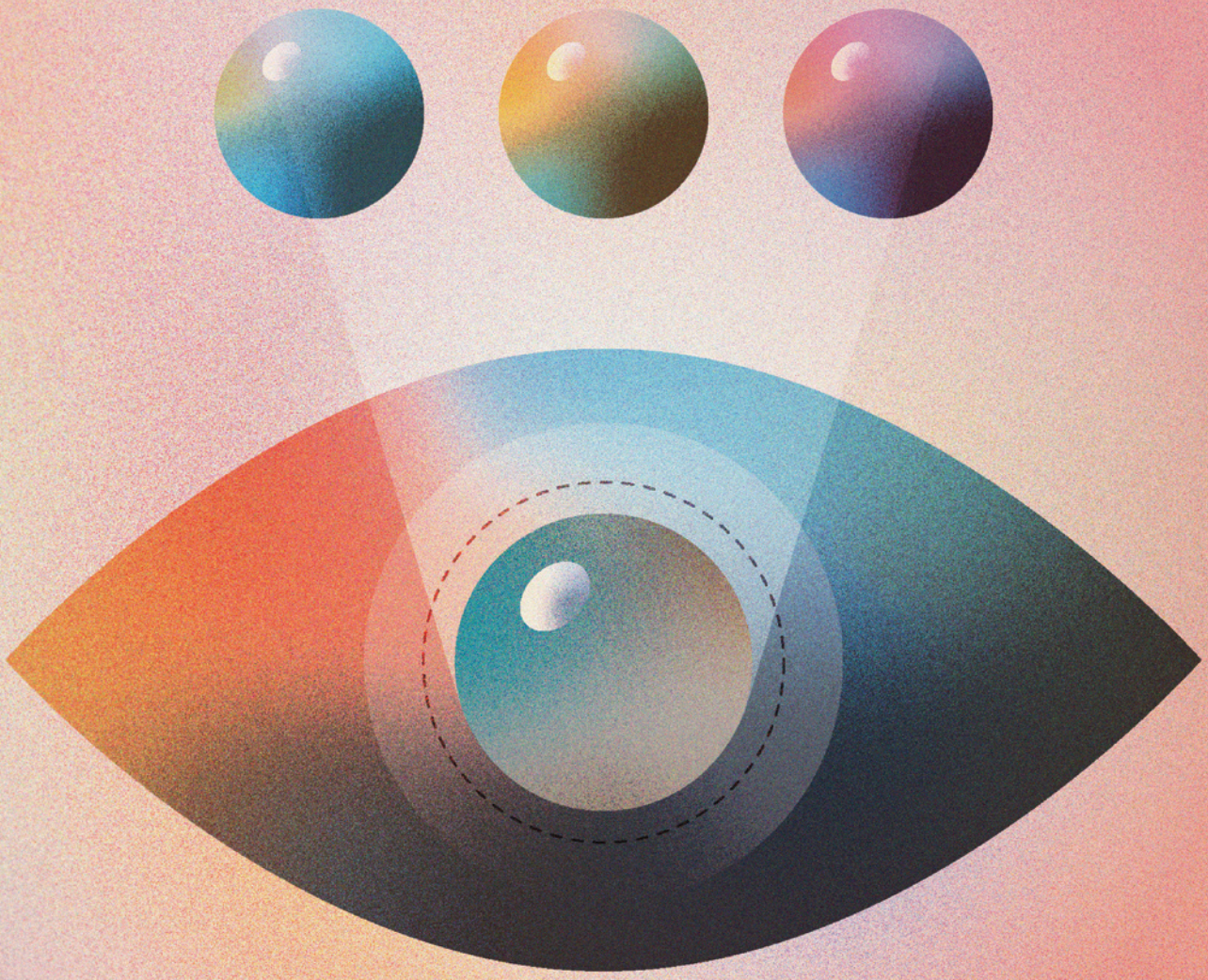
WINTER 2024

Defenceupdate

- Planning for retirement
- Voluntary assisted dying
- Medicare update
- Medico-legal Case Book
- First Defence for junior doctors



The power of visualisation

Medico-legal content
FOR MEDICAL PRACTITIONERS

MDA National
Support Protect Promote

Nerissa Ferrie
Medico-legal Adviser, MDA National

Welcome to our Winter 2024 edition of *Defence Update*.

Most people find the inner workings of the global insurance market confusing at best, and mind-numbing at worst. Dr Michael Gannon provides a real-world view on reinsurance and what this means for you, as a Member of MDA National (page 3).

Dr Julian Walter tackles one of the most difficult and vexing issues for doctors, patients and their loved ones. How do you manage unsolicited patient information in your practice? Check out page 6 for some practical advice.

Whenever there is an increase in the cost of living, we see a rise in requests from patients seeking alternate sources of income. I take a look at the growing number of requests for total and permanent disability payments, and what you need to think about before completing a claim form for a patient (page 8).

Our Education Services team are proud to unveil a new Learning Management System (page 11) which will allow easy access to our online and on-demand learning activities to help you meet your CPD requirements (page 10).

Retirement, however scary, comes to us all. The sooner you plan, the easier the transition. Karen Stephens from our Support in Practice team looks at all aspects of this life stage in our medico-legal feature (page 13).

Casebook is a popular part of *Defence Update*, due to the focus on case studies. Nicole Golding looks at WA's first decision on Voluntary Assisted Dying (page 18); I examine the law around correcting or deleting medical records (page 20); and Janet Harry's parting retirement gift is her wise advice on coronial matters involving hospital doctors (page 22).

As always, our guest authors offer their insights on some thought-provoking topics, including the power of visualisation (Dr Jonathan Ramachenderan, page 24); Dr Ramya Raman provides food for thought on the challenges facing general practice (page 4); and Dr Michelle Johnston continues to impress with her ability to tackle the tough issues with her trademark wit and humour (page 26).

We see *Defence Update* as a pulse check on all things medico-legal. We hope you continue to find value in the insights offered by our in-house team and guest authors, each and every edition.

In this issue

It's renewal time!

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

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CONTRIBUTING AUTHORS

Dr Ramya Raman
General Practitioner & Chair,
RACGP (WA)

Dr Jonathan Ramachenderan
Pain Medicine Fellow
General Practitioner & Anaesthetist

Dr Michelle Johnston
Emergency Medicine Clinician

Niranjala Hillyard
Director, Inkpot & Pixel
Freelance Writer, Editor & Designer

Elissa Cohan
Education Services Manager

Nerissa Ferrie
Medico-legal Adviser

Nicole Golding
Manager, Dental Cases
Case Manager (Solicitor)

Janet Harry
Medico-legal Adviser

Natalie Jones
Risk Adviser, Medicare Compliance

Gae Nuttall
Risk Adviser

Karen Stephens
Risk 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

Dear Members,

There has been another year of consolidation for MDA National. One external measure of our success is our regular meetings with our reinsurance panel.

The global reinsurance industry enjoyed something of a reprieve in the last 12 months, having faced massive losses in their property portfolios due to severe weather events in recent years. Medical indemnity insurance falls under their 'casualty' line, which has presented them less of a problem, making us a more attractive investment. Nonetheless, many comparable professional indemnity organisations have struggled to obtain reinsurance in the same timeframe.

Our ability to buy reinsurance at an affordable price reflects the confidence these global companies have in our mechanisms to protect their investments. We are able to explain to our reinsurers the close involvement of doctors in our Cases Committees, our Clinical Underwriting Committee and our Mutual Board. We are able to reassure them about the high level of in-house legal and underwriting expertise we have.

As a practising obstetrician and gynaecologist, I well understand the impact of premium increases. For my entire career in private practice, I have paid a premium in the 'prestigious' Level 10 band. At MDA National, we are aware of the impact such increases have on the profitability of our Members' practices. In recent years, we have done the 'heavy lifting'. We do not take for granted the loyalty of our Members. Most of you will have observed significant increases in the cost of your general insurances. The fact that we have been able to avoid a major increase in the cost of buying reinsurance, when every other insurance premium is increasing, is testament to the confidence these global giants have in our organisation.

I recently attended the Medical Professional Liability Association (MPLA) Conference in Washington DC. While focused on the American industry, I also met with organisations representing doctors in the UK, Canada, Ireland, South Africa and Hong Kong. Fortunately, so called 'nuclear verdicts' into the hundreds of millions of dollars from jury trials are not part of the Australian experience. Other issues are universal.

There is much interest in the emerging medico-legal issues around inequity of access to care, task substitution by non-medical healthcare providers, voluntary assisted dying, and gender-affirming care. I suspect that delay in diagnosis, poor case selection and poor documentation will be ever-present themes. The threat of cybercrime, and the potential opportunities and threats presented by artificial intelligence, are key considerations for our insurance businesses.

