Avant
By doctors for doctors

Issue 21 | October 2023

Connect

Dr Vennassa Wong
Avant member

Sustainable healthcare

How member initiatives are contributing to high-quality care

Payroll tax for practices

What is the impact of the latest rulings?

Ahpra complaint due to GP recall failure

Pathology results requiring patient recall not picked up

Off-label prescribing

How to avoid problems if you choose to prescribe off-label

130 YEARS

1893 2023

"Avant has served many generations of doctors over the 130 years of its existence. As a mutual organisation run by doctors and for doctors, we are keenly focused on running Avant in a manner that is true to the values of today's members and will deliver value well into the future. The importance of a sustainable health system is a concept that drives us to constantly assess our activities to ensure a strong and viable future."

Dr Beverley Rowbotham
Chair, Avant Mutual

Connect with us

We'd love to hear what you think of *Connect*, or what you'd like to see more of – email editor@avant.org.au.

Improving member experience

We're always looking for ways to improve your interactions with Avant.

As we expand our products and services to meet your professional and personal needs, our website will be evolving to deliver a more personalised and convenient experience.

avant.org.au | 1800 128 268

Welcome

Sustainability

Case studies

Insights

130 years of supporting doctors

1893

Sydney Medical Association Established

1894

Becomes the NSW Medical Union

1895

Medical Defence Association of Victoria (MDAV) established

1934

NSW Medical Union incorporated and name changed to NSW Medical Defence Union Limited

1976

NSW Medical Defence becomes the first Medical Defence Organisation (MDO) to obtain an insurance licence

1982

NSW Medical Defence becomes a discretionary mutual association (and relinquishes insurance licence)

1989

NSW Medical Defence regains insurance licence reposed in Australasian Medical Insurance Limited

Premiums started to vary according to risk

1997

United Medical Protection (UMP) forms from merger of NSW Medical Defence Union, Medical Protection Society (NSW) and Medical Defence Society Queensland

1998

Medical Defence Union (UK) withdraws from Australia and its members join UMP.

2002

Medical indemnity crisis sparked when MDOs required to account for incurred but not reported liabilities

2003

Government medical indemnity reform package

Tort law reform across all states and territories

2007

UMP and MDAV merge to create Avant Mutual

2009

Avant established Australia's only specialist medico-legal practice – Avant Law

2011

Avant is the first MDO to launch a loyalty reward plan

RiskIQ is launched (now the Avant Learning Centre online information resource)

2012

Doctors' Health Fund acquired

Early Career Research Program introduced

2013

Avant Travel Cover launched

2014

The industry-first Retirement Reward Plan is introduced

2016

Avant acquires My Practice Manual and re-launches as PracticeHub

Quality Leadership Grants introduced to fund members' research

2017

Avant Foundation established

Avant Life Insurance launched

Avant business insurances offered

2018

Avant Foundation funds AIDA to support Indigenous medical student bursaries

2019

Cyber insurance is offered to practice indemnity policy holders

Avant Board elects its first female Chair

2020

Avant appoints first female CEO

2021

Avant acquires 25% of Team Medical Supplies

2022

Avant Law extended services introduced on fee for service basis

Hoxton Medical Practice Management acquired

Kooyong financial services fully acquired

Cgov fully acquired

2023

Avant Practice Solutions launched

Working for long-term sustainability

Doctors are under ever-increasing pressure to keep up with the demand for their services, and their time. The strategies that have driven the great step forward we have seen in modern healthcare – access to care, preventative care and monitoring – have driven this demand. Doctors are now on the front line in finding ways to ensure the quality of our healthcare can be sustained. This is familiar territory for us. Doctors are, by virtue of our training, future focused: the patient's future, the system's future.

Similarly, Avant, run by doctors for doctors, is future focused. We have served doctors for 130 years and are committed to serving the next generation of our members. The importance of a sustainable health system is a concept that drives us to constantly assess our activities to ensure a strong and viable future.

When developing our sustainability framework, we identified those areas where Avant could have most impact. Many members are doing great work in these areas from which others, including Avant, draw inspiration. In this issue of *Connect*, we look at some member initiatives, many supported by Avant, that are positively impacting the sustainability of the healthcare system. These include activities related to improving healthcare, health and wellbeing, and diversity, equity and inclusion.

In the following pages, we hear from two Avant members who have a particular interest in Indigenous and remote healthcare; Dr Vennassa Wong is our profiled member, and Dr Gillian Farrell, an Avant director, also provides her perspective after setting up a new program to give access to specialist plastic surgery services in the Northern Territory.

One way we support our members to improve the sustainability of healthcare is through our investment in medical research. Early Career Research Program grant recipient, Dr Al-Rahim Habib's work *Using artificial intelligence to beat ear disease in Indigenous children*, is ground-breaking and promises life-changing healthcare.

Providing confidence to doctors so they can keep serving the community is another core aspect of sustainability that is central to our purpose. Understanding the regulations under which we practise, and the potential pitfalls we face, is an important element in having that confidence and providing good quality care. Avant's Advocacy, Education and Research team creates a wealth of high-quality material to assist members' understanding of many of these matters and, in this issue, they share insights into prescribing off-label.

An area of concern in recent months for many doctors running their own practices has been payroll tax. Since first hitting the headlines last year, there has been a great deal of commentary on the implications, with the situation evolving as each state has developed their position. Avant Law's Commercial and Corporate team has been helping many members and practices understand what this will mean for them, and their article on page 18 provides some important advice on what should be done to manage the changes.

Members are always keen to understand their obligations and best practice in delivery of quality healthcare, and our case studies are always a popular way for them to gain insights. In this issue, three common situations are covered: ensuring follow-up isn't missed, a patient's rights to having a second opinion, and the risks of prescribing for family and friends.

As we all know, despite our best efforts, things can go wrong. This is very distressing for doctors and can dent our confidence. Avant Deputy Chief Medical Officer, Dr Mark Woodrow, looks at how a complaint impacted him before reflection taught him to view complaints as feedback and an impetus for improvement.

This is my final editorial for *Connect* magazine as I retire from the Avant Board at the Annual General Meeting next month. Avant is strongly positioned to serve today's and tomorrow's members. It remains as committed to its intergenerational mission of doctors looking after doctors as it ever was.

My sincere thanks to the members, for your inspiration and your support. I wish you well in your careers. The practice of medicine is a higher calling and it has been an honour to serve the profession in this role.

Best regards,

Beverley Rowbotham

Dr Beverley Rowbotham
Chair, Avant Mutual

130 YEARS
1893 2023

Working to improve healthcare for remote and rural communities

Dr Vennassa Wong
Rural & Remote General Practitioner, Anaesthetist
Indigenous Health Coordinator, School of Rural Medicine, Charles Sturt University
Avant member

Dr Vennassa Wong is a proud First Nations woman who is a rural generalist, educator and advocate for Indigenous, rural and remote health. She grew up experiencing the challenges of living in resource-limited areas, and also raised her six children in rural and remote areas across North Queensland, Western Australia, New South Wales and an overseas placement in the Pacific. This lived experience provides her with a unique insight into the daily trials and tribulations faced by both the people in rural areas and the health professionals dedicated to their wellbeing.

