An Annual Update for MDA National
GENERAL PRACTITIONER MEMBERS

GP**Update 2015**

Overview

MDA National is celebrating 90 years of supporting, protecting and promoting our Members this year.

Our *GP Update* aims to keep you informed of the perennial medico-legal issues specific to GPs; equip you with practical medico-legal advice; and support your delivery of quality medical care.

This edition includes articles on:

- abuse and misuse of prescription medication
- how to say "no" to patients
- listening as part of communication
- the benefits of a practice policy
- the GPSA – promoting our Indigenous doctors
- a case study on mandatory reporting of child abuse
- a reminder about bioCSL Fluvax vaccine.

Our Medico-legal Advisers are available to address any specific questions on any of the above matters on **1800 011 255** or **advice@mdanational.com.au**.

On behalf of all of us at MDA National in our 90th year – thank you for your Membership and loyalty.

Celebrating 90 Years
of Member Support

Abuse and Misuse of Prescription Medication

Case history

The Victorian Coroner recently held an inquest into the deaths of three unrelated people.[1] All three of them were found to have dangerous quantities of addictive prescription medication in their system.

Mr S was a 24-year-old man who had been under the care of a Psychiatrist and had been prescribed paroxetine and ziprasidone for anxiety and depression. His usual treating GP continued these medications as well as alprazolam. Mr S's drug use escalated, so he attended other GPs who provided him with extra scripts for these medications. He then developed back pain, and in the last week of his life he was supplied with 60 capsules of tramadol, 60 tablets of codeine phosphate with paracetamol and 30 oxycodone tablets by several different doctors.

His death was found to be due to multiple drug toxicities, with codeine, oxycodone and paroxetine levels in the toxic range.

At the inquest it was found that his usual GP was unaware that Mr S was obtaining medication elsewhere. Furthermore, a serious lack of communication between Mr S's GP and Psychiatrist resulted in both of them prescribing paroxetine and ziprasidone at one stage.

Prescription drug misuse is a complex and difficult issue for GPs and the problem seems to be escalating.

Mr A was a 34-year-old man who had a long history of drug and alcohol abuse. The inquest revealed that he was attending multiple GPs to obtain large quantities of prescribed medications. In the 12 months prior to his death he attended 22 different GPs. In the last six months of his life he obtained 75 scripts, 38 of which were for various benzodiazepines, mirtazepine, quetiapine, alprazolam and opioids, which escalated in the final weeks of his life. Several of the treating doctors were under the mistaken impression that they were Mr S's main or sole GP.

A post mortem revealed that he had toxic levels of codeine, oxycodone and paroxetine.

Ms B was a 35-year-old woman who suffered from depression, insomnia and back pain. She attended a large general practice and saw many different doctors there. She was taking amitriptyline for her depression, as well as tramadol, paracetamol, codeine, doxylamine, and diazepam, nitrazepam and temazepam. She attended the surgery very frequently, and obtained large quantities of these medications, at a rate that far exceeded her prescribed dosage.

Her cause of death was multiple drug toxicity, and post mortem testing revealed that she had lethal levels of tramadol, codeine and amitriptyline, as well as toxic levels of paracetamol and doxylamine.

Medical experts at the inquest were critical of the care provided at the medical centre. The doctors there were aware of the amounts of medication prescribed, but there was inappropriate assessment and management of her prescription drug dependence, and a lack of any clear plan to tackle her obvious addiction and drug misuse issues.

Discussion

One of the main focuses of the inquest was to try to determine why none of the present systems of prescription regulation resulted in any of the deceased patients coming to the attention of doctors or pharmacists. The Coroner found that the Prescription Shopping Information Service had no significant impact on the prescribing to any of the deceased.

The Victorian Coroner made a number of recommendations including that steps be taken to implement real-time, web-based prescription monitoring of both Schedule 8 drugs and benzodiazepines. He also recommended more education for GPs on:

- management of chronic non-cancer pain
- prescription of benzodiazepines
- prescription of opioids.

This same issue was also the subject of a Coronial inquest held in WA in March 2015.[2] The WA Coroner considered three unrelated deaths concurrently. The common theme was that all three were addicted to prescribed drugs of dependency. The Coroner made it very clear that the focus of the inquest was on systemic issues around prescribing, notification systems and dispensing of these drugs, and support particularly for GPs. The WA Coroner is yet to hand down her findings.

Abuse of prescribed medications is a serious issue for GPs, and one that seems to be on the increase.[3]

Real-time prescribing data would enable GPs to readily check those patients who present after hours requesting medication with stories of lost/stolen scripts, recent move from interstate, etc.