While conscious of the need to remain competitive on premium, we continue to celebrate the very high levels of capability within our Cases and Advisory team. Many of you will also have availed yourself of the high-quality education that we develop.

As we approach 100 years of service to our fellow doctor Members, I am buoyant and excited about the future of our organisation. We are in the process of implementing an industry-leading customer relationship management (CRM) system. Our staff and doctor-led management committees have the expertise to be cognisant of emerging risks, managing them at industry and individual policy level, continuing to lead the profession in Australia. Every day, across the business, we live our values of supporting, protecting and promoting high quality medical practice.

General practice

Is it really the ‘easy’ specialty?

Dr Ramya Raman (MDA National Member)
Director, The Garden Family Medical Clinic, Piara Waters
General Practitioner & Chair, RACGP (WA)

“As an urban general practitioner working in the post-COVID era, with an ageing population and the mental health consequences of the pandemic, I toss around the question of why a junior doctor would choose to become a general practitioner.

I often hear from medical students and junior doctors that having a good work-life balance is a good reason to become a general practitioner (GP). This makes me question what’s actually defined as good work-life balance. Are we achieving this in our clinical practice as GPs?

Other than having a supposed good work-life balance, are there ‘qualities’ which we are respected for by our colleagues, medical students and junior doctors? Office-based general practice is becoming more and more unattractive to medical students. As one of my students said, procedural specialties are much more “exciting” and they pay better.

To do well in general practice, we need an all-encompassing skill set that includes not only clinical skills, but clinical reasoning, organisation, clinical prioritisation capability, procedural and communication skills. Yet, general practice is still viewed as the 'lesser specialty' by many junior doctors, despite the complex skill set and breadth of knowledge required. So, why is this?

Most established GPs are booked ahead by about a week to 10 days, which means patients have already formulated their 'problem list' by the time they see their GP.

For example, a patient of mine who booked two weeks ahead of his appointment came in telling me so much had happened in the six months since I saw him last.

"My wife's health has been deteriorating with the onset of memory issues, she really needs to see you. I've become her sole carer, and I need help getting carers' allowances from Centrelink.

"I'm struggling to look after my health, work commitments and the home. My sugar levels are high, and I've been self-adjusting my insulin levels as I've been too scared to get my Hba1c done.

"My mental health is worsening; I've put on weight; sleep is poor; and I really don't want you to check my blood pressure.

"And before I forget, I need all my scripts renewed. One of the diabetes injection medications was recently unavailable, so I need a substitute. I haven't had my flu shot yet, but I did get my COVID-19 jabs."

And so began a multifaceted consult that called on the need for longitudinal coordinated care for this patient.

Training to be a GP includes broad knowledge and several years of experience to become proficient in managing patients of different ages, races, ethnicity, and socio-economic backgrounds; and building the capability to switch between various 'organ' related or unrelated problems. This enables a GP to manage uncertainty with a level of comfort and responsibility. While this may look easy from the outset, it's not a skill set to be taken for granted.

As a citizen of this country, and a daughter and wife, I do recognise that access to health care is an essential component of our country. But access to good health care delivered by appropriately trained health professionals is key.

The current Medicare system is under significant strain, with funding cuts and a growing number of patients presenting with complex and multiple health problems. This is compounded by the fragmentation of patient care, with some allied health sectors basing their care on tunnel-visioned clinical reasoning, rather than a holistic approach to patient care. While allied health professionals play a vital role in the healthcare system and have a significant impact on patient outcomes, GPs need to be the stewards leading the coordination of care for patients.

Complexity in health is not pre-announced as a patient walks in through the doors. I recently saw a 40-year-old gentleman, previously fit and well, who presented to see me with tiredness, abdominal bloating, a few cervical lymph nodes that were raised and tender, and symptoms of anxiety. He and his wife (also a patient of mine) were expecting a baby. This seemingly unrelated group of symptoms has since been diagnosed as lymphoma, which completely changed his world within a span of two weeks.

This is the invisible work that is done in general practice. Common things are common, and protocols will work within reason – but there will be outliers in patient presentations which, if not carefully worked up, will lead to poorer outcomes.

Early exposure to general practice enables positive role models and experience building for junior doctors. I am an alumnus of the Prevocational General Practice Placements Program (PGPPP) that gave me the opportunity to 'trial general practice' as a resident medical officer (PGY3). This provided experience in continuity of care, importance of preventative care, chronic disease management, treatment of acute illness and injuries, care coordination, and small procedural skills.

The loss of funding for PGPPP has certainly played a role in the decline of junior doctors considering general practice as a specialty. Reinstating programs like the PGPPP will give junior doctors the opportunity to experience the true essence of working as a GP.

We need to teach our junior colleagues the importance of long-term care and management of patients in office-based general practice. But, to complement this, we need better investment in general practice which has not kept pace with the cost of providing care, including the Medicare rebate freeze that has impacted significantly on general practice remuneration.

> *We need to rebuild the foundations of our healthcare system and address the impending issues around workforce in general practice. Part of this is to prioritise investing in general practice in a sustainable manner that makes it an attractive profession – not necessarily the 'easy' option.*

Don’t tell them I told you

Managing unsolicited patient information from third parties

Dr Julian Walter
National Manager, Advisory Services
MDA National

> *Dad’s actually an alcoholic. He shouldn’t be on the road. But he never tells you this stuff. He just says he’s great. Make sure you get his licence cancelled … and whatever you do, don’t tell him I told you this.*

Privacy law

Under the Commonwealth Privacy Act, health organisations should collect personal information (relevant to providing healthcare services) from the patient personally, or from third parties where the patient has consented, or where the patient would reasonably expect the information to be provided.

Where the patient is not the provider, has not consented, or would not reasonably expect the information to be provided, unless an exception applies, the information should be destroyed. Exceptions include information required by law or professional obligations; information kept or actioned so as to minimise a serious threat to life/health/safety or a missing person; investigating serious misconduct or unlawful activity; or information necessary for a legal claim.

The information provider

You don’t owe the information provider a duty of confidentiality – but if you store the information without their consent (using personal identifiers) you’re potentially breaching *their* privacy. Even deidentifying the information may be insufficient if the patient can still identify the source. The information provider may make a regulatory or privacy complaint, or they could be exposed to serious risk if their identity becomes known.

The therapeutic relationship

If you do tell the patient about the information and where it came from, therapeutic trust may be fractured once the patient discovers you have recorded unverified information about them in the records. Talking about them with a third party without their consent is not a breach of confidentiality if all you do is listen, but it may be perceived as a breach of trust.

If you don’t tell the patient, the information provider may later ‘confess’ to the patient about the discussion with you, leaving the patient to doubt your candour and honesty, and raise concerns about breach of privacy, confidentiality and trust.

Is the information legitimate?

Without being able to discuss the nature and source of the information with your patient, you can’t be sure the information is genuine. Storing unverified information in the patient records risks it being promulgated by other care providers, or being disclosed when you release records to other parties. Other providers and record recipients may inadvertently discuss the content with the patient.

Redacting information from the file (presuming your record system allows this at all) may be impossible if the information has been provided to other care providers and incorporated in their records and health documents.

Where to store the information

Storing the information can be problematic. Retrospectively demonstrating how you responded to the request can be difficult if you keep no records – but if unsolicited information is inappropriately stored in the records, it may be difficult to unwind the decision.

If storing the information in the patient record is not possible, then what are the options? Refusing to accept the information

in the first place is ideal (with an explanation as to why). However, information may be sent to the practice and opened before the nature of the unconsented disclosure is understood. Returning the information, or destroying the document, is usually appropriate.

There may be matters where there are competing legal, ethical or professional reasons as to why the information should be both deleted and kept. Otherwise, you may have difficulties demonstrating why you refused to accept and act on the information. In the example above, how would you remember or prove the exchange at an inquest several years later, where the relative alleges that you refused to act on their driving safety concerns, leading to the death of the patient in an MVA? Determining a suitable location to store the information is problematic – it may be necessary to obtain medico-legal advice (and your MDO may store the document as part of that advice).

How to respond?

Prompt recognition and discussion about unsolicited information being provided by third parties allows you to set boundaries early. A workplace policy on unsolicited information empowers staff to manage these situations consistently. The information provider should be encouraged to share their concerns with the patient, or to attend a consultation with them. If the information is important enough, they may allow you to tell the patient about their concerns.

Some information must be acted on (e.g. mandatory reporting or a serious risk of harm) – even if this is against the instructions of the person providing the information.