Dr Wong is committed to providing healthcare in rural and remote communities, with a particular priority on First Nations health. Her focus extends to enhancing infrastructure, healthcare accessibility, education and fostering economic opportunities. She says, "I lament the persistent struggle to get adequate funding, particularly given that rural and remote communities have borne the brunt of recent challenges. The lack of both medical and allied health staff and the challenges in accessing resources such as paediatric services, or having to travel long distances for specialist referrals, exemplifies the challenges doctors in these areas grapple with."

In her role as Lecturer in Medicine and Indigenous Health Coordinator at Charles Sturt University, Dr Wong actively advances culturally sensitive Indigenous medical education. She is focused on forging collaborative partnerships with stakeholders and engaging medical students in cultural awareness initiatives. The significance of organisations like Avant investing in the development of a Reconciliation Action Plan, is something Dr Wong understands. "This type of commitment is vital for raising awareness about the importance of developing culturally-tailored education and resources," she says.

Dr Wong's involvement in various initiatives to expand opportunities for Indigenous youth has been spurred on by her awareness of the systemic hurdles faced by Indigenous communities, particularly those in remote regions. As an Avant member, Dr Wong is pleased that the Avant Foundation makes funding available for the Australian Indigenous Doctors Association, which in turn supports bursaries for Indigenous medical students.

Alongside scholarships, Dr Wong knows how important it is to offer mentorship programs that connect students with role models who share their background. She's proud to be a sponsor for Boots to Scrubs, an initiative recently set up by Chloe Campbell and Georgia Goodhew, her Year 3 medical students at Charles Sturt University. This nationwide project aims to address the rural doctor shortage by inspiring, empowering and supporting women from the country to pursue a career in rural medicine.

"I envision the expansion of such programs to encompass the early years of high school, with a specific focus on encouraging the engagement of First Nations students, as this is a key period for inspiring students to consider healthcare as a potential career path."

With a career dedicated to driving change, Dr Wong reflects on the challenges of practising medicine where access to primary care services is limited, and referral and retrieval processes to larger centres are often "intricate". She emphasises that "a significant portion of a rural doctor's role is devoted to advocating for their patients – a commitment that aligns with the vocation's ethos." ●

Dr Vennassa Wong and daughter

> "I firmly believe that bolstering Indigenous representation across the entire healthcare system is pivotal for enhancing the sustainability of healthcare provisions for Indigenous Australians.

Seeking to make a difference

A/Prof Gillian Farrell
Plastic and Reconstructive Surgeon
Avant Mutual Director

Like many members, I'm increasingly concerned with social, ethical and environmental issues, in particular where these contribute to healthcare. These concerns motivate me to consider what I can do to make a difference, which has included helping to set up a project in Darwin to provide a plastic surgery service to the Northern Territory.

Going to the NT with the Darwin Workforce Project was a great opportunity for me to support an under-serviced community. This initiative, a partnership between the Australian Society of Plastic Surgeons and NT Health, was established in 2020 to bring specialist plastic surgeons to a region that had minimal access to this specialty.

Admissions have almost doubled since the project started, with over 60% of patients having an Aboriginal or Torres Strait Islander background, and around half of these coming from remote communities.

We soon found that without the support of local Indigenous interpreters to assist with language and cultural communication, it was very difficult to provide the level of service we want to deliver. Educating and learning from Aboriginal Health Workers who understand the differences in culture and social structure has helped us address some of the issues that our established system was causing. I've realised that the success of programs intended to improve the health of remote communities is only possible with the involvement of health professionals who come from these communities.

Supporting diversity, equity and inclusion

While an increasing number of First Nations Australians are joining the health workforce across Australia, some, like other people living in rural and remote regions, can encounter obstacles to education and a career in health. A new Medical School has commenced at Charles Darwin University, with a major aim to facilitate undergraduate entry to medicine for students growing up and being educated in the Northern Territory. Innovative pathways are being developed to support those from diverse backgrounds to transition into the medical program, including First Nations Australians.

Throughout my career, I've seen how discriminatory behaviour so often deters good young doctors from developing and continuing in the profession. It's something I particularly notice for female doctors. Fostering a workplace environment where women are supported to take on senior positions, especially in surgical roles which have traditionally been very male dominated, is something I've been working on through being a role model and a mentor.

Looking after our colleagues

I'm concerned about the growing mental health crisis within the medical profession. The success of the Darwin project relies on attracting doctors to live and work in a remote area. Supporting these people, who are needed to provide care to others, can be an additional challenge in places where they may not have colleagues to speak with.

I was invited to attend one of Avant's 'The Quake, The Cave, The Commando' events and was interested to see how members clearly appreciated the opportunity to be honest among their peers about the struggles they had experienced. It's so important that as a community we support each other and recognise the risk of poor mental health and suicide that doctors face.

Avant's initiatives to support doctors' health and wellbeing is something that's given me a real sense of pride. It's important we all contribute to a sustainable healthcare system, and it's great to have organisations like Avant providing support. ●

A/Prof Gillian Farrell

Key messages

My experience with the Darwin Workforce Project has shown me first-hand how important it is to:

- involve local community health workers to act as 'the bridge' when treating Indigenous patients
- preference Indigenous people who are capable and wanting to work in healthcare
- ensure there is an environment that fosters inclusion and enables development
- look out for your colleagues who may be impacted by the pressure of work or life.

Using artificial intelligence to beat ear disease in Indigenous children

An innovative artificial intelligence (AI) tool shown to accurately triage ear disease in rural and remote Indigenous children, was developed with the support of a 2021 Avant Doctor in Training Research award. The project team is now building on its initial findings, supported by further funding from Avant.

The idea for the algorithm, DrumBeat.ai, was conceived by otolaryngology registrar, Dr Al-Rahim Habib, in conjunction with senior ENT mentors during his internship in the Northern Territory, where he observed the challenges Aboriginal and Torres Strait Islander children face accessing tertiary ENT services. In fact, rural and remote-dwelling Indigenous Australian children experience the highest rates of ear disease in the world.

A shortage of rural and remote area ENT specialists and the limitations of telehealth can lead to delays in triage and early treatment, increasing the risk of detrimental hearing loss, and adversely affecting language development, academic performance and quality of life.

"The overarching purpose of DrumBeat.ai is to enhance the capacity of frontline healthcare workers in rural and remote areas to quickly identify ear disease, inform judgement, and improve clinical decision-making," Dr Habib explains. "This project has the potential to profoundly improve the daily life, academic performance and future employment prospects for Aboriginal children living in these areas."