The RACGP recently renewed its request for a national electronic recording and reporting of controlled drugs system to try to help reduce overdoses from prescription drugs.

Prescription drug misuse is a complex and difficult issue for GPs and the problem seems to be escalating. While there is no doubt that real-time prescribing information would be of enormous benefit, there are strategies that GPs can employ to minimise harm to their patients.

References

1. State Coroner's Court of New South Wales. Inquest into the Deaths of Christopher Salib, Nathan Attard and Shamsad Akhtar. Sydney: State Coroner's Court of New South Wales, 2014.
2. Clarke T. Inquest into 'Doctor Shopping' Deaths. *The West Australian* 9 March 2015. Available at: au.news.yahoo.com/thewest/wa/a/26563183/inquest-into-doctor-shopping-deaths/.
3. Pilgrim JL, Yafistham SP, Gaya, et al. An Update on Oxycodone: Lessons for Death Investigators in Australia. *Forensic Sci Med Pathol* 2015;11(1):3-12.
4. Monheit, B. Prescription Drug Misuse. AFP 2010;39(8):540-546.

Further reading

RACGP's guide: *Prescribing Drugs of Dependence* is about to be released.

MDA National's *Prescribing Schedule 8 Drugs* from the Things to Think about series.

Ten Strategies to Prevent Misuse of Prescription Drugs

1.	Develop a policy for your clinic on requests from new patients for drugs of addiction. Try to ensure that all staff know this policy and agree to implement it (except in very exceptional circumstances).
2.	Write tamper resistant prescriptions and keep all prescription pads and computer prescription paper under control.
3.	Ongoing prescribing drugs of addiction (Schedule 8 drugs) requires a permit or authority (depending on jurisdiction). Ensure this is obtained from state health authorities. Reminders to renew time limited permits can be added to the clinic's computer recall system.
4.	Have the telephone number of your state's drugs of dependence unit readily available as they can also provide useful information about permits, treatment programs and legal issues regarding treating drug dependent patients.
5.	Have the telephone number of the Prescription Shopping Information Service readily available (1800 631 181). Register your name with this service.
6.	If unsure what to do about a patient's unusual or apparently unreasonable requests for drugs consult with a peer, supervisor or drug and alcohol specialist for advice.
7.	In chronic pain management adopt a "universal precaution" approach for all patients. This includes taking a brief drug and alcohol history, monitoring for aberrant drug behaviour and recognising that pain and addictive diseases exist as a continuum rather than as two distinct patient groups.
8.	For patients requiring ongoing prescription of drugs of dependence a treatment plan (or care plan) should be developed with the patient. There are invariably complex chronic medical and psychosocial issues involved. Share the management with others if possible, especially mental health workers, chronic pain clinics, and drug and alcohol services in your region.
9.	If things go really wrong, for example, you are threatened by the patient, cease the treatment program immediately. The patient-doctor relationship has been violated. Advise your medical defence association, the senior person at the clinic and the police if necessary to protect you and clinic staff. You may suggest another treatment service for the patient if you wish, but you are not required to do so.
10.	If you are the type of doctor who is too "soft" or gets overwhelmed by patients' requests for drugs then don't start treating drug addicts. Leave it to someone else. It is hard to justify writing a prescription just because the patient wants it. Remember, the Coroner and health department holds you responsible for every prescription you write.

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Know When to Say No

By Dr Reg Bullen MBBS, FRACGP, FRNZCGP

Nyet, nada, non, nein, no! In any language, "no" is generally an unacceptable word, even more so at first acquaintance.

But in medicine (especially in General Practice), it has the ability to fracture a working therapeutic relationship. In some fraught encounters, it may even pose a genuine risk to the one proffering it as a response. Sometimes a refusal is seen as unreasonable, unreasoned and not within the recipient's immediate past experience.

You may be refusing to bulk bill, prescribe a sought medication (not just narcotics, steroids or "benzos"), order an unnecessary test or investigation, backdate a certificate or a referral, or partake in some wonderful financial partnership opportunity or social event. I've had them all offered to me!

The above events do not occur in isolation.

The absolute requirement for making a request of a doctor used to be when the patient was in the same geographic location as the doctor. This is no longer the case with the advent of telemedicine, social media and various internationally based prescribing/dispensing services which, in my opinion, should be avoided.