Take-home message

Managing unsolicited information from third parties remains one of the most complex medico-legal issues we deal with. You may receive opinions about your patient which are impossible to interrogate. Is the person offering the information being well-meaning or malicious?

If managed poorly, you risk the loss of therapeutic rapport, as well as complaints from the patient, the information provider, or both.

In difficult situations, seek medico-legal advice early – *before* the information is stored in the record. Promising that you will accept and act on the information, without revealing the source, creates a very challenging professional, legal and ethical dilemma from which there may be no easy way back.

Total & permanent disability

Doctors often feel conflicted when patients seek written confirmation of total and permanent disability (TPD). What should you consider before completing a TPD form?

Nerissa Ferrie
Medico-legal Adviser, MDA National

Jim makes an appointment to see you. You inherited him from a colleague who recently retired, and you've only seen him once or twice.

Jim is 45 years old, with a history of chronic back pain. He hasn't returned to his construction job since he accepted a workers' compensation settlement two months prior.

He comes in today asking you to complete a TPD form.

You eventually sign the form, after pressure from the patient's lawyers. Jim hasn't been in since, so you're surprised when he presents a year later, with a stack of paperwork in hand.

"I blew my TPD payout on jet-skis and holidays, and now I need to return to work. Can you give me a certificate to say I'm completely fit to work in the construction industry? My back feels much better now."

You offer to examine him, while noting it will be difficult to provide a clearance so soon after signing a TPD form.

Jim snatches up the paperwork and leaves the consultation, yelling expletives.

What is TPD?

Definitions can vary according to the terms of the policy. A patient may be eligible for a TPD payment when they lose the ability to work in their own profession. More commonly, eligibility is triggered if a patient can never return to any occupation reasonably suited to their education, training or experience.

This is a fairly high threshold, and you must read the wording carefully before you sign a TPD form, in accordance with 10.9.1 of the Medical Board's *Good Medical Practice: A Code of Conduct for Doctors in Australia.*

Things to think about

- How old is the patient, and when did they become disabled?
- Is there objective evidence of a permanent disability?
- Is the patient compliant with treatment recommendations?
- Has the patient reached maximum medical improvement?
- Factor in any comorbidities, psycho-social influences, education and work history.

Should I sign the form?

Medico-legally, you should exercise your best clinical judgement based on information available to you at the time, and document this clearly in the notes.

Consider a referral to an occupational physician if necessary, and don't allow anyone to pressure you into completing the form if you don't feel it is appropriate to do so.

If you support the patient's TPD claim, you can complete the form as requested. Consider advising the patient that if they opt to rejoin the workforce without any identifiable improvement to their disability (i.e. new treatment or surgical intervention), it may be difficult for you to provide a certificate of fitness.

If in doubt, contact our Medico-legal Advisory Services team for prompt and personalised advice.

Should I provide my colleague with a character reference?

Janet Harry
Medico-legal Adviser, MDA National

Dr White is an ED consultant in a public hospital. One of the senior registrars approaches Dr White and asks her for a character reference. They've worked together for about two years, and the registrar has always been professional, punctual and reliable. His clinical skills are excellent, and Dr White has never had any issues with him in the workplace.

Given their position of trust in the community, it's not uncommon for doctors to be asked to provide character references. It's rare for a doctor to know a patient well enough to provide a character reference – but what about colleagues?

What is a character reference?

Generally, it is a letter that speaks to the subject's positive attributes. Ideally, you should have known the subject for some time, and you must provide your honest opinion.

What will it be used for?

Common reasons for requests relate to:

- employment or rental applications
- court proceedings – including criminal, civil, family disputes and restraining orders
- disciplinary matters.

It's important to know why the reference is being requested.

What should I say in the reference?

- Include information about how long you have known the person, and in what capacity.
- Address your understanding of why you have been asked to provide a character reference.
- Avoid using stock phrases such as "is of good character" or "an upright citizen". Your colleague may behave appropriately in the workplace – but not so much in the home environment, or under the influence of alcohol or other substances.
- Be specific about positive attributes, but don't shy away from addressing negative attributes, particularly if the person has taken steps to rectify this.
- The wording should be factual, clear, fair and informative.

Are there any potential pitfalls?

Things you should think about before agreeing to write a character reference:

- You may be contacted for a verbal follow-up, so you should be prepared for this.
- Would your hospital or employer think it is appropriate for you to author a character reference, particularly if it relates to a hospital disciplinary matter?
- If you provide a character reference, and your colleague is later subject to adverse publicity in a very public forum, will your support of your colleague damage your own reputation?
- If the matter is before the courts, be prepared to be subpoenaed as a witness.
- Don't address your letter "to whom it may concern". A character reference should be addressed to a specific person, otherwise it could be used for a purpose you didn't contemplate when you wrote it.
- If you can't genuinely speak to a colleague's good character, it may be best to decline the request.

If in doubt, contact our Medico-legal Advisory Services team for advice.

What's new in Education Services

Elissa Cohan
Education Services Manager

Continuing Professional Development (CPD)

In 2023, the Medical Board of Australia revised the *Registration standard: Continuing professional development*. The revised standard is designed to strengthen CPD by supporting doctors' access to relevant, effective and evidence-based activities. The changes aim to provide doctors with an individualised approach to developing learning goals to maintain and build personal and professional skills, with a view to ultimately fostering a lifelong learning mindset for doctors in Australia.

Requirements at a glance

- Prepare your annual professional development plan (PDP).
- Participate in learning activities for a **minimum of 50 hours** per annum.
- Complete CPD across the range of CPD categories – Education Activities (EA), Reviewing Performance (RP) and Measuring Outcomes (MO), fulfilling the breakdown of these activities as follows:

  25 hours: across RP and MO with minimum 5 hours in each
  12.5 hours: in EA
  12.5 hours: in any type of activity of a doctor's choosing.
- Have a CPD home (unless exempt).
- Log your CPD activities and completions with your CPD home.
- Declare your CPD home in your 2024/25 registration renewal (30 September for medical practitioners. For doctors with a provisional or limited registration, it is on the anniversary date of your registration being first granted).

Selecting a CPD home

As part of the new registration standard, all doctors need to select a suitable CPD home from 2024 (unless exempt).

Areas to consider when selecting a CPD home include:

- a college or non-college CPD home that aligns to your scope of practice
- ability to meet any specialist high-level CPD requirements for your specialty
- the range of content and format options available
- how CPD is logged and reported
- annual fees and other inclusions.

Doctors who are specialist trainees or specialist IMG graduates with limited registration in a specialist pathway are required to meet their CPD requirements through the relevant specialist medical college.

Do any exemptions apply?

Groups exempt from CPD requirements are:

- medical students
- interns and PGY2 doctors participating in an accredited training program
- doctors with a non-practising or short term (less than four weeks) registration
- doctors granted a CPD exemption from their CPD home due to a continuous absence from practice of at least six months for approved circumstances.

How MDA National can help?

MDA National provides Members with access to a variety of programs and resources in the following CPD categories:

Education activities (EA)

- Courses and workshops
- Live webinars
- On-demand webinars
- e-Learning modules
- Library including case studies, articles, blogs and podcasts

Reviewing performance (RP)

- Course self-reflections and action plans
- Round table case discussions

Measuring outcomes (MO)

- Practice visits and audits
- Practice systems and process reviews

More information & resources

AHPRA & NATIONAL BOARDS

2023 Registration standard: Continuing professional development
medicalboard.gov.au/registration-standards.aspx

About CPD homes
medicalboard.gov.au/professional-performance-framework/cpd/about-cpd-homes.aspx

Professional development plans and types of CPD
medicalboard.gov.au/professional-performance-framework/cpd/professional-development-plans.aspx#

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Concise advice – Revised CPD registration standard
mdanational.com.au/advice-and-support/library/concise-advice/revised-cpd-registration-standard

Browse a range of education resources for MDA National Members
mdanational.com.au/member-benefits/education

Browse MDA National's library with more than 500 items containing articles, case studies, blog posts and podcasts for your reading, listening and viewing of education materials
mdanational.com.au/advice-and-support/library#

Learn about Support in Practice
mdanational.com.au/member-benefits/support-in-practice

Learning Management System (LMS)

Launched in May 2024, MDA National's new Learning Management System (LMS) provides a central place for our Members to access our learning programs. The LMS will provide an enhanced Member experience – bringing together all of MDA National's educational content in one platform – making it easier for you to browse and consume content, with ongoing access to courses and learning materials.

What's changed?

