Avant
By doctors for doctors

Issue no. 18

Connect

Getting back on track

As we transition to 'living with COVID', we look at some of the challenges doctors face. In these articles our experts offer advice to help you adjust.

Dr Laksmi Sakura Govindasamy
Avant member

In this edition

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Getting back on track

It's been a very long two years for healthcare professionals and, while stress levels remain high, it appears we are moving into a new norm of 'living with COVID'.

What this new normal looks like is starting to take shape, with both our doctor members and their patients adapting to the new world, while taking stock of the lessons from the last two years. We are focusing this edition of *Connect* on the issues which may need a reset after the COVID pandemic took us off the beaten track.

One of the biggest challenges we face is catching up with patients after the delays in their screening, health checks and follow ups. The serious consequences of a delayed diagnosis are well known to all of us but are not a front-of-mind consideration for our patients. A key first step is to encourage patients back into the practice. After two years of social distancing and avoiding in-person contact, patients may have become comfortable with remote care and forgotten the benefits of seeing their 'regular doctor' in person. We welcome Avant's new Chief Medical Officer, Dr Michael Wright's advice on ways to re-establish that vital personal connection that exists between doctors and patients.

Although telehealth has proved to be an invaluable tool during COVID, we all recognise its limitations and it is now time to consider where it works best in each of our unique practices.

Our medico-legal experts provide some pragmatic tips on managing patients using telehealth and keeping up with the rapidly changing rules and good practices.

If COVID has any silver linings, one of them has been that the community has been willing to discuss its impact on their mental health. These conversations are a welcome step towards the recognition by Australian society, that mental healthcare is a part of general healthcare. Doctors, who are already recognised as having a higher frequency of mental health issues than average, have carried a tremendous additional strain from the pandemic, which is likely to take some time to abate.

Despite wanting to seek help, many doctors perceive barriers to doing so. Overcoming these barriers is a focus of an article in this issue. Our Doctors' Health Fund has sought to respond to this need by increasing cover for mental health issues, as outlined in our article on how private health insurance is adapting post-COVID.

The last two years have also impacted doctors' finances, whether directly through cancelled elective surgery, or indirectly through the general economy. Our finance experts share their views on how to take stock and get your finances back on track.

A doctor who was on the front line during the pandemic is our member featured on the cover. She tells us how COVID highlighted some deficiencies, challenges and a few upsides for healthcare workers. Drawing on her dual public health and emergency medicine interests, her PhD research is looking into improving conditions for healthcare workers.

Outside of COVID, we continue our usual care for our patients, and Avant plays an important role in improving healthcare. We have been doing this through the Avant Foundation and share an example of how a project we are funding will improve pneumonia diagnosis.

Making a good diagnosis for any condition can be a challenge at times, so we have profiled a world-first study conducted here in Australia, interviewing the lead researcher who provides some useful insights that could benefit our diagnostic processes.

There is so much excellent work done by doctors right across the country, but one that really demonstrates the care and altruism of healthcare workers is Street Side Medics. The story of how it was set up to provide care to the homeless is truly inspirational.

Lastly, Avant sees many incidences where something has gone wrong in providing healthcare, whether it be a mistake by the doctor or the perception of a patient. Members value the Avant case studies and in this issue we share the lessons from four very different clinical experiences. In all of these, the doctor required legal support.

Our medical advisers and other experts share their insights here in *Connect* and through our other publications and educational content. If you have feedback or ideas on topics you would like us to cover, please let us know using the contact details opposite.

I hope you find these articles useful and that you enjoy this issue of *Connect*.

Best regards,

Beverley Rowbotham

Dr Beverley Rowbotham
Chair, Avant Mutual

Improving conditions for healthcare workers

An interview with Dr Laksmi Sakura Govindasamy
BMed, BA, MD, MPH, MIPH(UNSW), DCH, FAFPHM, DRANZCOG,
PhD Candidate (Swinburne University of Technology), ACEM Advanced Trainee

Can you tell us about your professional background?

I'm a first-generation Australian, born and raised on the lands of the Bundjalung Peoples in far northern NSW. I studied medicine in Sydney and completed most of my training as a public health physician in NSW. I now work as an emergency medicine registrar at Austin Health. I'm also undertaking PhD studies at Swinburne University.

How was your experience as a frontline worker during COVID?

