Bulletin

Securing your information with MIGA

There was a time when we didn't think too much about the value of our personal information. But you only have to look at the financial valuations of the tech giants Facebook and Google to appreciate the business value of personal information. They essentially trade on the personal information they harvest from their platforms to provide services and assist advertisers target users.

Unfortunately, the value of personal and particularly medical information has also made it a target for hackers and extortionists.

According to the January 2021 Notifiable Data Breaches Report from the Office of the Australian Information Commissioner:

- The health sector remains the highest reporting industry sector, notifying 23% of all data breaches
- Malicious or criminal attacks remain the leading source of data breaches, accounting for 58% of notifications, with the finance and health services sectors ranking 1 and 2 respectively in the number of these types of incidents.

As a financial services organisation servicing medical and healthcare professionals, this weighs heavily on our minds as we fully understand the importance of adequately protecting your personal information.

This was the leading reason we recently introduced our new renewal process which places your insurance information and documents within a secure Client Portal.

We appreciate this was quite a significant change for you and that the secure login using 2 Factor Authentication presented challenges for some members and clients. However, in this rapidly changing environment the balance between convenience and security must tip in favour of security.

If you haven't yet set up your MIGA Client Portal account, we encourage you to do so. It will make future access to your information and documents much easier and enable us to continue to provide service to you in an environment where you have confidence that your personal information remains secure.

If you need assistance setting up your Client Portal account, please contact your Client Services Officer on 1800 777 156 and they will be happy to step you through the process.

Mandy Anderson
CEO and Managing Director

October 2021

Welcome to the October edition of the MIGA Bulletin. In this issue our Legal Services team look at the Duty of Care of healthcare professionals and provide some guidance for our members and clients.

We also review the importance of the medical record and your notes, which can make the difference between a great defence and no defence. Are your records as good as they could be?

In addition, we look at the new requirements in terms of Australians seeking access to nicotine vaping products, which will need a doctor's prescription from 1 October 2021.

Please remember we are here to help when you need it. I hope you enjoy this issue and gain value from the case studies we have provided.

Nick Maycock
Solicitor – Legal Services

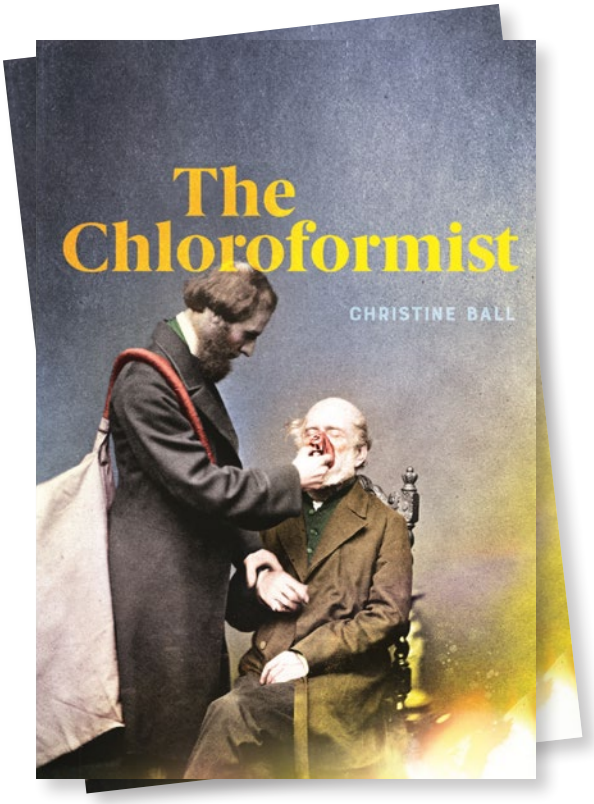
National Anaesthesia Day
16 October 2021

Last year, as part of MIGA's 120th Anniversary, we delved into the history of medicine. We explored a number of medical discoveries and advancements which proved to be equal parts 'amazing' and 'fascinating'.

