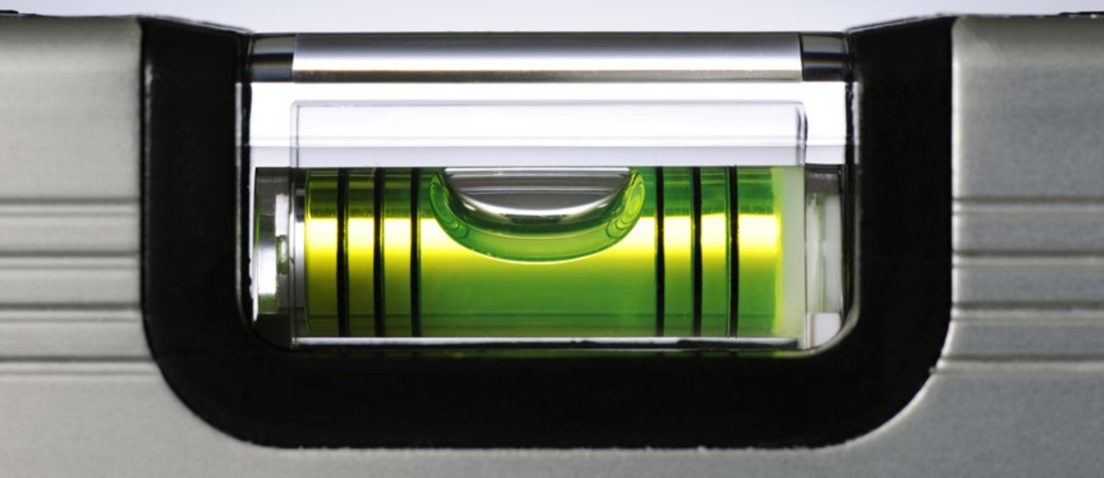
Bulletin



Seeking 'sensible' and 'fair' in healthcare

Healthcare is constantly evolving. The medico-legal frameworks are debated and reviewed regularly.

Pressure for change can come from a variety of sources – patients, media, politicians, regulators and the profession. Often the interests of those involved can differ significantly. It can be a challenge to find an outcome which is sensible and fair to all involved.

MIGA is a significant voice in medico-legal and broader healthcare industry debates. Our advocacy focuses on issues which affect doctors, other health practitioners and healthcare organisations in daily practice. This includes matters to do with regulation, professional standards and other medico-legal issues.

MIGA's advocacy aims to ensure that expectations and frameworks for providing healthcare are sensible, fair, practical and realistic. MIGA regularly engages with governments, regulators, parliaments, colleges and associations and law reform bodies in legislative and policy inquiries, reviews and industry dialogue.

Here is a snapshot of some of our key recent work:

Treating practitioner mandatory reporting

MIGA has been involved in consultations and dialogue with governments and stakeholders about potential models for treating practitioner mandatory reporting reform.

We are advocating for a model which reduces barriers to doctors seeking care for health issues, and provides clarity and practicality for treating doctors in interpreting their obligations.

Medical Board and AHPRA standards

MIGA has been involved in a range of consultations on Medical Board and AHPRA standards. Our work concerning information sharing is detailed in the Bulletin article "Information overload? What should be shared about me by regulators?"

We have also provided detailed submissions to reviews of the Medical Board's Good Medical Practice Code and complementary Sexual Boundaries Guidelines for doctors.

Prescription opioid misuse

MIGA has been involved in a range of consultations and professional dialogue on prescription opioid misuse. Our August Bulletin article "An opioid epidemic? Dealing with the implications of opioid prescription" summarises our recent work in this area, to which can now be added advocating in a recently closed ACT Health consultation.

Medical treatment consent

MIGA has been involved in consultations and reviews on medical treatment consent in South Australia, New South Wales, Queensland and Tasmania. Our work on this issue focuses on uncertainties in current medical consent regimes, particularly around advance care directives, capacity, substitute consent and treatment withdrawal and refusal.

