SUMMER 2024/25

Defenceupdate

Managing patient complaints

Referrals 101

Early release of super

Non-sexual boundaries

Medico-legal Case Book

First Defence for junior doctors

Artificial intelligence

Medico-legal content
FOR MEDICAL PRACTITIONERS

MDA National
Support Protect Promote

EDITOR'S NOTE

Welcome to our Summer 2024/25 edition of *Defence Update*.

Artificial intelligence (AI) is a hot topic across all industries at present, and the medical fraternity is no exception. MDA National Vice President Dr Simon Benson is an early adopter of technology and new models of care. In his message to Members, Simon talks about the benefits and challenges of this brave new world, and how MDA National protects and supports you as the medical landscape evolves (page 3).

The importance of like-minded organisations working together for the greater good of the profession is an ongoing focus for AMA(WA) President Dr Michael Page, as he talks about his own leadership journey (page 4-5).

Deborah Jackson provides some timely advice around the ethical and regulatory issues emerging in the use of AI in medicine (page 6-7). Are you and your staff adequately prepared?

History shows that having a sexual relationship with your patients is a one-way ticket to suspension – but what about other transgressions attracting the attention of the regulator? I look at some of the non-sexual boundary violations which might result in disciplinary action (page 8).

Kate Rowan-Robinson, a recent addition to our Medico-legal Advisory Services team, provides some useful advice on responding to the increasing number of requests for early release of super (page 9), and our Support in Practice team answer your questions on referrals (page 10-11).

The stress around cost of living can lead to an increase in patient dissatisfaction, and unhappy patients can be difficult to navigate. So Karen Stephens provides her best advice on managing patient complaints in our Medico-legal Feature (page 13-16).

Intimate partner violence is on the increase and in the spotlight. In our Case Book (page 18-23), we shine a light on the important role doctors play in these challenging and distressing situations; Emma Jack unpicks the findings of a Tribunal matter involving allegations of sexual harassment against a hospital doctor; and Dr Karen Lam provides some timely advice on rules around Clozapine prescribing.

In First Defence (page 24-27), we speak to our Education Services team about the value of real-life learning and take a sneak peek at the upcoming series for early-career doctors – aptly named 'Lifeline'; and Dr Claudine Cerda-Pavia talks to me about her unique pathway to medicine, and her fantastic work with the Binar Futures project.

The sun is shining, and summer is on the way! We hope you manage to take a well-earned break over the festive season, with a copy of *Defence Update* in one hand and a nice cold drink in the other. Thank you for your ongoing support, and please drop us a line if there's something you'd like to see in a future edition.

Nerissa Ferrie
Medico-legal Adviser, MDA National

In this edition

FROM THE VICE PRESIDENT 03
A message to our Members

DOCTORS FOR DOCTORS 04
Meet AMA (WA) President, Dr Michael Page

Artificial intelligence 06

Non-sexual boundaries 08

Early release of super 09

Referrals 101 10

MEDICO-LEGAL UPDATE 12

MEDICO-LEGAL FEATURE 13
Managing patient complaints

- Patient complaints and legal requirements
- Sample documents

EDUCATION FOR MEMBERS 17

CASE BOOK 18

- Friendly banter or unlawful workplace harassment?
- Intimate partner violence
- Clozapine: a cautionary tale

FIRST DEFENCE FOR JUNIOR DOCTORS 24

- The value of real-life learning
- In profile: Dr Claudine Cerda-Pavia

CAREER SUPPORT FOR EARLY-CAREER DOCTORS 28

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

FROM THE VICE PRESIDENT
A message to our Members

Dear Members,

Australian healthcare is undergoing a digital revolution, with technology playing an increasingly vital role in patient care and practice management. This technology aims to streamline workflows and free up valuable time to focus on what matters most – patient interaction. As you know, we must balance innovation with the responsibility of delivering the best care to our patients.

At MDA National, we ensure your cover evolves alongside the profession. We have developed education content for Members on the risks and benefits of using artificial intelligence (AI), and we continue to closely monitor its use in healthcare to ascertain how we can further assist Members navigate this area of emerging risk.

Large Language Models (LLMs) are poised to revolutionise healthcare by generating concise patient summaries, streamlining workflows, and providing faster access to the ever-expanding universe of medical guidelines. With the National Health Interoperability Plan pushing for integrated records across platforms, LLMs hold the potential to solve one of my biggest pain points as a GP – to deliver a holistic view of a patient's medical history. This would have enormous benefits to patient care and the broader health system.

A recent study published in the British Medical Journal found that 20% of UK GPs are already using AI in their practices. As AI adoption rises in Australia, we are committed to supporting our Members on this journey.

While AI tools offer immense promise, their integration into healthcare requires careful oversight. LLMs can improve efficiency, but they are not without risk. Data privacy, security and sovereignty are paramount concerns.

AI tools can also omit significant information or misrepresent context; error propagation (particularly in LLM-generated summaries) is another potential concern. It's crucial to maintain a human-in-the-loop approach to ensure quality control and avoid unintended consequences.

To navigate these challenges, we've developed a comprehensive guide, *Using Artificial Intelligence Tools for Record Management in Doctor Consultations*, to help you understand and utilise AI responsibly, while maintaining high standards of patient care.

As the healthcare landscape evolves, so does its risks. Our Board continuously monitors emerging trends such as changes in scope of practice and new guidelines for ageing practitioners. This proactive approach ensures your cover remains comprehensive and relevant.

Our core purpose is to protect and support you at the times that matter most. We're here for you with reliable industry advice, resources and expertise to help you keep on practising with safety and confidence.

We also understand the concern over rising healthcare costs. While premiums have increased to reflect market realities, we take great care to balance affordability with the need for robust protection when making adjustments. You will recall that we kept premiums stable during the pandemic, as part of our commitment to your financial wellbeing.

By choosing MDA National, you gain more than just insurance. You are part of a supportive community that supports your practice in an ever-evolving environment. We offer high-quality medico-legal advice, educational resources, unwavering support during claims processes, and a deep understanding of the unique challenges you face as a healthcare professional. We're here for you, every step of the way.

Dr Simon Benson
Vice President, MDA National

Meet AMA (WA) President and Chemical Pathologist Dr Michael Page

Niranjala Hillyard
Publication Manager & Designer, *Defence Update*

When Dr Michael Page first got involved with the AMA (WA) as Co-Chair of the Doctors In Training Committee, he never imagined he would someday be president of the organisation.

Starting off his career as a pharmacist, Michael turned his hand to medicine and specialised in chemical pathology. He was appointed AMA (WA) President in June 2023.

Michael took the time to talk to me about the reasons for his early involvement with the AMA (WA) during his medical training years; his key priorities in the presidential role; and how the AMA (WA)'s longstanding relationship with MDA National benefits the members of both organisations.

Let's talk about your career path that led to you becoming the AMA (WA) President – how did this come about?

I've had other leadership positions, but nothing as substantial as my current role. I think the more you associate yourself with an organisation, especially one as important to the system as the AMA, you see all the good things it can do. The influence it can have on the health system; and the importance it has to the broader community as an authoritative, trustworthy voice of advocacy – not just for doctors, but for patients too. That's quite inspiring. And the more you get involved and find your interests are aligned, it becomes something that's worth contributing to in a bigger way.

As I journeyed down that path with the AMA (WA), the role of President came about as a natural progression. I did get a push along the way from a couple of people, like Dr Michael Gannon. It's flattering when people you respect encourage you for such a role. It gives you the courage and self-confidence in your ability to perform the role; and you know those people will be there for you – which is really important. Leadership can be lonely, if you don't have the support of people who've been there before. People who understand the challenges. People who know that whatever may be happening in any given moment, all you're trying to do is achieve the best outcome for the members.

What's your leadership style?

I learn from other leaders. I like to know what others think, and I take more of a consultative approach to find a consensus. I believe it's important to bring people along as much as you can with you, rather than direct or micromanage them. Empowering the people and other leaders around you will bring out their best and get more out of the team.

As the AMA (WA) President, what are your main priorities or the issues most important to you?

Unity is the overarching theme for me, and it's around finding all the common ground in our profession. Medical students and junior doctors have a lot of common ground, but they tend to form silos and drift apart as they move into different specialties. In my view, we all have so much in common as doctors.

We're all leaders in our respective fields, functioning as the main navigator of care for any given patient, and taking responsibility for the outcomes. I think it's these common aspects, and the important role we play as doctors, that we should celebrate and protect.

There are so many threats to good quality patient care. Governments looking for cheaper ways to do things. Shortages of doctors pushing governments down dangerous roads of inferior models of care. Using different types of health professionals instead of qualified medical doctors to deliver patient care.

We could end up with a health system that's on the ropes, if we don't make some good strategic decisions about medical training in particular, as well as health system planning and the relationships between public and private healthcare.