With National Anaesthesia Day occurring on 16 October (the anniversary of the first ether anaesthetic demonstration, conducted in Boston Massachusetts in 1846), we acknowledge the contribution that Anaesthesia and Anaesthetists have made to medical practice. Anaesthesia has facilitated incredible medical advancements by enabling complex and lengthy procedures. It is a critical element of practice for so many of our clients. It is almost impossible to imagine what practice would look like without it.

One for the history buffs

In a recently published book 'The Chloroformist', Dr Christine Ball recounts those early days prior to and immediately after the advent of anaesthesia. Through her research she has uncovered the biography of Joseph Clover, a man credited with developing the relationship between surgeons and anaesthetists. She explores the personal lives of individuals involved in this tumultuous time in medicine and the challenges they faced as the world rapidly evolved around them.



Find out more

'The Chloroformist' by Dr Christine Ball
Available at www.mup.com.au/books/the-chloroformist-electronic-book-text

Navigating a new world of nicotine prescription

From 1 October 2021, Australians seeking access to nicotine vaping products will need a doctor's prescription.

The Therapeutic Goods Administration (**TGA**) intends for this to "*prevent adolescents and young adults from taking-up nicotine e-cigarettes while allowing current smokers to access these products for smoking cessation on their doctor's advice …*".

Doctors, particularly GPs, are now likely to see not just those wanting to quit smoking, but also those who want to continue vaping.

This has been a controversial reform, with a range of views across the medical profession about whether liquid nicotine has a role in smoking cessation.

Given the realities of the new regime MIGA has been working closely with the Commonwealth Health Department, TGA and peak medical bodies on expectations of doctors, issues they are likely to face and the guidance/support they need.

Is clinical guidance available?

The TGA contemplates liquid nicotine being prescribed to assist with smoking cessation.

The RACGP is currently updating its *Supporting smoking cessation – A guide for health professionals* – a new version is expected to be released shortly. Its current recommendations include:

- *All people who smoke should be offered brief advice to quit smoking, and referral to telephone call-back counselling services should be offered to all people who smoke*
- *Nicotine-containing e-cigarettes are not first-line treatments for smoking cessation – a range of alternative treatments are recommended first*
- *For people who have tried to achieve smoking cessation with approved pharmacotherapies but failed, and who are still motivated to quit smoking and have brought up e-cigarette usage with their healthcare practitioner, nicotine-containing e-cigarettes may be a reasonable intervention to recommend. This needs to be preceded by an evidence-informed shared decision-making process, whereby the patient is aware of the following:*
  - *no tested and approved e-cigarette products are available*
  - *the long-term health effects of vaping are unknown*
  - *possession of nicotine-containing e-liquid without a prescription is illegal*
  - *in order to maximise possible benefit and minimise risk of harms, only short-term use is recommended*
  - *dual use (i.e. with continued tobacco smoking) needs to be avoided.*

What are the new Medicare items?

New Medicare nicotine and smoking cessation counselling items have recently been released, both for face-to-face and telehealth.

A number of issues raised by MIGA and others with the draft items have been addressed, particularly around assessment requirements and co-claiming.

Like all Medicare items, it is important to familiarise yourself with their specific requirements before use. The Commonwealth Health Department have released an FAQ. At this stage, these items are only in place until 30 June 2022.

Am I covered for nicotine prescribing?

MIGA covers doctors and healthcare practices[1] for:

- Healthcare provided within your insurance category/scope of practice or healthcare business
- That is consistent with your qualifications, training, experience or the healthcare provided by your practice/business
- Subject to the existing terms and conditions of your insurance policy.

Within these limits, doctors and practices are covered for claims and inquiries arising from nicotine prescribing and smoking cessation services more generally.

It is important to ensure that you comply with all relevant requirements and guidelines.

What else do I need to think about?