In our practice we have several protocols in place: signs declaring narcotics/S8s will not be prescribed on first visits; that anything requiring a signature requires the requestor's personal presence; that co-prescribing will only occur after the practice has received an appropriate request and has agreed to participate; that anyone on narcotic medication will sign an individual prescription contract (and breaking that contract ends the relationship at the first instance).

These are all good aids to appropriate practice. But the foundation to them all is what I call my "philosophy of patient engagement."

At the first consultation with a new patient (that is, new to me, not new to the practice) after establishing why they have attended, I explain how General Practice works for me, and therefore if they still wish to see me, how it will work for them.

The conversation goes along these lines:

The way I like to work is to form a partnership with my patients that enables us to best meet your healthcare needs. Both of us bring some differing expertise to the partnership, so I suggest we both retain the right to say 'no' to the other's requests.

Now I'm a little sneaky, and if you say 'no' to something I think is really important, I will try to persuade you but I will not force your compliance... Equally there are occasions when you will request something and I will say "no" to that particular request. Does that sound fair to you?

This establishes a foundation for an acceptable, medically relevant consultation outcome while also presaging the doctor's absolute right to say no. It does so without any risk to reputation, verbal or physical abuse, or referral to the various authorities that oversee our profession.

It will not stop the "end of session, strung out, desperate addict", but not much will. However, it does provide for a consistent platform for ethical decision making and the provision of good reputable practice.

Also, over time, it will mean you will not be the "other" doctor who is quoted by the patient in an effort to provide implied "peer pressure to comply" on one of your colleagues.

Shut Up and Listen

Dr Paul Nisselle AO
VIC General Practitioner and MDA National Mutual Board Director

Two separate articles some years ago reported that, on average, the gap in a consultation between asking, "And what has brought you to see me today?" and the doctor interrupting with the first question was:

- General Practice 18 seconds
- Emergency Departments 11 seconds.

However, another study has shown that if you sit on your hands (figuratively) and don't interrupt at all, the patient will conclude their "opening" usually in less than a minute, and occasionally 90 seconds. And, if you "shut up and listen", the consultation will actually take less time than if you keep interrupting.

When I introduced the (then) Bayer Institute for Healthcare Communication's workshops to Australia and New Zealand in 1992, getting doctors to come to those workshops was like getting patients to go to VD clinics. (If you go, you're telling everyone that you've got a problem.)

Now, communication skills are an essential component of training for all disciplines, and especially for General Practice. I recently facilitated about 200 communication workshops over four years in the UK and Ireland. How quickly they were fully booked was very notable! GPs –at least in some parts of the world– are responding to the communication message.

So how do you convert communication theory into practice?

- **Introduce yourself and "engage"**
  As you take the patient from the waiting room to the consulting room, introduce yourself if it's a new patient, and "connect" as two human beings before it becomes "doctor" and "patient".
- **The opening**
  Use an opening question that is intended to elicit the patient's expectations, not just their symptoms. If you ask "What's the problem?" you might get the reply "I've got a sore throat". If you ask, "How can I help you today?" the reply could be "I've got a sore throat and I've come to get some antibiotics." Now you might not think antibiotics are indicated, but knowing that expectation, you can address it, even if you don't plan to meet it – "Your throat looks very sore, but it looks like a virus infection and antibiotics would not fix it. What I suggest is..."
- **The golden minute**
  Let the patient know you're listening. Turn away from the computer and make eye contact at least 50% of the time. (Less than 50% is interpreted as disinterest; more than 50%, you're staring.) Encourage them to keep going by using non-verbal cues such as head nods, perhaps augmented by a soft grunt.

  If the patient is giving a lot of information, and you're worried you will not remember what they've said, it's okay to turn towards your computer and as you're turning say, "I'll just make note of what you're telling me, but please go on".
- **Nudging**
  If the patient seems reticent to say more, or seems to have run dry, resist the temptation to start asking closed questions. Instead, ask an open question such as, "Can you tell me more about that?".
- **The empathic paraphrase**
  When you think the patient has completed what they wanted to tell you, summarising what you've heard is a powerful way of indicating that you really have been listening. You could say:

  Now let me see if I've got this right... You vomited two days ago and it had some black blood in it. Yesterday you passed a very black motion. Today you've vomited twice and each time there was bright red blood in it. Is that correct?

  That's good, but it would be much better to make it an empathic paraphrase by adding the associated emotion:

  Let me see if I've got this right. Two days ago you were concerned when you vomited and saw some black blood in it. Yesterday you were even more concerned when you passed a very black motion. Today you were alarmed when you vomited and noticed bright red blood in in the vomit. Is that correct?