World-first database of eardrum images improves early detection

DrumBeat.ai is the first tool of its kind and is comparable to ENT experts at recognising normal and abnormal eardrums and detecting hearing loss. Using the tool, healthcare workers can identify children who need to see a specialist, and predict high-risk children needing urgent treatment to prevent infection or permanent hearing loss.

With the initial funding, Dr Habib and his team developed an algorithm using more than 10,000 otoscopic eardrum images from over 4,000 Aboriginal and Torres Strait Islander children, from more than 100 rural and remote communities in the Northern Territory and Queensland.

The DrumBeat.ai project is a collaboration between Indigenous community leaders and healthcare professionals, including the Deadly Ears Program, the departments of Otolaryngology - Head and Neck Surgery at the Royal Darwin Hospital and Westmead Hospital, University of Sydney, University of Queensland, Griffith University, and Microsoft's AI for Good Lab.

Further funding helps research team explore integration into clinical practice

Dr Habib's initial research has demonstrated substantial performance in virtual training environments.

A further grant from Avant through the Early Career Research Program is now allowing Dr Habib and his team to move from lab-based simulations to real-world testing.

"I am grateful to Avant for supporting our research two years in a row. This grant provided me the opportunity to explore an area of research which I am passionate about and to continue my clinical role," Dr Habib reflects. "Avant's support has granted us an incredible opportunity to refine our existing models and explore how they could be applied in Australia and abroad. Our team published two manuscripts in international peer-reviewed scientific journals. I was able to present our findings at national and international scientific conferences and share our research with the public through news articles, radio and online interviews. We now have the opportunity to expand our research questions and work towards revolutionising telehealth services by integrating AI into existing clinical workflows." ●

> We are now exploring how we can integrate the algorithm into daily clinical practice, to improve efficiency and time-to-treatment, and reduce costs by focusing resources on children who need specialist care.

Dr Al-Rahim Habib, Doctor in Training Research Scholarship recipient 2021, Early Career Research Program grant recipient 2022

Improving healthcare

Improving healthcare is central to doctors' purpose and instincts as they work to support their patients. Overlaying this is the challenge of increased demand as people live longer and have higher expectations of the care they receive. Meeting this challenge and ensuring the sustainability of healthcare means finding better ways to deliver at an individual, organisational and system level.

Many members are involved in initiatives that will contribute to a stronger and more sustainable healthcare system. We are proud to support these projects through our grants program and the Avant Foundation.

Advancing clinical care

A tremendous amount of work is being done by members to find new or improved ways to care for patients. Research to improve diagnosis, treatment and understanding of conditions have had profound impact on patient care, not only in Australia, but around the world.

One example is Dr Shejil Kumar's work investigating the best multidisciplinary care approach for older Australians with osteoporosis by combining drug and exercise treatment. It's estimated that 6.2 million Australians, aged 50 years or older, had osteoporosis or osteopenia in 2022. "Our study will be the first to investigate effects of romosozumab on muscle and physical performance in humans," says Dr Kumar. This is relevant as improvements in muscle and physical performance may reduce the risk of falls.

Better efficiency in emergency departments

Work that looks at improving system processes is delivering better patient experiences and reducing their risk of clinical deterioration.

Dr Nicole Ghedina is an emergency physician and lead researcher for a project at St John of God, assessing the use of e-triage to reduce waiting time and improve clinical care for ED patients. An electronic triage kiosk system with direct patient data entry will replace nurse-performed verbal and physical assessment, while allowing for simultaneous nurse-performed data entry.

Dr Ghedina says, "E-triage kiosk systems have been introduced in overseas hospitals with improvements in time to care. We expect that implementing a patient self-registration and e-triage kiosk system to our ED will provide similar improvements in our delivery of healthcare."

Developing the next generation

Surgeon Professor Richard Turner, is leading a project at the University of Tasmania where a telehealth simulation program develops skills for Australia's future healthcare workforce. "The project will influence health education policy in the university sector by consolidating the place of our model for telehealth training in medical school curricula around the country," Professor Turner states. "In the hospital sector, partnerships with Telehealth Tasmania and the Postgraduate Medical Education Council of Tasmania, may support an adapted version of the model becoming a mandatory requirement of internship."

Improving professionalism

The profession is under greater scrutiny, with patients having higher expectations of the service provided. Doctors are having to work to ever-higher professional standards to be seen as delivering good care. This includes ensuring appropriate professional boundaries with peers, friends, family and other healthcare professionals.

At the University of Newcastle, Associate Professor Lisa Lampe, is leading research that explores doctors' and medical students' awareness of boundary issues, including how frequently these are experienced, associations with stress and burnout, and the personal and professional problems that may follow.

A/Prof Lampe says, "I recognised the importance of understanding the challenges of navigating non-sexual boundaries and realised that they are common and stressful, but doctors only have limited preparation in dealing with them.

"By identifying perceived impacts and current levels of awareness, this project represents a first step in fixing a current gap in the education and professional development of doctors," says A/Prof Lampe. ●

Practising safely to improve healthcare

As doctors continue to develop their clinical skills, improvements to healthcare can also be achieved through areas such as communication, effective record keeping and understanding Medicare. The Avant Learning Centre, our newsletters and Medico-legal Advisory Service are all there to help. And if you or a colleague have a research project, take a look at the grants available from and Avant and through the Avant Foundation.

Avant Learning Centre
avant.org.au/avant-learning-centre

Health and wellbeing

The wellbeing of doctors is essential for the sustainable delivery of healthcare. However, the reality is that medicine is a stressful profession with doctor burnout and mental health issues all too common, and this is exacerbated as doctors are often not good at taking care of themselves or seeking appropriate professional help. The consequences are not good for the doctor, their patients or the profession.

The medical profession unfortunately has a pervasive culture where doctors are expected to endure difficulties and develop resilience. An inability to do this is often perceived as a failure, which creates a barrier to seeking mental health support or even admit to facing such challenges.

So, it is good to hear that several doctors have taken on board the saying 'physician, heal thyself' to aid their colleagues.

Encouraging conversations

Avant member, Dr Geoff Toogood, established Crazy Socks 4 Docs to encourage open discussion by doctors and healthcare professionals about their mental health. Like many doctors, he had delayed seeking help for his depression, partly because he was concerned about the implications for his career. After recovering, he wanted to share his story in the hope of reducing the stigma associated with mental health issues and was amazed by the huge amount of support his initiative received. This has led to an annual event to address doctors' wellbeing.

AMA president, Dr Stephen Robson, is another member who has spoken about his mental health experiences as a junior doctor, "At the time I would have been mortified if my colleagues knew how I was feeling or what was going through my mind. But it would have been really important to have that discussion. I'm incredibly lucky that I'm even here at all; it was perhaps through random chance, perhaps a deliberate act by my colleagues, that I was saved from harming myself. I think that's what brought it home for me – that it's important we look out for our colleagues, and ourselves; try to recognise how we're feeling and not be embarrassed or ashamed, or not seek help or speak to somebody about things."