Other key issues to consider when faced with requests for nicotine prescription:

- It's ok to say no if you are not comfortable prescribing liquid nicotine
- Familiarise yourself with available clinical guidance, particularly the latest RACGP guidelines, and TGA requirements (more below)
- The TGA provides information about risks associated with nicotine use as part of its scheduling decision, and has developed a nicotine vaping 'hub', with a range of further information
- If you are considering prescription but are unsure of indications, assessment parameters, advice to patients on potential risks or benefits, dosages or monitoring regimes, speak with specialist or experienced senior colleagues, or liaise with your peak body
- If using telehealth, ensure you can provide the same level of care as you would face-to-face, and have appropriate arrangements in place to see patients face-to-face if needed
- As there are currently no TGA-approved nicotine vaping products:
  - TGA approval is needed to prescribe products dispensed at an Australian pharmacy - the Authorised Prescriber scheme, which does not require approvals on a patient-by-patient basis, can be used
  - Vaping products dispensed by an Australian pharmacy must meet new TGA standards on quality and safety
  - Patients can access three months' supply from overseas under the TGA Personal Importation Scheme, with a doctor's prescription, and TGA approval is not required
- The TGA "*strongly encourages*" reporting adverse events involving e-cigarettes and nicotine vaping products
- Advertising prescription medications is generally prohibited by the TGA, but pharmacies have been given certain exceptions to advertise that they dispense nicotine vaping products.

If you have further questions, contact MIGA's Legal Services team.

Timothy Bowen
Manager – Advocacy & Legal Services

1 If you are a doctor whose practice entity employs other doctors or others who bill in their own name, you must ensure that they have their own insurance arrangements in place to cover their involvement in nicotine prescribing and smoking cessation services generally

Resources

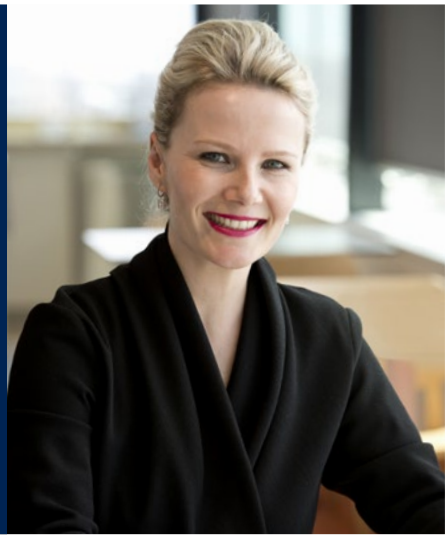
TGA
Nicotine vaping hub
www.tga.gov.au/nicotine-vaping-products

RACGP
Supporting smoking cessation – A guide for health professionals
www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/supporting-smoking-cessation

Commonwealth Health Department
Nicotine & smoking cessation counselling MBS item FAQ
www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/BFB90D144704E4B8CA25871B0013463B/$File/faq-smokcess.pdf

Case Study

What is your 'duty of care'?



Marie-Clare Elder
Manager – Legal Services

The Legal Services team have been busy responding to COVID-19 related enquiries across a wide and evolving range of issues. However, the non-COVID-19 queries continue and are a good reminder that some medico-legal principles don't change too much.

In our conversations with members and clients, they often report that their understanding of where their 'duty of care' begins and ends is confusing and they rightly seek clarity from us.

Consider the following scenarios:

A patient of the practice presents to reception without an appointment seeking medical attention. I am the only doctor present; do I have a duty to see him/her?

The patient in question presented with radiating chest pain. Although 'walk-ins' can be challenging for time management and for other waiting patients, clearly the nature of the presentation warranted immediate assessment.

Ideally in this type of scenario, where time is truly of the essence, a rapid clinical assessment ought to occur so an ambulance can be called for urgent transportation to hospital, if required. The assessment should take place in a private room and the patient monitored closely whilst a plan is formulated and an ambulance called, if required.