- **Ease of access** to all educational resources via a simplified login experience. This includes single sign-on and enhanced security with two-factor authentication from MDA National's Member Online Services portal or the MDA National App.
- **A one-stop shop**, the LMS now houses our full suite of education activities – including e-learning activities, on-demand recordings, live webinars and online workshops; registration for face-to-face workshops; and access to learning materials and resources. Additionally, it keeps track of your completion records and certificates, making CPD easier to track and manage.
- **Improved functionality**, including easier searching and filtering of content by topic, format, career stage and specialty; personalised learning space with all your enrolments and completion records; and easy identification of CPD recognition.

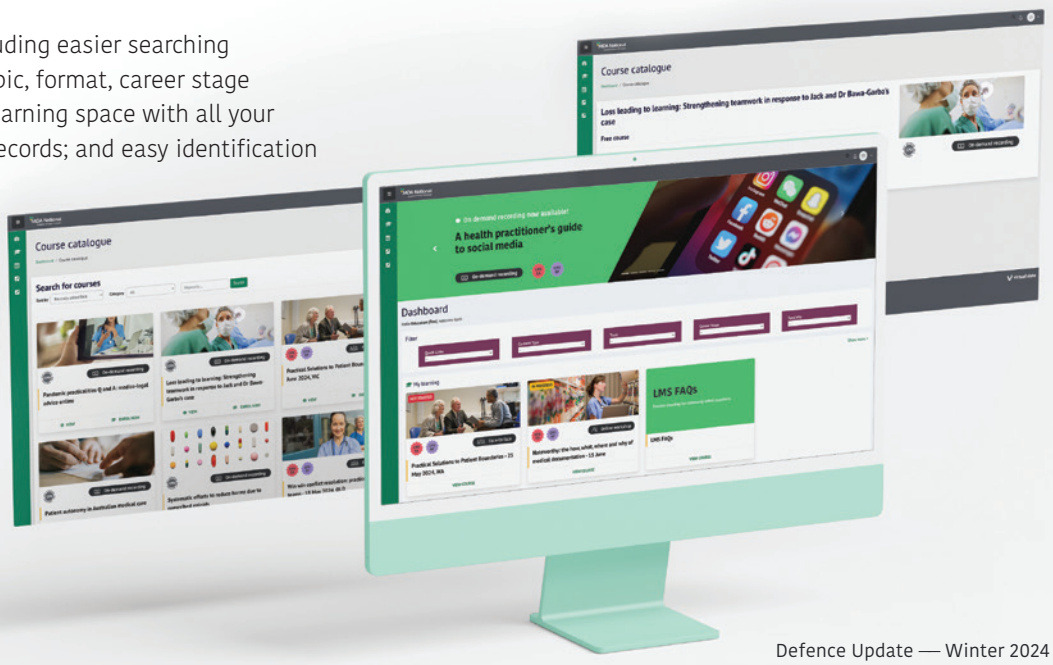
How to access?

MDA National Members can access the LMS in three convenient ways. Choose what works for you by joining with your MDA National login credentials via:

- the LMS website: **learn.mdanational.com.au**
- your Member Online Services account: **members.mdanational.com.au/login**
- the MDA National App: **Download via the App Store or Google Play**

MDA National Practice Indemnity Policy holders and their practice staff will benefit from increased accessibility to MDA National education services, with the ability for practice staff to create an account and access content on the LMS.

To sign up for an account, visit **learn.mdanational.com.au/login/signup.php?**



Medicare news for Members

Gae Nuttall & Natalie Jones
Risk Advisers, MDA National

Are you billing telehealth correctly?

Throughout the pandemic, the Department of Health and Aged Care (DHAC) increased the number of telehealth MBS item numbers and benefits to provide better access to necessary health care. Numerous changes to these items made it difficult for busy health practitioners to keep up with them.

We are currently assisting Members with Medicare compliance activities relating to after-hours telehealth items. Some pandemic telehealth item numbers are now inactive, but some of the remaining telehealth item numbers are being claimed incorrectly. These include telehealth item numbers **92210** and **92211** due to confusion between phone consults and video consults. Some items are phone-specific, and some are labelled 'telehealth' which, in the *Health Insurance Act 1973* (Cth) means 'video'.

Definitions

The applicable legislation is the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* which states:

telehealth attendance *means a professional attendance by video conference where the rendering health practitioner:*

(a) has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and

(b) is satisfied that it is clinically appropriate to provide the service to the patient; and

(c) maintains a visual and audio link with the patient; and

(d) is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

phone attendance *means a professional attendance by telephone where the health practitioner:*

(a) has the capacity to provide the full service through this means safely and in accordance with professional standards; and

(b) is satisfied that it is clinically appropriate to provide the service to the patient; and

(c) maintains an audio link with the patient.

Urgent after-hours services (92210 and 92211) are described as a 'telehealth' attendance; therefore, video is required. There is no equivalent urgent after-hours phone item.

GPs and OMPs – please be mindful of the '12-month rule' for MBS-funded telehealth services included in the latest factsheet *Continuing MBS Telehealth Medical Practitioners in General Practice:* **mbsonline.gov.au/internet/mbsonline/publishing.nsf/content/factsheet-telehealth-updates-april%202023**.

If you are claiming telehealth MBS items, please refer to the item descriptor via MBS Online or the factsheet relevant to your sector at **mbsonline.gov.au/internet/mbsonline/publishing.nsf/content/factsheet-telehealth-updates-april%202023.**

Further information is available in the MDA National Telehealth Toolkit: **mdanational.com.au/advice-and-support/library/concise-advice/telehealth-toolkit.**

Introducing Natalie Jones: the newest member of the MDA National Medicare Committee. Natalie recently joined MDA National in a newly created role: Risk Adviser – Medicare Compliance. Natalie has a background in business, nursing and medical practice management. She will be focusing on creating new resources and updating older material, as well as providing advice to our Cases and Advisory team and to you – our valued Members.

We are committed to assisting Members with 'all things Medicare'. So please contact us with your Medicare queries on **1800 011 255** or email **advice@mdanational.com.au**.

RETIREMENT: WHAT YOU NEED TO KNOW

It comes to most of us; that tricky time in your career when you need to start planning your retreat. Here are the best tips from our Support in Practice team for a smooth transition into a well-earned retirement.

Planning for retirement

Karen Stephens
Risk Adviser, MDA National

Plan early

The age of 55 has been proposed as the latest age by which doctors should write a formal transition to retirement plan. While retirement itself may be years away, planning early can lessen the emotional and financial toll of retirement.

Many doctors delay retirement planning, with fears of abandoning their patients, loss of collegiality with peers, boredom, financial stress and relationship changes.

Delaying for too long carries risks. Having dedicated so much of your life to your practice of medicine, it would be a shame to end your career on a low note. Older doctors are at increased risk of physical and cognitive changes that may adversely affect their practice.

Remember that retirement can bring new opportunities as well as time for hobbies, travel, family and friends. Speaking to former colleagues who have retired may be valuable.

> ***Suddenly stopping a busy professional life with tight timetables was a bit daunting – what am I actually going to do with all this free time? I needn't have worried – within a few months I had to restart a daily diary to fit everything in.***
>
> Dr Tom Hugh, NSW

General considerations

Your physical health

The physical demands of some specialties might lead to an earlier retirement. See your own GP regularly and look after yourself with your diet and exercise. Listen, if family or colleagues have concerns about your health.

Your mental and emotional health

Where possible, manage your workload to avoid burnout. Develop interests outside medicine. Consider establishing strong social networks and setting goals, e.g. increasing personal fitness; undertaking additional formal or informal education.

Your family's health

Sometimes a family member's health may impact when you retire.

Financial preparedness

Obtain financial advice and develop a financial plan particularly if you are self-employed.

Easing out

Consider reducing your hours gradually; limiting patient numbers; not seeing complex cases; stopping one part of your work (such as out-of-hours or public work); or having the doctor who will take over your practice start working some sessions before you depart.

Transition to 'encore' work

Options include research; mentoring junior doctors; surgical assisting; and governance or management roles.

> ***I have kept busy being appointed to the Governing Council of the Country Health Service ... and the local hospital board. I also arrange conferences at the local rural clinical school and maintain an interest in the progress of former registrars.***
>
> Dr Ian Lishman, WA

If you are closing a practice

The Medical Board's code of conduct includes this statement:

When closing or relocating your practice, good medical practice involves:

4.16.1 Giving advance notice when this is possible.

4.16.2 Facilitating arrangements for the continuing medical care of all your current patients, including the transfer or appropriate management of all patient records. You must follow the law governing health records in your jurisdiction.

Informing patients

(See sample letter on page 16.)