Continued on page 2

October 2018

Your obligations
Assaults and reporting of domestic violence

Back to basics in bariatrics

Midwives
Beware the hazards of your social media activity

Treating the elderly
When is it too much or too little?

Information overload?
What should be shared about me by regulators?

In this Bulletin we talk to some issues which commonly result in calls to the Claims and Legal Services Department – social media, reporting (should I report, or not), treating of the elderly and the myriad of concerns these can raise.

We also provide some learning following an inquest involving bariatric surgery and post-operative complications and, in relation to our advocacy work, we outline our thoughts on AHPRA's scope to share information about practitioners following complaints.

Medicine is a complex business and often the articles in our Bulletin serve to highlight that medical practice isn't always about clinical issues. Supporting you in your practice is what we aim to do, so we encourage you to contact us with your questions. We know that it isn't always straight forward and it's rarely 'black and white'.

I hope you enjoy this edition.

Emma Cocks
Solicitor – Claims & Legal Services

Seeking 'sensible' and 'fair' in healthcare (Continued from front)

Other work, and more to come…

MIGA has been engaged in a range of other issues such as eHealth, privacy, professional standards, Medicare, elder abuse, advertising and private hospital regulation.

We will be involved in consultations in the coming months on the Medical Board's new Professional Performance Framework and Health Practitioner Regulation National Law reform proposals.

Rest assured that MIGA is working hard to advocate in your interests and those of the broader medical and healthcare professions.

Mandy Anderson
CEO and Managing Director

Win a share of *10 million* Qantas Points! Winners announced

We recently drew the 20 lucky winners of our competition with each receiving half a million Qantas Points!

With so many ways to use their Qantas Points for rewards, from flights and upgrades, to hotel accommodation and gift vouchers, to shopping at the Qantas Store and buying food and wine through Qantas epiQure – we hope the decision on how to use their Points isn't too difficult!

Congratulations to each of our winners – we hope you have loads of fun using your Points.

Mandy Anderson
CEO and Managing Director

The lucky winners are:

Dr John Blue
Dr Tanya Boast
Dr Claire Bolton
Dr Rachel Brookes
Dr James Bushell
Prof David David
Prof Paul Fagan
Dr Hilman Harryanto
Dr Alex Jovanovic
Dr Kiran Kalal
Dr Ned Kinnear
Dr Steven Knox
Dr Bronwyn Lever
Dr Valerie Lim
Dr Bradley Martin
Dr Sean Murray-Smith
Dr Scott Spencer
Dr Sonya Stemper
Dr Simran Thethi
Dr Geoffrey Thompson

Information overload?
What should the regulator share?

Who might know things about me?

Imagine you are:

The subject of a complaint by a former patient to the Medical Board about the care you provided to them – the Board decides to take no action, but gave the reasons for its decision to the patient, who then published them on social media, seen widely by your patients.
How might this affect your practice?

Referred for a health assessment by the Medical Board following a patient complaint - the patient is told that you had undergone a health assessment, but no details were released.
How might this affect your health and well-being?

Informed about disciplinary action taken against a colleague who works down the hall from you, but with whom you have little contact and no clinical interactions.
Are you supposed to keep an eye on them or do anything about it?

These are some of the potential examples MIGA has had in mind in its advocacy over recent months involving what the Medical Board/AHPRA can share with other bodies and the public about you.

There was significant outcry when the Medical Board announced its decision earlier this year to link externally published court and tribunal decisions involving health practitioners to the practitioner's public registration page, which is accessible through the AHPRA website.

AHPRA subsequently decided it would only link to those court and tribunal decisions where there were adverse findings against a practitioner, not when there were no adverse findings made.

When patients and other complainants should know reasons for a Board decision
MIGA has been involved in ongoing consultation around how much a patient or complainant should know about the reasons for Medical Board decisions.

