

defenceupdate

Publication for MDA National Members

Autumn 2016



 **MDA National**
Support Protect Promote

**Medicare Provider Numbers:
Provider Beware**

The Second Opinion

**Choosing Wisely and
Defensive Medicine**

Upstream or Downstream

**Harnessing the Potential
of Social Media**

MDA National CaseBook

**Medico-legal Feature:
Testamentary Capacity**



Editor's Note

Welcome to the first edition of *Defence Update* for 2016. Published three times a year, *Defence Update* aims to keep you up to date with emerging and perennial medico-legal risks.

We are committed to providing you with advice and support to reduce your medico-legal risk, and to improve the quality of patient care. This year, we are introducing a medico-legal blog to provide you with prompt and easy access to information about medico-legal cases and legislative changes which have an impact on contemporary clinical practice. You will soon receive an invitation to subscribe.

In this edition of *Defence Update*, we have a wonderful essay which won the 2015 MJA, MDA National, Nossal Global Health Prize in the medical student category (pages 15-16). Written by Victoria Smith, the essay reflects on her time in the children's ward at Alice Springs Hospital. Part of the theme of this essay is highlighted in Dr Jane Deacon's CaseBook article on the complex issue of childhood obesity, and the interaction between medical and child protection services (page 18). Of note, this case and our other CaseBook article on emerging problems associated with iron infusions (page 17) were brought to our attention by our Members.

Other articles in this edition include a discussion by Professor Frank Martin, an Ophthalmologist member of our Eastern Cases Committee, on providing second opinions (pages 6-7); the delegation of billing to hospital and other staff (page 5); and an outline of the *Choosing Wisely* initiative (pages 8-9). On page 10, Dr Ben Veness, Resident Medical Officer, challenges us to harness the potential of social media in clinical practice. And, in our regular pull-out feature, Dr Julian Walter provides a comprehensive guide on the assessment of testamentary capacity (pages 11-14).

I hope you find this edition engaging, informative and topical.

Dr Sara Bird
Manager, Medico-legal and Advisory Services



Defence Update Online

Visit defenceupdate.mdanational.com.au.

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Doctors for Doctors

MDA National is known for its “doctors for doctors” culture which has been embedded for the past 90 years. This culture only grows stronger, and it permeates the whole organisation.



At the time I was asked to author this column, I was doing some positive procrastination - sifting through old files - when I came across a letter from the year 2000 reminding me of United Medical Protection's (UMP) call for a payment of \$2,527.33.

This was the catalyst for my husband and me, as well as many other doctors, to leave UMP and search for a reliable and trustworthy medical defence organisation (MDO). Back then, my personal research showed MDA National had never made a compulsory call from its Members. In fact, it was the first MDO to:

- change to “claims made” indemnity
- achieve true full funding.

Unrivalled education

Since joining, I believe MDA National's education and risk management support is unequalled in Australian medical indemnity today. Our education is designed to benefit both the professional lives and wellbeing of Australian doctors. It addresses crucial professional attitudes and behaviours we always need to apply that are underpinned by the importance of our own health and wellbeing.

Strong advocate for Members

I've always known MDA National to be an advocate for our wellbeing as doctors. Today, we're continuing to lobby state governments to change the National Law and introduce mandatory reporting exclusions similar to those that currently exist in WA.

I have been fortunate to be involved with the formation and implementation of the President's Medical Liaison Council (PMLC) since its inception in 2010. It has provided a medically skilled resource bringing Members' issues to the Mutual Board. It also is a nurturing ground for future Mutual Board members, and we welcome Dr Patrick Mahar OAM, a former PMLC member, who was elected to the Mutual Board in November 2015.

Doctors for doctors

Our organisation is known for our “doctors for doctors” culture which has been embedded for the past 90 years and only grows stronger. This culture permeates the whole organisation and it is thanks to the leadership of Peter Forbes, and now Ian Anderson, that similar beliefs and ethical values are upheld by all MDA National people.

MDA National occupies a very strong position today and for the future. We commissioned a Reputational Audit Research in 2014 which indicated that **MDA National is Australia's most trusted MDO.**

We also proactively foster collaborative and open relationships with key industry stakeholders, including colleges and associations which benefit our Members, in regards to timely responses between our organisations as well as enhanced advocacy and educational opportunities.

Every day, we demonstrate our “doctors for doctors” ethos via our proactive case management philosophy, thanks to the many doctors who sit on our Cases Committee assisting our highly skilled Claims and Advisory Services team.

Our Doctors for Doctors Program enables Members to share experiences with another doctor during the course of any medico-legal incident. This can be escalated as required to our Professional Support Service which provides Members with confidential access to a Psychiatrist who is able to, if needed, give professional and emotional support during a medico-legal incident.

Remember - if you have any query, small or large, make sure you contact us.

We are **Doctors for Doctors.**

Dr Beres Wenck
Vice President, Mutual Board
MDA National Member since 2002

Notice Board

Are you up-to-date with the revised Professional Indemnity Insurance (PII) Registration Standard?

The Medical Board of Australia's revised PII registration standard came into effect on 1 January 2016. The revised standard states that medical practitioners with professional indemnity insurance must have "appropriate retroactive cover for otherwise uncovered matters arising from prior practice undertaken in Australia" by **1 October 2016**.

What do you need to do?

1. Visit medicalboard.gov.au/news/2015-12-01-revised-pii-standard.aspx for details on the changes.
2. Ensure you have appropriate indemnity cover for your current practice and any prior practice. Your *Certificate of Currency* includes your current retroactive cover – you can obtain a copy via our Member Online Services – log in at mdanational.com.au.
3. If you have any questions relating to your retroactive cover or need to make a change to the date, please contact our Member Services team on **1800 011 255** Monday to Friday, 8.30am to 8.00pm (AEST).



View more details under Latest News at mdanational.com.au.

RACS Action Plan on Discrimination, Bullying and Sexual Harassment

RACS has launched its action plan – *Building Respect, Improving Patient Safety* – on discrimination, bullying and sexual harassment in surgical practice. This follows last year's RACS report which found nearly 50% of college fellows, trainees and international medical graduates reported being subjected to discrimination, bullying and harassment.

The action plan articulates eight goals to enable the college to monitor its progress and ensure its actions make a difference. It aims to change the culture of surgical practice and training, and focuses on cultural change and leadership, surgical education and complaints management.

View the RACS action plan at: surgeons.org/about/building-respect,-improving-patient-safety.

New Privacy Guidelines

The Office of the Australian Information Commissioner has developed a series of new health privacy resources reflecting the introduction of the Australian Privacy Principles (APPs) and the 2014 reforms to the *Privacy Act 1988* (Cth). The resources provide guidance on the APPs specific to the obligations of health service providers – they are available at: oaic.gov.au/engage-with-us/consultations/health-privacy-guidance/.

Diagnostic Error in Health Care

Allegations of "failure to diagnose" comprise up to 50% of the claims against GPs, and are a significant underlying cause of claims involving other specialists.