Having been involved with the AMA (WA) for nearly a decade before my presidency, I know how much the organisation does to advocate for our members and patients. One of my key priorities is to engage our membership and bring them closer to understanding what we do, and how we do it.

You're now into your second year as President. Is your role everything you thought it would be?

The challenges have probably been different to what I may have anticipated. The structural challenges facing the AMA are real, and running a member-based organisation in 2024 is difficult.

As WA's peak medical body, we believe membership of our organisation is very important for doctors, and we need the members to enable us to remain relevant and viable. The bigger our membership, the stronger our voice can be to effect change and make a difference.

But maintaining membership is difficult when people are having to make hard decisions on how they spend their money. Everyone's got personal priorities; cost of living is increasing; and wages and Medicare rebates have not kept pace with inflation.

On a wider scale, when we have different groups of members with varying and competing views and ambitions, it makes it difficult for us work out what the AMA (WA)'s role is, and how to provide advocacy. This consensus-building can be challenging in a profession as broad as ours. But then again, it comes down to finding common ground – and thinking about what's best for our whole membership; and what's best for our health system and our patients.

How do you think the AMA (WA)'s longstanding relationship with MDA National benefits the members of both organisations?

Both organisations are so important to the wellbeing of doctors. As an independent association and the peak medical body in WA, the AMA (WA)'s overarching offering to doctors is to improve their quality of life, in one way or another. Whether that's advocating for wages and conditions for doctors and negotiating industrial agreements; or upholding the standing of doctors in the community; or advocating for general practice; or providing professional assistance to individual members when needed.

MDA National has always had a very strong presence in WA. We have a similar culture and similar goals. We are aligned in many ways, but our roles don't overlap. I'd describe it as a good symbiotic relationship; one that helps us achieve our common objectives in supporting and protecting doctors – which in turn benefits both our memberships.

Doctors are at their lowest point when undergoing significant disciplinary matters. How can MDA National work with the AMA (WA) to ensure doctors get through it with their careers intact?

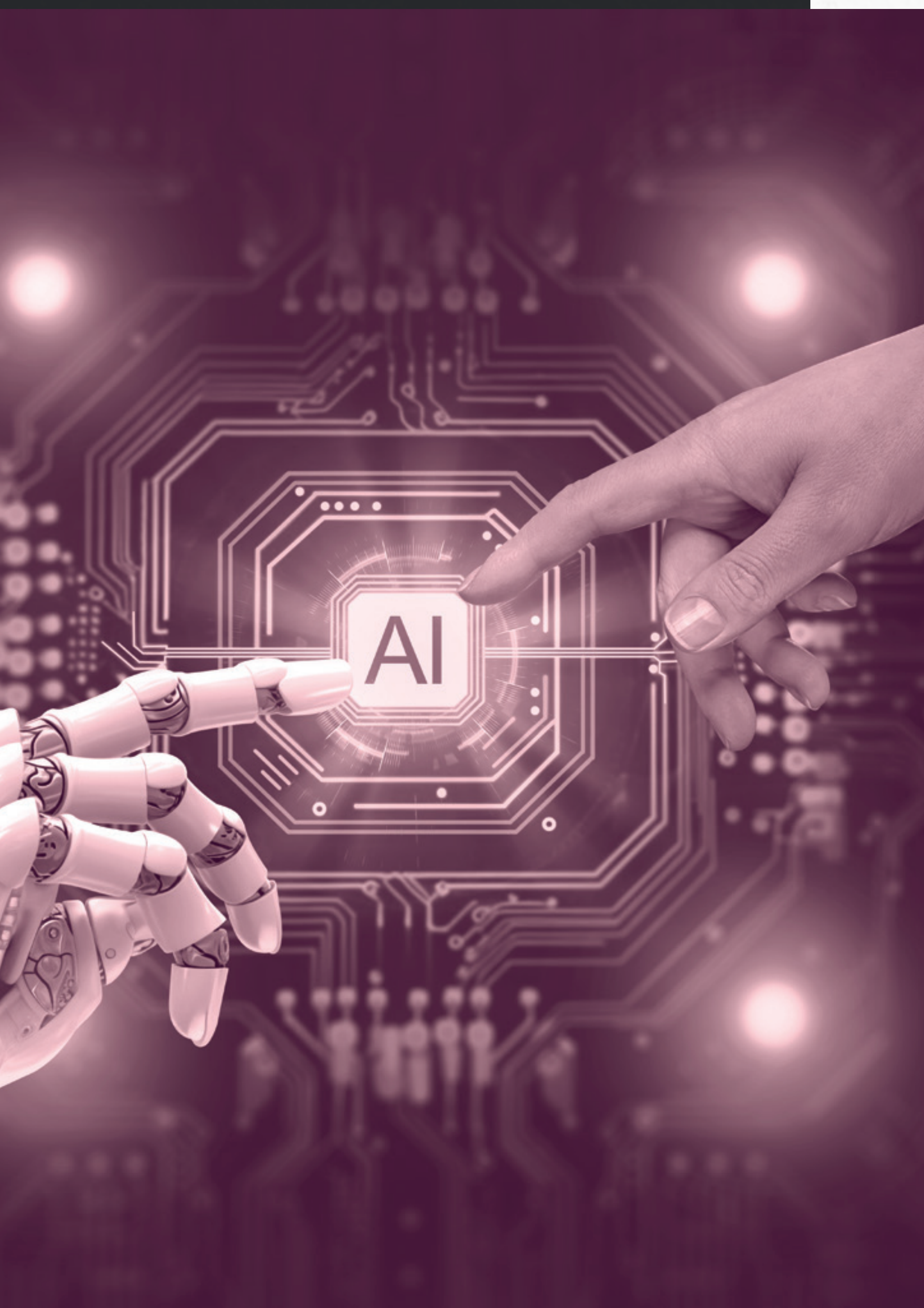
MDA National has a very good reputation when it comes to being there for doctors at those times. Doctors in difficulty will often need help with medical indemnity, just as they may need help from the AMA for individual assistance or in the broader industrial setting. So, we do often work together with MDA National to support doctors in the instance of an adverse event.

Doctors are under a lot of pressure from both the government and the community – being expected to do more with less, and with more scrutiny. It's not an easy road. That's where like-minded organisations like ours can make a significant difference by working together to achieve better outcomes for our doctors and the medical profession as a whole. Whether it's preventing doctors from getting to that point where they are under pressure due to litigation or some workplace issue; or supporting doctors during those times of difficulty.

Mental health of doctors, at both the junior and senior level, is something that's been a big focus for the AMA (WA) for a number of years. Doctors' wellbeing has become a big part of what we think about on a daily basis, and we work closely with the Doctors' Health Advisory Service WA on this. This is certainly an area where MDA National can work with us.

What's one piece of advice you can give to junior doctors interested in medical leadership roles?

I'd encourage them to start by seeing themselves as leaders. You can do so much more in a position of leadership by putting your hand up and contributing or actively participating in an organisation like the AMA or MDA National. Your reach is longer; your ability to influence things for the better is greater; and it's something you never really regret doing. Something you can look back on and be proud of.



Artificial intelligence

Deborah Jackson
Medico-legal Advisory Counsel,
MDA National

Artificial intelligence (AI) is rapidly transforming the healthcare industry by automating processes, aiding in diagnostics and improving patient care. However, along with its benefits, AI also raises significant legal, professional and ethical challenges. The professional obligations surrounding the use of AI in healthcare, and the existing and emerging guidelines of AI adoption, are all crucial areas for exploration.

Patient safety and quality of care

Healthcare providers must be satisfied that AI systems meet safety standards, minimise harm, and deliver a quality of care that is at least equivalent to human-led interventions. According to recent guidance published by the Australian Health Practitioner Regulation Agency (Ahpra),[1] AI should support the clinician's judgement, not replace it, thereby maintaining a human-centred approach to healthcare.

The Therapeutic Goods Administration (TGA) plays a critical role in this validation process, particularly for AI systems classified as medical devices. The TGA ensures these systems meet safety and performance standards before they are deployed in clinical practice, in the interests of patient safety. Developers and manufacturers must adhere to stringent regulatory requirements, including post-market surveillance and reporting of adverse events.

According to the TGA, software will be considered a medical device where its intended medical purpose includes one or more of the following:

- diagnosis, prevention, monitoring, prediction, prognosis or treatment of a disease, injury or disability
- investigation, replacement or modification of the anatomy, or of a physiological process or state
- to control or support conception.

Apps that track a person's health information to diagnose diabetes, or software that analyses skin images to screen for melanoma, are deemed to be medical devices[2] – whereas generative AI tools used in clinical practice (such as AI scribing) are not regulated by the TGA.