We have been aiming for appropriate recognition of doctors' rights to privacy and avoiding unnecessary disclosure of information. In particular, we advocated against any presumption in favour of disclosing reasons for decisions made to patients or other complainants, and emphasised the range of factors to consider when making a decision on whether to do so including information being taken out of context and used in other, unintended ways (for example in coronial processes or civil damages claims).

When AHPRA should disclose information to colleagues about action taken
MIGA has also been dealing with the scope for AHPRA or the Medical Board to request practice information from doctors and to disclose action taken against a doctor to professional colleagues.

MIGA has been concerned about the potential for unnecessary disclosures, including to colleagues who merely work in the same building but have little, if anything, to do with the doctor. Importantly, this raises questions around what obligations this may create for those colleagues.

Pleasingly, recently finalised AHPRA guidelines incorporate a number of MIGA's proposals:
- Clarifying when it is really necessary to request practice information and disclose actions taken against a doctor
- Circumstances when it is acceptable that information has not been provided and what this might mean for the practitioner
- When information needs to be provided about a practitioner's voluntary healthcare roles.

Upcoming advocacy – National Law review
MIGA is now considering its response to the second stage of the Health Practitioner Regulation National Law amendments which is, focused on whether the National Law remains up-to-date and suitable for modern practice.

There is a major focus on information sharing and disclosure, including issues such as:
- Further grounds for doctors, other health practitioners and employers to report certain events to AHPRA
- How much information about a practitioner should be on the public register
- Whether AHPRA should know about payments of compensation relating to settlements or judgments in civil claims
- Potential further powers to issue public warnings about practitioners.

MIGA's advocacy will continue to seek fair, practical and sensible frameworks for sharing information with the public where required, whilst ensuring appropriate public protection but avoiding unnecessary disclosures and unwarranted invasions of practitioners' privacy.

Timothy Bowen
Senior Solicitor – Advocacy, Claims & Education

2018 Annual General Meeting

An invitation to the AGM for current members is enclosed with this Bulletin. It is being held on Saturday, 24 November 2018 at the Hilton Hotel Adelaide at 9.00am. If you would like to attend please ensure you RSVP by Wednesday, 7 November 2018.

The business of the Annual General Meeting includes the election of Directors to the Board of MDASA.

As per Article 46 of the MDASA Constitution, Dr Andrew Pesce and Associate Professor Peter Cundy offer themselves for re-election.

Nominations for these two Board positions closed on Friday, 14 September 2018. No additional nominations were received.

As there were no other nominations for the two vacancies, no election is required and the Chairman will declare Dr Andrew Pesce and Associate Professor Peter Cundy duly elected at the Annual General Meeting (as per Article 48A(b) of the Constitution).

Although there is no need to conduct an election for Directors this year, if you cannot attend and wish to provide a proxy to vote on the adoption of the financials and last year's AGM minutes, you may still do this. Please contact us on 1800 777 156 if you wish to do so.

The AGM will again be held in conjunction with our Adelaide Risk Management Conference which is scheduled for Saturday, 24 November 2018.

We hope you will join us at the AGM to hear about developments in the last year at MIGA and to ask questions of the Chairman and CEO.

If you attend in Adelaide, we also invite you to join us afterwards for morning tea with our Boards and staff. It is a great opportunity to get to know them better.

We look forward to presenting our year-end results and meeting with members in an informal setting.

For our members in other States and Territories, over the next 12 months you will have the opportunity to meet with us personally and raise any issues at Risk Management Conferences which are being held in key locations across Australia.

Mandy Anderson
CEO and Managing Director

Case Study

Your obligations
Assaults and reporting of domestic violence

Key issue
What are your obligations when confronted with a patient who may have been the subject of physical violence?

Key takeaway
Your primary role is to provide medical care and support to your patient, but it is also important to understand the legal framework so you can help the patient make informed decisions.

Belinda Cullinan
Solicitor – Claims & Legal Services

Scenario A
Dr Jones was working at the local emergency department late one Saturday evening when a patient arrived via ambulance following a period of unconsciousness. The report provided by a family member to the ambulance crew was that the patient had slipped in the bathroom and hit her head on the tiles. On questioning, the patient reported to Dr Jones that she had been hit in the back of the head with a baseball bat by a family member. The patient was reluctant to report the matter to the police. After clearing the patient of any head injury, but before further discussion can occur, the patient absconds from the hospital.