In 2015, the Institute of Medicine released a comprehensive report, *Improving Diagnosis in Health Care*, which summarises what is known about diagnostic error and proposes recommendations to reduce its occurrence: iom.nationalacademies.org/reports/2015/improving-diagnosis-in-healthcare.aspx.

Website Enhancements

Our corporate website – mdanational.com.au – is changing for the better, and it will be more Member-friendly than ever before.

You will have **access to more of our medico-legal resources online**, including articles, blogs, case studies and more.



Australia Day Honours 2016

Congratulations to our Members who were awarded the Order of Australia in the Member (AM) General Division – **Dr Timothy Cooper**, **Dr Peter Pratten** and past MDA National President **A/Prof David Watson**.

View more details under Latest News at mdanational.com.au.

Medicare Provider Numbers: Provider Beware

Medical practitioners should be aware that if they authorise others to bill patients for services provided by them under Medicare or private health insurance arrangements, the medical practitioner remains responsible for the services billed under his or her Provider Number. In the event of inaccurate or inappropriate billing, the practitioner will be liable.

Responsibility for billing arrangements

Increasingly, Staff Specialists and Visiting Medical Officers (VMOs) in the public hospital system are asked to authorise hospital staff to bill non-admitted patients for services provided to those patients using the Staff Specialists' and VMOs' Medicare Provider Numbers. These billing arrangements are often conducted with minimal input from the Staff Specialist or VMO concerned.

In general practice, it is practice staff who are usually responsible for billing patients. General practice billing continues to grow in complexity given the breadth of services that GPs provide to patients. While there are more opportunities for GPs (and specialists consulting in private practice) to be involved in the billing process than there is for medical practitioners in the public hospital system, there are a number who rely heavily on practice staff. Medical practitioners need to ensure they are aware of the billing practices being undertaken on their behalf.

In the event that incorrect and/or inappropriate billing on behalf of a medical practitioner does occur, Medicare and/or private health insurers will hold the medical practitioner concerned responsible regardless of who conducted the billing on their behalf. Medicare will seek recovery of incorrectly and/or inappropriately billed services from the medical practitioner as provided for under the *Health Insurance Act 1973* and any applicable private health insurance fund rules.

If the medical practitioner wishes to pursue the medical practice or hospital for the money, this will be a matter for that medical practitioner, not a matter for Medicare or the health funds.

In addition to the possible repayment of money, engaging in inappropriate billing may have more serious consequences for practitioners including, in some cases, a period of suspension from Medicare.

Finally, before entering into private practice billing arrangements in the public hospital system, medical practitioners should seek advice regarding the possible consequences prior to entering into such arrangements, to satisfy themselves that the proposed arrangements comply with the provisions of the *Health Insurance Act 1973* and/or the National Healthcare Agreement.

Dominique Egan
TressCox Lawyers



Risk management strategies

Suggested strategies to minimise risk where billing is conducted by others on behalf of a medical practitioner include the following:

- Any direction from hospital administration or practice administration regarding the conduct of billing and compliance with Item Number requirements should be in writing, and should be retained by the medical practitioner in the event of a Medicare or private health insurer audit. If in doubt about a direction given, seek advice from MDA National.
- Where possible, medical practitioners may wish to have their own staff conduct billing in order to retain some control over the billing process.
- Medical practitioners should give clear directions to staff regarding Item Number requirements, and it is the medical practitioners who should determine whether the requirements for the Item Number for a service have been met.
- Medical practitioners should conduct regular audits of the billing undertaken on their behalf to identify any issues or concerns.
- Medical practitioners should seek and retain records of billings (date and time of service, Item Number, justification for clinical requirements of Item Number) in the event of an audit.

The Second Opinion

It is not uncommon for patients to request a second opinion in relation to diagnosis and management. Doctors need to be aware that the second opinion is about the patient and not about the doctor. The patient's request for one or more additional opinions must be respected.

The treating doctor may sense the patient's anxiety and doubt about their management, and will initiate the second opinion even before the patient requests it. In managing complex medical conditions where the medical practitioner is uncertain as to the diagnosis and best form of management, the practitioner will offer the patient the option of a second opinion from a colleague(s).

In both the above situations, there is usually a very good patient-doctor relationship and open communication as to what is in the patient's best interest.

Treating doctors should always listen to the concerns of their patients and their family. The patient (or their family) may request that the second opinion be sought from a specific doctor of their choice. If the treating doctor feels this would be an inappropriate referral, this should be communicated to the patient and alternative practitioners be suggested for the second opinion.

Medical practitioners should be alert to the concerns of their patients and if they sense the patient's doubt as to diagnosis and management, they should initiate the second opinion. The treating doctor is usually better placed than the patient or family on the choice of the practitioner from whom the second opinion should be sought.

Problems may arise when:

- the patient seeks a second opinion without the knowledge of their treating doctor. In this situation, the doctor giving the second opinion may not be fully aware of the facts relating to the patient's diagnosis and previous management, and should advise the patient that it is in their best interest to request details of previous management from the original treating doctor (consent to seek records must be obtained)
- the doctor whom the patient consults for the second opinion may not be the best qualified person to give the opinion on that specific medical problem
- there may have been previous conflict (unbeknown to the patient) between the doctor consulted for the second opinion and the original treating doctor.

Providing a second opinion

The doctor providing the second opinion needs to respect not only the patient, but also the doctor who was the primary carer, irrespective of whether the patient was referred or not by the primary carer. Disparaging and off-the-cuff comments must be avoided – these may lead to medico-legal action against the primary treating doctor in situations where the care given to the patient was appropriate, and at or above the expected standard of care.

It is also important to bear in mind that where clinical details are not available, the patient may give a history that is not completely accurate and lead to bias in forming the second opinion. Personal conflict between doctors must be put aside in offering the second opinion.

During my career, I have been faced on two occasions with threatened litigation and a report to the Health Care Complaints Commission (HCCC) arising from second opinions sought by parents of patients without my knowledge.

Case 1

A two-year-old girl underwent uncomplicated surgery for left ptosis using fascia lata. Post-operatively she was progressing well with the eyelid in a good position. The child had a fall and subsequently developed preseptal cellulitis. This was managed in hospital with IV antibiotics. The cellulitis was resolving and the child was discharged from hospital on oral antibiotics.

On leaving the hospital, the parents sought a second opinion from another Ophthalmologist who, unaware of all the details of treatment, made a comment: "What butcher did this to your child?" My good relationship with the family allowed me to explain what had transpired. The child had a good outcome from treatment and there was no medico-legal action.



Professional obligations

The Medical Board's *Good Practice - A Code of Conduct for Doctors in Australia*¹ states:

4.2 Respect for medical colleagues and other healthcare professionals

Good patient care is enhanced when there is mutual respect and clear communication between all healthcare professionals involved in the care of the patient. Good medical practice involves:

4.2.1 Communicating clearly, effectively, respectfully and promptly with other doctors and healthcare professionals caring for the patient.

4.2.2 Acknowledging and respecting the contribution of all healthcare professionals involved in the care of the patient.

Case 2

I looked after a low birth-weight baby born at 29 weeks for several years. The clinical records were detailed, and at each consultation an attempt was made to record visual acuity using an age-appropriate method. The baby had no signs of retinopathy of prematurity. There were signs of developmental delay and this was being monitored by a Paediatrician.