Whether the patient has been seen before by the only doctor present is not a factor which should be considered when dealing with an acute presentation. The definition of a patient is interpreted widely. In this context, it was not in dispute that the patient was a regular patient of the practice, therefore a duty existed.

Indeed, even if the person has no previous relationship with the practice, a doctor could be open to criticism if he/she refused to render assistance, particularly when the practitioner was in a well-equipped clinical setting.

In short, if in doubt assess the patient, seek assistance from the ambulance service if necessary, and document the interaction as you would for any other patient.

A patient has been discharged from the practice for aggression and drug seeking behaviour. The patient keeps turning up to the practice demanding to be seen whilst abusing reception staff. Do I have a duty to see them?

During the call, we established that the practice had a long history with this patient. Many doctors had tried in earnest to assist the patient without success. The patient was erratic, non-compliant, abusive, and frequently did not attend appointments. He refused to see pain management or mental health specialists, demanded excess prescriptions of drugs of addiction and threatened complaints if he did not get what he wanted.

With assistance some months back from MIGA, the practice had sent a letter to him clearly terminating care and offering other treatment options (MIGA can provide guidance on terminating care of patients, including what to include in a letter to them). There were many practices in the area he could attend, he had received multiple verbal and written warnings and he had been notified to the prescription shoppers hotline.

Given the history and the frequent attempts to engage and help the patient, although a duty had existed previously, the practice had terminated the care in very clear terms to the patient.

But if the patient presented acutely (as per example 1) the approach would mirror that scenario – i.e., assess and call an ambulance.

In this case however, the patient was obviously menacing so, if the staff felt intimidated or threatened, it would be appropriate to call the police.

In the absence of an emergency, there was no duty to arrange a consultation with the patient.

I have operated on a patient and she has demanded further procedures as she is dissatisfied. I do not want to perform further revision surgery, but do I have a duty to?

This is an enquiry we receive frequently from a range of specialists. The scenario is common in cosmetic/plastic patients, but persistent post-operative discomfort or pain can cause a patient to press for further revision as it is assumed this can be rectified surgically.

The surgeon stated that it was her opinion that maximum surgical intervention had been reached. Clinically, she could find no rationale that would support further revision.

In that case, it would not be appropriate to offer further surgery. A doctor cannot be forced to perform procedures which are inconsistent with good surgical practice.

However, it would be prudent to refer the patient to a trusted colleague for a second opinion or discharge the patient back to the referring general practitioner, suggesting that a second opinion is arranged.

As in every case, clear documentation was key and the letter to the GP should be detailed including the clinical rationale for declining further intervention.

In summary

In relation to your 'duty of care':

1. Treat worrying presentations, regardless of the relationship, as quickly as possible and if in doubt or isolated, call an ambulance
2. Document interactions thoroughly and be clear in correspondence with patients and colleagues
3. Call the Legal Services team at MIGA for assistance when presented with challenging scenarios, we have a wealth of experience and are here to assist you.

Case Study

‘Spoken words fly away, written words remain’

Mark Helier
Solicitor – Legal Services

This phrase is based on the Latin proverb ‘*Verba volant, scripta manent*’ which essentially means spoken words might easily be forgotten, but written documents can be conclusive. MIGA solicitors assist doctors with claims, complaints and notifications and understand the value of good medical records when assisting our members in dealing with these matters. They make a huge difference.

The touchstone for the content of medical records, as indicated by the Medical Board of Australia and Medicare, is that they must be sufficient to facilitate continuity of care. It is essential the records contain relevant details of clinical history, clinical findings, investigations, diagnosis, information given to patients, medications, referrals and other management.

What we sometimes find, when reviewing medical records as part of responding to a claim or complaint, is that additional, important information is not in the medical records which would have assisted in responding to concerns. Conversely, occasionally we have also found information within the medical record that should not be included.