Scenario B
Dr Smith has a patient who has presented on three occasions reporting altercations with her partner which have resulted in bruising to various parts of her body and face. At each presentation, Dr Smith notices that the extent of the bruising is becoming more severe. At each consultation, the patient has been adamant that she does not want to report the matter for fear of reprisal but informs Dr Smith that her husband has threatened that he will kill her. Her young children have witnessed the violence. She also divulges that during the most recent assault he raped her.

Scenario C
Dr Bates is working at the emergency department when an 18 year old male presents with serious stab wounds to his arm. The male is refusing to provide any information as to the events that led up to the incident and becomes aggressive when Dr Bates indicates the police will be contacted.

The three scenarios described above represent situations a number of our members are confronted with in their day-to-day practice. Frequently the member rings MIGA for advice. The underlying concern that most doctors have in this situation is whether they have a duty, or are required, to disclose the physical assault to the authorities where the patient refuses to do so or to otherwise take steps to ensure their safety. Doctors we speak to are understandably concerned that if they fail to take action when the patient refuses to, further violence may occur which could be life-ending.

Maintaining a patient's privacy is a fundamental component of the doctor-patient relationship and the platform upon which mutual trust is built. This is now enshrined in the Privacy Act 1988 including the Australian Privacy Principles and some State legislation.

The role of a health practitioner when managing adult patients who are experiencing physical violence is to provide medical care as opposed to legal advice. However it is important for health practitioners to have a good understanding of the legal framework so that information can be given to the victim patient who can then make an informed decision.

We highlight below some important considerations to bear in mind when confronted with adult patients who have encountered acts of violence.

Medico-legal considerations:
When treating a patient who is suffering from, or is worried about, threats of violence:

- MIGA recommends that practitioners record a detailed history of the assault, violent incident or threat.
- Those notes may ultimately become evidence in legal proceeding so it is important they provide a clear, accurate and contemporaneous account of the patient's presentation.
- If you are required to provide a statement to the police or give witness evidence in a legal proceeding, the more detailed your notes are the better your evidence will be.

Reporting obligations and steps to take:
The mandatory reporting obligations vary between States and Territories however, we provide some key information regarding doctors' obligations below:

- Unlike in the case of the sexual or physical assault of children, there is no mandatory obligation to report physical harm to the police in Australia except in the Northern Territory, where there is a mandatory obligation to report any instance of serious physical harm from domestic violence. There are protections for persons who make reports in good faith.
- In the Northern Territory, New South Wales and Tasmania there are legislative requirements to report the exposure of a child to domestic violence. If you practise in these jurisdictions, ensure you have obtained sufficient history from the patient to assess whether you are required to make a mandatory report.
- When taking the patient's history, it is important to assess the patient's safety and inform them of options such as seeking police assistance, the availability of court protection orders and what local support services are available.
- If the patient doesn't want to report, continue to support the patient by adopting a multi-disciplinary approach and assist the patient to engage with local support services.
- If the injury is serious and potentially life-threatening involve appropriate hospital or local support services and consider seeking the patient's agreement to notify police.
- Under the Privacy Act 1988 and relevant State and Territory legislation and policy directives, disclosure without consent is permissible in some circumstances including to lessen or prevent a serious threat to the life, health or safety of any individual or to public health or safety.
- Gunshot or knife wounds may require reporting in your State or Territory.

Sexual Assaults:
Domestic violence can often lead to a patient disclosing allegations of sexual assault including rape. Where a patient presents that has suffered from sexual assault:

- A physical examination is best performed as soon as possible after the patient presents.
- If you are not trained in the collection of forensic evidence, refer the patient to a sexual assault service.
- Refer the patient to a counselling service whether or not the patient chooses to report the assault to the police.