It is important to give patients as much advance notice as possible. Communicate the date you will cease practice; whether you will sell or close the practice; options for ongoing care; and how to arrange transfer of records.

If it is appropriate to do so, you can tell patients about your plans:

- during consultations
- in notices posted in the practice
- in website or social media posts
- by post or email (as per your usual method of communicating with patients).

In Victoria, you must publish a notice in a local newspaper (if one exists) and in non-English newspapers, if many patients are non-English speaking (unless you are a radiologist or pathologist); place a notice in the practice; and inform all current patients in writing. Any fee for access to records must not exceed a prescribed maximum fee.

In the ACT, a notice in a daily local newspaper (including where records will be held and any fees payable for records transfer) and informing ACT Health are required.

> ***Looking back [I wish I had] communicated better with patients and colleagues with explanatory and especially 'thank you' letters.***
>
> Professor John Murtagh, Victoria

Continuity of medical care

This depends on what will happen with the records, but a formal handover to another doctor may be needed for complex patients. Ideally, it's best to stop seeing patients or ordering investigations well before finishing up; or be available to review incoming results for a short time afterwards.

Where you plan to delegate the responsibility, a formal arrangement with your colleague is helpful (e.g. copying in a colleague to the results). The patients should also be informed about who will be following up the results. A pre-arranged and agreed understanding of what will happen is helpful to all parties involved.

Surgeons should cease operating in sufficient time before retirement, so that patients are not in standard postoperative review periods at the time you cease work. If patients have a My Health Record, you may be able to check or provide an updated Shared Health Summary or Event Summary.

Medical records

- If leaving a group practice where your patients will see other doctors within the practice, no specific arrangements are necessary.
- If the above does not apply, give patients the option of providing a copy of their records to a doctor of their choice or to the patients themselves.
- Records remaining in your possession should be stored securely for seven years from the date of last entry or, for a child, until the patient turns 25. Set up a simple manageable way for patients to access records after the practice closes (maybe a phone message about the practice closing; and tell them to email if they need to contact you or obtain records). You have 30 days to transfer records after a request.
- For storage of electronic health records, seek advice from the software company and your IT service provider.
- After the required retention period, you can delete or destroy records – but this must be done securely. If you use a commercial company, request a written record of its certification and written notification of destruction.
- In the ACT, NSW and Victoria, a register of date of destruction must be kept.

Informing others

Consider notifying:

- colleagues, hospitals, pathology and radiology services
- Medicare (cancel your provider number)
- Ahpra
- your MDO. Ensure you maintain appropriate cover, particularly if you intend to continue your medical career in another capacity, such as teaching or medico-legal reporting
- your college.

Continued on page 16.

Planning for retirement (cont'd)

Business arrangements

- Banking, including closing bank accounts and returning EFTPOS machines
- Leases and equipment
- Disposal of consumables and clinical equipment
- Utilities (telephone, internet, water, electricity, gas, alarm system) and mail
- Insurance policies (e.g. public liability, workers' compensation, income protection, building and contents)
- Websites, domain names, and other IT systems
- Seek advice from an accountant about financial matters, such as tax and superannuation.

Medications and prescribing

- Dispose of any unused drugs appropriately – contact your state or territory drugs and poisons regulator.
- Destroy any paper prescription pads.
- Notify drugs and poisons regulators in your state or territory of cessation of practice, if you have a licence, e.g. S8 medication.

Employees

- Keep staff informed of your plans.
- Consider the need to retain one staff member in the immediate post-retirement period to assist you with administrative tasks.
- Employers' obligations, such as those relating to tax, superannuation, termination payments and group certificates, are outlined in a guide from **business.gov.au**.
- Return keys and practice-owned equipment.
- Retain employee records securely for seven years.

Sample letter to inform patients

Dear *[patient name]*

I appreciate the trust you have shown in allowing me to provide for your medical needs.

I am writing to announce the closure of my medical practice *OR* I am retiring after many years of practising medicine.

My practice will close for patient appointments on *[date]*. No medical services will be provided after this date.

If no doctor is taking over your practice:

For your ongoing health care, you will need to see another GP *[or type of specialist]. Give details of how patients may go about this, such as seeing another doctor in the same practice or getting a referral from their GP.*

I will be happy to provide your new doctor with copies of the necessary records from your file. Please sign and return the enclosed authorisation along with your instructions about where to send your records, and return it to my office no later than *[date]*.

After this date, all requests for medical records should be sent to *[address and/or email address]*.

If a doctor is taking over your practice:

I feel fortunate to have found Dr *[name]* to take over my practice.

Dr *[name]* trained at *[training organisation]* and has worked as a *[position held]* for *[duration]* years. Dr *[name]* will begin working with me on *[commencement date]*.

If you are visiting the practice before I leave, I will be pleased to introduce you to *[him/her/them]*. Your medical records will automatically remain with Dr *[name]* unless I receive written authorisation (form enclosed) from you to transfer them to another doctor.

Once again, I am grateful for the opportunity to have been your *[doctor/specialist]*.

Yours sincerely

[signature]

View the references online: **mdanational.com.au/retirement-planning**

New on-demand learning activities and resources available for Members

Designed to keep you up to date with changes to laws and your professional obligations, these resources aim to provide practical guidance in easily digestible formats, accessible at a time and place that suit you.

On-demand webinars

Designed to provide guidance and advice on the key medico-legal issues doctors need to be aware of, using case scenarios to assist in navigating your professional obligations:

- A health practitioner's guide to social media
- Employment law update — understanding changes to the Fair Work Act
- Practicalities of Medicare
- Understanding Voluntary Assisted Dying laws

CPD certificates are issued on completion and can be used to self-report your participations to your CPD home.

Scan the QR code or visit
learn.mdanational.com.au/course/index.php?categoryid=24

Concise advice

Designed to provide you with quick, easy and useful answers to specific medico-legal questions on a range of topics:

- A health practitioner's guide to social media
- Using artificial intelligence tools for record management in doctor consultations
- Telehealth toolkit
- Voluntary Assisted Dying laws

Scan the QR code or visit
mdanational.com.au/advice-and-support/library?contentType=Concise%20Advice

Voluntary assisted dying

WA's first decision

Nicole Golding
Manager, Dental Cases
Case Manager (Solicitor), MDA National

With the staggered introduction of state-based voluntary assisted dying (VAD) laws, and minor differences in the eligibility criteria, interpreting the legislation can be confusing for medical practitioners.

On 12 February 2024, the Western Australian State Administrative Tribunal (the Tribunal) considered its first application for a review of the VAD laws.

Case study

Mr AB approached his general practitioner Dr CD on 13 October 2023, requesting access to VAD pursuant to the *Voluntary Assisted Dying Act 2019* (WA) (the Act). Mr AB had been diagnosed with lung cancer in December 2019. In June 2022, he was diagnosed with brain cancer and given a life expectancy of 12 months.

At the time Mr AB was diagnosed with lung cancer, he was living in Western Australia (WA). He subsequently moved to New South Wales in July 2020, then relocated overseas in July 2023 to live with family.

Mr AB returned to WA in September 2023 as he became seriously unwell. One month later, he saw Dr CD to make a first request for VAD.

Dr CD assessed Mr AB's eligibility to access VAD. In Dr CD's opinion, Mr AB met all eligibility criteria except for the requirement under section 16(1)(b)(ii) of the Act that he be ordinarily resident in WA for a minimum of 12 months before making a first request to access VAD. In interpreting this provision, Dr CD noted that Mr AB had only lived in WA for one month prior to making the request.

Dr CD discussed her views with the VAD Care Navigator who agreed with Dr CD's interpretation of the 'ordinarily resident' requirement. Dr CD advised Mr AB that, in her opinion, the eligibility criteria wasn't met, and she was unable to progress his application to the next stage.

Mr AB made an application to the Tribunal for a review of the decision of whether he had or had not been ordinarily a resident in WA for a period of at least 12 months prior to his first request to Dr CD.

Discussion

The Tribunal concluded that the correct and preferable decision was that Mr AB met all eligibility criteria. It found that, at the time of making the first request to Dr CD to access VAD, Mr AB had been ordinarily resident in WA for a period of 12 months and therefore satisfied the criteria under section 16(1)(b)(ii) of the Act.

The key question for the Tribunal to consider in this case was the meaning of 'ordinarily resident', which is not defined in the Act. The Tribunal considered each word in isolation. The word 'ordinarily' was interpreted using the ordinary and natural meaning "...in ordinary cases, usually; in the ordinary way; and to the usual extent...".

The word 'resident' was also interpreted using the ordinary and natural meaning "...to dwell permanently or for a considerable time, to have one's settled or usual home in or at a particular place...".