Developing strength from adversity

Practising medicine requires resilience and an ability to bounce back from adversity. Dr Dan Pronk not only had the challenges of a career in medicine, he also served as a combat doctor with the SAS in Afghanistan. He experienced countless personal traumas and witnessed the major injuries and deaths of mates in combat, which resulted in him developing post-traumatic stress. In his post-military life, he explored methods to improve his responses to stress and therefore improve his resilience. Dan's experience led him, together with two other ex-SAS servicemen, to develop The Resilience Shield, a methodology to help others develop greater resilience in their professional and personal life.

Supporting doctors in need

There are many support services doctors can access, but speaking with a colleague provides the sense that the person listening truly understands your perspective. Hand-n-Hand was founded in 2020 in response to the growing emotional burden that came with the COVID pandemic, and is another grassroots initiative. It offers confidential peer support for health professionals and, with support from Avant Financial Services (formerly Kooyong) and other industry bodies, this free service continues to provide emotional and wellbeing assistance into its third year.

Australian Doctors in Recovery was set up to support doctors experiencing issues with addiction, including alcoholism. This collegiate support group was established by Avant member Ruth and a colleague in 1991 after they shared their experiences. They recognised that the fear of people knowing, guilt, and shame are particularly significant for doctors, due to the high standards they set themselves. The anonymous and confidential service helps remind doctors they are not alone and it will get better. They also stress the importance of taking the first step of reaching out and not trying to face things on your own. ●

Avant wellbeing resources

If you or a colleague need support, Avant offers members a range of support tools, including six sessions of external counselling, as part of our Personal Support Program.

avant.org.au/Key-support-services

To assist in assessing mental wellbeing and identifying burnout, Avant members also have free access to the My Well-Being Index app developed by the Mayo Clinic.

avant.org.au/health-and-well-being

Diversity, equity and inclusion

Better representation of minority groups in medical practice can deliver clear benefits. Research has consistently shown that if you have more diversity in your organisation, you attract top talent, make better decisions, and you're more innovative.

Making good connections

Gender, ethnicity, disability and sexual orientation are all diversity groups that can be underrepresented. Having doctors from diverse backgrounds helps with connecting to patients and communities.

Myles McKenzie is a medical student who was awarded a bursary by the Australian Indigenous Doctors Association, funded by the Avant Foundation. Keen to make a difference, Myles says, "I aspire to become one of the few Aboriginal psychiatrists in regional North Queensland so I can work to reduce the soaring rates of Indigenous mental illness and youth suicide."

Dr Sam Heard, Medical Director of the Central Australian Aboriginal Congress in the NT, believes trust and reciprocity are the basis of good care. "I think you have to come from a compassionate point of view; if you are willing to go the extra mile for the patient, they can tell you really care about them. When language is different and understanding is reduced, you've got to spend extra time."

Dr Gillian Farrell, a plastic and reconstructive surgeon and Head of the Darwin Workforce Project, also recognises the importance of effectively connecting with Aboriginal patients to get better outcomes. She notes, "The long-term success of programs intended to improve the health of remote communities desperately needs the involvement of health professionals who have come from within these communities."

Enabling diversity

Like any other professional group, doctors can experience ill health or disability. Many who are disabled or have a long-term health condition, successfully study and practise medicine.

While at medical school, Dinesh Palipana had an accident that left him with quadriplegia. "I wanted to return to medical school from the moment the accident happened," says Dr Palipana OAM, who is now a registrar in the Emergency Department at the Gold Coast University Hospital and Senior Lecturer at Griffith University.

"In Australia it can be difficult to go through medical school with a disability. When I returned, there were guidelines that could be interpreted strictly to exclude people with disabilities. That's why Drs Hannah Jackson, Harry Eeman and I founded Doctors with Disabilities. We saw there were barriers against physically diverse people coming into medicine, so we felt we needed to advocate for them.

"I think now is the time within our profession to look forward and be accepting of a diverse range of people. This will benefit patients and our profession. By embracing different people and giving people an opportunity, we can not only improve the profession, but we can improve society and be a leader in inclusivity."

Encouraging women in medicine

When Dr Jennifer Green started out, there weren't any female orthopaedic surgeons in Sydney. Despite the lack of visible female representation in her specialty, Dr Green says she did not suffer any discrimination or setbacks, "It's an 'unconscious bias', rather than discrimination".

"Historically, when joint replacements had to be done by hand, there was a reason why tall, strong males were the dominant members of the orthopaedic fraternity. We have had power tools for more than 50 years which mean strength is not a priority and there are also many more sub-specialties to choose from.

"People think diversity is something nice to have but not really relevant, but if you don't have a diverse work force, your patients will suffer. Evidence shows this leads to profound healthcare inequities," says Dr Green. ●

Key messages

- Review and revise recruitment and hiring practices to eliminate biases and promote diversity.
- Evaluate and adjust workplace policies and practices to be more inclusive. This could involve accommodating for different abilities, zero-tolerance of discrimination and harassment, and ensuring equal access to development opportunities.
- Offer ongoing diversity and inclusion training for all employees. This raises awareness about biases and stereotypes and also provides strategies for building an inclusive workplace.

Prescription monitoring system flags doctor's prescribing mistake

Nicola Kent
MCCJ, LLB, BA
Senior Associate, Professional Conduct, Avant Law

The introduction of real-time prescription monitoring has changed the way doctors' prescribing is being monitored, as this doctor found after prescribing drugs of dependence to help a family member.

In this case, through prescription monitoring, the state's health department identified that a member had inadvertently self-prescribed drugs of dependence while attempting to prescribe to her husband.

Doctor prescribes to husband

The doctor's husband had been unwell with COVID and had severe back pain due to repetitive coughing. An orthopaedic surgeon had prescribed a non-steroidal anti-inflammatory medication for his back pain.

However, the medication did not relieve her husband's pain and the doctor received a call from him while she was at work, saying he was in severe pain. To help alleviate his pain, she wrote him prescriptions for paracetamol and codeine, and an opioid pain medication.

In her haste to quickly write a prescription, the doctor issued the prescriptions from her own record in the practice software (that she used to order medications), rather than creating a new patient record for her husband.

Unfortunately, the doctor's attempts at altering her own record were only partly successful. As a result, the prescriptions were in her own name, rather than her husband's. Neither the doctor, nor her husband, nor the pharmacist noticed this at the time and the prescriptions were dispensed to her husband.

Health department alerted to prescribing

Later that month, the doctor received a notice from the health department's medicines compliance regulatory body asking her to provide information about the prescriptions, including confirming she had issued them.