Extra time required? Yes, a couple of seconds, and the patient will know that you've got the complete message.

Roger Federer needed a great backhand as well as a great forehand to become the greatest tennis player of all time. Doctors need **both** great communication skills and great clinical skills to be great doctors!

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Practice Policy – Why Do You Need It?

MDA National Insurance's Practice Policy responds to complaints and claims arising from the actions of practice staff.

Here are some case scenarios that show the value of having a Practice Indemnity Policy:

Breach of confidentiality*

A practice received a District Court Summons to Produce (Subpoena to Produce) patient records in relation to a criminal matter. A receptionist misread the cover letter and mistakenly released an entire copy of the notes directly to the defendant's solicitors. The notes should have been produced to the Court, not to the solicitors, and some of the documents were later deemed to be "protected documents" under privacy legislation.

The patients were very understanding and appreciated the steps taken by the practice to mitigate the damage, however this was a very serious breach of confidentiality. As the error occurred without any input from the doctors in the practice, MDA National Insurance's Practice Policy responded to the patient's complaint of breach of confidentiality.

Misrepresentation and breach of privacy*

A friend of a patient contacted the practice and asked to speak to the friend's treating doctor. The request was declined as the patient had not given consent for the treating doctor to discuss personal medical information with the friend. The friend called several times, and while the receptionist consulted with the treating doctor, another administrative staff member intercepted the call which had been on hold for some time.

When the staff member asked "How can I help you?" the patient's friend provided lengthy comment on the patient's care before the staff member was able to interrupt and advise that she was not a doctor. The staff member was then accused by the patient's friend of impersonating a doctor and breaching the patient's privacy. Our Practice Indemnity Policy responded to a claim that was subsequently brought against the practice staff.

Clinical incident^

A patient attended her local general practice after travelling overseas for two years. The patient had last attended the practice a month before she left the country for review of a lump she had found during breast self-examination. The patient was referred for a mammogram, which she assumed was normal because she had not heard from the practice. When the patient told the doctor that the breast lump had been getting bigger, the doctor reviewed the medical records and saw that the Radiologist had recommended a biopsy of the lump two years prior. The doctor was very apologetic and advised the patient that she did not recall receiving the results, or she would have contacted the patient before her trip.

Further investigation within the practice revealed that a new receptionist had filed the results without referring them to the doctor for review and initialling. The doctor arranged an urgent referral for the patient, who was subsequently diagnosed with metastatic breast cancer. MDA National Insurance's Practice Policy will respond to complaints or claims arising from the actions of practice staff.

* These case scenarios are based on actual medical negligence claims or medico-legal referrals; however certain facts have been omitted or changed to ensure the anonymity of the parties involved.

^ This case study is fictitious and demonstrates the breadth of our policy coverage.

Protecting Your Practice

At the heart of your medical practice is a team of clinical and practice staff who may need protection in the event of a medico-legal matter, complaint or claim against them or the practice.

MDA National's Practice Indemnity Policy provides peace of mind in knowing that your practice and staff are covered. The policy complements your own individual professional indemnity cover by ensuring your practice entity is protected from proceedings not covered by the individual professional indemnity policies that you and other practitioners within the practice hold.

What is covered by Practice Indemnity Insurance?*

Practice Indemnity Insurance covers non-medical practitioner employees and partners for their acts or omissions that could lead to a medico-legal claim. A Practice Indemnity Policy will respond to claims made against the practice entity itself and provides cover for any of the following matters that could be made against the practice or its employees as a result of providing healthcare services:

- civil liability claims
- investigations
- privacy complaints
- loss of documents
- intellectual property disputes
- defamation claims
- trade practices claims.

Multiple limits of indemnity are available to suit the needs of the practice.

What is covered by a doctor's Professional Indemnity Insurance Policy?*

The Professional Indemnity Policy provides cover for:

- medical practitioners in relation to claims and inquiries arising out of the provision of healthcare services
- investigations by a professional registration body or Professional Services Review Committee
- legal costs including obtaining an Apprehended Violence Order arising out of the provision of healthcare services
- legal costs arising out of breaches of fair trading legislation
- certain employment disputes
- certain disputes with medical colleges arising out of involvement in a training program
- loss of documents
- unintentional breaches of the Privacy Act
- certain criminal proceedings arising out of the provision of healthcare services.

The policy also provides Members with cover if they contract certain communicable diseases within the policy period.