The AMA issued a position statement in 2023 on the application of AI,[3] including automated decision making (ADM) and application of Large Language Models (LLMs) in healthcare.

Informed consent and transparency

Informed consent is a cornerstone of medical ethics, and it extends to the use of AI in healthcare. Patients should be informed about the involvement of AI in their care, and have the right to understand how AI tools might affect their diagnosis or treatment. Transparency is essential for maintaining trust – patients must be aware of the role AI plays in their treatment, and the potential risks and limitations associated with it.

Accountability and responsibility

One of the significant challenges in using AI is determining accountability when errors occur. Healthcare professionals are ultimately responsible for the decisions made using AI tools. However, the lack of clear guidelines regarding the division of responsibility between the AI system developers, healthcare institutions, and the professionals using these tools presents an ongoing challenge. Ahpra stresses the need for healthcare providers to remain accountable for the outcomes of their clinical decisions, even when AI is used as a supportive tool.

Data privacy and security

AI systems in healthcare rely on vast amounts of patient data to train algorithms and improve accuracy. Healthcare professionals must protect sensitive health information and ensure AI tools comply with data protection requirements pursuant to the Australian Privacy Principles and the Privacy Act.[4] Ahpra also highlights the importance of safeguarding patient privacy, ensuring that data collected for AI-driven processes is securely managed and protected from breaches.

View the references online: **mdanational.com.au/artificial-intelligence**

REGULATION

The regulation of AI in healthcare is still in its early stages, with regulatory bodies working to establish frameworks that ensure the safe, ethical and effective use of AI. Several key regulatory measures are being developed and enforced globally and within Australia. Australia's current regulatory framework is not fit for purpose to respond to the risk AI poses.

Ahpra's role in AI regulation

Ahpra has taken a proactive role in providing guidance and regulatory oversight for the safe and ethical use of AI in healthcare in Australia. Ahpra recognises the transformative potential of AI technologies, while emphasising the need for healthcare professionals to understand its risks and limitations.

TGA regulation of AI as medical devices

The TGA plays a crucial regulatory role in ensuring that AI systems used in healthcare meet the necessary safety and efficacy standards. AI technologies that are classified as medical devices – such as those used in diagnostic imaging or treatment recommendations – must undergo a comprehensive evaluation by the TGA before they can be approved for use in Australia.[5] The TGA also monitors the ongoing performance of AI-based medical devices through post-market surveillance to ensure they continue to meet safety and performance requirements.

Voluntary safety standards

In August 2024, the Department of Industry, Science and Resources (DISR) issued a voluntary AI standard providing guidance around responsible AI implementation while regulation is being developed. The *Voluntary AI Safety Standard*[6] sets out 10 'guardrails' designed to provide practical guidance to AI developers and AI deployers on the safe and responsible development and deployment of AI systems in Australia.

In September 2024, the DISR issued a *Proposals paper for introducing mandatory guardrails for AI in high-risk settings*[7] (includes healthcare).

Ethical guidelines

The DISR published *Australia's 8 Artificial Intelligence (AI) Ethics Principles* in 2019. The principles support the importance of professional oversight, ensuring AI systems complement rather than replace clinical decision-making, and the need for clinicians to remain informed about the tools they use.

Non-sexual boundaries

Nerissa Ferrie
Medico-legal Adviser, MDA National

The Medical Board of Australia provides specific guidance to doctors on sexual boundaries in the doctor–patient relationship,[1] but what are the other boundaries you should be aware of in your day-to-day practice?

Some doctor–patient boundaries are established in *Good Medical Practice: a code of conduct for doctors in Australia*[2] (the Code) including conflicts of interest, financial and commercial dealings, and research ethics. Other boundaries may be more subtle.

We take a look at some of the common boundary breaches we see in complaints and disciplinary matters, and how you can avoid the pitfalls.

Treating friends, family and staff

This is addressed in the Code, and yet we still see complaints made either by the patient when the therapeutic relationship breaks down, or by a disgruntled third party. The Code states that doctors should "whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship".

For the safety of your patients, and to protect yourself medico-legally, you should ensure you keep your personal and professional lives separate.

Recognising when a therapeutic relationship is no longer healthy

This one can sneak up on you. Beware the patient who makes statements like "you are the only person I trust", "no one else understands me", or "I don't know what I would do if you ever stopped being my doctor". If a patient becomes too dependent on you, it is time to question whether the therapeutic relationship is still healthy.

When advocacy goes too far

Patients often ask doctors to provide medical reports and letters of support. Becoming too involved, too emotive, or too invested in a patient's court action – whether it be a claim for compensation or a Family Court matter – can actually diminish a valid clinical opinion. Providing a clear, factual account of the situation is more valuable to the patient in the long run, and you may avoid a complaint or notification for unprofessional behaviour.

Respect your colleagues

You may not always agree with your colleagues, but you should always behave professionally and maintain a level of respect when communicating with or about your colleagues.

A straight talker in a "woke" world

Remember the funny thing you say to put patients at ease? They always laugh – until that one time a patient takes offence and reports you to Ahpra. Best to keep your political views and clever quips for the family BBQ. It is not always possible to know who will be offended, and by what, so keep it professional at all times.

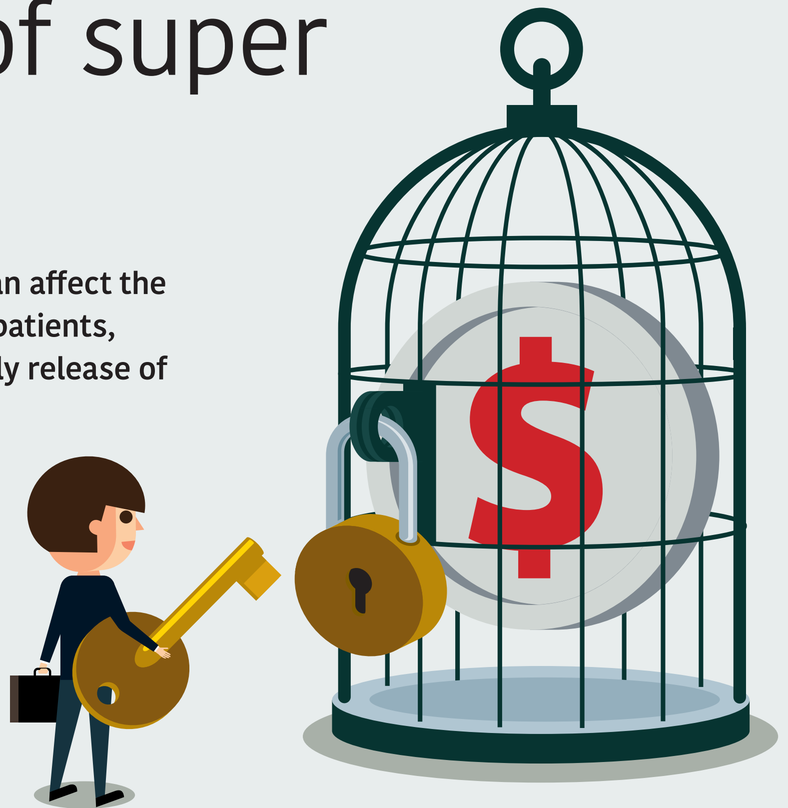
Don't overshare

Sharing a personal story with a patient might be a fast track to building rapport, but the patient is not there to hear about your family situation or your personal health problems. So try and avoid oversharing.

View the references online: mdanational.com.au/non-sexual-boundaries

Early release of super

Kate Rowan-Robinson
Medico-legal Adviser, MDA National



High inflation and cost-of-living pressures can affect the affordability of medical treatment for some patients, leading to an increase in applications for early release of superannuation on compassionate grounds.

In 2022-2023, the ATO received 75,600 applications for early release of superannuation, resulting in the approval of 41,800 applications, totalling $761.7m in funds withdrawn.[1]

What should you be aware of before you support a patient's application for early release of superannuation; when should you support the application; and what are the medico-legal risks?

Eligibility

To be eligible for the compassionate release of superannuation, the patient must meet two conditions.

Firstly, the medical treatment must be necessary to:

- treat a life-threatening illness or injury (a medical condition likely to result in severe degeneration or death within 12 months);
- alleviate acute or chronic pain; or
- alleviate acute or chronic mental illness.

Secondly, the proposed medical treatment cannot be readily accessed through the public health system.

Application

To make an application, support is required from two medical practitioners (with at least one being a relevant specialist) who can each provide a report on the patient's eligibility to access their superannuation early.

Eligible treatment includes:

- surgery
- psychiatric treatment
- medicinal drugs
- in-vitro fertilisation treatments
- dental treatment.