The regulatory body was alerted to the doctor's prescribing through the state's real-time prescription monitoring system. In almost all Australian jurisdictions, it's an offence punishable by a fine and/or imprisonment to self-prescribe or self-administer certain medicines including Schedule 4 and Schedule 8 medications, without reasonable excuse. Also, all doctors are required to practise in accordance with the Medical Board of Australia's *Good medical practice: a code of conduct for doctors in Australia* which prohibits self-prescribing and prescribing Schedule 8, psychotropic medication and/or drugs of dependence for anyone they are close to.

Avant assists doctor

Avant's medico-legal team helped the doctor submit a response to the regulatory body, clarifying the prescription had been written for her husband, not for herself, and she had not intended to breach the legislation.

The doctor readily acknowledged she shouldn't have written the prescriptions for her husband and instead, he should have consulted his own treating doctor. She expressed regret that she had prescribed for her husband and completed education on prescribing obligations and treating family and friends provided by Avant.

The regulatory body considered the doctor's explanation, her remorse, and the insight she had demonstrated by completing further education.

No further action was taken by the regulatory body. ●

Key lessons

- The introduction of real-time prescription monitoring has enabled greater tracking of prescribing.
- While it can seem expedient to write a prescription for a family member or friend, doctors should avoid treating anyone with whom they have a close personal relationship, except in an emergency. Doctors are prohibited from prescribing Schedule 8 medication and drugs of dependence for anyone they are close to.
- Never self-prescribe. It is prohibited by the Medical Board's code of conduct for any medication, and self-prescribing certain drugs, including Schedule 4 and Schedule 8 medications is illegal in most Australian jurisdictions.

Avant factsheet
Treating family members, friends or staff

The case discussed in this article is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

Opioid prescribing insights

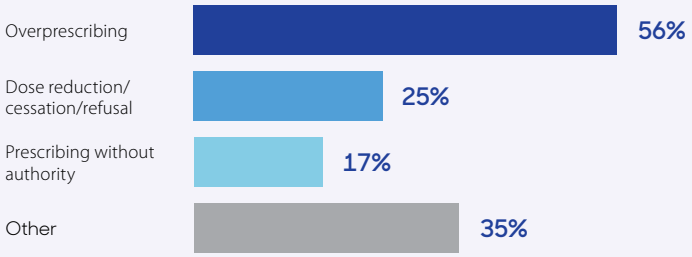
Our data reveals 1 in 17 claims and complaints* involved opioid prescribing practices.

Overprescribing was the most common issue raised in 56% of these claims and complaints. In more than half of these cases the doctor did not meet the standard of care, emphasising the need to take care when treating patients for pain which is neither acute nor cancer related.

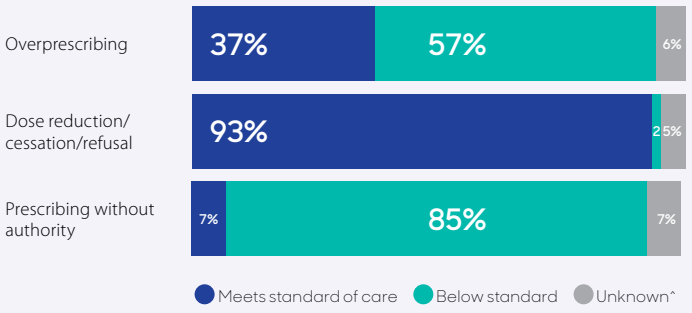
Prescribing without authority was an issue in 17% of opioid prescribing claims and complaints. In more than three-quarters of these cases the standard of care was not met, highlighting how important it is to know and comply with legislation in your state or territory. Other issues included self-prescribing and prescribing that was not clinically indicated.

The data sends a clear message to doctors to be confident about refusing to prescribe opioids or deprescribing, when clinically appropriate.

Opioid prescribing issues (some cases had more than one issue)



Assessment of claims and complaints involving opioid prescribing issues



*The results were based on an analysis of underlying themes of more than 15,000 claims involving Avant members from all specialties including regulatory complaints and compensation claims closed between FY2018–22.

^'Unknown' is used when the standard was not assessed or the final assessment report was unavailable.

A doctor's perspective

Dr Patrick Clancy
MBBS, FRACGP, MHlth&MedLaw
Senior Medical Adviser, Avant

This case highlights some unique challenges when considering prescribing for family members, friends, or staff.

The Medical Board's code of conduct says that wherever possible, doctors should avoid providing medical care to anyone with whom they have a close personal relationship. It specifically prohibits prescribing Schedule 8 and psychotropic medications, and drugs of dependence in those situations, as well as self-prescribing.

Prescribing in these situations can be unsafe and inappropriate. While it may be unavoidable in some rare urgent or acute situations, always ensure you have considered all other alternatives. For example, in the case here, the doctor could have assisted her husband to contact his treating doctor to provide further prescriptions via a telehealth consultation.

If you do find yourself in a genuinely unavoidable situation, the following actions are important:

- Only provide a limited prescription to address the acute or urgent situation, in relation to dose and amount, and avoid including repeats on the prescription.
- Document the prescription you provide and the reasons for it, including the circumstances of the acute or urgent need.
- Consider contacting the pharmacy where the prescription will be dispensed so they are aware of the situation.
- Communicate with the person's usual treating doctors about the steps taken.
- Avoid prescribing drugs of dependence at all.

Surgeon successfully defends advising against risky surgery

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A court's decision has clarified whether a surgeon has a duty to refer a patient for surgery when they believe the risks outweigh the benefits, after a neurosurgeon faced a negligence claim for initially recommending conservative treatment.

In this case, an 11-year-old patient was diagnosed with a brain tumour with leptomeningeal metastases.

At the time of diagnosis, given the child's symptoms were relatively mild, neurosurgeon A advised the risks of surgery outweighed the benefits. The tumour appeared benign and slow growing and did not pose an immediate threat to his life. The neurosurgeon advised the best approach was to treat conservatively and observe. He referred the patient to an oncologist.

About four years later, the patient was referred to another neurosurgeon (B) who agreed to operate and removed around 98% of the tumour. Neurosurgeon B advised the patient's solicitors that surgery should have been performed earlier.

The patient later sued neurosurgeon A and the oncologist. He claimed that even if, in their opinion, the risks of surgery outweighed the benefits, they should have advised him earlier that surgery was a treatment option that other surgeons, acting reasonably, would agree to perform with appropriate patient consent.

At the time of the decision, the patient had hemiplegia with no other symptoms.

Duty of care

The court found neurosurgeon A did have a duty to advise that surgical removal of the tumour was the preferred treatment, but that the risks of doing so "at that point in time" exceeded the potential benefits. The court was satisfied neurosurgeon A had given this advice.

Neurosurgeon A also had an obligation to give "frank advice" about the risks of resection at the time, the court found, which he had done. It was appropriate for him to offer his opinion and advise against surgery.

The court accepted defence expert evidence that surgery at that time would have carried a high risk of neurological deficit and given the patient's relatively good circumstances, it was not a reasonable choice prior to 2000.