When considering whether to include or exclude information in medical records, the starting point is whether the information relates to the patient and facilitates continuity of their care. With that in mind, additional information that may need to be in the medical record includes:

- If this is the first time the patient has consulted you, including a phrase like “new patient to me”
- Any third parties that attended the appointment e.g. which parent of a child or which son or daughter of the patient
- Duration of the consultation, especially for those more complex and lengthy consultations
- Patient failure to attend an appointment
- Patient consent to physical examination
- The offer of chaperone and the patient response
- Results given
- Letters discussed e.g. letter from treating specialist
- Details about the advice you provided which the patient did not follow
- Advice from colleagues you may have obtained via the “corridor discussion”
- If the patient brings in documents which are discussed, then these can be scanned or copied
- Correspondence from third parties including health insurers, travel insurers, State or Commonwealth entities, to/from family members, medical records which have been transferred from the patient’s previous clinic
- Relevant emails and SMS
- Relevant phone messages.

Sometimes you might be asked by a patient or their lawyer to provide a medico-legal report. Although this is normally part of the clinical record, it may also be subject to legal professional privilege and may have specific rules about disclosure to third parties. It is important to note clearly on the file where there might be privileged material, and to consider whether to contact the patient if you receive a subpoena or summons for their records.

Other important information which may follow from more difficult or challenging situations, to include in the medical records includes:

- Inappropriate or embarrassing topics raised by the patient e.g. if a patient makes an inappropriately sexualised comments towards you or your colleagues, it is important to include a reference to this. The exact details of the conversation could be set out in a “medico-legal” folder which is discussed below
- Warnings relevant to the patient such as no benzodiazepines, no Schedule 8 medication, presence of Family Court Orders, Domestic Violence Orders
- Special instructions such as, in the case of a child patient, if a family member is or is not to be provided with information
- Family Court documents such as Court Orders which often include details about parental responsibility
- Police search warrants or if the police won’t allow you to retain a copy of it, then a reference to it
- Coronial documents such as Summonses or Directions to Enter, correspondence to and from the Coroner including a coronial statement
- Your consideration of whether to make a mandatory report e.g. child protection, fitness to drive (South Australia and Northern Territory only), firearms (SA and NT only), gunshot injuries (Tasmania only) or Ahpra.

The information we recommend not be included in the medical records is:

- Advice from MIGA solicitors, whether verbal or written, regarding the patient (We do, however, recommend the advice is documented in a “Medico-legal” folder separate from the medical record)
- Draft letters
- Claims for compensation e.g. court documents such as a Statement of Claim
- Complaints received via Ahpra, a State / Territory health complaints body or Office of the Australian Information Commissioner
- Medicare audits.

For the above documents, we recommend you set up a special folder (“Medico-legal”) outside of the patient records where this information can be filed away but also referred to if needed.

These lists are by no means exhaustive and are only meant to serve as a guide. As the treating practitioner you will be best placed to determine what information provides for continuity of patient care. What information would you like available if you had to see a colleague’s patient? We recommend you contact a MIGA solicitor to assist you where you may be unsure or if it is unclear.

Did you miss it?
Chronic pain management

We all know the world view is changing on the use of addictive drugs as the first line treatment in managing chronic pain.

In a webinar earlier this year MIGA focused on the prevalence of over-prescribing opioids in treating chronic pain. What we saw were some very strong messages to the profession, from the Coroner's Court, on the dangers inherent in this practice. The TGA and PBS presented the regulatory changes to opioid prescribing.

The impact of these changes for medical practitioners, and their patients, is significant. So last month we offered a second event which explored the practicalities of treating patients with chronic pain.

The principal question was "how do we engage our patients in changing their perspectives on pain and pain management?" A complex and challenging discussion ensued.

The expert panel looked at several factors, including:
- Data from recent studies
- The new regulatory guidelines
- New approaches to treatment
- The process of reducing medication and improving health.