Applying the natural and ordinary meaning of 'ordinarily resident', the Tribunal interpreted this to mean a person who usually, commonly or habitually dwells, or has their settled or usual home, in a particular place. In Mr AB's case, he was found to be ordinarily resident in WA.

The Tribunal also had to consider whether Mr AB was ordinarily resident for a period of at least 12 months prior to making the first request to Dr CD. The Tribunal found the term 'period' to mean "any specified division or portion of time".

The Tribunal also found the reference to 'at least 12 months' is not confined to the 12-month period immediately preceding the first request to access VAD. Instead, the provision requires the person to be ordinarily resident in WA for a minimum of 12 months at any given time.

Mr AB had been ordinarily resident in WA from 1991 to 2021, and in the Tribunal's opinion he therefore met the criteria under section 16(1)(b)(ii) of the Act. The Tribunal set aside Dr CD's decision that Mr AB was not eligible to access VAD. There were no ramifications for Dr CD in declining Mr AB's first request.

Take-home message

VAD laws can be difficult for medical practitioners to navigate. Given this is relatively new legislation, we will likely see the courts more frequently involved in interpreting the meaning of provisions in the legislation where they are ambiguous. For those practitioners working in the VAD area, it is important that you keep up to date with decisions made by the courts, as this may affect your assessment of a patient's eligibility.

The health departments for the respective states have some excellent resources for practitioners wanting to know more about the VAD guidelines. MDA National also has an informative webinar on the relevant VAD laws, accessible through our new Learning Management System (see page 11). If you have any questions about VAD, contact our Medico-legal Advisory Services team for advice.

Correcting or deleting medical records

Nerissa Ferrie
Medico-legal Adviser, MDA National

There can be any number of reasons why patients and doctors might want to amend or delete an entry in the medical records. We take a deep dive into when it is and isn't appropriate to do so.

Case study

Dr Scott receives an angry email from a former patient. Dr Scott was involved in Tracey's care when she was diagnosed with schizoaffective disorder during an inpatient stay. Her mood stabilised following treatment with an antipsychotic.

Tracey says she wrote to the practice, asking them to remove a diagnosis from her medical record because she doesn't agree with it. The practice said no.

Tracey is asking for a complete copy of her medical record, and she again asks for her mental health diagnosis to be removed. Tracey is going through a custody dispute with her ex-husband and doesn't want him to subpoena the notes.

When Dr Scott reviews the record, she notes a very long entry made by a receptionist following a confrontation that led to Tracey being banned from the practice.

The practice is correct, insofar as it is not appropriate to correct or delete the diagnosis from Tracey's medical record. But is it enough to just refuse?

Requests to correct or delete records

You must take reasonable steps to correct health information you hold about a patient, if you are satisfied the information is incorrect and the patient asks you to correct the information. Health information may be incorrect if it is inaccurate, out-of-date, incomplete, irrelevant or misleading.

The *Guide to Health Privacy* published by the Office of the Australian Information Commissioner (OAIC) has an excellent flow chart in Chapter 5, page 4, and your privacy policy should provide information to patients on how they can request a correction to their health information.

Requests for correction may relate to factual information that can be easily amended. If the information is incorrect, you should take steps to notify other entities of the correction, provided it is practicable to do so.

If the request is more complex, and refers to clinical information or diagnoses, it may be more appropriate to invite the patient to "associate a statement".

According to the OAIC: *... your medical opinion is not inaccurate just because a patient disagrees with it. Your opinion may be 'accurate' provided you present it as an opinion, it accurately records your view, and takes into account competing information and views.*

If you consider the information does not require correction or deletion, you must provide written notice of your decision not to correct or delete health information within 30 days, detailing:

- the reason for the refusal;
- the patient's option to associate a statement; and
- avenues for complaint if the patient is unhappy with the decision.

In the first instance, you can invite the patient to make a formal complaint to the practice. If the patient is not happy with the response from the practice, they can escalate the complaint to the OAIC or a health complaints body.

Associating a statement

If patients don't agree with a diagnosis or a clinical finding, you can invite them to "associate a statement" which is kept on the medical record in a way *"that makes it apparent to other users of the health information"*. The OAIC recommends the statement not be more than one page in length.

Requests to delete records

It would be unusual for medical records to be deleted or destroyed prior to the timeframes set out in state legislation and/or our general recommendations.

Aside from the obvious issues relating to continuity of care, you have additional obligations to keep medical records, including Medicare compliance.

Can we delete something that doesn't belong on the patient's medical record?

What of the inappropriate and gratuitous commentary noted in the records by Dr Scott's receptionist?

Most practices have an administrator who can remove or delete entries from a patient's medical records, but this function is limited for good reason.

On occasion, information that is saved to a medical record doesn't belong there. In this case, the receptionist has written chapter and verse about how badly Tracey behaved in reception. This resulted in the practice ending care.

The medical record should ultimately benefit the patient and ensure continuity of clinical care. Whilst it might be appropriate to note that care has ended, Dr Scott considered it wasn't clinically relevant to have included a lengthy and emotive blow-by-blow account.

While removing an entry from a patient's medical record is not done lightly, it may be reasonable to 'transfer' the entry to a more appropriate place. This is often the case in the collection of unsolicited health information (see pages 6-7).

If the information should never have been collected, and does not belong on the medical record, then it can be transferred to a more appropriate location (e.g. the OSH incident reporting file in Tracey's case) or deleted if it was scanned in by error (e.g. a copy of the practice phone bill).

Take-home message

The OAIC's *Guide to Health Privacy* is an excellent resource, but there are some jurisdictional differences – so pay special attention to the examples (in yellow) and helpful hints (in grey).

Like unsolicited information, there are a lot of things to think about when considering whether to correct, delete or transfer a medical record, and it is easy to make a bad situation worse. So please contact our Medico-legal Advisory Services team for advice.

Coronial matters involving hospital doctors

Nerissa Ferrie & Janet Harry
Medico-legal Advisers, MDA National

Hospital doctors often find it difficult to know who will be looking after them in the event of a notifiable patient death. Should they contact MDA National or accept representation from the hospital?

Case study

Dr Green is a registrar working a night shift at a busy tertiary hospital. She's writing up notes at the nursing station when there is a MET call for a post-operative patient. Dr Green attends the MET call and commences resuscitation with two colleagues. The patient is eventually stabilised and sent to ICU, but he doesn't survive.

The patient was a 54-year-old man with no comorbidities who underwent a routine hernia operation. The patient suffered a massive stroke which caused an irreversible brain injury. The death is reported to the State Coroner (the Coroner) and several months later Dr Green is asked to attend a meeting with the hospital's legal team.

The Coroner

It is a legal requirement to notify the Coroner of a reportable death. Once notified, the Coroner will investigate to determine the cause of death. This can take two weeks, two years, or even longer! The matter may be closed after investigation, but a small number of reportable deaths will proceed to a Coronial Inquest (Inquest), which is a court hearing run by the Coroner. There are some state differences, such as in the ACT where the entire process is referred to as an Inquest, even if there is no hearing.

Inquests are generally held when further investigation of the death is in the public interest. The Coroner MUST hold a mandatory Inquest in some circumstances, including a death in custody or the death of a patient detained under a Mental Health Act.

Who looks after the doctor?

A doctor who is employer indemnified and/or employed by a public hospital will usually be offered assistance and representation by the hospital lawyers. Hospital lawyers often coordinate and facilitate responses to the Coroner during investigation, and you should cooperate with this process. If the matter proceeds to Inquest, the hospital lawyers will engage Crown or State Solicitors who may contact you for a statement.

If you work in a private hospital, the offer of assistance or representation will often depend on the terms of your engagement. In some instances, you will be offered representation. But if you are a locum or a VMO, you may be advised to contact your own MDO for assistance.

Will the hospital "hang me out to dry"?

This is one of the common misconceptions we hear during requests for advice on coronial matters. If you are employer-indemnified, and the hospital offers you representation, there is no benefit to a hospital in hanging you out to dry. If they do, it will adversely impact the hospital.

That is not to say there won't be other reasons why it might be appropriate for a doctor to be represented separately. The most common reason is a conflict of interest. If the hospital lawyers are representing the doctors, nurses and everyone else involved in the patient's care, and there is a significant difference between the versions of events provided by a doctor and another employed healthcare worker, the hospital lawyers may advise the doctor it is in their best interests to seek separate representation.

Another example is where the Coroner raises the likelihood of a serious adverse finding and/or referral to Ahpra for a doctor involved in the case. This may be the result of an independent expert report, and affected doctors are usually offered a right of reply. Again, the hospital lawyers might direct the doctor to contact their MDO for advice.