It was not reasonable to expect the patient's doctors to refer him to another surgeon to attempt surgery for these reasons:

- There was insufficient evidence from either experts or contemporaneous literature, that any surgeons were performing surgery on these tumours at the time. Therefore, it would be unreasonable "to impose a duty to advise that an unnamed and unknown surgeon somewhere in the world, acting reasonably, would have resected the tumour."
- Given peer consensus that the risks of surgery outweighed the benefits in this case, any surgeon who attempted resection would not have been acting reasonably nor conformed to the standard of reasonable care and skill required of a neurosurgeon.

> The court found the surgeon had a duty to advise that surgical removal of the tumour was the preferred treatment, but that the risks of doing so "at that point in time" exceeded the potential benefits.

Standard of care met

There was no dispute that neurosurgeon A's treatment was provided at the standard of reasonable care and skill reasonably expected of a neurosurgeon. It was accepted that neurosurgeon A acted in accordance with proper practice at the time, as accepted by peer opinion.

The fact that surgery was later successfully performed did not justify a finding that it should have been attempted earlier.

The court dismissed neurosurgeon B's view that he would have resected the tumour earlier. It found he had not provided any reasons other than his conviction that, at the time, he and other surgeons were performing this type of surgery. Having accepted evidence that the patient's condition was relatively stable at the time, the court was not persuaded by neurosurgeon B's claim the patient was in a grave situation and dying, and earlier surgery was required.

Court rules no negligence

The court also considered the issue of causation and whether earlier surgery would have avoided the patient's current disabilities.

The court noted that the leptomeningeal metastases also required treatment and the preferred treatment at that time was chemotherapy. This would have been required, even if surgery had been performed earlier.

The evidence indicated conservative treatment was appropriate and had been beneficial. There was no evidence the tumour had grown considerably in the years between diagnosis and eventual surgery. It was likely the disabilities the patient experienced were a result of the surgery and would have occurred regardless of when the surgery was performed.

The court dismissed the patient's claim against both neurosurgeon A and the oncologist. ●

Key lessons

Surgeons have a duty of care to give clear advice about the risks of surgical intervention based on the available information.

Patients have a right to seek a second opinion, and doctors are required to facilitate this.

However, doctors are not required to refer patients to another doctor to pursue treatment that, at the time, would not be accepted by peer opinion as competent professional practice.

Avant factsheet
Consent: the essentials

The case discussed in this article is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

GP's failure to recall patient leads to Ahpra complaint

Nicola Kent
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A GP's systems for patient recall were inadequate and led to a complaint with Ahpra, after he failed to recall a patient when pathology results indicated she required further treatment.

Practice systems for patient follow-up and recall can be critical to patient outcomes, particularly where pathology results are involved. In this case, a GP relied on an informal process of checking and following up on pathology results, and failed to pick up that the patient's results indicated further treatment was required.

Treatment

The GP had consulted with the patient in relation to a lesion that had been identified through biopsy as a fast-growing basal cell carcinoma (BCC) requiring excision. After discussing the need for this procedure with the patient, and obtaining informed consent, the GP performed the excision under local anaesthetic and sent the excised lesion for pathology testing.

In the days that followed, the patient returned to see the GP several times for wound care. The day after the excision was performed, the histopathology report of the lesion was sent to the GP. This report identified the lesion as an ulcerated moderately differentiated basaloid squamous cell carcinoma, measuring at least 25mm x 20mm. While the margins were noted to be clear at 3 o'clock, 6 o'clock, 9 o'clock and 12 o'clock, it was also noted that the deep margin was focally involved.

It was this finding of deep margin focal involvement that ought to have prompted the GP to discuss the result with the patient and either perform a deeper excision himself or refer her to a specialist.

A number of months later, the patient went to a surgeon for removal of lumps that had appeared under her arm. These were subsequently identified as BCC and it was alleged that the GP's failure to obtain clear deep margins had led to the spread of the BCC to the patient's lymph nodes. The patient subsequently lodged a complaint with Ahpra, alleging that the GP's failure to perform a deeper excision or refer the patient to a specialist had led to a deterioration in her condition.

Failure of systems

Unfortunately, in this instance, the system that the GP had been relying on to alert him to results of this nature that required further action, was not effective.

The GP advised that, in the usual course, he would be notified of results such as these by checking his email inbox, which he would do numerous times each day. When he would receive a result like this in his inbox, his practice had been to note the result and ensure that he discussed it with the patient when they next attended at the practice, for example, for wound care.

Considering this matter with the benefit of hindsight, the practitioner was not able to identify whether he had not picked up the patient's results, or whether he was alerted to them but then failed to take further steps to action them. Regardless, the result was the same; his system had failed and the patient was not recalled and advised that further excision of the lesion was necessary. ●

The case discussed in this article is based on a real case. Certain information has been de-identified to preserve privacy and confidentiality.

Avant's medico-legal team helped the GP submit a response to Ahpra... who determined that no further regulatory action was required.

Responding to the complaint

Avant's medico-legal team helped the GP submit a response to Ahpra that outlined his treatment of the patient, as well as providing his sincere apology to the patient that the systems he had put in place for recall had not worked as they should have in her case.

The GP also set out in his response the steps that he had taken to change his practice to ensure that such an error would not occur again. These included:

- Using the practice software to generate a reminder to discuss pathology results with patients. This would mean that whenever he or another practitioner at the practice opened the patient's file, it would have a reminder to discuss the pathology results with the patient.
- Instituting a practice of printing out pathology results in hard copy to give to the patient when they next attended at the practice, as a further prompt to remind him to discuss the results.
- Creating a routine practice to always discuss pathology results for skin excisions when the patient attends the practice for wound review or removal of their sutures.

The GP also engaged with Avant's Risk Advisory Service and, in order to improve his practice, proactively completed a course of education relating to patient follow-up and recall provided by Avant

The Medical Board considered the explanation provided by the GP and, taking into account his reflection, his sincere apology and the actions he had taken to improve his practice, determined that no further regulatory action was required.

Key lessons

- Deficiencies in practice systems with respect to patient recall and follow-up can have a real impact on patient outcomes.
- The best systems for patient recall and follow-up make use of practice software systems and do not depend on individual practitioners remembering to take certain steps.
- The use of 'reminder' or similar functions in practice software can be invaluable to ensure important results are not missed.
- Our experience is that, when responding to a matter of this kind, candour and genuine remorse and reflection on the part of the practitioner will be taken into account by the regulator.

Prescribing off-label: factors to consider

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Off-label prescribing of the diabetes medication Ozempic for weight management has thrown a spotlight on doctors' obligations when making these clinical decisions. We look at the key factors to consider when prescribing off-label to ensure the patient's safety, and that standards of care are met.