When the child was aged three years, I received a telephone call from the mother telling me she was going to lodge a complaint with the HCCC and commence medico-legal action as I had missed the child's diagnosis. She agreed to attend another consultation to discuss her concerns. She told me she had seen a very senior Ophthalmologist who found that her child's vision was impaired and had told her: "Your son should have been referred to the Royal Blind Society a long time ago. It would have made a big difference to his visual outcome."

We reviewed my clinical records together. The child's vision at all consultations was found to be age appropriate. The child had not been able to read letters on the Snellen chart due to his age and developmental delay. I also attempted to explain to the mother that an earlier referral to the Royal Blind Society would not have made any difference to her son's visual outcome. The mother proceeded with the complaint to the HCCC. The case was dismissed and there was no further action.

In both the above clinical situations, comments by the doctor offering the second opinion were inappropriate and unhelpful to the patient's management, as well as being derogatory to the treating doctor. The full clinical details were not known to the doctor offering the second opinion. Better communication would have prevented the families of the children losing confidence in the treating doctor and threatening legal action. Derogatory comments as described above are not in the best interest of the patient.

Summary points

- Treating doctors should not hesitate to refer patients for a second opinion. They should try to pre-empt the need for the second opinion, especially if they have concerns as to diagnosis and management, or sense that the patient is losing confidence in their management.
- If the patient seeks a second opinion, the treating doctor should not feel threatened, but react positively and refer the patient to the most appropriate medical colleague to give a second opinion.
- Doctors seeing patients for a second opinion should have the patient's clinical wellbeing as the first priority. They should try to obtain detailed records of previous treatment before giving the second opinion. Hindsight bias must be avoided.
- Personal conflict between doctors should be put aside and the doctor giving the second opinion should always avoid disparaging comments about fellow practitioners.
- The doctor giving the second opinion may have a mandatory requirement to refer the matter to the Australian Health Practitioner Regulation Agency (AHPRA) if he/she believes that the treating doctor's management has been inappropriate.²
- Remember - the second opinion is about the patient, and not about the doctor.

Professor Frank Martin (MDA National Member) Ophthalmologist

- 1 Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
- 2 Australian Health Practitioner Regulation Agency (AHPRA). Guidelines for Mandatory Notifications. March 2014. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx



Choosing Wisely and Defensive Medicine

Up to 30% of healthcare expenditure in the United States (US) is wasted on activities that add no value to care.¹ The figure for Australia is not known.

The *Choosing Wisely* campaign was launched in 2012 by the American Board of Internal Medicine Foundation to identify commonly used medical interventions where evidence shows they provide no benefit or, in some cases, lead to harm. *Choosing Wisely* aims to help the community, including doctors and their patients, to start a conversation about improving the quality of health care by eliminating unnecessary and sometimes harmful tests, treatments and procedures.

Initially, nine US medical societies created “Top Five” lists of tests, treatments and procedures in their discipline for which there was strong scientific evidence of overuse and significant potential harm. The US campaign now involves 70 societies. Thirteen countries have subsequently adopted and implemented *Choosing Wisely*.

The five principles underlying *Choosing Wisely* are:

- physician led
- patient focused
- evidence based
- multi-professional
- transparent.

Choosing Wisely focuses on professional values and doctor-patient interactions and, importantly, includes a community education component. Ultimately, the goal is to reduce low or no value care, avoid harm and decrease waste in health care.

Choosing Wisely Australia

Choosing Wisely Australia was launched in 2015.²

To date, the following colleges and societies have developed “Top Five” lists which provide recommendations of the tests, treatments and procedures that clinicians and consumers should question:

- Australasian College for Emergency Medicine
- Australasian Society of Clinical Immunology and Allergy
- Royal Australian and New Zealand College of Radiologists
- Royal Australian College of General Practitioners
- Royal College of Pathologists of Australasia.

Why do doctors order unnecessary tests?

The underlying factors are complex and often intertwined:

- patient expectations – the majority of patients overestimate the benefits of interventions and underestimate their harm³
- doctors’ estimation of patient risk with interventions – consent discussions may include overstatements about the benefits and minimisation of the risks⁴
- tension between a doctor’s obligations to the individual patient (especially if there is no potential harm to the patient from the intervention) and obligations to society to use resources appropriately, saving unnecessary costs of health care
- fragmentation and lack of continuity of care – e.g. re-ordering tests on admission to hospital
- cognitive biases:
 - › anticipated regret about missing a diagnosis – regret about a patient experiencing an adverse event if an investigation or procedure is not performed
 - › commission bias – tendency towards action/intervention, rather than inaction
- fear of reputational damage for the doctor if a diagnosis is missed
- doctors’ training – new evidence on safety, effectiveness and/or cost effectiveness may have come to light since training; resistance to “de-innovation” (stopping the use of older, less effective tests or treatments); or tendency for “indication creep” (using new technologies for indications where effectiveness has not yet been proven)
- time limitations – easier to order the intervention than to discuss benefits and risks
- financial – including fee-for-service for procedures
- fear of being sued.

The future

In the future, will we see claims arising out of an allegation that an intervention, although performed appropriately, was unnecessary and therefore any adverse outcome is negligent? There is no doubt that when an intervention is not clinically indicated and leads to patient injury, any claim arising out of the injury will be indefensible.

Dr Sara Bird
Manager, Medico-legal and Advisory Services
MDA National

Defensive Medicine

Defensive medicine can be defined as the ordering of tests, treatments and procedures primarily to help protect the doctor from liability, rather than to substantially further the patient’s diagnosis or treatment.⁵

While the fear of litigation is not the sole reason for ordering unnecessary interventions, it is a potential barrier to the implementation of *Choosing Wisely*.

In a 2005 survey of US specialists at high risk of litigation, 96% reported practising defensively.⁵

A 2013 survey of UK hospital doctors revealed that 78% reported practising defensive medicine, including:

- 59% ordering unnecessary tests
- 55% making unnecessary referrals.⁶

A survey of Australian doctors in 2007 reported changes in behaviour due to medico-legal concerns, with:

- 55% of doctors ordering more tests than usual
- 43% referring patients more than usual.⁷

Of note, doctors who had experienced a medico-legal matter were significantly more likely to perceive they had changed their practice in response to medico-legal concerns.

Does practising defensively actually reduce your risk of being sued?

The short answer to this question is we do not know.

A recent study explored whether hospital doctors in the US who provided more costly care were less likely to be sued.⁸ The study found that those doctors who were in the highest fifth of spending had the lowest rates of malpractice claims. For example, physicians in the highest spending fifth were five times less likely to be sued than their colleagues in the lowest spending fifth. Obstetricians who had the highest rate of caesarean sections had almost half the rate of claims, compared to those who had the lowest rate. Of note, family medicine physicians were the only clinicians in the study in whom this association was not observed.