Is it better to be represented by the hospital or my MDO?

We generally recommend accepting representation from the hospital if it is offered to you. This is particularly relevant if your involvement in the case is minimal. We don't like to single doctors out unless it is necessary, as this can often draw unwanted attention during the Inquest. In our experience, it is best to stay with the 'herd'. The interests of the hospital and employed doctors generally align, so it is usually best to continue to receive assistance from the hospital lawyers who have access to all the relevant documentation.

How can my MDO assist me if I accept hospital representation?

We are always happy to discuss any concerns or questions you have about your involvement in the case, and the coronial process in general. We can also act 'in the background' to review any draft reports or statements. The importance of us remaining in the background is that it's not appropriate for an MDO to actively interfere in the legal representation you have accepted from the hospital. If anything comes up that raises significant concerns, we will then discuss with you whether it might be in your best interests for MDA National to take over representation.

Most hospitals are comfortable with (or even encourage) their MDO-insured doctors seeking advice or requesting the review of a statement by their MDO – but you should check with them first. We are used to working closely with the hospitals.

Some handy tips

- Don't gratuitously add to, or alter, the medical record after a patient is deceased. It's a bad look to see four lines of notes written at the time the patient died, followed by four pages of defensive or self-serving notes written two weeks after the event.
- Contact MDA National if you become aware of a coronial investigation regarding a patient you have treated. We can talk through the details of the case, and provide advice and support to best suit your individual circumstances.
- A coronial investigation is distinct from a claim for negligence. Our article ***Patient claims involving hospital doctors*** may help to explain the distinction. You can access it from our library at **mdanational.com.au/advice-and-support/library/articles-and-case-studies**.

The power of visualisation

Dr Jonathan Ramachenderan (MDA National Member)
Pain Medicine Fellow
General Practitioner & Anaesthetist

Visualisation can help connect our conscious thoughts with our subconscious mind. We all visualise outcomes, whether we know it or not.

If you've ever been anxious about anything, or excited about something – such as a potential experience or result – you've practised visualisation. You've more than likely created an image in your head, with the accompanying emotion, about how you will feel and what you may do, as you interact with this experience.

Our mind serves as a powerful engine of thought, imagination and blue-sky dreaming that, if utilised correctly, can help us through our long years of medical training and practice.

Professional athletes are most adept at this practice. They use high-order imagery in meditation and thinking about their training, competition and rehabilitation.

In pain medicine, 'graded motor imagery' is a powerful evidence-based intervention that utilises 'imagined movements' of painful and poorly functional limbs to engage the pre-motor and motor cortex, which helps with the rehabilitative process of moving again.

In medicine, imagery interventions have also been used in skill acquisition and stress management through imagined movements, meditation and mindfulness exercises.

> Visualisation is a powerful tool, especially if you use it to steer your life towards what you want and the person you want to be. Live intentionally.

Practising visualisation

I only had one goal in 2023 – to pass my Fellowship exam.

We'd moved as a family from our idyllic country life in Albany to Perth, for me to pursue a Fellowship in pain medicine.

Overnight, I was a trainee again. Scrambling to keep up with the chasing, calling, consults and chaos that come from being a subspecialty registrar in a tertiary hospital.

As the study began in mid-April, a gloominess, dread and guilt crept over me, coinciding with the cool autumn change.

"My winter is coming," I thought as I sized up the enormity of my task ahead. But this wasn't the first exam campaign or medical challenge I'd faced.

As a PGY-17, I'd learnt a few lessons through the experience of failing and falling short at exams, both at medical school and as a registrar. I was familiar with the temptations and distractions of life, and I had acquired a few skills that served me well.

One of those skills was developing a clear vision of what I wanted, and being certain about what I would do to achieve that goal. And it all starts with the power of visualisation.

As the days became shorter and the workload intensified, I practised visualisation.

I visualised two specific goals each day:

1. The post-fellowship ceremony with my name being called.
2. A hot Christmas day in Perth where shade was a premium; but despite the heat, I was immensely grateful for having passed my exam and not needing to study anymore!

Both these goals filled me with a positive and deeply satisfying feeling of achievement that helped to quell my worry.

More potently, this visualisation of the person I wanted to be – "Jonathan, who passed his Fellowship examination" – helped shape what I needed to do each day to achieve this clear goal.

However, consider the opposite circumstance – a person with no clear vision, thus no clear goal. Without a clear goal and destination, stress and worry can accompany a directionless path. Other tasks and priorities can derail our progress towards achieving the overarching goal.

In your early years of training, visualisation may be in the form of: "I just want to get through this term" or "I'd like to learn how to be better at this."

Key lessons

Lesson 1: Our words to ourselves matter

Shad Helmstetter in his book *What to Say When You Talk to Yourself* describes the relationship between the conscious and subconscious as that of a captain on the ship and the engine-room worker respectively. The captain gives the order, and the worker follows his command.

If we are unkind and speak negatively to ourselves, for example, "I'm not very good at procedures" or "I'm not smart enough to pass that exam", our subconscious mind will work to help achieve these outcomes.

Being careful with your language is the first practice in visualising the future you want.

In those winter months, I spoke to myself almost every day: "Jonathan, keep going. You are on the right track. This will be over soon." And quite soon, it was.

Lesson 2: Be clear about what you want

The second lesson in effective visualisation is founded on what Stephen Covey famously said, "everything is created twice". Firstly, it is imagined and birthed in our minds; and secondly, it is created and brought to life in our physical world.

Just like an architect first creates the vision for a home in their mind, and then sketches the design. Months to years later, the house is complete – the second creation.

Likewise, everything we desire and hope for is created in our minds first, before it is created in the physical world.

What is it that you specifically want? How do you want your working and home life to look? What type of medicine do you want to practise? What do you want from this year or this term?

For me, in 2023, it was passing my exam and being a good dad and wonderful husband. This shaped every decision, helping me to say "no" to several things and "yes" to only a few that got me what I wanted.

I imagined taking the 'best bits' of all the registrars and consultants who'd taken the time to teach, guide and nurture me through my training – with their words, techniques and emotional intelligence incorporated into my practice.

Be clear about the specific future you seek, the work-life you desire, and the exact goals you wish to achieve – because it all begins in our mind before we can savour them in the world.

Dr Michelle Johnston at her book launch for *Tiny Uncertain Miracles*.

The sweet spot between creativity & medicine

Niranjala Hillyard
Director, Inkpot & Pixel
Freelance Writer, Editor & Designer – *Defence Update*

MDA National Member and Emergency Medicine Clinician Dr Michelle Johnston published her debut novel *Dustfall* in 2018, and she hasn't stopped there – with her second book *Tiny Uncertain Miracles* launched in 2023.

It does seem miraculous that Michelle has found the time, energy and headspace to achieve her writing goals, in the midst of her busy clinical and educational roles.

I had the pleasure of interviewing Michelle – a charming and down-to-earth personality with a quirky sense of humour, and an innate appreciation of the smallest things in life. Here's what she had to say.

Q1. What motivated you to become a doctor?

I hailed from an era of sub-optimal school career counselling and a gender-inequality empire still clinging to its reign. So, when it came to choosing a career, and all I had was a vague desire to 'help people', I was told I should become a nurse. A slap of realisation came at subject selection time that I had the marks to do medicine – and a quick pivot had me stream right into medicine at UWA.

Choosing emergency medicine as my specialty wasn't an active choice, more like being washed along the tide of inevitability. In an early RMO ED term, Dr Steve Dunjey (the great god of Perth emergency medicine) said, "You're rather good at this …". That was that. Plus, I loved the uncertainty and the unknowns of emergency medicine, the raw humanity, and the fact it was all action and few meetings. I was wrong about that last one!

Q2. Has writing always played an important role in your life?

Writing is vital to me. Particularly fiction. It's my only way of making sense of the world. Writing also stops me sleepwalking through life. Having to pay attention; tear the covers off the tedium of reality; find the beauty in everyday things and transform them into the music of language... writing might be the only thing that saves me.

Q3. How do you juggle life as a clinician, educator, author, wife and mother – while still retaining your sanity?

There is no balance, and possibly only a shred of sanity remaining. My habits are unswervingly bad, habits I'd recommend to nobody. But if you really love doing something, there's always time to do it. And the end point makes it all worthwhile – when you're able to share your hard work with a few other souls, and have them actually enjoy spending time inside your precious creation.

Q4. Tell us about your latest book, *Tiny Uncertain Miracles*.