In September 2022, Wegovy (semaglutide) was approved for inclusion in the Australian Register of Therapeutic Goods for chronic weight management. Although approval was granted by the Therapeutic Goods Administration (TGA), the manufacturer has not commenced the supply of Wegovy to the Australian market. Consequently, doctors resorted to prescribing Ozempic – the same medication, just with different dosage, presentation and approved usage – for this purpose, in an off-label capacity.

Doctors often prescribe medications 'off-label', which means the medication is prescribed for an indication/condition, patient group, dosage, or administration route that is not specifically approved by the TGA.

It's not illegal for doctors to prescribe off-label when they believe it's in the patient's best interest. However, as with any prescription, it's important doctors follow professional guidelines and the principles of evidence-based medicine to ensure patient safety.

Your professional obligations

Off-label prescribing can range from well-established practices informed by many years of use and experience to more innovative and experimental uses of medications.

While off-label uses have not been subjected to the same level of scrutiny as TGA-registered indications, it does not mean they are automatically inappropriate. If your off-label prescribing were ever questioned, you would need to establish that it met appropriate standards of care.

Your prescribing should comply with good medical practice as set out in the Medical Board of Australia's Code of Conduct. As with any treatment you recommend, ensure your prescribing is based on the best available information, a reasonable expectation of clinical efficacy, and is in the best interests of the patient.

You should also be comfortable that your peers would consider your prescribing as competent professional practice.

Ensure you have adequate knowledge and skills to provide safe clinical care. This includes recognising the limits of your competence and clinical ability and involving other colleagues or specialties where appropriate.

When your prescribing is experimental and not supported by a high-quality evidence base, it should only be done within an approved clinical trial.

Patient selection and consent

It's important to be satisfied the patient is a suitable candidate for the proposed medication. Only prescribe where you have enough information about the patient's past medical history and current medical conditions and medications to satisfy yourself the prescription is appropriate and not contraindicated.

Discuss the risk-benefit profile of the medication with the patient, inform them whether the treatment is recognised or unusual, and what prescribing off-label means. Make sure you are satisfied the patient understands this information and can provide informed consent to treatment. Keep careful records of any information you provide the patient about the treatment.

Documentation and communication

As with all treatment you provide, maintain records of your consultations to enable another doctor to take over care of the patient. This includes information about the patient's history, examination and test results, diagnosis, medications prescribed, outcomes of the treatment and the ongoing treatment plan. ●

Avant eLearning course
Prescribing principles: Part one: general prescribing issues

What's holding back your practice's growth?

Associate Professor David Williams
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General Manager, Avant Practice Solutions

Demand for healthcare is growing and this represents a great opportunity for practices. However, growth can put pressure on your resources and systems and, when these don't perform, the impact can be detrimental to the business.

The first step to avoiding problems is to identify where operational inefficiency may be holding you back.

Doctors don't get taught how to start or run their own medical practice – it's a steep learning curve where you rely on others to help. As the doctor-owner of a start-up or growing practice, you're juggling a lot of balls. So how do you know if growth is being held back, and what should be done to deliver success?

Common challenges that hold practices back

As with assessing patients, it's the symptoms that provide the first clues and reveal problems related to the underlying cause. Some of the symptoms that your practice is not operating optimally are:

- You are unclear how your practice manager is running the practice.
- You don't have a clear understanding of the practice's finances.
- The practice staff are stressed out.
- You're too busy to provide leadership to your staff.
- The team is not operating in a smooth and cohesive way.
- Revenue is not growing as you would expect.

Opportunities to drive growth

There are a few issues that commonly hold practices back. Assessing and investigating these can help you diagnose the cause of the symptoms outlined above. They include:

- a lack of capacity or capability in your practice manager
- poor or inadequate management reporting
- sub-optimal financial management
- inefficient use of resources
- under-developed or disengaged staff
- poor compliance with procedures and processes
- disruption as the practice struggles with change.

Key elements for success

As the saying goes, a failure to plan is a plan to fail. Developing and implementing an overall operational business strategy needs to be foundational. This should include a strategic vision for your practice, a system that takes care of your responsibilities as a business owner and employer, tools to provide performance measurements, and human resource management. All are essential to ensuring your practice is operating efficiently, and to minimise risk and maximise business opportunities while maintaining a high standard of patient care.

When all these elements are in place, it is also important to maintain and regularly review processes, plans and procedures to ensure your practice continues to meet its agreed aims and objectives.

The most successful practices draw on a range of expertise as needed. Your lead secretary or practice manager will be central to day-to-day general management. Solicitors, accountants, bookkeepers and practice management consultants can provide the specialist input to help you diagnose and manage potential barriers to success. Making sure you have the right expertise on hand is the key to help you build and grow a resilient and profitable practice. ●

Payroll tax for medical practices

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Payroll tax has been in the headlines over the last year, following several legal decisions that raised concerns for practice owners about their payroll tax liability in relation to doctors' incomes.

The key issue is around the proper classification of the relationship between an independent doctor and the medical practice, which has legal, tax and accounting implications.

Recent decisions have increased the risk of payroll tax liability for practices that provide facilities and services to health practitioners under a 'relevant contract'. Legislation on this is largely harmonised across the states and territories, except for Western Australia.

Payroll tax public rulings

In December 2022, the Queensland Revenue Office released a public ruling addressing payroll tax for medical practices, with which South Australia, Victoria and New South Wales revenue offices have generally aligned. The rulings are not law, but they reflect the revenue offices' interpretations of the laws and their approach to audit activity.

The public rulings provide that a 'relevant contract' will generally exist where:

- a practitioner carries on a business or practice of providing medical-related services to patients
- in the course of conducting its business, the practice provides medical-related services and engages a practitioner to supply these services to the practice by serving patients on its behalf, and
- a payroll tax exemption does not apply.

In September 2023, Queensland released an amended version of its initial public ruling, noting that where Medicare benefits and out-of-pocket fees are assigned and paid directly to a practitioner who is a sole trader, these payments will not be deemed wages for payroll tax purposes. To date, no other state or territory has followed suit.

Amnesties and audit activity

Queensland and **South Australia** have announced payroll tax amnesties that only apply to payments made to general practitioners and not to other medical or health professionals. The deadline to register for these amnesties is 10 November 2023 for Queensland and 30 November 2023 for South Australia.

Victoria and New **South Wales** have no payroll tax amnesty.

In New South Wales, amendments have been made to tax laws preventing Revenue NSW from conducting payroll tax audits for GPs for a period of 12 months. There will also be a 12-month pause on penalties and interest accrued on outstanding payroll tax debts incurred before, and at the commencement of, the 12-month period.