This study suggests that if doctors spend more per patient, and use more resources, they are less likely to be sued. However, there are a number of limitations to this study. It is not possible to determine if the increased spending and procedure rates actually represent defensive medicine or if it represents additional, appropriate care that led to fewer adverse events. It would also be interesting to know if the doctors in the highest spending categories had been involved in a claim before the study period. If so, these doctors are likely to be more alert to the risk of claims and may also be employing other strategies to reduce their medico-legal risk.

For a full list of references, visit defenceupdate.mdanational.com.au/articles/choosing-wisely-defensive-medicine.

Harnessing the Potential of Social Media

Social media holds great potential for doctors, regardless of the degree to which we wish to engage in public debate.

Social media can strengthen connections

None of my generation (of doctors in training) would remember Malcolm Fraser's prime ministership, let alone the circumstances that got him there, yet I clearly remember @MalcolmFraser12's tweets. In an age of inattention, a former Liberal PM who left the party in protest of its changing values could easily have been a single day's news story before fading into Wikipedia anecdotalism. Instead, Mr Fraser embraced social media as a tool to shape public sentiment and policy, sending more than 10,000 tweets and amassing a following of over 44,000 within two-and-a-half years of joining Twitter.

One of Mr Fraser's favourite topics was asylum seekers. He used the medium of Twitter to counter their vilification by politicians, a sympathy shared by many of us. From campaigning for the release of children from detention to calls for the repeal of penitentiary threats within the *Australian Border Force Act 2015* (Cth), medicos have been leveraging social media to increase awareness of the perniciousness of government policy, and to help fulfil our role as advocates for the sick, the poor and the disadvantaged.

Public activism, however, can struggle to find a comfortable position in our professional bed. Medicine threatens to be all-consuming for trainees and consultants. We tend to be risk-averse, and we soon learn it's much harder to earn a good reputation than it is to develop a bad one. Social media's role, for most, is constrained to a communication tool between friends. Facebook, Instagram and Snapchat are the mainstays.

However, avoiding public forms of social media, particularly Twitter, due to a perception that it's risky or time-consuming, is fast becoming a professional risk in itself. Just as social media can strengthen our connections to friends and family, so too can it support a medical career.

You can benefit professionally

- A public social media presence reflects directly on your professional reputation. Patients, colleagues, employers and the press can (and do) access what we say, share and "like" online. While this poses downside risks, it can also help us to build a positive reputation and to share both our work and our considered thoughts with a broader audience.
- Likewise, both LinkedIn and Twitter allow you to follow leaders whose thoughts you're interested in. Reading the tweets and re-tweets of @BillGates, @Atul_Gawande, @HelenClarkUNDP, @GillianTriggs and @SussanLey exposes me to their work and gives insight into their reading lists. It can do the same for prominent clinicians in your fields of interest.
- Frequently, a public online presence yields new professional relationships. I've made great friends and colleagues across Australia and internationally, thanks to Twitter conversations. These typically develop from online to "real life" at conferences or alongside other travel.
- Medical conferences use Twitter to facilitate networking and interaction, running live Twitter feeds on screens and encouraging face-to-face "Tweet-ups" during breaks.

- Free and open access medical education (#FOAMed) was born of social media. One of my favourite teachers is Professor Chris Semsarian (@CSHeartResearch) who runs "ECGTweetorials" based on cases from his genetic heart disease clinic. For junior doctors, emergency physician James Edwards is building a bank of practical podcasts on his "On the Wards" blog - onthewards.org.
- Keeping up with new research is easier if you follow academic journals on Twitter and Facebook, e.g. @TheLancet, @bmj_latest and @NEJM. Letters to the editor are no longer the only way to engage with editorial staff: @theMJA frequently re-tweets doctors' tweets, and The Lancet editor's personal account (@richardhorton1) provides a fascinating and honest critique of global health politics every time he attends WHO and UN meetings.
- Online journal clubs such as #urojc (urology) and #rheumjc (rheumatology) help doctors at all stages of their career, and from anywhere in the world, to discuss significant new papers.
- The Royal Colleges are on social media. During recent debates about sexual harassment in medicine, the Royal Australasian College of Surgeons used Twitter to great effect, communicating well-considered statements in full and without reliance on the print media.

Your patients can benefit too

- Patients increasingly use the internet in search of diagnoses, prognoses, and management recommendations. The increased presence of doctors on social media helps to crowd out and correct the effect of charlatans such as anti-vaccine shonks.
- Innovations such as the "My GI Health" app seek to provide patients with novel support tools. They use the power of social media to connect patients with others with a similar disease, with the potential for moderation by treating teams and the tracking of data on symptoms to aid disease management.

What next?

To mitigate the risks of social media, be sure to read the Medical Board's social media policy.¹ You can also seek guidance from MDA National and refer to relevant articles in their Member publications.^{2,3} Having done so, jump in.

The work of Professor Simon Chapman, an esteemed public health researcher, has achieved supernormal reach because of his strong engagement with Twitter and Facebook. His advice sums it up: "Use social media. A lot!"

**Dr Benjamin Veness (MDA National Member)
Resident Medical Officer
Royal Prince Alfred Hospital, NSW**

 **Follow Ben on Twitter @venessb.**

1 Medical Board of Australia. Social Media Policy. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Social-media-policy.aspx
2 Usback D, Chambers K. Social Media and Medicine: A Case of #medicalmadness? *Defence Update* Winter 2015:6.
3 Krusys E. Social Media in Modern Medicine: *Defence Update* Autumn 2014:8.

Testamentary Capacity

An all too common scenario faced by our Members is when they are either asked to comment retrospectively on the testamentary capacity of a deceased patient, or to provide a prospective report for someone who is contemplating writing a will.

Testamentary Capacity

Providing an opinion on testamentary capacity is a very complex area that can land you in considerable difficulty – as a witness being cross-examined on the basis for your views,¹ disciplinary findings,² or even judicial review.^{3,4,5} Fortunately, adverse outcomes arising out of negligent assessments are uncommon. This article aims to provide some clarity on the issues involved.

Case history

Violet was elderly and wealthy when she died. She had loyally attended your practice for the last twenty years, although she had been a bit vague and dodderly of late. Sadly, even before the family's mourning had ended, the war for her assets began.

The Executor of her estate writes and asks for your opinion on Violet's prior testamentary capacity. "That's easy", you think to yourself, optimistically hoping that the Mini Mental State Examination (MMSE) you performed last year would be enough for the lawyers as you begin to put pen to paper.

Capacity

Capacity (or competence) is a legal concept and refers to an adult's ability to make their own decisions.⁶ Adults are presumed to have capacity, although the presumption is able to be disproved. While cognition (a medical concept) and capacity are intertwined, impairment of cognition does not mean that a patient will lack capacity.

Capacity is time and decision specific, so fluctuating cognitive states and varying decision tasks will alter the assessment of the patient's capacity. Subsets of capacity can also be determined, such as financial capacity,⁷ consent to medical treatment, testamentary capacity, and capacity to stand trial. A more detailed article on capacity can be found in the Spring/Summer 2015 edition of *Defence Update*.

Prospective assessment of testamentary capacity

Testamentary capacity is a specific legal concept, and it is not a medical diagnosis. It refers to the ability of a patient to make a will. The required capacity will vary with the complexity of the proposed will and potential claimants involved. As such, doctors should be very sure of what they are doing if they are to provide opinions regarding testamentary capacity.