I worked in the public health response and clinically in the emergency department during COVID. In both settings, resource and system limitations have left individual healthcare workers (HCWs) feeling the need to plug in gaps. Many HCWs have made personal sacrifices to provide high quality care, which is simply unsustainable long-term. Unfortunately, I think many of us are experiencing a degree of trauma and burnout from both the pandemic and longstanding system challenges, and we don't have sufficient recovery time as we move from one disaster to the next.

During the waves of Delta and Omicron, it's been especially difficult for clinical settings to manage with the impact on our health workforce. Historically, because we all know our rosters are often underfilled, many of us have felt the obligation to work even when we are unwell. COVID has really emphasised that this is not safe for us, for our colleagues, or for our patients. I think this is an important culture shift, and goes back to the basic tenets of infection prevention and occupational work, health and safety, to ensure HCWs have access to these rights to sick leave and carers' leave.

What positives have come from the pandemic?

One thing I think is really important, yet still under addressed, is having effective infrastructure to enable provision of safe care for both patients and HCWs. Until COVID, the infrastructure in many emergency departments was not really fit for purpose when it comes to managing aerosol transmission. Tertiary departments may have access to one or two negative pressure rooms, but smaller or rural hospitals may not. Obviously COVID is not the only airborne infectious disease and our ability to provide effective isolation and spacing for patients in an overcrowded ED is really limited. Incredible work has gone into making rapid adjustments to separate and cohort patients. What's been really positive to come out of this is the emphasis on appropriate training and fit-testing of PPE for staff.

What other lessons came from the pandemic?

In light of the recent flood disasters in eastern Australia, and in the context of the climate crisis, we can expect natural disasters are going to occur more frequently and with greater severity. One of the major lessons from the pandemic response is how important it is to have effective and coordinated state and federal level disaster response.

It has also emphasised that HCWs are an invaluable asset but a finite resource. Substantive investment in public health capacity would really help, particularly in jurisdictions like Victoria where there are public health physician workforce shortages. The workforce issues in public health are truly an ongoing challenge and require long-standing and substantive investment.

Your PhD explores gender and leadership development in emergency medicine. What inspired you to take this lens?

I suppose this is an area that directly affects me. As a female doctor from a mixed-Asian background, direct and indirect experiences with racism and sexism in medicine have influenced my career trajectory. Coming from a public health perspective, I'm interested in how we can make our health systems work better for all of us, so we can provide better and safer care.

Although the majority of HCWs are women, there is a persisting leadership gap when it comes to gender representation and more broadly, in terms of diverse representation in leadership within healthcare systems. My PhD is exploring some of the factors that drive this, specifically in emergency medicine, to try to understand how leadership development can be more inclusive.

Dr Laksmi Sakura Govindasamy

> Healthcare worker experiences of bullying, discrimination and burnout can affect patient outcomes, especially through influencing our ability to provide high quality care. This is a key reason why it's important we have access to a safe and supportive workplace.

Dr Michael Wright
MBBS, MSc, PhD, FRACGP, GAICD
Chief Medical Officer
Avant

Resuming preventative care

After two years of dealing with COVID-19, much routine healthcare has taken a back seat to the pandemic. Many patients have become used to remote consultations and getting patients safely back to the practice, and resuming routine care, is important. Resuming regular cancer screening, and chronic disease management (CDM) are particular priorities to avoid consequences of delayed diagnosis and worsening health outcomes.

Reduced screening and treatment

As resources were diverted to manage COVID-19, many cancer screening services were closed during the pandemic and practices had reduced physical access. This has resulted in a drop in non-COVID related care and has potential to delay diagnoses, resulting in worse patient outcomes and possible claims against doctors. Delays in cancer diagnosis and treatment also may affect patient survival. Recent data shows decreased rates of cancer screening[1] and cancer treatment[2] during the pandemic. There have been multiple impairments to providing routine care, including reduced staffing, reduced referrals, and patient hesitancy to attend face-to-face visits[3].

Avant claims data indicates that 1 in 5 claims were primarily about diagnosis.

75%

of those claims related to missed or delayed diagnosis.

Reviewing recalls and reminders

One way to resume routine care is through your practice recall systems. Most practices have these systems, but they have probably been less utilised and less effective during the pandemic. As patients have avoided face-to-face care and staff have been absent due to COVID, many practices will also need to review outstanding recalls. By resuming recalls for cancer screening, immunisation or blood pressure check, you can signal to patients that routine care is safely happening at your practice.