You must be comfortable that the proposed medical treatment is necessary for the purpose of managing a life-threatening condition, alleviating pain, or alleviating mental illness. The ATO provides guidance on how to complete the report.[2]

Overseas treatment

If the patient intends to access medical treatment overseas, there may be additional considerations before you provide a report in support of the treatment. The patient should consider the destination, healthcare facilities, qualifications and experience of medical providers, the proposed procedure, treatment aftercare and insurance. In the event the treatment goes wrong, there may be an implication that you approved the overseas treatment by supporting the application for early release of super.

Summary

Good Medical Practice: a code of conduct for doctors in Australia[3] requires medical practitioners to be "honest and not misleading when writing reports and certificates, and only signing documents you believe to be accurate" – so you need to be certain the patient meets the eligibility criteria before providing a report. It is also important to remember that the other doctor providing a report may also be providing the treatment, and may therefore have a vested interest in the application being approved.

Managing requests for the compassionate release of superannuation can be difficult to navigate – particularly if you don't feel comfortable providing the report. If you find yourself in a challenging situation with an unhappy patient, you should contact our Medico-legal Advisory team for further advice.

View the references online: **mdanational.com.au/early-release-super**

Referrals 101

Support in Practice, MDA National

Our Support in Practice team provide some helpful guidance on your most frequently asked questions about referrals.

How do I choose a specialist to refer to?

You and/or the practice should maintain an up-to-date list of practitioners with their subspecialties or special interests. You can also use the online platform *HealthPathways* available through your Primary Health Network, use directories produced by specialty bodies, or ask colleagues. Involving the patient can help, considering factors such as location, cost or past experience.

Should I write an open or a named referral?

There is no requirement for a specific name of the specialist or physician on a referral. If you or the patient have a specific doctor in mind, then you can enter the relevant details on the referral. A referral can be rejected in limited circumstances, as it's at the discretion of the specialist's practice or hospital if they are willing to accept the referral.

How do I write an effective referral letter?

Consider the person who will read it, and what they need to know to provide care. Standardised information, such as that produced by records software, is helpful; but referral letters must be tailored to the individual patient. Current information about medications, comorbidities and allergies is vital (these should be regularly reviewed and updated in the records). Family history, smoking and alcohol consumption, and occupation may be helpful.

Do not include sensitive patient health information that is not relevant to the referral. The RACGP provides suggested phrasing and structures for referral letters.[1] In specialist-to-specialist referrals, it's usually helpful to copy in the patient's regular GP.

Do referral letters need to be printed and hand-signed?

No. Referrals can be sent electronically if acceptable to the referee, and if reasonable security measures are taken. Depending on the circumstances, this may involve using a secure messaging system, sending referrals as password-protected or encrypted files, double-checking the 'send' address, deleting emails from the 'sent box', having staff trained in safe email and internet use, and using general IT security measures. Medicare accepts electronic signatures. The referral needs to be generated by sole-usage software and must include the date the referral was created, with a timestamp. Sign off the letter "electronically signed by" with the designation and name of the practitioner.

What do I need to know about provider numbers and Medicare?

You must have your own unique provider number to be able to refer, request and claim MBS items via Medicare. You need a specific provider number for each location you work at. If you work in the reserve of GP respiratory practices or in a Medicare Urgent Care Clinic, you will require additional provider numbers. If you leave a location and close any provider numbers (where the patient hasn't yet seen the specialist), the Medicare claim will be rejected.

What is a valid referral for Medicare purposes?

To be valid, a referral must include patient contact information, relevant clinical information, previous or current management and/or any investigations. It must include the date the referral was created, and the provider number and signature of the referring health professional.

How long are referrals valid for?

The standard single-course treatment referrals from a GP to a specialist or consultant physician are valid for 12 months, which starts from the patient's first visit to the specialist.[2]

GPs can refer beyond 12 months or indefinitely if the patient needs ongoing care. However, a new referral is needed if the patient has a new or unrelated condition while on an indefinite referral.

'Specialist to Specialist' referrals are valid for three months.[3]

Can I backdate a referral?

Patients who have let a referral lapse may ask you for a backdated one so they can claim Medicare benefits for seeing a specialist. You should not agree to do this, as it is unlawful under the *Health Insurance Act 1973* (Cth). Ensure practice staff know this. Try to prevent such requests by educating patients about valid referrals.

Do I need to check that the patient attends?

At the time of making a referral, a doctor must decide whether the outcome for the patient is likely to be clinically significant and, if so, the patient should be flagged for follow-up.

The system for following up the flagged items should ideally be an agreed practice-wide system which is documented and followed consistently by the whole team. This usually involves use of the recalls function of the practice software. Where there are inadequate practice systems, you can create your own system such as a spreadsheet, using the Tasks function in software, or a paper-based log. See the RACGP's *Standards for general practices, 5th edition*:[4] Criterion GP2.2 for further detail.

A recent Court decision[5] found that a referring doctor's duty to follow up referrals does not extend so far as to advocate on behalf of their patients to the referring specialist to ensure the patient is seen in a timely manner.

What should I expect from the practitioner I referred to?

You can expect timely communication about the patient's condition and planned treatment, any guidance or instructions for you, clarification of responsibility for ongoing scripts, copies of investigations, and updates on management (including if they have discharged the patient).

More resources

Department of Health & Aged Care
A guide for GPs – referrals to medical specialists
medicalcostsfinder.health.gov.au/resources/guide-for-gps-referrals-to-medical-specialists-gp

RACGP
Referring to other medical specialists
racgp.org.au/running-a-practice/practice-resources/general-practice-guides/referring-to-other-medical-specialists

Providing good patient care includes... Referring a patient to another practitioner when this is in the patient's best interests...

Medical Board of Australia – Code of Conduct

View the references online: **mdanational.com.au/referrals-101**

Here are some short bites of medico-legal information which may be relevant to your state or specialty.

According to the Department of Health and Aged Care (DHAC), the new **National Lung Cancer Screening Program** uses low-dose computed tomography scans to look for lung cancer in high-risk people without any symptoms. It aims to find lung cancer early and reduce deaths from lung cancer. Screening services will begin for eligible people from July 2025. More information can be found at: **health.gov.au/our-work/nlcsp**.

End of Life Law for Clinicians (ELLC) is a free national training program for medical practitioners, nurses, allied and other health professionals about the law on end-of-life decision-making. ELLC recently launched updated online training modules to include the new law and enhance interactive learning. Learn about the law on voluntary assisted dying, substitute decision-making, capacity and consent, providing pain relief, and more at: **palliativecareeducation.com.au/?tenant=ELLC**.

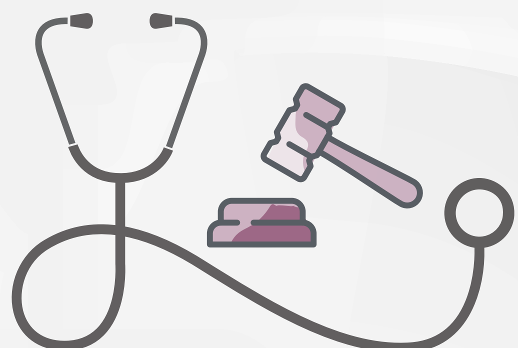
In September 2024, the DHAC released Consultation Paper 1 of the **Review of the National Registration and Accreditation Scheme**. You can access NRAS Consultation Paper 1 via the DHAC website: **health.gov.au/resources/publications/consultation-paper-1-review-of-complexity-in-the-national-registration-and-accreditation-scheme**.

The Medical Board of Australia sought **public submissions on a range of issues**, including the draft revised registration standard for specialist registration, review of the criminal history registration standard and health checks for late career doctors. Further information can be found at: **medicalboard.gov.au/news/past-consultations.aspx#**.

The Health Complaints Commissioner in Victoria released a revised **Complaint Handling Standards and Service Charter**. The standards aim to strengthen and improve complaint-handling systems across the Victorian health sector. They will provide a common benchmark that all health service providers will meet, offering consistency for consumers, complainants, health service providers and other stakeholders. Each standard includes guiding principles for implementation that aim to provide direction for the design of effective complaint-handling processes in all health service providers. The new standards can be found at: **hcc.vic.gov.au/providers/complaint-handling-standards**.

On 15 May 2024, the *Health Practitioner Regulation National Law (WA) Act 2010* (the Previous Act) was repealed and replaced with the ***Health Practitioner Regulation National Law Application Act 2024* (WA)** (the New Act) which subjects Western Australian health practitioners to a new legislative regime. For more information on the changes, see: **pmlawyers.com.au/blog/2024/05/health-blog/new-national-law**.

Privacy reform is on the agenda both federally (**ministers.ag.gov.au/media-centre/better-protection-australians-privacy-12-09-2024**) and for the public sector in Western Australia (**wa.gov.au/system/files/2024-03/prisfactsheet.pdf**).