The **ACT** has proposed, but not yet legislated, that it will take the following steps:

- waive some historic payroll tax liabilities for practices that have not previously paid payroll tax on GP payments, provided these practices register with the ACT Revenue Office by 29 February 2024
- allow general practices that support the community with reasonable levels of bulk billing until 30 June 2025 to review their taxation arrangements, seek advice, and implement changes to ensure future compliance with their payroll tax obligations
- offer a payroll tax exemption on GP payments until 30 June 2025 for medical practices making payments to GPs, where these practices are bulk billing 65% of all patients, the practice has registered for MyMedicare, and the practice has registered with the ACT Revenue Office by 29 February 2024.

The **Northern Territory** and **Tasmania** revenue offices have not, to date, issued public rulings or amnesties, but their payroll tax legislation is harmonised with the other eastern states and territories.

In Western Australia the payroll tax legislation is different, and payroll tax is generally only payable on wages paid to health practitioners where they are engaged as employees at common law.

Practices should seek legal, tax and accounting advice about their operating model and agreements with health practitioners, to ensure they meet their operational needs in light of these developments. ●

Avant resource
Avant Law payroll tax checklist

On the scene of an accident

Healthcare professionals assisting in emergencies

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Very early one morning you are on a quiet road. You hear an engine roaring then a screech and the sound of scraping metal and glass breaking. Can or should you stop to help?

Aid in medical emergencies

If you are confronted with an emergency where someone needs medical care, as a healthcare practitioner you have an ethical obligation to try to help and provide assistance where safe to do so.

If you do provide assistance, you should continue to do so until this is no longer required.

Can you choose not to get involved?

It is not usually an option to ignore an emergency – particularly if you are asked to help. In some jurisdictions, laws reinforce the ethical obligation – making it an offence or professional breach to 'callously' or unreasonably fail to provide assistance.

Context is important

However, there is no absolute obligation to assist. The law, and the professional codes of conduct, expect you will also need to consider:

- your own safety – you are never expected to put yourself in harm's way
- the safety of any patients in your care
- your skills and experience
- your capacity to assist – including whether you are impaired by alcohol or drugs
- the other options for assistance.

So if the scenario above took place outside your practice before your first patient arrived and you heard someone calling out that there's been an accident, as a health practitioner you may be expected to go and see if you could help.

However, consider if it is 3am on a dark, remote road with no mobile reception and you have narrowly escaped the accident yourself. You might be fine to stop but it also might be reasonable to drive to a nearby police station for help, especially if you would put yourself in danger by going to investigate.

What if you are unable to help

In Avant's experience, most practitioners do want to try to help if they can. The questions we hear are more likely to be about whether they are liable if something goes wrong.

In all Australian states and territories, there are legal protections known as 'Good Samaritan' provisions. These mean that if you attempt to help in an emergency with no expectation of payment or reward you generally cannot be sued personally, as long as you act in good faith and exercise reasonable care.

Can you assist if you have been drinking?

Now consider that the scene takes place as you are leaving a bar to walk home at closing time. The Good Samaritan protections generally do not apply if you are impaired by drugs or alcohol, but unfortunately there is no definitive answer to whether you can still assist if you have had one or two drinks. You will need to decide if you are fit to assist based on the nature of the emergency, how impaired you are, and who else can help.

Avant generally advises that in this situation you identify yourself and explain that you have been drinking and may be impaired.

When the emergency is outside your area of expertise

At an accident site, you are not expected to provide expert medical treatment or to be able to diagnose and treat issues outside your area of expertise.

If someone had sustained an eye injury in the accident you may be able to take the lead on dealing with that issue. Even if a situation is beyond your experience, any assistance is likely to be better than nothing at all, and any healthcare training better than none. If you have first aid skills or can liaise with emergency services, that may make a difference in the outcome. Your clinical experience may also mean you are the calmest person in attendance.

However, always be honest about your level of expertise and how recent your experience is.

After an accident

You might be asked to make a statement to police after an accident. This does not mean that your care is being criticised or questioned. We recommend you make a note about the event as soon as possible afterwards.

Even if you are very experienced, an accident scene is likely to be chaotic and distressing. Make sure you also take care of yourself and contact your indemnity provider if you need advice and support. ●

Scenarios in this article are fictitious and any resemblance to real persons, living or dead, is purely coincidental.

I wish to make a complaint

A personal reflection

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Complaints in healthcare are serious business. Not only are patients and families increasingly likely to complain, the avenues for expressing dissatisfaction are more accessible and the consequences potentially greater. However, the impact of complaints can be mitigated, and reframed as a beneficial opportunity for all concerned.

I recall one of my first complaints quite vividly. Naively empowered by all the knowledge and wisdom of a medical degree and one year as an intern, I felt omnipotent as I was unleashed upon a small rural community as an unsupervised hospital doctor. The patient repeatedly presented with medically unexplainable symptoms. As we both became increasingly frustrated for different reasons, the patient became aggressive and complained, accusing me of a lack of caring, and then a lack of competence. I responded in all the wrong ways: I became defensive and entrenched, met hostility with hostility, blamed the patient and attempted to restrict access. The issue escalated to a media campaign, a community outraged and executive intervention. There were no winners.

The second complaint was unexpected. It was several years later; my humility and wisdom had grown with experience, and I was proud of my personal and professional development. The patient presented on a Sunday with an acute on chronic painful knee preventing her from weight-bearing. After a thorough assessment and mutually agreed management plan including an urgent referral, she was discharged, and everyone seemed happy. Almost a year later I received a formal complaint indicating that I failed to diagnose her properly, and she had subsequently developed a chronic pain syndrome. Her complaint had apparently been informed and encouraged by her specialist.

I did not become defensive, I became introspective. I reviewed the record numerous times. What did I miss? What should I have done? What could I have done? If an orthopaedic surgeon said I stuffed up, maybe I am not as competent as I thought? What sort of a doctor am I if I can't manage a simple, painful knee?

I discussed it with colleagues, but then rejected their validation as collegiate and insincere, and assumed they were muttering behind my back. A simple complaint became an assault on my ability and identity, and I took it very personally. I lost sleep and confidence. My practice became more cautious, and I became paranoid.

My response to the first complaint escalated unnecessarily and could have been managed with better communication and greater empathy and humility, exploring the real reasons for the behaviour while acknowledging my own limitations. The complaint was expressed as a personal attack, but it was really a reflection of the patient's experience.

My response to the second complaint was counterproductive. Reflection and insight are incredibly valuable, but the rumination and self-flagellation are maladaptive. I took the complaint personally, and for a doctor that can be profoundly destructive. I should have analysed it, learnt from it, and moved forward. We are often our own worst critics, even compared to the many people ready to criticise us.

As Dr Dan Pronk espouses, resilience can develop with post-traumatic growth in response to stress, but can also be improved proactively. Training and education about preventing and managing complaints, developing a support network, and looking after yourself, are critical to longevity in medicine and the inevitable complaints you will receive.

I expect most of us can relate in some way to the experiences I have recounted above. Complaints shouldn't be feared or seen as annoying, frustrating, or depressing. They should be seen as feedback and an impetus for improvement.

We can always do better. ●

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