It also explored the challenges for the prescriber and the medico-legal implications of getting it wrong. In summary:

Challenges in Practice
- Reluctance to prescribe
- Patient reluctance to change (understanding pain)
- Deprescribing challenges & skilful deprescribing
- Access to specialists
- Resources

Medico-legal
- Inappropriate/high dose prescriptions
- Inadequate history/assessment/treatment plan
- Lack of specialist involvement
- Poor records
- Greater accountability stemming from changes in regulatory requirements

If you would like more practical advice on managing deprescribing and difficult clinical conversations with a patient why not consider completing the excellent new NPS MedicineWise Learning module on *Chronic pain: Supporting patients to taper opioids.* **www.nps.org.au/cpd/activities/chronic-pain-supporting-patients-to-taper-opioids**

This module attracts 5 MIGA Points. Simply load the completion Certificate into the *External Activities* course in REO.

We also provide a list of resources that you may find valuable on the topic of Chronic Pain Management. These resources are designed for the clinician and their patients. **www.miga.com.au/MIGA/media/MIGA/Risk%20Management/Opioid-prescribing-Useful resources.pdf**

Over 500 of your colleagues attended the MIGA webinar which provided an opportunity to ask questions, hear practical advice and receive guidance on complex areas of medicine.

Liz Fitzgerald
National Manager - Risk Services

Don't miss our next webinar!

Putting my health first
The paradigm shift

Our next webinar will look at how you can shift the focus of health to yourself. How do you make real and lasting change to achieve a better work-life balance? Discover strategies you can implement to change entrenched life habits and cope better with daily stressors. Our expert panel will include a doctor and a psychologist who are both life coaches experienced in helping doctors change their lives for the better. This could change your life too!

Get in early to secure your place!

Wednesday, 20 October 2021, 7pm (AEDT)

Book via REO Events
miga.eventsair.com/21phf01/NEpage

2021 Annual General Meeting

AGM

With COVID restrictions and limitations still in place in some States our 2021 AGM will be held as a hybrid meeting providing members with the option to either attend in person or via video conference. It is being held on Saturday, 20 November 2021 at the Hilton Hotel Adelaide commencing at 9:00am (ACDT).

If circumstances change due to COVID and we cannot offer an option for members to attend in person in Adelaide, we will revert to the AGM being a virtual one only. We will monitor the situation and advise members closer to the time if this occurs.

An invitation to the AGM will be emailed to members (or mailed if we do not have your e-mail address). It will contain a link to enable you to register your attendance and indicate if you will attend in person or via video conferencing. After registering, if you have indicated to attend the meeting via videoconferencing, a link to attend the meeting online will be provided to you closer to the meeting date. If you would like to attend please ensure you register your attendance by Wednesday, 17 November 2021. We hope to see many of our South Australian members in person at the Hilton Hotel Adelaide.

The business of the Annual General Meeting includes:

- Adoption of the Financial Report, Financial Statements and Annual Report for June 2021
- Proposed change to the MDASA Constitution to enable us to hold hybrid meetings (i.e., in person and virtual), without relying on ASIC COVID-19 determinations.

Election of Directors

As per article 46 of the MDASA Constitution, Assoc. Prof. Susan Neuhaus and Dr Stephen Parnis retire by rotation or have been appointed during the year to fill a casual vacancy and stand for re-election.

Nominations for these two Board positions closed on Friday, 10 September 2021.

As there were no other nominations for the two vacancies, no election is required, and the Chairman will declare Assoc. Prof. Susan Neuhaus and Dr Stephen Parnis duly elected at the Annual General Meeting (as per Article 48A(b) of the Constitution).

Submit a proxy if you cannot attend the AGM

At the AGM every member of the Association shall have one vote and each member entitled to vote may do so at the AGM either in person or on-line or by proxy.

Members will be provided with a Proxy Form for use if they wish, if they are unable to attend the AGM.

In order for your vote to be valid at the AGM, Proxy Forms must be received at the offices of MIGA **by 5.00pm (ACDT) on Wednesday, 17 November 2021. Proxy Forms received after this time will not be accepted.**

Details of the voting and proxy process, along with information about how members will be able to participate in the meeting if attending on-line, will be provided with the AGM Notices, which will be distributed to members by email or post on Monday 25 October 2021.