The limit of indemnity for the Professional Indemnity Policy is $20 million in the aggregate for all matters for which you seek indemnity under the policy and several sub-limits apply for investigations, inquiries and other matters.

Please contact our Member Services team for more detail about our policies and your specific medical indemnity needs on 1800 011 255 or peaceofmind@mdanational.com.au.

*Subject to the terms and conditions of the policy and Underwriting approval.

As a doctor-owned mutual since 1925, we understand the challenges you may face in private practice, and are here to support you in identifying and managing medico-legal risks.

Mandatory Reporting of Child Abuse

Dr Murphy saw a new patient, Ellie, aged four. Ellie's mother, Julie, told Dr Murphy that after picking Ellie up from her father's, she had noticed some abrasions on her inner thighs when helping her get changed for her swimming lesson. Dr Murphy asked if Ellie had a usual GP and Julie said she did, but she wanted to see a doctor who did not know the father. When Dr Murphy asked Julie about the status of her relationship with Ellie's father, she replied that she was divorced and had shared custody of Ellie and her older brother.

Dr Murphy examined Ellie and found her to be a giggly, ticklish, healthy four-year-old, and she did not appear to be in any discomfort. Dr Murphy noted small abrasions on the inner aspect of both upper thighs and thought they may have arisen from a friction-type injury. Dr Murphy was not certain of the cause of the abrasions. Dr Murphy, with Julie's consent, performed a visual examination of Ellie's external genitalia and did not note anything of concern.

At the end of the consultation, Dr Murphy asked Julie to bring Ellie back for further review if she had any concerns. Before leaving the consultation room, Julie abruptly asked Dr Murphy to provide her with a copy of what he proposed to report to DOCS (Department of Community Services). Dr Murphy replied that, in his opinion, the matter did not reach a reporting threshold and in the absence of any other information, he did not have any objective reason to make a report to DOCS. Julie became enraged, picked up Ellie and stormed out of the practice.

The next morning, a detective attended the practice. Dr Murphy was surprised to hear that Julie had made a police report alleging that Ellie had been abused by her father and that Dr Murphy had dismissed these concerns. Dr Murphy informed the detective that Julie had not relayed this allegation and had simply asked for a copy of his DOCS notification.

The complaint

Four months later, Dr Murphy received a letter from AHPRA advising him that the police had lodged a complaint against him for failing to make a mandatory report to DOCS. In the notification, the police went so far as to assert that they had grave concerns about Dr Murphy's ability to treat paediatric patients as he did not have any appreciation of his mandatory reporting obligations.

Dr Murphy prepared a comprehensive response to the complaint, in which he set out precisely what occurred during the consultation and why he did not believe the marks had been caused in a manner suggestive of Ellie being a child at risk. Dr Murphy then set out his understanding of his mandatory reporting obligations and of the fact that he takes child protection issues very seriously. He also stated that upon receiving the notification, he had reviewed the child protection legislation relevant to his state to ensure he had not misunderstood his mandatory reporting obligations at the time he had seen Ellie. Dr Murphy explained that he knew the Act required him to make a report if he had reasonable grounds to suspect Ellie was at risk of significant harm, but in this instance, nothing about the history provided by Julie or his examination findings caused him to have any concerns for Ellie's safety, welfare or wellbeing. Dr Murphy concluded his submission by stating he did not believe any of the relevant criteria were present to any extent, let alone to a significant extent and that accordingly, he did not have reasonable grounds to suspect that Ellie was at risk of significant – or any – harm.

The matter was discussed by the State Board of the Medical Board of Australia where it was determined that Dr Murphy had satisfied the Board's concerns. No further action was taken.

Discussion

This case exemplifies the importance of medical practitioners knowing the mandatory reporting obligations and the threshold at which concerns must be notified to the family and community service within their state or territory.

Members are encouraged to telephone our Claims and Advisory Services on 1800 011 255 for advice, or with any queries about mandatory reporting obligations with respect to child protection.

Supporting Our Indigenous Doctors

Indigenous GP Supervisors around the country are on a mission to increase the number of GP Supervisors available to support both Indigenous and non-Indigenous doctors in training.

Dr Cody Morris, Dr Olivia O'Donoghue, Dr Latisha Petterson, Dr Trish Baker (GPSA Board Member), Dr Aleeta Fejo, Ms Margo Field (Previous GPSA CEO), Dr Aaron Davis, Ms Michelle White (MDA National).

There are presently 34 Aboriginal registrars (0.85% of 4,000 registrars) in the Australian General Practice Training (AGPT) program, well below population parity. With great needs in Aboriginal health, the success of our Aboriginal and Torres Strait Islander peers is vital.