Ultimately your patient may decide not to take any action. As difficult as that is, it is important that you continue to support the patient and provide them with options. They may not report initially but with the right support and information available, some patients will go on to take steps to address the violence they have encountered.

Please note that this article does not constitute legal advice. If you are uncertain about your obligation to report an assault or act of violence involving a patient, we encourage you to call MIGA's Claims and Legal Services team who can assist you to obtain the advice you need.

Further resources
RACGP clinical guidelines

- Abuse and Violence: Working with our patients in general practice
- Intimate partner abuse: identification and initial validation

CFCA Mandatory reporting of child abuse and neglect

MIGA Firearms and reporting obligations

Case Study

Back to basics in bariatrics

Key issue
This case highlights the importance of basic decision making relating to patient selection, along with pre and post-operative patient management.

Key takeaway
Sound judgement and patient management are critical to yours and the patients success. When using new equipment or procedures your consenting and management of the patient, clear and appropriate documentation and evidence-based judgement will be your best defence.

Marie-Clare Elder
Senior Solicitor – Claims & Legal Services

NSW Deputy State Coroner Magistrate Ryan handed down her decision regarding post-operative bariatric surgery complications resulting in the death of a much-loved mother and grandmother on 26 April 2018[1]. The patient died from sepsis as a result of gastric perforation following the procedure.

Aside from the statutory obligation to determine cause and manner of death, the inquiry centred on three key issues:

1. Whether the patient was a suitable candidate for the bariatric procedure known as IntraGastric Balloon procedure [IGB]
2. Whether the patient was warned of and consented to the risks of IGB
3. Whether the post-operative advice and care was adequate.

Patient suitability

The patient, aged 67, had struggled with weight gain following the birth of her two children. Her past medical history included anxiety, hypertension and sleep apnoea. Importantly, severe reflux necessitated a partial fundoplication to be performed in 2012.

In January 2015 the patient had a BMI of 46 and had suffered two seizures thought to be related to her sleep apnoea – directly associated with her obesity. This led her to research surgical options that might be available to her. This included a consultation with another surgeon who recommended reversal of her fundoplication as well as substantial dietary and lifestyle variations. The patient did not return to that surgeon following the consultation.

After researching the IGB, an inflatable balloon temporarily placed into the stomach to create the feeling of fullness and limit the capacity for food intake, the patient attended a weight loss clinic, had pre-operative consultations and ultimately underwent the procedure on 22 June 2015.

The inquest heard evidence that the surgeon used the Spatz 3 device. In 2015, the manufacturer of the device did not publish directions on its use, rather it referred to the directions for a device called the Obera fixed device which was formally in use before the Spatz device was introduced.

The Obera directions which were current at the time the procedure was performed stated that one of the contraindications for its use was *"prior gastrointestinal or bariatric surgery".*

The court heard evidence that peer-reviewed research current at the time listed prior-gastric surgery as a contra-indication and that the Position Statement of the American Society of Gastrointestinal Endoscopy identified previous gastric surgery as *"an absolute contraindication".*

Risks versus benefits discussion

The surgeon gave evidence justifying his decision to proceed with the IGB procedure. He said that he considered the patient's partial fundoplication placed her at a much lower risk than had she undergone a full fundoplication previously. The experts disagreed with this evidence, relying on the peer-reviewed literature available at the time which made no distinction between the extent of previous gastrointestinal surgeries nor the two devices. The Coroner concluded that performing this operation in these circumstances was *"a significant error of judgment"* and that *"there was no evidence to support the proposition that an IGB device . . . was safe or appropriate".*

In relation to whether the patient was warned of the risks and benefits of the procedure the Coroner could find no reference to these discussions in the surgeon's notes stating *"These are wholly inadequate consisting in each case of little more than a few scrawled lines".*

In relation to whether or not the patient ought to have been made aware of the contraindication of previous gastrointestinal surgery as per the manufacturer's instructions, she stated that *"There can be no doubt that [the patient] was entitled to know this".*

Post-operative care and advice

The Coroner found that the post-operative advice given to the patient led to a delay in her seeking treatment. The patient started vomiting and dry-wretching post-operatively and became severely dehydrated. The post-operative instructions stated *"If after two days you are experiencing any severe nausea or vomiting"* the surgeon should be contacted. The Court heard evidence from the patient's son that she did not seek assistance earlier as she was following the instructions. Therefore, by the time the patient presented to hospital, she was so severely dehydrated, the gastric perforation and resulting sepsis was past the point of no return.