MANAGING PATIENT COMPLAINTS

Having a clear process can make it easier to deal with complaints, reduce the chance of the situation escalating, and provide an opportunity to improve systems and processes.

Managing patient complaints

Karen Stephens
Risk Adviser, MDA National

Why do patients complain?

Patients most commonly complain because they want:

- to be 'heard' and express dissatisfaction at how they were treated;
- an apology and/or explanation;
- to stop it happening to someone else; or
- a refund.

Documented policy and procedures

You should have written complaint management policies and procedures – including a commitment to effectively manage complaints; process workflows and step-by-step instructions for staff; staff responsibility and delegation; timeframes; behaviour expected of staff and complainants; how to manage unreasonable conduct from complainants; the health and safety of staff; informing patients about how to make a complaint; documentation of complaints; and review of complaints to identify trends and system improvements.

Staff can be involved in creating the policy; and should have easy access to the documents and be trained in the processes. Training in customer service, managing difficult conversations, conflict resolution and cultural safety will also be helpful. Complaint handling can be stressful, and staff should be offered support.

Responding to direct complaints

The effectiveness of direct resolution may determine whether the grievance will end there, or will go further through a formal complaint process or legal action.

Verbal complaints – initial response

- Listen without interrupting and maintain eye contact (if face to face).
- Try to understand the patient's view and respond with empathy. Treat the patient with courtesy and respect, and show that you take the complaint seriously.
- Check that you have understood by repeating back or asking questions.
- Although it's natural to experience some initial defensiveness, try not to come across as defensive or dismissive.
- Ask the patient what they believe should have happened, and what they want to happen now. This may clarify the reason for the complaint and determine an appropriate response.
- If the complaint is complex, it may be best to ask the patient to put their concerns in writing.
- Tell the patient what will happen next and provide realistic timeframes. If the complaint relates to clinical care, it's best that the doctor responds directly to the patient as soon as possible.

Written complaints – initial response

Acknowledge the complaint promptly, and outline next steps and timeframes. You don't need to respond in detail immediately, but you should acknowledge that the complaint has been received and will be acted upon. Delays in dealing with complaints can add to tension and generate further resentment.

Resolving the complaint

Record all complaints, and keep notes of all meetings, phone calls and any correspondence in relation to the complaint. Store these documents separately from the patient's medical records – although if the complaint is clinical in nature, it may be relevant to include some factual clinical information for continuity of care.

A complaint should be treated confidentially and stored securely in accordance with privacy laws. If the complaint is from a patient's relative or other source, do not respond without authority from the patient.

Triage the complaint, and decide who should review and respond.[1]

Be objective and fair in reviewing the complaint and considering potential remedies or actions. Give the complainant regular updates on the progress of their complaint, and an explanation for any delay.

Communicate the outcome. It might be appropriate to invite the patient to meet with you to discuss the issues – although often, if the complaint was made in writing, it is best to respond in writing.

When responding in writing, take care to address the specific issues raised in the complaint. Use plain language, avoiding

jargon or medical terminology. Be open and honest, including apologising when appropriate – see the *Australian Open Disclosure Framework: Saying sorry – A guide to apologising and expressing regret during open disclosure*.[2] Provide information about the options available to the complainant, if they are not satisfied with your response.

Reflect on the complaint, looking for what could have been done better and how lessons could be applied to the practice and its processes.

Formal complaints

If you receive a formal written complaint via a dedicated health complaints body (such as Ahpra, the Office of the Health Ombudsman or the Health Care Complaints Commission) or a broader complaints body (such as the Office of the Australian Information Commissioner), **you must notify your medical indemnity insurer**.

Each complaints body will have a formal process which you must comply with. There are a wide range of timeframes and possible outcomes. The complaint may be dealt with relatively quickly and be closed with no further action; or it may result in a series of assessments, audits and/or hearings which may ultimately result in disciplinary action on your medical registration.

MDA National's Cases and Advisory Services team can help you understand the process, and assist you with matters that trigger the policy. You may be invited to an interview or case discussion, but often a written response or submission is the first step.

When preparing a written response, you should:

- carefully review the complaint and medical records
- use a professional tone
- express empathy for the patient's concerns or disappointments. Phrases such as "I am sorry you are upset..." are not an admission of liability, and do not require the expression of guilt or wrongdoing
- address any misperceptions or inaccuracies expressed in the complaint by summarising the events as you know them. Be concise, but address each of the issues raised. It may be useful to summarise the events and then use headings to address the allegations or complaints not already answered in the summary
- if appropriate, advise the patient what steps have been taken to prevent a similar event from occurring in the future, and thank the patient for bringing their concerns to your attention.

A formal complaint can be very confronting, and the process may be lengthy. You can seek support from your GP, colleagues, family and friends, MDA National, or the Doctors' Health Advisory Service in your state or territory.

Continued on page 16.

LEGAL AND PROFESSIONAL REQUIREMENTS

- *Good Medical Practice: a code of conduct for doctors in Australia*:[3]

  Patients who are dissatisfied have a right to complain about their care. When a complaint is made, good medical practice involves:

  4.12.1 Acknowledging the patient's right to complain

  4.12.2 Providing information about the complaints system

  4.12.3 Working with the patient to resolve the issue, locally where possible

  4.12.4 Providing a prompt, open and constructive response, including an explanation and, if appropriate, an apology

  4.12.5 Ensuring the complaint does not adversely affect the patient's care. In some cases, it may be advisable to refer the patient to another doctor

  4.12.6 Complying with relevant complaints law, policies and procedures

  4.12.7 Reflecting on the complaint and learning from it.

- **Victorian** complaint handling standards under the *Victorian Health Complaints Act 2016*.

- **Accredited** health services under the *National Safety and Quality Health Service Standards* must have a complaint-handling system and processes.

- **The right to make a complaint** and provide feedback is included in the *Australian Charter of Healthcare Rights*.

- **Australian Standard** AS 10002:2022 *Guidelines for complaint management in organisations*.

SAMPLE DOCUMENTS – Complaints Management

Complaints Policy

1. Purpose of this policy
2. Definition of a complaint
3. Principles for complaints management
   a) Access
   b) Timeliness
   c) Confidentiality
   d) Resolution
4. Declining complaints
5. Process for dealing with complaints
   a) ....
   b) ....
6. Complaint documentation
7. Conflict of interest
8. Responsibilities
9. External agencies

Complaint Form

The following details are recorded by the person managing the complaints and placed in the complaints/incidents administrative file, once resolved.

Date of complaint: .... / .... / ....

Patient name: .... Date of birth: .... / .... / ....

Regular patient ☐ New patient ☐

Description of complaint (as provided by complainant): ....

....

....

Follow-up action taken: ....

....

....

Situation resolved: Yes ☐ No ☐

If 'No', reasons why: ....

Further action to be taken: ....

....

....

Manager/Staff name: ....

Manager/Staff signature: .... Date: .... / .... / ....

Complaints Register (Template)

Date	Time	Name	Phone/Email	Complaint type	Response action	Actioned by	Status	Date	Complainant satisfaction	Link to associated documents

More resources

Ahpra
Checklist for practitioners handling feedback and complaints

MDA National
The doctor or the practice – who should respond to a patient complaint
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2022/12/the-doctor-or-the-practice

Managing negative reviews
mdanational.com.au/advice-and-support/library/articles-and-case-studies/2019/11/managing-negative-reviews

NSW Ombudsman
Managing unreasonable conduct by a complainant
ombo.nsw.gov.au/guidance-for-agencies/managing-unreasonable-conduct-by-a-complainant

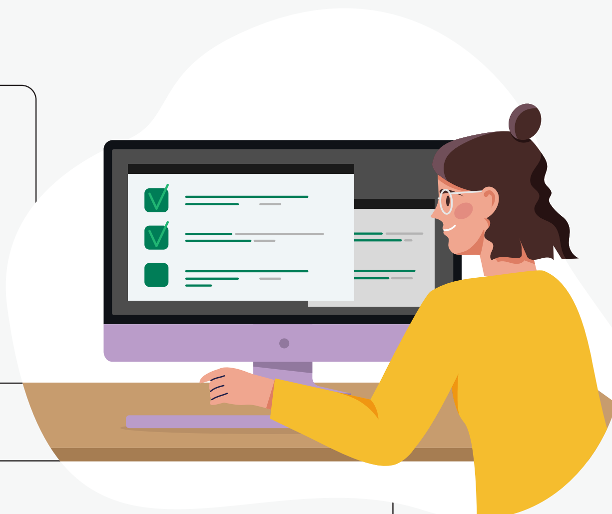
View the references online: **mdanational.com.au/patient-complaints**

Do you need to top up your CPD by the end of the year?

Make the most of the resources available through your MDA National membership to assist in meeting your CPD obligations for the year. Available 24/7, our on-demand webinars and eLearning modules attract CPD hours for education activities and reviewing performance.

