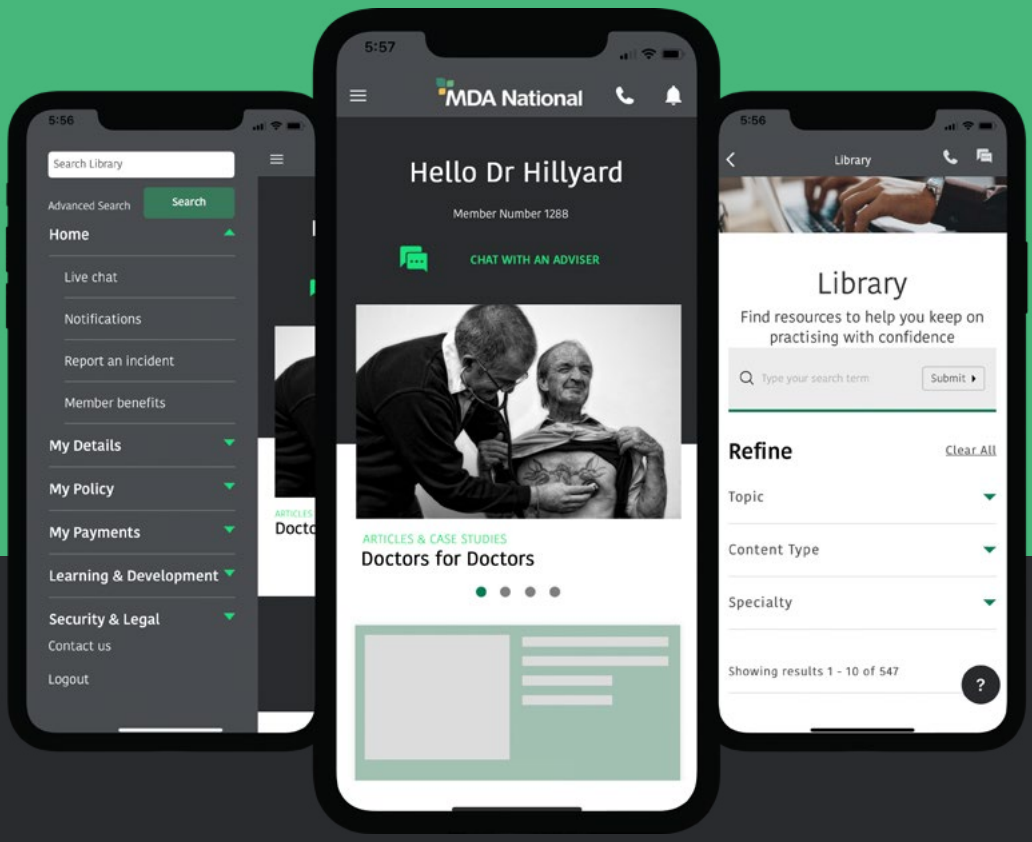
Member feedback:

"*This is extremely helpful. I feel thrilled. This is the last missing piece of the puzzle.*"

"*Thank you for your help. I have been telling everyone to consider doing this - it is so good to feel confident in what I am doing and why.*"

SCAN QR CODE
Learn more

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



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

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

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

Download on the App Store

GET IT ON Google Play

mdanational.com.au

1800 011 255 peaceofmind@mdanational.com.au