Testamentary capacity assessment requires very specific understanding and skills, and should generally only be performed by those with the relevant knowledge and experience. It involves far more than an assessment of cognition. Given that testamentary capacity assessment requires consideration of the proposed will, a solicitor should be involved in providing instructions including the necessary background information.

The legal test is surprisingly old – found in the English 1870 case of *Banks v Goodfellow*⁸ and still relied on by lawyers today. It is clever in that it recognises the interaction of medical factors (cognition/mental health) and individual facts of the matter (assets and benefactor).⁹ The case related to the writer of a will who had delusions – but were the delusions enough to invalidate the will? The court concluded they were not.

The person making the will must:

- understand the nature of making a will and its effects
- understand the extent of the assets they are bequeathing
- comprehend and appreciate the (moral) claims to which they must give effect
- not be affected by a disorder of the mind that "perverts the sense of right" or decision-making.

Formal assessment of testamentary capacity thus requires some understanding of the assets and potential beneficiaries involved, and will also involve working through the scenario with the patient.

Doctors should generally avoid signing a pre-prepared statement (affidavit) prepared by lawyers involved in testamentary (will) disputes without first seeking advice from MDA National and/or ensuring that their own views are accurately reflected.

A doctor is not obliged to provide an opinion on a patient's testamentary capacity and, as noted above, such opinions should be reserved for those with the necessary expertise.

Doctors generally conceptualise “cognitive assessment” when considering capacity issues and need to be careful that the two are not confused. As an alternative, it may be that factual information about the patient’s *cognitive* state can be provided without making any comment about testamentary capacity.

Consent to provide a retrospective assessment of testamentary capacity

Appropriate authority to disclose confidential patient information should be carefully considered prior to any discussion or the provision of a report to third parties. Doctors still have a professional and legal duty to maintain patient confidentiality even when a patient is deceased or no longer has decision-making capacity.

For an incompetent patient, the legal guardian or substitute decision maker will likely have this authority. For deceased patients, appropriate authority will typically reside with the appointed Executor/Administrator of the will. Any dispute over the patient’s testamentary capacity may invalidate the appointment of that Executor/Administrator if the will was made at the time the patient was incompetent. These can be challenging cases to unravel and advice should be sought where there is any doubt as to whether appropriate consent has been obtained.

Retrospective assessment of testamentary capacity

It is generally very difficult to *retrospectively* provide detailed information about testamentary capacity, e.g. after death, particularly if there is no detailed assessment to refer to. Such a situation might flow from an entry on a death certificate indicating a patient had dementia (often without a limiting timeframe) that was relevant to the period the patient made a decision in relation to bequeathing assets.

We strongly recommend that doctors refrain from providing a retrospective opinion about testamentary capacity unless a historic formal assessment has already occurred. However, a doctor may be able to offer relevant facts as to the state of the patient’s cognition at the specific time, if available (see example on page 14).

Although similar information regarding the patient’s cognitive state might be relevant to a *prospective* assessment, many doctors may additionally choose to refer the patient to a relevant expert.

Dr Julian Walter
Medico-legal Adviser
MDA National

Conclusion

Matters involving testamentary capacity can be particularly complex, especially in the context of a background dispute. They are often best discussed with MDA National’s Medico-legal Advisory Services team on **1800 011 255**. We are experienced in resolving these matters and dealing with the solicitors of the various parties involved. We are also happy to review any documentation you might consider providing to a third party.

- 1 [Anaesthetist expertly documenting changed will prior to surgery] *Frizzo & Anor v Frizzo & Ors* [2011] QSC 107 (12 May 2011). Available at: austlii.edu.au/au/cases/qld/QSC/2011/107.html
- 2 [Caution and reprimand for Unsatisfactory Professional Conduct in not assessing testamentary capacity prior to signing document attesting testamentary capacity] Medical Practitioners Board of Victoria. Dr Athanasios Gouras [2004] MPBV 10: Reasons for Decision. [Melbourne]: MPBV, 2004. Available at: austlii.edu.au/au/cases/vic/VMPBV/2004/9.pdf?stem=0&synonyms=0&query
- 3 [In relation to capacity, rather than testamentary capacity where a patient was to engage in voluntary euthanasia, but was demented and a new will was written] *R v Shirley Justins* [2008] NSWSC 1194 at [20] and [38] where the “irresponsibility” of the doctor is noted”. Available at: austlii.edu.au/cgi-bin/sinodisp/au/cases/nsw/NSWSC/2008/1194.html?stem=0&synonyms=0&query=%22Graeme%20Wylie%20%22
- 4 *Ocalewicz v Joyce* [2012] NSWSC 1163. Available at: austlii.edu.au/au/cases/nsw/NSWSC/2012/1163.html
- 5 [Where a displaced benefactor suing a solicitor (as a non-client intended beneficiary) for not correctly making an informal will prior to the 90-year-old’s death] *Howe v Fischer* [2014] NSWCA 286 and *Fischer v Howe* [2013] NSWSC 462. Moran, P. Informal Wills: Do Solicitors Owe a Duty to Intended Beneficiaries? Available at: cbp.com.au/publications/2014/december/informal-wills-do-solicitors-owe-a-duty-to-intend
- 6 Attorney General’s Department NSW. Capacity Toolkit. Sydney: NSW Attorney General’s Department, 2008, p10.
- 7 Gardiner PA, Byrne GJ, Mitchell LK, Pachana NA. Financial Capacity in Older Adults: A Growing Concern for Clinicians. *Med J Aust* 2015;202(2):82-85.
- 8 *Banks v Goodfellow* (1870) LR 5 QB 549.
- 9 Hamilton B, Cockburn T. Capacity to Make a Will and Enduring Power of Attorney: Issues New and Old. *Queensland Law Society Journal* 2008;28(2):14-18.

Sample letter

Retrospective assessment of testamentary capacity

Here is a sample letter relating to the case study on the previous page.

PRIVATE & CONFIDENTIAL

Dear Solicitors

I refer to your request as to the testamentary capacity of Violet Smith (deceased). I cannot provide any information about Violet's "testamentary capacity", because this is a specific legal test rather than medical diagnosis, and no historical assessment of testamentary capacity was undertaken. However, I can provide the following facts in relation to Violet's cognitive state which might enable a third party to conclude as to her testamentary capacity at the relevant time.

Violet's relevant past history included:

(Consider focusing on history that affected cognition, alertness and mental health. Be specific and provide accurate dates.)

- physical illness
- mental illness
- medications
- imaging/pathology
- assessments *(refer to specific dates and times, indicating if a screening test, e.g. MMSE/GCS assessments, and what the results indicate)*
- demeanour as at critical dates *(particularly any indirect clinical information, e.g. ability to keep appointments, recollection of past appointments and discussions, clarity of thought)*
- past history - depression/anxiety/cerebral events *(e.g. delirium, seizures, CVA, dementia, head injuries).*

(Consider whether you are able to state an opinion - for example:)

Based on the above limited assessments and retrospective information, I was not able to discern any impairment in the patient's cognition as at [specific] date.