On-demand webinars

- A health practitioner's guide to social media
- Practicalities of Medicare
- Intimate examinations: respect and responsibility



Upcoming workshops and webinars

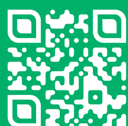
Get ahead of the pack and secure your place at our upcoming webinars and workshops:

WEBINAR

- ***AI in record management for doctor consultations***
  Online — 20 February 2025

WORKSHOPS

- ***Open Disclosure: Practical Steps for Everyday Clinicians***
  Melbourne — 22 February 2025 | Sydney — 1 March 2025
- ***Engaging Teams Through Postive Culture & Effective Feedback***
  Perth — 22 February 2025
- ***Enhancing Patient Understanding: Health Literacy & Communication***
  Brisbane — 29 March 2025 | Adelaide — 5 April 2025



For more information and to enrol:
Scan the QR code or visit
learn.mdanational.com.au

Friendly banter or unlawful workplace harassment?

Emma Jack
Legal Counsel, MDA National

An ICU medical officer has been found guilty of unsatisfactory professional conduct and professional misconduct in relation to his conduct towards three female nurses who worked with him at a private hospital in NSW.[1]

The doctor denied the particulars of the complaints (including sexual remarks and inappropriate touching of his colleagues) and described himself as friendly and "something of a joker".

Ultimately, the Tribunal accepted the evidence of the three nurses and noted that despite the doctor's denials, he had so readily identified the complainants in his response, and there was *'significant force in the submission that the [doctor] well knew who the complainants were because of the way he had conducted himself around them'.*

Case history

The complaint prosecuted by the Health Care Complaints Commission related to three female nurses who had worked with the doctor at the hospital.

In summary, Nurse A worked with the doctor between April-July 2022 and alleged that the doctor invaded her personal space, poked her in the stomach with his pen, grabbed her pen out of her breast pocket, pulled her surgical mask down, massaged her shoulders, made comments that she looked prettier with her hair down or without her mask, asked if she had a boyfriend, and touched her lip with his thumb. Nurse A had asked the doctor to stop harassing her, but he brushed it off as a joke. She ultimately complained and was referred to her GP and psychologist due to 'sexual harassment in the workplace'.

Nurse B also alleged that the doctor had grabbed her pen out of her breast pocket, poked her with his pen, massaged her shoulders, and made comments that she was "beautiful" and "sexy"; and that she had told him the conduct made her feel uncomfortable, but he would laugh it off and do it again.

Nurse C alleged that the doctor had also made sexual remarks, commented on the size of her bottom and touched it, poked her side to get her attention, and grabbed her pen out of her breast pocket.

The doctor denied the conduct, so the Tribunal needed to assess his credibility and be "comfortably satisfied" of the facts noting that *'the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what is sought to prove'.*[2]

The Tribunal accepted the nurses' evidence. Nurse A had contemporaneously reported the concerns to a colleague, had wanted to leave her employment due to the doctor's conduct, and had been referred to a psychologist (whose records were tendered in evidence). The accounts from Nurse B and Nurse C were largely the same which, in the Tribunal's view, tended against them being fabricated, and it was not suggested they had collaborated in their accounts.

The outcome

In finding that the doctor's conduct was improper and unethical, amounting to unsatisfactory professional conduct, the Tribunal cited section 5.2.3 and 5.4 of the Code of Conduct that good patient care:

- *'is enhanced when there is mutual respect and clear communication between all healthcare professionals involved in the care of the patient [and] involved behaving professionally and courteously to colleagues'; and*
- *'involves not discriminating against, bullying or sexually harassing others'.*

The Tribunal considered that some of the doctor's conduct (namely that he had grabbed Nurse A and taken her to the treatment room and touched her lip, and that he had remarked on and slapped Nurse C's bottom) was sufficiently serious to amount to professional misconduct.

The proceedings are to be listed for hearing to determine the orders necessary to protect the health and safety of the public. (We will update the online version of this article with any published outcome.)

Medico-legal discussion

Doctors are expected to demonstrate respect towards their colleagues (and patients). Failure to do so creates an unsafe work environment, and can lead to adverse disciplinary and employment action.

Whilst some conduct will clearly cross workplace boundaries, other behaviour (like remarks on a person's appearance or seemingly 'innocuous' touching) may seem less obvious.

Sexual harassment means any unwelcome sexual advances or conduct likely to humiliate, intimidate or offend. The benchmark is whether a 'reasonable person' would anticipate that reaction in all the circumstances. Such behaviour can include inappropriate jokes, unwanted touching, and remarks of a sexual nature. The *Safe Work Australia Model Code of Practice: Sexual and gender-based harassment*[3] is a useful resource.

In this case, although the doctor subjectively believed he had friendly relationships with his colleagues and had not behaved in an inappropriate way, his conduct was perceived differently by the three nurses who all reported the doctor's conduct as upsetting, which made them feel uncomfortable and scared, and was objectively evaluated by the Tribunal as below the standard expected. Importantly, each of the nurses had communicated their discomfort and disapproval of his actions, but the doctor did not take them seriously. Had he listened to the feedback and adjusted his behaviour accordingly, he may have been able to avoid disciplinary action.

Summary

- Re-familiarise yourself with your obligations under the **Code of Conduct**,[4] specifically section 5, which refers to maintaining respectful relationships with your colleagues and other healthcare professionals.
- Frequently self-audit your workplace behaviour to ensure you are not becoming over-familiar with your colleagues with your commentary or conduct.
- Evaluate and action any feedback from colleagues about your workplace conduct as required.

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

The statistics are staggering and appear to be increasing.

So, what is intimate partner violence (IPV), and what role do health practitioners play in protecting patients from harm?

Intimate partner violence

Nerissa Ferrie
Medico-legal Adviser, MDA National

Case study

Ruby was a regular patient, and Dr Carlton noticed a gradual change in her mood. She had recently moved in with her boyfriend, but also lost her job, so he put her anxiety down to financial stress.

Until she came in with a large cut over her eye.

He asked Ruby to sit on the examination table, but she visibly winced as she moved. Dr Carlton asked if she had other injuries, and Ruby broke down.

"He said it wouldn't happen again," she said, as she lifted her shirt to show dark bruising around her ribs and torso.

Further discussion revealed that Ruby's unemployed partner had prevented her from going to work, so her boss eventually fired her. Now he was angry because they had no money. The coercive control increased gradually, but the abuse recently became physical.

Dr Carlton's first instinct is to call the police, but Ruby begs him not to tell anyone. She says the violence has been escalating and she's concerned for her safety if her partner finds out she has told anyone. She confirms she has a plan to leave, but that she needs to leave in her own time, when it's safe for her to do so.

Dr Carlton dresses Ruby's wound, and she advises him she feels safe to return home. He asks her to return for follow-up in a few days, so that he can think about next steps.

In 2022-23, one woman was killed every 11 days, and one man was killed every 91 days, through IPV.[1] The statistics for women are incredibly high, but IPV can occur regardless of gender, age, education and socio-economic status.

The Australian Institute of Health and Welfare (AIHW) defines IPV as "any behaviour within an intimate relationship (current or previous) that causes physical, sexual or psychological harm." This can include physical and sexual violence, coercive control, and emotional, economic and technology-facilitated abuse.

When it comes to disclosures of IPV, doctors play a vital role in the treatment and support of victims (and sometimes perpetrators).

Medico-legal discussion

Should Dr Carlton disclose the abuse and, if so, to whom should it be reported?

Ruby has a right to privacy, and she has expressly asked Dr Carlton not to share the information with anyone – including the police. Dr Carlton accepts that he must respect Ruby's decision, as his research indicates that reporting violence without consent can put the patient at greater risk of harm.

Does he have a mandatory obligation to report the abuse?

Dr Carlton and Ruby are both located in Victoria, so the answer is no.

The Northern Territory (NT) is the only state or territory in Australia which has laws mandating the reporting of domestic violence. Under s.124A of the *Domestic and Family Violence Act 2007*, every person over the age of 18 in the NT must report to the police if they believe a person has caused, is causing or is likely to cause, serious physical harm to someone with whom they are in a domestic relationship. Failure to report can result in a fine of up to $20,000.

If there are children involved, a disclosure of IPV can trigger a mandatory notification to child protection in some states and territories. If your IPV patient has children, you should seek advice from your medical defence organisation (MDO).

Is there ever a circumstance when privacy should be breached, regardless of the patient's wishes?

This is a rare exception, and one which should include a discussion with your MDO, as the ramifications can be significant for the patient.

The privacy legislation makes provision for a disclosure *"… where it is unreasonable or impracticable to obtain consent to the use or disclosure, and you reasonably believe the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual, or to public health or safety"*.