The Coroner, after hearing expert evidence, found that, had the patient sought medical attention on 23 June (day one post-op) *"her chances of surviving would likely have been enhanced".*

Lessons for our members

1. Whilst there is always debate in medicine about the validly and efficacy of various trials and literature, peer reviews and literature will frequently be referred to and relied on by experts and the courts in a legal setting. We encourage you to stay up to date in your speciality.
2. In this case, although the surgeon said that he did weigh up the risks versus benefits of the prior gastrointestional surgery, there was a missed opportunity to have his recommendation peer reviewed. A second opinion by an equally-qualified surgeon can only benefit the doctor and the patient where there are increased risks or uncertainty as to next steps.
3. The doctor's lack of clear and thorough documentation led to blunt criticism by the Coroner. Contemporaneous entries in the medical records are crucial for any defence of a complaint or claim.
4. Ensure your post-operative instructions are clear and thorough and ensure patients and their carers understand that advice or treatment can be sought at <u>any</u> time post-operatively.

It is important to note that the surgeon was commended for his co-operation, insight and significant changes to his practice since the tragic event. He was deeply remorseful.

The Coroner recommended that the Australian and New Zealand Metabolic and Obesity Surgery Society consider developing guidelines and compiling outcome data for all bariatric patients.

1 Findings in the Inquest into the death of Margaret Ann Pegum, handed down 26 April 2018 http://www.coroners.justice.nsw.gov.au/Documents/Findings%20Margaret%20Pegum.pdf

Medical practices
Beware the risks of over confidence

In the past there has been a view that responsibility for patient outcomes rests solely with the doctors working in a practice and that responsibility for insurance similarly rests with doctors. In recent years there has been a shift in this view as the role of medical practices in the provision of services to doctors and patients has emerged. Contributing to this has been the emergence of multidisciplinary practices and staff at many levels playing a greater role in patient care.

This evolution of the practice structure and the manner in which healthcare services are provided across wider teams of medical and non-medical staff means that the risks that practices carry are greater than they have ever been.

As an insurer we see this change in the increasing numbers of enquiries, complaints and claims reported to us by medical practices over recent years. It is becoming more common for claims to be made solely against the medical practice or made jointly against the medical practice and doctors.

Whilst doctors must have medical indemnity insurance as a condition of registration, there is no statutory obligation for medical practices to have their own insurance, even though the risks and financial consequences of not being insured can be equally severe.

Insurance held by doctors is designed principally for the sole benefit of the doctor, whereas MIGA's Healthcare Professional Indemnity Insurance Policy is developed specifically to meet the needs of medical practices.

Some features of MIGA's Healthcare Professional Indemnity Policy are:

- It covers the:
    - Medical practice for claims made against it for which it is legally liable
    - The practice staff (other than doctors) for claims made against them arising from the services they provide in the conduct of their duties
- It provides protection for a range of matters including allegations of breaches of privacy, mandatory data breach notifications, employment and contract and workplace disputes
- It includes access to 24 hour medico-legal and risk management advice at no additional cost
- You can select your limit of cover between $1 million and $20 million with an automatic reinstatement of the selected limit at no additional cost.

Importantly, the cost of the insurance is geared specifically to the risks of the practice.

The financial consequences of an uninsured claim can be devastating to any business and medical practices are not immune from such outcomes.

For further information or advice in relation to MIGA's Healthcare Professional Indemnity insurance and how it can protect your practice, please contact us – we are here to help.