Yours sincerely

Dr X

Our Medico-legal Advisory Services team is happy to review any documentation you intend to send to a third party. You can send documents to us by email: advice@mdanational.com.au or fax: **1300 011 235**.

Need more information or advice?

Contact our Medico-legal Advisory Services on **1800 011 255** or email advice@mdanational.com.au.



Photo courtesy of Dr Victoria Smith.

Upstream or Downstream?

Victoria Smith, winner of the 2015 MJA, MDA National, Nossal Global Health Prize (medical student category), uses the analogy of a river to describe the health continuum from prevention to treatment.

When I first looked at a map of Alice Springs, the ephemeral Todd River was marked as a deceptive blue snake, winding its way through the centre of town. For the local Arrernte people, the river is known as Lhere Mparntwe. In my head, I pictured a desert oasis, brown-skinned children gleaming with sun and water, screaming with glee as they plunged from rope swings into the cool river water. During my first week in Alice, somebody told me that it's only after you have seen the river flow three times that you can be considered a local. The rest of the time it's just a dusty creek bed, filled with the soft rusty sand that has now found its way into almost every item that I own.

Smith VC. Upstream or downstream?. Med J Aust 2015; 203(10):412-413.
© Copyright 2015 The Medical Journal of Australia. Reproduced with permission.

In public health, there is the concept of “upstream” and “downstream” factors. The analogy of the river is used to describe how pre-existing social, cultural, financial, environmental and historical factors ultimately go on to influence health outcomes in a profound way.¹

The children’s ward at Alice Springs Hospital is busy. The nurses exasperatedly chase a young boy down the corridor. This pint-sized patient is surprisingly speedy as he makes his naked bid for freedom. A happy little boy and exceptionally cute, this child has quickly become a favourite of mine. It’s close to a month since he was first admitted for ongoing weight loss on a background of acute gastroenteritis. He has had chronic diarrhoea since he’s been here, his stool best described as a microbiological zoo. His small body has been bombarded with every antibacterial, antifungal and antiparasitic agent we have. His poor gut is so damaged from his numerous recurrent infections that it’s essentially no more than a slippery dip. It’s difficult for him to absorb any nutrients from his food, and we desperately need him to gain weight so his body and brain can grow.

In the treatment room *Bananas in Pyjamas* is playing. The room is crowded. In between the paediatrician, two nurses, the surgical registrar, mum and a writhing, screaming patient, there are bubbles. So many bubbles. The young surgical trainee gingerly examines the numerous boils that cover the little girl’s legs and groin. They will require an operation to drain them. She too has been with us for a week already. Her kidneys are struggling, after her body mounted an autoimmune reaction to the streptococcal infection from the boils. We closely monitor her weight and blood pressure until her kidneys are out of the woods.

The diabetes educator and paediatrician discuss a 13-year-old girl, who has just been diagnosed with type 2 diabetes mellitus. Already she weighs over 100 kg. Her case being outside the realm of conventional paediatric practice, the paediatrician is seeking advice on the best management plan for this patient. The girl’s mother, in her 30s, already suffers from retinopathy from her diabetes. One of the challenges of managing type 2 diabetes in an adolescent is the general lack of evidence to inform practice. It’s simply too new a phenomenon. The evidence to inform the management of type 2 diabetes in an Indigenous child is virtually non-existent.

At the hospital, we are so far downstream that we are practically out to sea. Essentially, we patch the kids up, keep them from dying, and make an attempt at educating the child’s parents about what has happened and why. It is grossly inadequate when almost everything that we see is preventable.

How is it then, in a wealthy nation like Australia which boasts a universal health system that is arguably one of the best in the world, that the life expectancy of Indigenous Australians is still (at a conservative estimate) 10-17 years less than their non-Indigenous counterparts? Why do the babies of Aboriginal mothers die at more than twice the rate of non-Aboriginal mothers? Why are so many remote communities still plagued by poor hygiene, overcrowding and dysfunctional living conditions, condemning their inhabitants to lifelong chronic disease? To me, it’s incomprehensible.

The instinct of many is to blame the individual. I know that I am often tempted to do so, especially when you see children who are suffering. However, blaming or inducing guilt is counterproductive. It does not help anyone. If anything, it alienates and denigrates. It is simply not correct to suggest that a person engages in certain behaviours by “choice”, and choice alone. It is too simplistic. To do so ignores the fact that every individual is a member of a community and is shaped by that community, his or her environment, education, and a personal and collective history.

To date, many health promotion programs have made a grossly inaccurate assumption that health education will automatically translate to behaviour change. It’s the same flawed logic that tells me I should floss daily and do at least 30 minutes of moderate-to-vigorous physical activity each day. Does knowledge alone empower me to change my behaviour? Sometimes it can, but only when the environment allows. Can I prevent my children from getting scabies when 15 people live in my home, multiple people share mattresses and I don’t have running water in the house, let alone a washing machine? Unlikely.

There is no strategic plan or coordination between services to promote hygiene improvement in remote communities.² The social determinants of health have been ignored or, at the very least, addressed in a piecemeal manner. Public servants in air-conditioned offices write hygiene promotion strategies that fail to address the functional state of housing infrastructure and the unique environmental conditions of remote communities. Obesity and micronutrient deficiency in remote communities is a direct result of food insecurity caused by low incomes and the high price of fresh, nutritious food. This is unlikely to ever be overcome as long as local stores (often the sole providers of food in remote communities) continue to be viewed as a small business, rather than an essential service such as health or education.³ The past and continuing erosion of Indigenous culture and language serves only to perpetuate the vicious cycle of poverty and poor health.⁴

Government departments are often only as far apart as a different floor in the same building, yet the level of communication and collaboration between departments would suggest there is in fact a chasm between them. Multisector collaboration and high-level engagement and partnership with Indigenous peoples are the only hope we have to “close the gap”.

Good health is not made in hospitals. Good health is made by the food we eat, the water we drink, by feeling safe, secure, loved and connected. It is the roof over our heads, our sense of purpose in the world. Education is not just power, but health too. It is health, not illness that I am passionate about. I need to be further upstream. Maybe I need to see the Todd River flow.

**Dr Victoria Smith (MDA National Member)
Intern, Western Health, Melbourne**

- 1 Taylor K, Guerin P. Health Care and Indigenous Australians: Cultural Safety in Practice. South Yarra: Palgrave MacMillan, 2010.
- 2 McDonald E, Baillie R. Hygiene Improvement: Essential to Improving Child Health in Remote Aboriginal Communities. *J Paediatr Child Health* 2010;46:491-496.
- 3 Lee AJ, Leonard D, Moloney AA, Minniecon DL. Improving Aboriginal and Torres Strait Islander Nutrition and Health. *Med J Aust* 2009;190:547-548. Available at: mja.com.au/journal/2009/190/10/improving-aboriginal-and-torres-straitislander-nutrition-and-health
- 4 King M, Smith A, Gracey M. Indigenous Health Part 2: The Underlying Causes of the Health Gap. *Lancet* 2009;374:76-85.