On Friday 13 March, Indigenous doctors from around Australia attended the Indigenous GP Registrar Network Workshop in Brisbane – a forum well regarded and attended by Indigenous doctors across the country.

Dr Trish Baker from the General Practice Supervisors Association (GPSA) ran a session at the conference for registrars and recent fellows about the role of the GP Supervisor, the eligibility criteria, and explored some of the key competencies of highly effective supervisors.

MDA National was proud to provide two Indigenous participants with flights and accommodation to facilitate attendance to help support their journey to become a GP Supervisor.

BioCSL Fluvax Vaccine Not to be Used for Children Under Five

All doctors are reminded that bioCSL Fluvax should not be used to immunise children under five years of age, and should be used with caution in children aged five to nine years.

The Department of Health has issued a warning that doctors who give the bioCSL Fluvax vaccine to children under five years of age are exposing themselves to legal risks. This follows reports that nine children have been wrongly administered bioCSL Fluvax since the beginning of the 2015 winter immunisation season and a multimillion dollar payout in 2014 when a five-year-old girl became severely disabled after receiving bioCSL Fluvax.

According to the Australian Technical Advisory Group, there are clear warnings against using the vaccine in children under five years of age and it is not recommended in children aged five to nine years due to an increased risk of fever and febrile reactions.

The PI for bioCSL's Fluvax now includes a black box warning, and the vaccine's packaging includes warnings to remind health professionals against using the vaccine in under-fives.

Beware Medicare

MDA National has become aware of a number of recent Medicare audit activities affecting GPs and other specialists. For more information see our *Defence Update* Winter 2015 at defenceupdate.mdanational.com.au.

NRAS Review

A review of the National Registration and Accreditation Scheme (NRAS) for health professions was recently conducted by Mr Kim Snowball, the former Director General of WA Health. A Consultation Paper released in August 2014^ sought feedback on a number of issues, including the handling of complaints and notifications, advertising of health services and the mandatory reporting of health practitioners.

MDA National provided a submission in response to the Consultation Paper in which we outlined concerns regarding delays, and a lack of consistency in the assessment phase of notifications and outcomes of investigations. We also reiterated the need for national introduction of the legislative exemption which exists in WA, where practitioners are exempted from mandatory reporting requirements when providing health services to other health practitioners and students.

^Available at: nhaa.org.au/docs/Submissions/Consultation_Paper_-_Review_of_NRAS_for_health_professions.pdf.

Education Resources for General Practitioners

MDA National delivers what we believe is unrivalled education in Australian medical indemnity today as part of our longstanding commitment to supporting, protecting and promoting the best interests of our Members.

Much of our education is accredited for professional development recognition with The Royal Australian College of General Practitioners and The Australian College of Rural and Remote Medicine, and all of it is complimentary for Members:

- face to face education events such as Complexities of Informed Consent Conversations, being delivered in various states around Australia in June 2015
- online education activities associated with our *Defence Update* publication
- booklets and information sheets on medical records, retirement from medical practice, telehealth and other topics
- Practice Self-assessment Checklist and Handbook – designed for GP Members who have consulting rooms.

Need more information?

Visit our online events calendar at mdanational.com.au, log on to our Member Online Services to do online activities and download resources, or call our Member Services team on 1800 011 255.

Interested in hosting a face to face session?

All you need is a group of participants and a suitable room. If we can fill your request, MDA National provides the session facilitator and all education collateral to support the activity. This is just one of the many practical ways we aim to support you and your practice.

For more information, contact your state MDA National Business Development Specialist:

NSW	Nikki McAusland	0417 927 990
QLD	Cathy Kayess	0448 137 240
SA	Megan Sheldon	0409 373 536
TAS	Jo Edwards	0438 923 597
VIC	Nina Soldatovic	0437 150 244
WA	Rose Cummins	0409 104 373

Contributors

Thank you to following editorial contributors:

Yvonne Baldwin
Claims Manager (Solicitor), MDA National

Shahana Datta
Senior Underwriter, MDA National

Dr Jane Deacon
Medico-legal Adviser, MDA National

Glen Wallace
CEO, General Practice Supervisors Australia

Specialty Reviewer

Dr Marianna Dare
MDA National Member and VIC PMLC Member

Freecall: 1800 011 255
Member Services fax: 1300 011 244
Email: peaceofmind@mdanational.com.au
Web: mdanational.com.au

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