This book is about fate, faith, and the question of why we humans believe in the things we do. It follows Marick, a (not very good) chaplain who never could make it to priest, as he wanders the labyrinthine tunnels of a hospital.

There he meets a scientist, Hugo, who has commandeered a forgotten laundry to use as a makeshift laboratory, where his prize E coli bacteria make proteins for a little side hustle. One day, Hugo discovers his bacteria have begun making gold.

Then Marick, the man of faith (who believes in science) and Hugo, the man of science (who reads his horoscopes) need to understand what's happened. Is it science? A hoax? Alchemy? A miracle?

Q5. What sparked the idea for this storyline?

I admit the concept is rather a stretch. I don't have any good excuse for the bacteria making gold at the heart of the story, except that when the muse floats a line into your head and it sticks, you've got to do something with it!

Of course, it's not a book about alchemy at all – but the strengths of our beliefs, the possibility of occurrences that aren't always explicable (sound familiar, fellow clinicians?). Universal themes and subtexts.

Plus, it felt like quite an important book to write, in the current wave of anti-science we're all struggling to understand.

Q6. You teach doctors about the sweet spot between creativity and medicine – can you expand on this?

It's taken me a long time to truly appreciate how important creativity is in a fulfilling life, whatever form that creativity may take.

My job in medicine now is to help inspire those following after me, to find joy and grace and awe. Without it, this intensely difficult career we've committed to can be overwhelming to the point of being destructive.

Addressing creativity is addressing humanity. Plus, all doctors have a novel in them. I love helping people find it.

Q7. Any words of advice for doctors wanting to pursue emergency medicine?

It's an incredible specialty. The job will remain deeply challenging and, like many areas in medicine, puts you at risk of moral injury (being prevented from taking the actions you know to be morally and ethically right). But meeting those challenges can also allow you to soar.

When seniors are angry, rude or dismissive, it often comes from a place of fear or exhaustion, or other personal issues. While you should never tolerate a medical colleague being rude to you or others, it does help to understand where they're coming from – that so many of us suffer under the weight of expectations and responsibilities, and not quite living up to almost impossible standards.

Start thinking early about your own area of interest or specialty. You don't want to be well into your 50s and purely doing clinical emergency medicine; 10-hour shifts day after day in the hothouse. Diversify your specialty. It's good for you and the department.

The human body is preposterously fascinating. Too complex for our little human brains to truly comprehend. And in medicine, we get to see its wonder all the time. So, remember to find the awe in the everyday. Learning will be lifelong, and it will be amazing.

Be kind to yourself – so clichéd but true. Be responsible for your own high standards. Find things that bring you joy. And DO THEM.

Scan the QR code to preview and purchase *Tiny Uncertain Miracles*.

Supporting you to become the best doctor you can be

As an early-career Member, you have access to a range of complimentary resources, including interview preparation training and Member discounts on textbooks and equipment.

Need help with your medical officer interviews?

Presented by Medical Interview Coach Dr Brooke Bullock, the *Interview Preparation* workshop series provides education on interview techniques, and training on how to tackle both standard and unexpected interview questions.

Topics include:
Interviewing for Doctors: How would you respond to the following scenario?
Interviewing for Doctors: What are your thoughts on XX?
Interviewing for Doctors: What are your best cards?
Interviewing for Doctors: Tell me about a time when?

Keep an eye on your inbox for upcoming updates from us, including event dates and registration information

Explore your Member benefits and discounts including **25% off textbooks** and **30% off scrubs**.

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 the areas of medicine they most enjoy, and assists participants in identifying the medical specialty that suits them best.

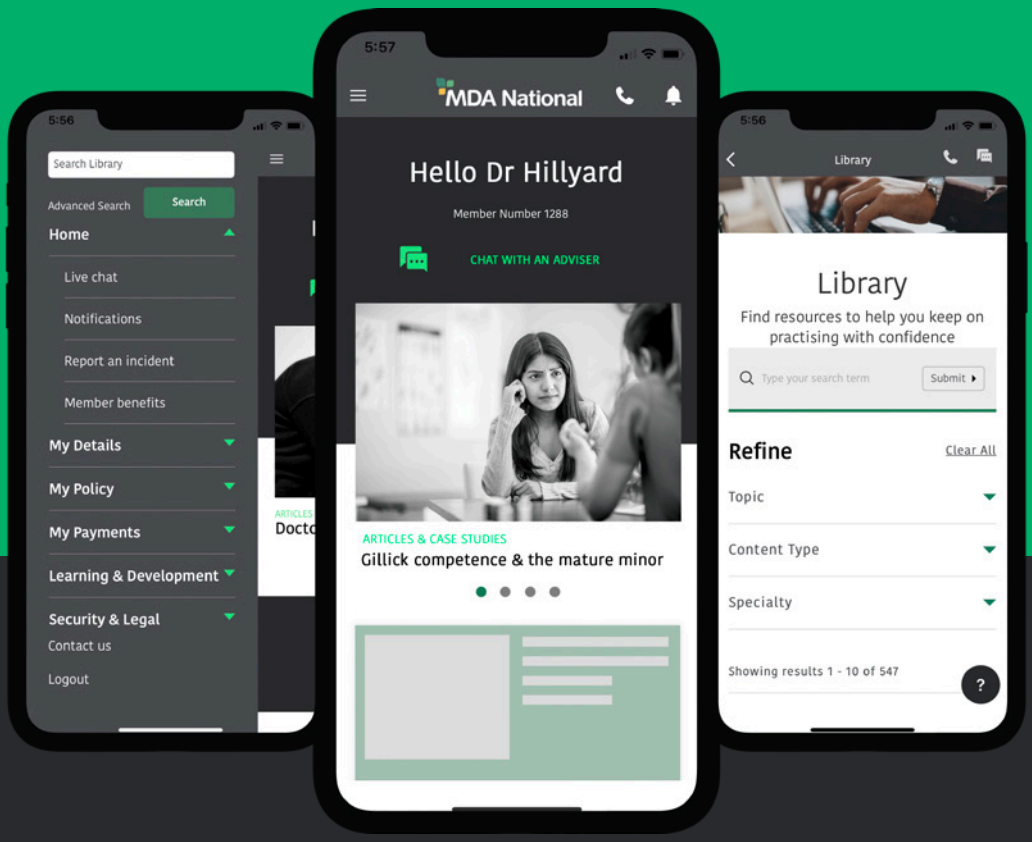
Topics include:
Your medical career: What to do when you don't know what to do!
Understanding individual personality traits and how these impact work satisfaction and career choices
Skills and strengths: The importance of identifying yours in your career planning, and when applying for your desired role

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.*"

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.

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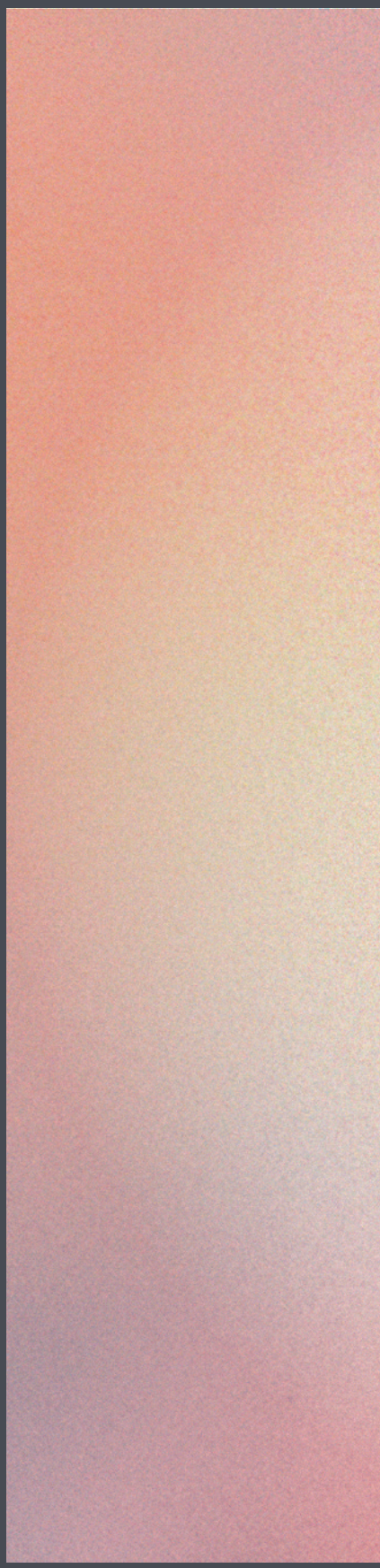

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1800 011 255 peaceofmind@mdanational.com.au