Adelaide Risk Management Conference

The AGM will be held in conjunction with our Adelaide Risk Management Conference, COVID-19 restrictions permitting.

If you would like to attend the Risk Management Conference (which is after the AGM) and you haven't already registered, we encourage you to book. Please contact either Jane Clark or Kerry-Ann Klop on 1800 777 156 and they will assist you with your registration.

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 person 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 an overview of the financial year and to meeting with members in an informal setting after the AGM.

Mandy Anderson
CEO & Managing Director

KEY DATES TO NOTE

AGM invite and notices to be sent to all members by e-mail or postcard
Monday 25 Oct 2021, by COB (ACDT)

Proxy Form must be received by MIGA
Wednesday 17 Nov 2021, 5.00pm (ACDT)

Close date to register to attend the AGM
Wednesday 17 Nov 2021, 5.00pm (ACDT)

Terminating the midwife/client relationship

How do you manage a client who will not follow your advice? This is one of the most common concerns that midwives call us about.

The facts

Jane wanted a home birth, and she made that clear at the time that she booked with you. She was 32 weeks. You were supportive of her plan and discussed with Jane that there were guidelines you were required to work within, while providing her with care for the remainder of her pregnancy.

Your discussion with Jane about the guidelines was detailed and recorded in the signed service agreement. All seemed great and you were looking forward to caring for Jane over the next few months.

In line with the ACM guidelines, you arranged for CTG monitoring and an ultrasound. However, Jane refused as she didn't believe they were necessary. This was the first sign that there were going to be challenges.

At 41+3 weeks, Jane was 10 days post-dates. You talked to her about the risks associated with prolonged pregnancy and reminded her that she had been given the policy on prolonged pregnancy. You also raised the concern of the increased chance of foetal demise in a prolonged pregnancy.

Unfortunately, Jane refused to consider any form of induction of labour until she had reached 43 weeks. Her compromise was that, then she would consider natural forms of induction. Jane believed that the date of her last menstrual period was incorrect and therefore her estimated due date was incorrect.

She refused to speak to a doctor as she felt she had been given enough information even though you had explained that collaboration was essential in these circumstances. It was becoming a real concern for you that Jane was completely disregarding your obligation to provide safe care within your professional guidelines.

You called MIGA for some support and guidance on this very difficult clinical scenario.

Written agreement between client and midwife

Jane had signed a service agreement agreeing to comply with the requests and recommendations of the midwife.

One option available was to terminate the relationship with Jane as she was in breach of the service agreement. The difficulty in making this decision was that she was already at 41+3 weeks.

Either party is entitled to terminate a midwife/client agreement when the relationship has been compromised, irretrievably, by the actions of the woman or the midwife.

In this case, the ability to manage and treat Jane's pregnancy is compromised significantly. Jane's expectations could not be met as they continued to be outside of the care that you are required to provide to her.

Considerations when withdrawing care

The National Midwifery Guidelines for consultation and referral provide an excellent overview of the considerations of withdrawing care and how they should be approached. These should be your guiding principles.

There are several factors that MIGA's Legal Services Team will work with you on. Any decision to bring a therapeutic relationship to an end is challenging and difficult, so we will support you through the process.

Together we will look at:

- The scope of the agreement
- The discussions when the relationship commenced
- The discussions at the times when Jane refused your advice or associated care
- Your documentation over the time you have been caring for Jane.

The reason for the termination of the relationship should never come as a surprise to the client. It is of paramount importance that your documentation is exemplary. This will be your best asset, should your decision be questioned and scrutinised.

We will take you through the next steps and ensure that your position is protected.

We are always available to discuss these types of scenarios with you and encourage you to call us. The earlier the better so that, where possible, the relationship can be salvaged, or the care of the client can be safely transferred to another practitioner.

Liz Fitzgerald
National Manager – Risk Services