Maurie Corsini
National Manager – Underwriting

Treating the elderly
When is it too much or too little?

You might be interested to know that in Japan when a person turns 60 years old it is a huge event. It marks a rite of passage into 'old age'.

Maybe 60 is a bit young, but it must be acknowledged that older people can be vulnerable, particularly as reliance on others increases and it becomes more difficult for them to express their desires and wishes, especially where they might feel under pressure to not be a burden.

According to the AMA, between 2010 and 2050, **the number of older Australians (65 to 84 years) will more than double** from 2.6 million to 6.3 million, and **the number of very old people (85 and over) will more than quadruple** from 0.4 million to 1.8 million.

All Australians have a right of access to medical care when they need it but what influence does age have on the decisions that are made?

Is there ever an age limit to medical interventions, particularly surgery for acute injury?

What is the legal environment in Australia when deciding on levels of care?

This year at our Risk Management Conferences our panel of experts will explore the issues of health care for the elderly with a focus on 5 areas:
1. When and how to treat – the question of frailty and medical futility
2. How to manage the consenting process
3. Advanced care directives and end of life
4. Medication management
5. Elder abuse

In healthcare, treating an elderly person comes with many complexities. The question of frailty and its impact on treatment decisions spans all areas of medicine: surgical, anaesthetic, non-procedural specialist care, general practice, out-patient and emergency.

Are you confident that you are providing optimal care and guidance to your elderly patients when it comes to understanding the unique issues of aging? This includes considering:
- Consent and the question of fluctuating capacity
- Advance Care Directives – what if you don't agree with the direction?
- Polypharmacy – what are the impacts on frailty and when should you prescribe or de-prescribe?
- Which of your patients are at risk of suffering abuse?

Types of Abuse

Financial 42%
Illegal/improper use of a person's finances or property

Psychological 35%
Infliction of mental anguish

Neglect 10%
Failure to provide the necessities of care

Physical 8%
Infliction of pain or injury

Social 5%
Prevention of social contact

Sexual 0.1%
Sexually abusive or exploitative behaviour

Source: Elder Abuse Prevention Unit Highlight Report 2015-16 financial year

These issues are never black and white and can be difficult to tackle as a lone practitioner. At this year's Risk Services Conferences we will walk you through real life scenarios while our experts offer opinion, share knowledge and provide you with tools and resources to support you in caring for the not-so-young patient.

Attend a conference in Adelaide, Sydney, Perth or Brisbane
To book visit REO via our website or call the Risk Services team on 1800 777 156

Liz Fitzgerald
National Manager – Risk Services

Dare to dream

Ever thought of extending your training, being a part of ground-breaking research, changing health policy in developing nations?

What about expanding your network, or becoming part of a passionate global team of researchers and change-makers?

We could help make your dream come true through the **MIGA Doctors in Training Grants Program**, just as we assisted Dr Henry Zhao, Dr Annabelle Enriquez and Dr Simone Sandler.

Expand your mind, expand your experience and be the change you want to see!

Visit **miga.com.au/dit-grants-program** to apply and view the full reports from our amazing grant recipients.

2018 Applications close Friday, 2 November 2018

Perhaps we can help make your dream a reality!

Dr Henry Zhao

Doctor of Philosophy in Clinical Acute Stroke Medicine

Though the Melbourne Mobile Stroke Unit is an important clinical asset, it also allows us to perform ground-breaking research. I am coordinating the world's first clinical trial of a drug designed to try to halt bleeding (using Tranexamic acid) for patients with a bleeding stroke in a Mobile Stroke Unit. There are otherwise no other treatments available for this devastating condition.

This trial would not be feasible in hospital, as patients must be treated within the first few hours of stroke onset, something only the Mobile Stroke Unit can usually achieve. We also have a second important clinical trial of a newer clot dissolving drug (Tenecteplase), which has shown that it has superior effect than the usual drug that is used. This, along with earlier treatment in the community, is hoped to be able to save more brain tissue and improve outcomes for patients.