Iron Infusion and Skin Staining – An Unwelcome Surprise

Case history

Dr Brown was consulted by Ms Austen, aged 31 years, who had a history of tiredness which she considered was due to “low iron”.

Blood tests revealed:

- Hb 120g/L (normal range 115-155)
- Mean Cell Volume 85fL (normal range 82-98)
- Ferritin 15 ug/L (normal range 15-300).

Ms Austen told Dr Brown that she wanted to increase her iron as soon as possible. She also mentioned that iron tablets did not agree with her, as they caused constipation.

Dr Brown suggested that Ms Austen have a Ferinject (ferric carboxymaltose) infusion to top up her iron stores. He warned Ms Austen that there could be some irritation at the infusion site, a cold feeling in her arm, and that there was a very small risk of a serious allergic reaction.

As per his usual practice, Dr Brown inserted the IV cannula, flushed it to ensure it was correctly placed, then connected the bag of normal saline containing the Ferinject, which was then run in over about 15 minutes. The practice nurse then flushed the cannula and removed it from Ms Austen's arm. No problems were reported at the time.

Three months later Ms Austen returned to see Dr Brown. She was very unhappy as she had a large area of brown staining on her arm around the infusion site. She had already seen a Dermatologist who had advised her that the staining was likely to be permanent, although laser treatment may help.

Dr Brown was unaware that Ferinject infusion could cause permanent skin staining, and he had not warned Ms Austen of the possibility. Ms Austen said she would never have agreed to the infusion had she known of the possibility of permanent skin staining. She worked as a personal trainer and felt the discolouration was embarrassing and off-putting to her clients.

Discussion

Skin staining occurs when there is extravasation or leakage of the infusion into the surrounding soft tissues. The possibility of permanent skin staining following intravenous iron infusion or intra-muscular iron injection is an important adverse event to discuss with patients.

This should form part of the consent process when discussing the risks of the iron infusion with the patient, enabling the patient to weigh up the benefits and risks of proceeding with this treatment. The cannula for infusion is usually sited in the arm, so an area of brown staining on the arm may be cosmetically unacceptable to many patients.

Practice tips

- Patients should be warned of the possibility of permanent skin staining as part of the consent process for iron infusions.
- Patients should be advised to report immediately if they experience any discomfort, which may indicate injection-site leakage or extravasation.
- Patients should be monitored by appropriately trained staff for anaphylaxis, hypertension, extravasation and other problems during the infusion and for 30 minutes afterwards.
- Cardiopulmonary resuscitation equipment must be available for managing anaphylaxis.

Dr Jane Deacon
Medico-legal Adviser
MDA National

Further reading

NPS Radar August 2014. Available at: nps.org.au/publications/health-professional/nps-radar/2014/august-2014



A Case of Paediatric Obesity

AA died on 29 September 2010 from hypoxic brain injury as a result of a cardio-respiratory arrest following complications of morbid obesity which, contrary to medical advice, were not addressed by his parents.¹ He was 10 years old at the time of his death.

Case history

AA was the youngest of six children. Both parents had a history of drug abuse and his mother had borderline personality disorder. The family had previous involvement with Community Services (CS).

When aged seven years, AA was admitted to ICU with respiratory distress. He was diagnosed with morbid obesity and obstructive sleep apnoea. His weight was 50kg and BMI 30. Upon discharge, his parents were informed that his obesity was serious and advised to adjust his diet and activity levels, attend a dietician and the ENT clinic, and have a glucose tolerance test.

However, AA continued to gain weight, missed the follow-up appointments arranged at the hospital, and was largely absent from school.

A year later his weight had increased to 68kg and he was again admitted to ICU with a respiratory infection. His parents were advised that his condition was at a medical emergency level, but he still continued to miss medical appointments. This period of time coincided with escalating drug use by his parents.

AA did not attend hospital again until a year later when he weighed 80kg. He lost consciousness at home, had a cardiac arrest on the way to hospital, never regained consciousness and died.

Extremely obese children may need to have the effective involvement of child protection services to adequately address their health issues.

Medico-legal issues

The Coroner noted that despite the doctors having impressed upon the parents that AA was in a life and death situation, the parents were unable to make the necessary changes.

During AA's contact with the health services, two reports were made to CS. The Coronial inquest highlighted that there was poor communication between CS and medical staff. AA had not been allocated a case worker, and his case had been closed by CS due to "competing priorities", meaning that no case worker was available to take the case.

A review of this decision found that CS staff had not adequately recognised the risk to AA, and the intersection of medical needs with neglect had not been understood. Effective management would have required a joint child protection and health service intervention - but high workloads, competing priorities, poor interagency collaboration and inexperienced staff meant that CS did not become involved.

Discussion

Twenty-six per cent of Australian children aged 5-14 years are overweight or obese.² This case is extreme, in that AA was very obese and his parents were unable to adequately address his medical needs. However, it is likely that there will be further cases where extremely obese children may need to have the involvement of child protection services to adequately address their health issues.

This is a very complex area. Good communication between medical services and child protection services is essential to adequately monitor such children and to determine what action should be undertaken, and when it should happen.

**Dr Jane Deacon
Medico-legal Adviser
MDA National**

1 NSW Coroner's Court. Inquest into the Death of AA. 26 September 2014. Available at: coroners.justice.nsw.gov.au/Documents/aa%20findings%20redacted.pdf
2 Australian Bureau of Statistics. Australian Health Survey: Updated Results, 2011-2012. Available at: abs.gov.au/ausstats/abs@.nsf/Lookup/33C64022ABB5ECD5CA257BB200179437

Education Activity - Autumn 2016

You can receive professional development (PD) recognition for this *Defence Update* issue by completing the questionnaire below. See page 22 for more information.

Activity learning outcomes

By the end of this activity participants should be able to:

- explain necessary considerations if you are requested to give an opinion on a patient's testamentary capacity
- discuss the drivers of inappropriate clinical investigations
- identify risk management policies that medical workplaces should effectively have in place where billing is conducted by others on behalf of a medical practitioner.