The threshold is high – for example, the patient says her partner is armed and waiting in the car outside, and he has threatened to shoot her once she walks out the door. This might warrant a call to the police. However, the possibility of an assault at some time in the undefinable future would probably not meet the test.

Take-home message

Sometimes the patient's doctor is the only person they feel safe disclosing the abuse to. This is both a privilege and a burden, particularly when the patient doesn't consent to you disclosing the abuse to anyone else.

How can you help a victim of IPV?

- Be aware of the clinical indicators for IPV and enquire with sensitivity.
- Listen without judgement when IPV is disclosed, and start to build trust.
- Encourage the patient to develop a safety plan.
- Provide details of available support services.
- Document any injuries clearly in the notes, as they may be necessary for court if the patient decides to pursue criminal charges.

Above all, it is important to remember that one of the key elements in IPV is the victim's loss of empowerment. So, where possible, respect the patient's autonomy and help them to regain the confidence they need to make decisions in their own best interests.

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

Clozapine
A cautionary tale

Dr Karen Lam
Medico-legal Adviser, MDA National

Clozapine can be a life-changing medication for patients who have treatment-resistant schizophrenia, but it requires strict monitoring due to its side-effect profile.

Case study

Mr A recently started attending Dr F's practice for a variety of minor conditions. Mr A requested a script for clozapine on his most recent visit, mentioning he had left the care of his psychiatrist months ago.

Having satisfied himself that the patient had been taking the same dose long-term to treat his schizophrenia, Dr F issued Mr A his Pharmaceutical Benefits Scheme (PBS) streamlined authority prescription. The local community pharmacy dispensed the medication.

A month later, Dr F and the pharmacy received correspondence from Mr A's previous psychiatrist warning them of the special requirements for prescribing, monitoring and dispensing clozapine, which they were unaware of.

When Mr A later presented with a sore throat and fever, Dr F requested a blood count, and both Dr F and the pharmacist were relieved that they were able to withhold treatment in time to prevent severe medication-induced agranulocytosis.

Discussion

Clozapine is indicated for use in treatment-resistant schizophrenia, where a patient has not responded adequately to two other antipsychotics. It is effective for the treatment of the positive symptoms of schizophrenia, but requires careful initiation and monitoring due to the risk of a constellation of serious side effects such as agranulocytosis and myocarditis.

It is a psychiatrist-initiated medication, but has become available to patients through their general practitioners and community pharmacies, following the introduction of shared care prescribing arrangements across states and territories within Australia. Practitioners and pharmacists must be aware of their obligations when prescribing and dispensing clozapine.

Initiation

Clozapine is typically initiated by a consultant psychiatrist within a hospital setting. Patients must be registered with a separate brand-specific clozapine monitoring service within Australia (ClopineCentral®; CPMS®; Juno Connected®) before treatment can be started. There may be jurisdictional brand preferences – Clopine® is used in Western Australia and Clozaril® in South Australia. Advice should be sought if a patient moves jurisdictions and the supply of their existing brand of clozapine cannot be continued, given the risks to monitoring continuity.

Prescribers, clinics and pharmacies must register

Prescribing medical practitioners, dispensing pharmacists, hospitals and other health facilities (GP clinics, community mental health clinics) must also be registered with the appropriate monitoring system under the central network. There may be various defined roles under the networks, including registered dedicated coordinators who oversee the program.

Patients need regular monitoring

Registration ensures regular monitoring of the patient's white cell count and neutrophils at specific intervals during and after the initiation period, as results must be entered into the system. The manufacturer will alert the registered centre if the patient is overdue for blood tests. Regular monitoring allows early detection of emerging neutropenia, preventing progression to potentially life-threatening agranulocytosis. Some states have developed specific clozapine initiation guidelines that require additional parameters for monitoring, such as the QT interval, CRP, and troponin levels with respect to myocarditis.

Patients who discontinue treatment for three months, or those starting treatment at a new centre, will need to be re-registered. Medical practitioners must re-register each time they relocate their practice to a different clozapine centre, or register at each clozapine centre in which they work.

PBS approvals are required

Clozapine is a section 100 highly specialised drug under the PBS. Accredited hospital-based prescribers can prescribe clozapine for both initiation and maintenance purposes.

A PBS authority approval is required for most highly specialised drugs listings, and for increased quantities and repeats. Accredited general practitioners can prescribe maintenance clozapine under the PBS community access arrangements, and a streamlined authority is available when prescribing at PBS-listed quantities and repeats.

The PBS criteria for continuing treatment requires that authorised treating medical practitioners act under the supervision and agreement of the treating psychiatrist, who is responsible for reviewing the patient at regular intervals.

Prescribers may need authorisation

Medical practitioners should be aware of any additional state regulations that must be met before they prescribe clozapine to patients. Clozapine is a schedule 4, regulated restricted medicine under the *Medicines and Poisons (Medicines) Regulation 2021* in Queensland. Only consultant psychiatrists and supervised psychiatry registrars are permitted to initiate or alter the dosage of clozapine. All other practitioners wishing to prescribe require approval from the Chief Executive Queensland Health. Further enquiries about specific requirements should be directed to the relevant medication approval and regulatory unit in the practitioner's state.

Summary

Clozapine can be a life-changing medication for patients who have treatment-resistant schizophrenia, but it requires strict monitoring due to its side-effect profile.

General practitioners and community pharmacists need to be aware of their additional obligations when prescribing and dispensing clozapine in the community.

These include registering with the brand-specific clozapine patient monitoring system, obtaining PBS authority, and obtaining approval to prescribe from the relevant regulatory authority by state and territory where required.

The value of real-life learning

Nerissa Ferrie
Medico-legal Adviser, MDA National

I caught up with **Elissa Cohan** (Education Services Manager & Producer) and **Meena McDonald** (Digital Learning Designer) from MDA National's Education Services, to find out what's new for our early-career Members.

Q1. Our junior segment, from interns through to senior registrars, have already been through several years of education before they start seeing patients. How does the education we offer differ from the medical education provided at a university level?

Much of the focus in the medical school curricula is on clinical training and outcomes. MDA National's point of difference is sharing the collective real-life experiences of our early-career Members.

This includes highlighting what can (and does) go wrong from a medico-legal perspective, what actionable steps our Members can take to identify the risks, and the preventative strategies or resources available to help reduce their exposure to medico-legal issues.

Q2. So much necessary information is crammed into medical school. What are some of the common themes our junior Members identify as potential gaps in their learning once they start practising?

There are some key themes around balancing the professional obligations of being a practising doctor, with the everyday challenges at work and at home. Examples include interprofessional communication (with more senior doctors and other health professionals); assertive communication to enable doctors to raise concerns succinctly and effectively; dealing with conflict in the workplace; treating patients in a culturally safe way; and the importance of medical documentation – including record-keeping, referrals, certificates and reports.

Another challenge we see is around professional boundaries, including requests to treat family and friends, 'corridor consults', prescribing or self-prescribing, and the appropriate use of social media.

Q3 Does the method of delivery differ between doctors in practice and doctors in training (DiTs)?

Many DiTs have formalised weekly education sessions as part of the training program they are in. This provides a structured opportunity to develop practical, on-the-job preparedness across a range of clinical and non-clinical topics. DiTs will also have access to an online portal containing recordings or e-learning modules on these topics.

For DiTs seeking additional education opportunities, we understand their preference for online delivery – with short and sharp on-demand recordings or podcasts, or online workshops, that provide an opportunity to learn from their seniors and share experiences with their peers.

Q4 I understand you are currently working on a new series written specifically for interns and DiTs. Can you tell us a bit about the project?

At MDA National, we frequently receive requests to deliver medico-legal related content to interns and residents for their weekly education sessions. We were keen to make this content more broadly accessible to our individual early-career doctors, and available to health service organisations as a key resource for their training programs.

Working closely with our colleagues from Cases and Advisory Services, we have identified a broad range of topics that are ideal for a range of short format videos. The videos will feature in our exciting new offering, *Lifeline: a medico-legal series for early career doctors*, which will highlight the relationship between the delivery of healthcare and common medico-legal risks that can arise. The videos distill key professional and legal obligations, accompanied with case scenarios to provide experiential learning opportunities.

Q5 When is the *Lifeline* series expected to go live, and what are the first topics you will be rolling out?

We aim to share common medico-legal issues encountered by doctors in their early professional years, and we have a broad range of topics currently in development.

The videos will highlight common issues and scenarios, explain the framework around regulatory requirements and professional obligations, and provide practical advice on how early-career doctors can manage these challenges.

The first series of topics will be available by the end of January, ready for the 2025 intern intake and those in residency positions.

Topics will include:

- reportable deaths and coronial matters
- death certificates
- communication within the healthcare team
- consent in practice
- confidentiality matters
- understanding medical indemnity.