Dr Annabelle Enriquez

Master of Medicine, Sydney

At the start of the millennium, it took 23 laboratories 13 years and $3 billion to sequence the entire human genome. There are now powerful sequencing machines that can sequence up to 18,000 entire human genomes annually. The goal of my research is to identify the causes of congenital anomalies, specifically the genetic changes that lead to cardiac and vertebral malformation. Congenital anomalies affect more children than most chronic childhood diseases including autism, cancer and type 1 diabetes.

Many families endure a diagnostic odyssey as they try to find the reason why their child is, or children, are affected. A definitive molecular diagnosis is important for overall patient management, even when it does not necessarily change treatment and exonerates the parents, as they usually feel guilt for somehow causing the Congenital Malformation. It also provides relief from the uncertainty, allowing families to move on, plan for the future and possibly explore therapeutic options.

Dr Simone Sandler

Harvard Program in Global Surgery and Social Change

The greatest resource I have been able to access during my time in the Program in Global Surgery and Social Change (PGSSC) has been the extraordinary professional networks and mentors I have met from around the world. Some of these amazing people include Massachusetts Eye and Ear hospital global otolaryngologists, who are facilitating outreach and education clinics in nearby developing nations such as Haiti, passionate general surgeons in rural India who are pioneering equitable healthcare for disenfranchised local tribal populations, and colleagues at the PGSSC who are facilitating surgical policy change with ministries of health in a variety of developing countries such as Zambia and Tanzania.

Working amongst PGSSC colleagues has been a warm and hospitable experience – a work environment both supportive and uplifting. I am grateful for the wonderful opportunity to rub shoulders and pick the brains of some of the most inspiring 'change-makers' in the field of global surgery.

Adam Hughes
Marketing Manager

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Midwives Beware the hazards of your social media activity

We hardly need to define social media these days. It has become a part of our lives whether we like it or not. Twitter, Facebook, Instagram and LinkedIn are used to connect with friends, family, colleagues and clients. Maintaining boundaries and professionalism when it comes to posting, responding and sharing on any of the social media platforms is paramount.

The Australian College of Midwives (ACM) sets out the three Golden Rules for using social media in its Guide for Midwives:

1. Use common sense
2. Remember the permanence of cyberspace
3. Consider legal and professional responsibilities.

If used responsibly and appropriately, social networking sites can offer several benefits for midwives. These include:

- Developing professional relationships
- Providing a platform for midwifery support networks
- Breaking down barriers and making it easier for midwives to connect with each other, as well as expectant parents and families.

As a midwife, it is your responsibility to ensure that any information that you provide via social media is evidence-based and correct to the best of your knowledge. Avoid discussing anything that does not fall within your scope of practice and you should avoid making general comments that could be considered inaccurate.

It is important to consider your associations on social media. For example, 'liking' or 'sharing' someone else's post can imply that you endorse or support their point of view.

There are a number of legal and professional responsibilities that impact midwives' behaviour and that includes behaviour in the online space.

ACM recommends that midwives use the following documents to guide their use of social media:

- Guidelines for advertising regulated health services (AHPRA, 2014)
- FAQ on the revised advertising guidelines (AHPRA, 2014)
- Social media policy (AHPRA, 2014)
- Code of Ethics for Midwives (NMBA, March 2018)
- Code of Professional Conduct for Midwives in Australia (NMBA, March 2018)
- ACM Social Media for Midwives (PDF)

Liz Fitzgerald
National Manager – Risk Services

Help us support the amazing work of the Australian Red Cross Blood Service and help save the lives of our fellow Australians

It's quick and easy to join our Red25 group at: **donateblood.com.au/red25/join-red25-group**
Enter the group name **'MIGA'.**

Don't forget to make an appointment and donate!

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Facsimile 1800 839 284

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(Office hrs and 24hr emergency legal support)
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Letters to the Editor

We encourage clients to contact us with their views by email to mandy.anderson@miga.com.au or follow the links on our website at miga.com.au.

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