Questionnaire

1	Rate the extent to which you agree with the following statements (this is a personal reflection exercise).	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
	Doctors giving a second opinion should always advise the patient that it is in the patient's best interest that details of previous management be requested from the original treating doctor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Doctors are generally good at responding to a patient's doubt regarding diagnosis or management by proactively initiating a second opinion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Doctors should not feel threatened when a patient seeks a second opinion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	It is generally very difficult to retrospectively give detailed information about testamentary capacity after a person has died.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Respond true or false to the following statements.				True	False
	Whoever undertook the billing process will be held responsible if inaccurate or inappropriate billing occurred - the medical practitioner whose provider number was used is not always liable.				<input type="checkbox"/>	<input type="checkbox"/>
	Suspension from Medicare is not a potential consequence of inappropriate Medicare billing.				<input type="checkbox"/>	<input type="checkbox"/>
	A person with cognitive impairment may have capacity to make an important decision.				<input type="checkbox"/>	<input type="checkbox"/>
	A person either has capacity to make all decisions or none.				<input type="checkbox"/>	<input type="checkbox"/>
	Testamentary capacity is a medical diagnosis of someone's ability to make a will.				<input type="checkbox"/>	<input type="checkbox"/>
	Assessing testamentary capacity requires very specific understanding and skills.				<input type="checkbox"/>	<input type="checkbox"/>
	A solicitor should be involved in providing information and instruction for a testamentary capacity assessment.				<input type="checkbox"/>	<input type="checkbox"/>
	A doctor is not obliged to give an opinion on a patient's testamentary capacity.				<input type="checkbox"/>	<input type="checkbox"/>
	Patient confidentiality no longer needs to be maintained when the patient is dead.				<input type="checkbox"/>	<input type="checkbox"/>
	Patient confidentiality no longer needs to be maintained when the patient has lost the capacity to make medical care decisions.				<input type="checkbox"/>	<input type="checkbox"/>
	MDA National recommends doctors give retrospective opinions on testamentary capacity in the absence of a historic formal assessment.				<input type="checkbox"/>	<input type="checkbox"/>
	The majority of patients overestimate the benefit of interventions and underestimate their harm.				<input type="checkbox"/>	<input type="checkbox"/>

3 Write short notes to answer the following questions.

What policies are documented in your workplace that safeguard accurate billing by others on behalf of a medical practitioner?

What would you do if a patient you are currently treating, and are moderately familiar with, required a testamentary capacity assessment?

How important do you think it is that the Choosing Wisely campaign is strong in Australia? Briefly explain the reasons for your opinion.

4 How common do you think the error of a doctor making a derogatory comment about another doctor in front of a patient is?

- Extremely uncommon Somewhat uncommon Neither common/uncommon Somewhat common Extremely common

5 What do you suspect are the most common causes of doctors in your field ordering unnecessary clinical tests? Number "1" to "5" in the boxes below to rank your thoughts about the top five causative factors.

- Patient expectations
- Doctors overstating the potential benefits and minimising the risks
- The unnecessary tests have no potential harm to the patient leading to the obligation to the patient outweighing the obligation to society to appropriately use resources
- Fragmentation and lack of continuity of care
- Anticipated regret about a patient experiencing an adverse event if the test is not performed
- Doctors' tendency towards action rather than inaction
- Fear of reputational damage for the doctor if a diagnosis is missed
- Doctors not knowing current evidence about the effectiveness of tests
- Doctors finding it difficult to stop using older tests
- Time limitations
- Financial gain
- Fear of litigation
- Other: _____

Activity evaluation

- 1 Please rate to what degree the activity learning outcomes were met.**
- | | Not met | Partially met | Entirely met |
|--|--------------------------|--------------------------|--------------------------|
| Explain necessary considerations if you are requested to give an opinion on a patient's testamentary capacity. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discuss the drivers of inappropriate clinical investigations. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Identify risk management policies that medical workplaces should effectively have in place where billing is conducted by others on behalf of a medical practitioner. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- 2 Rate to what degree your personal learning needs were met.**
- Not met Partially met Entirely met

- 3 Rate to what degree this activity was relevant to your practice.**
- Not relevant Partially relevant Entirely relevant

- 4a Has the content in *Defence Update Autumn 2016* caused you to consider making any change(s) to your practice?** Yes No

- 4b If you answered "yes" to question 4a, what change(s) do you envisage making?**

- 5 How likely is it that you would recommend this activity to a friend or colleague?**

	0	1	2	3	4	5	6	7	8	9	10	
x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

- 6 Please rate the quality of the following in relation to *Defence Update Autumn 2016*.**
- | | Very poor | Poor | Neutral | Good | Very good |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Magazine content | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Magazine presentation (hard copy) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Questionnaire content | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Questionnaire presentation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- 7 What could be done to improve this activity?**

- 8 What future educational resources would you like MDA National to produce? Feel free to nominate any topics and any delivery formats, e.g. "responding to errors, online presentation", "cross-cultural communication, face-to-face workshop", "managing staff, *Defence Update* article".**

9 Please indicate your career stage:

- Prevocational Vocational trainee Early career Mid-career Late career Retired

10 If chosen, please indicate your specialty: _____

Your details

Name	
Email	Phone
Address	
Name of college PD program in which you participate	
RACGP/ACRRM identification number (if applicable)	MDA National Member number

Please sign and date here

Signed _____ **Date (DD/MM/YYYY)** / /

Tick here if you do not wish to receive your completion certificate by email.

In completing the evaluation, you consent to your evaluation comments being used for promotional purposes by the MDA National Group.

Tick here if do not consent to your evaluation comments being used anonymously by the MDA National Group for promotional purposes.

Activity directions

- Read *Defence Update* Autumn 2016.
- Complete the education activity questionnaire in hard copy . Fill out the activity evaluation and provide your details.
- Submit your activity by:
 - > **email** peaceofmind@mdanational.com.au
 - > **fax** 1300 011 244
 - > **post** Level 3, 100 Dorcas Street, SOUTHBANK, VIC 3006
- Receive your completion certificate.
- Report to your college's PD program if it is a self-reporting program.
- MDA National will report relevant points for the following programs on your behalf:
 - > Royal Australian College of General Practitioners (RACGP) Quality Improvement and Continuing Professional Development (QI&CPD) Program
 - > Royal Australian and New Zealand College of Ophthalmologists (RANZCO) CPD Program
 - > Australian College of Rural and Remote Medicine (ACRRM) Professional Development Program (PDP).

Accreditation details

Visit mdanational.com.au for this activity's PD recognition details.

This activity is usually accredited with colleges for General Practice, Emergency Medicine, Ophthalmology, Obstetrics and Gynaecology, and Radiology. Other specialists can receive PD recognition too.

What's On?

MDA National Education Events for Members

March 2016

5	Practical Solutions to Patient Boundaries Brisbane, QLD
8	Online Communication for Medical Professionals Melbourne, VIC
16	The Challenging Emotions of Difficult News Sydney, NSW
19	The Challenging Emotions of Difficult News & Online Communication for Medical Professionals Hobart, TAS
23	The Challenging Emotions of Difficult News Perth, WA

May 2016

31	Avoiding Misunderstandings Around Physical Contact and Intimate Examinations Adelaide, SA
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June 2016

25	Enhancing Patient Understanding - Health Literacy and Communication & Achieving Valid Informed Consent: Explicit Treatment Consent with Adults Wagga Wagga, NSW
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We continually add education sessions to our events calendar. Avoid missing out - keep an eye on **What's On** at mdanational.com.au.

To register for any of the MDA National events, visit mdanational.com.au or contact us on **1800 011 255**.

Access *Defence Update* on the Apple App Store and Google Play

Read *Defence Update* on your iPhone, iPad or Android device - it's complimentary for our Members!

- Head over to the **Apple App Store** or **Google Play**.
- Type "Defence Update" in the search tool.
- Store and access *Defence Update* in a whole new way.



Medico-legal Blog

Coming Soon!

MDA National will be launching a Medico-legal Blog in 2016 to help keep our Members informed about medico-legal cases, court judgments and legislative changes relevant to medical practice and the profession.

Watch this space - you will soon receive an invitation to subscribe!



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