Q6 Can you tell us about some of the existing resources our interns and DiTs can access on demand, and what are the most popular topics?

We offer a range of resources, including e-learning and on-demand recordings. Some of the most popular topics include medical record-keeping, prescribing, communicating difficult news, informed consent, privacy and confidentiality, Medicare compliance, and social media use.

We also have annual programs tailored to the needs of early-career members.

Career development & planning: designed to help Members gain career-path clarity, by reflecting on their personality traits, strengths and weaknesses, and how these can influence career choices and satisfaction.

Interview skills and preparation: Refining their CV and written application, education on interview techniques, practical advice on common interview pitfalls, and how to tackle standard and unexpected interview questions.

Professional development workshops on communication, collaboration and culture: Effective communication and collaboration within a team is vital in healthcare for delivering quality and safe patient care, and reducing the risk of medico-legal claims and complaints. These workshops offer guidance on approaches and methods for building effective communication in the workplace, developing and managing key relationships in healthcare teams, and assisting with conflict resolution.

Q7 We always welcome feedback at MDA National. How can our junior doctors contact the Education Services team if they have ideas for future education?

Yes, absolutely. We value feedback from all Members. Junior doctors can reach out and provide feedback via email on **education@mdanational.com.au** or call **1800 011 255** to discuss this directly with a member of our Education Services team.

In profile
Dr Claudine Cerda-Pavia

Nerissa Ferrie
Medico-legal Adviser, MDA National

> *I think operating well as a doctor is really a lot about life skills. Obviously, there's a very strong clinical and academic component, but medicine is also about positively influencing others.*

Dr Claudine Cerda-Pavia is an energetic and engaging GP registrar who excelled in a variety of corporate roles before focusing on a career in medicine. We caught up with Claudine to talk about her professional journey and her work with Binar Futures.

What inspired you to pursue a medical career, particularly in general practice?

I took a fairly atypical path to get to where I am today. I started out with a science and commerce double degree and pursued a graduate career with Shell. I spent some years working around the world before becoming a management consultant with Deloitte. I had quite a strong interest in medical science, so I decided to study medicine.

Of all the specialties, general practice is the broadest when it comes to opportunity, diversity and the ability to experience constant change, which is why I pursued general practice at this stage of my life. Once you start specialising, it can narrow your focus – which is obviously fantastic for some doctors – but that wasn't for me.

How does your career as a doctor help with your work in other areas, such as change management and business transformation in the medical sector?

I started off in change management and influencing negotiations in the corporate sector, so I gained a lot of valuable experience. I haven't completed my GP training, but I think operating well as a doctor is really a lot about life skills. Obviously, there's a very strong clinical and academic component, but medicine is also about positively influencing others. It's about getting the best outcomes for your patients, working with teams, and being organised and diligent. The skills I've developed in previous roles help me as a doctor – and when I look at medical executive work or other projects within medicine, the skills are the same.

I recently had the pleasure of meeting you in the beautiful "Red Centre". Can you tell me about Binar Futures, and what led you to work with this incredible project?

Binar Futures is a grassroots community organisation with a mission to engage Aboriginal youth, promote healthier lives, and develop more resilient and empowered young people who can build positive futures. I was approached by my colleague, Corey Dalton, who is a GP trainee and an Indigenous doctor. He suggested I have a chat with Andrew Vlahov, the Chair of Binar Futures, who had a vision about creating these health-check camps using sport as an incentive.

The Indigenous kids come for basketball tournaments in country Western Australia, but also participate in a health check during the tournament. It works because we potentially pick up things that could help save lives.

What advice would you give to someone considering a medical career, especially with non-profit medical projects or in remote areas?

In terms of not-for-profit medical projects, this is a first for me. But I think there are many types of such medical projects out there. I think the key is to think carefully about the needs you are addressing. Are you bringing something that's new, or are you overlapping with an existing service? How will you achieve a benefit, whether it's closing the gap or increasing detection of a medical condition?

There are lots of examples, but one of the most interesting is Operation Smile – a group of surgeons and nurses who travel around the world fixing cleft and craniofacial conditions in impoverished areas. It's a need that won't otherwise be addressed, but it's a large-scale project that takes a lot of money, a lot of people, and a lot of vision to develop. But we have some great initiatives in our own backyard as well. My advice would be to find a need, find something that you think you can contribute to, and then just start having lots of conversations.

Working as a doctor can be quite overwhelming. Do you do anything to support your mental health?

I've worked in other very highly stressful careers, so I became aware at a young age that mental health is really important. In my first job out of university, I worked 80-hour weeks because that's just what you did. You worked, you went to a work dinner, you went home, and then you did a teleconference at midnight because you worked in an international team.

I'm very driven, and I did this for a very long time and it was fine. But I was young, and I had stamina. At some point you do get tired. Most people suffer burnout before they realise that self-care is important. We talk a lot more about burnout now, which I think is a good thing – it means we're more likely to take some action.

You have a lot of demands on your time. How do you fit it all in?

I know when I'm getting overwhelmed. I'm not great at it, because I take on too many things. I run projects outside of work, I have children, I participate in marathons – so I do a lot. I try to exercise every day, but it probably happens three or four days a week and I take that as a win. Once I get home, I take my professional hat off and I cuddle my kids a lot.

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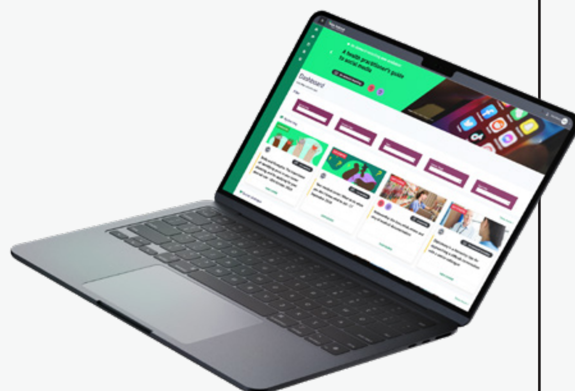

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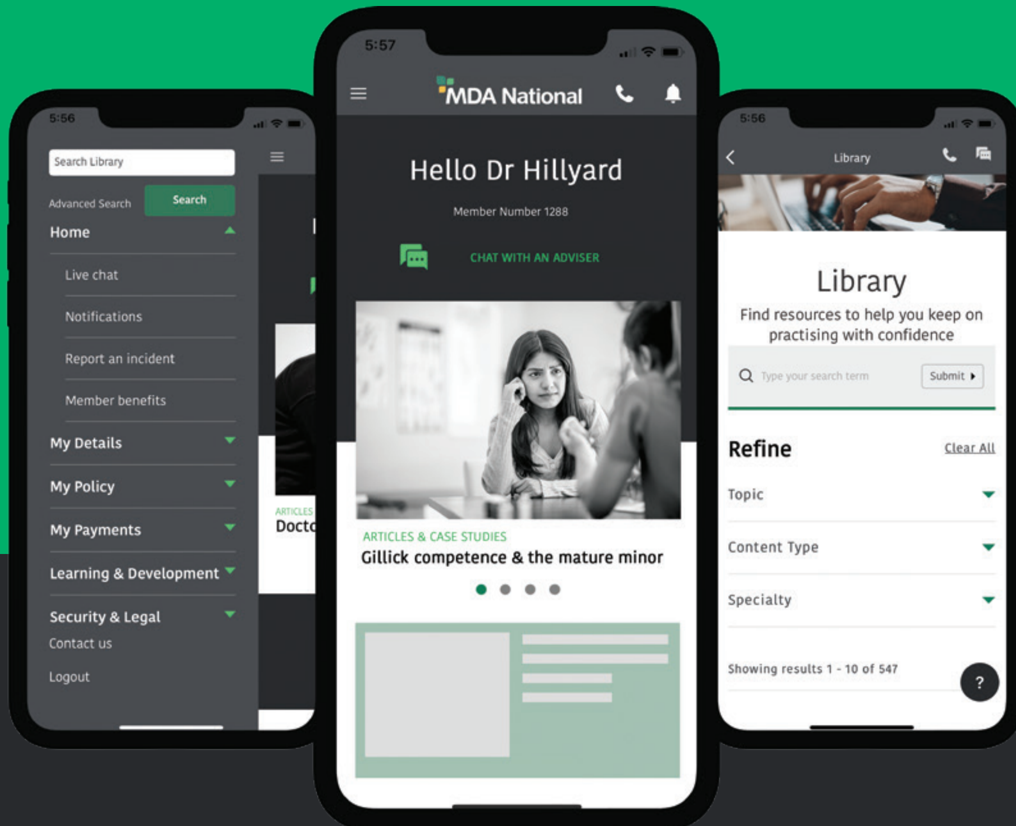

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