Standard steps for follow-up

Doctors have a responsibility to follow-up and track clinically significant issues, including referrals and tests to be repeated. If these recalls are clinically significant there are steps you can follow.

When recalling a patient for a significant clinical reason, consider the seriousness of the results and their circumstances. This should guide the number and frequency of attempts to contact the patient, which may involve telephone calls at different times of the day, sending an SMS, email and/or letter by registered mail. Be sure to document all attempts to contact the patient in their health record.

If you later receive a claim or complaint, it is helpful if you can show firstly that you contacted the patient, and secondly that you stressed to the patient the importance of following up results, or attending a recommended referral.

Getting your patients back in person

Patients may be hesitant about coming into the practice after being previously discouraged from attending during lockdowns or due to ongoing perceived risks of infection. Overcoming this might require reassurances about practice policies for mask wearing, vaccination and infection control.

Often, in practice software, there can be confusion between reminders (not clinically significant and which carry no responsibility to track) and recalls or clinically significant referrals (which do need to be tracked). Try to agree on the difference between reminders and recalls before you start recalling everyone on your practice list.

Related resources

Factsheet: Managing COVID-19 health and safety risks in medical practice – **avant.org.au/Resources/Public/Managing-COVID-19-health-and-safety-risks-in-medical-practice**

Factsheet: Patient follow-up and recalls – avant.org.au/Resources/Public/Patient-follow-up-and-recalls

References

1. Australian Institute of Health and Welfare 2021. *Cancer in Australia 2021*. Cancer series no. 133. Cat. no. CAN 144. Canberra: AIHW
2. Cancer Australia, 2021. *The impact of COVID-19 on cancer-related medical services and procedures in Australia in 2020: Examination of MBS claims data for 2020, nationally and by jurisdiction*, Cancer Australia, Surry Hills, NSW.
3. Parkinson A, Matenge S, Desborough J, et al. The impact of COVID-19 on chronic disease management in primary care: lessons for Australia from the international experience. *Med J Aust*. 2022 Apr 10. doi: 10.5694/mja2.51497. Epub ahead of print. PMID: 35403236.

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Embedding telehealth

At the start of 2020, no one could have predicted that face-to-face patient consultations will be an exception and telehealth the norm for many doctors.

How you choose to see your patient is important in providing good care, with guidelines and specific requirements also to take into consideration. However, they may not always be the right way to see your patient and there are guidelines and requirements to consider.

A permanent fixture

Since 1 January 2022, telehealth consultations have become a permanent fixture in the Medicare Benefits Scheme (MBS). This is great news for practices that want to fully integrate telehealth video and telephone into their standard operations and offers patients greater and more flexible access to healthcare.

Like any other patient interactions, doctors and practices need to adhere to professional standards and understand the Medicare requirements. The Medical Board's Guidelines for technology-based patient consultations, in conjunction with *Good Medical Practice*, make explicit the standards of ethical and professional conduct expected of doctors who conduct telehealth consultations. For example, considering whether a direct physical examination is necessary.

Old and new rules

The 'established clinical relationship' rule is one that is here to stay for general practitioners. If your patient wishes to claim the Medicare benefit for the telehealth consultation, they will have to see you (or another doctor at your practice) in person at least once every 12 months. In extenuating circumstances, for example if you are impacted by a natural disaster, some exceptions may apply to this rule.

A new 30/20 rule is coming into effect from 1 July 2022. Doctors will not be able to conduct 30 or more telephone consultations on 20 or more days in a 12-month period. A breach of this rule will see doctors being referred to the Professional Services Review (PSR). All telehealth services will also be included in the prescribed pattern of practice 80/20 rule.

New technology, same standards

When deciding on how to conduct the consultation with your patient, virtually or face to face, professional judgement by you and your practice is needed more than ever.

With so many telehealth platforms available and advancements in technology, information can easily be transferred between yourself and the patient, but the same standards as if you are conducting a face-to-face consultation apply.

You will need to keep an appropriate record of the consultation. If the platform does not allow you to save your notes to a medical record, document the consultation separately in the patient record.

When you are seeing a patient for the first time via telehealth, and you don't have access to their medical records or prior knowledge or understanding of their condition(s), take a full medical history.

Don't forget, the MBS item numbers define telehealth consultations as involving an audio and/or video link, not online chat consultations.

Related resource

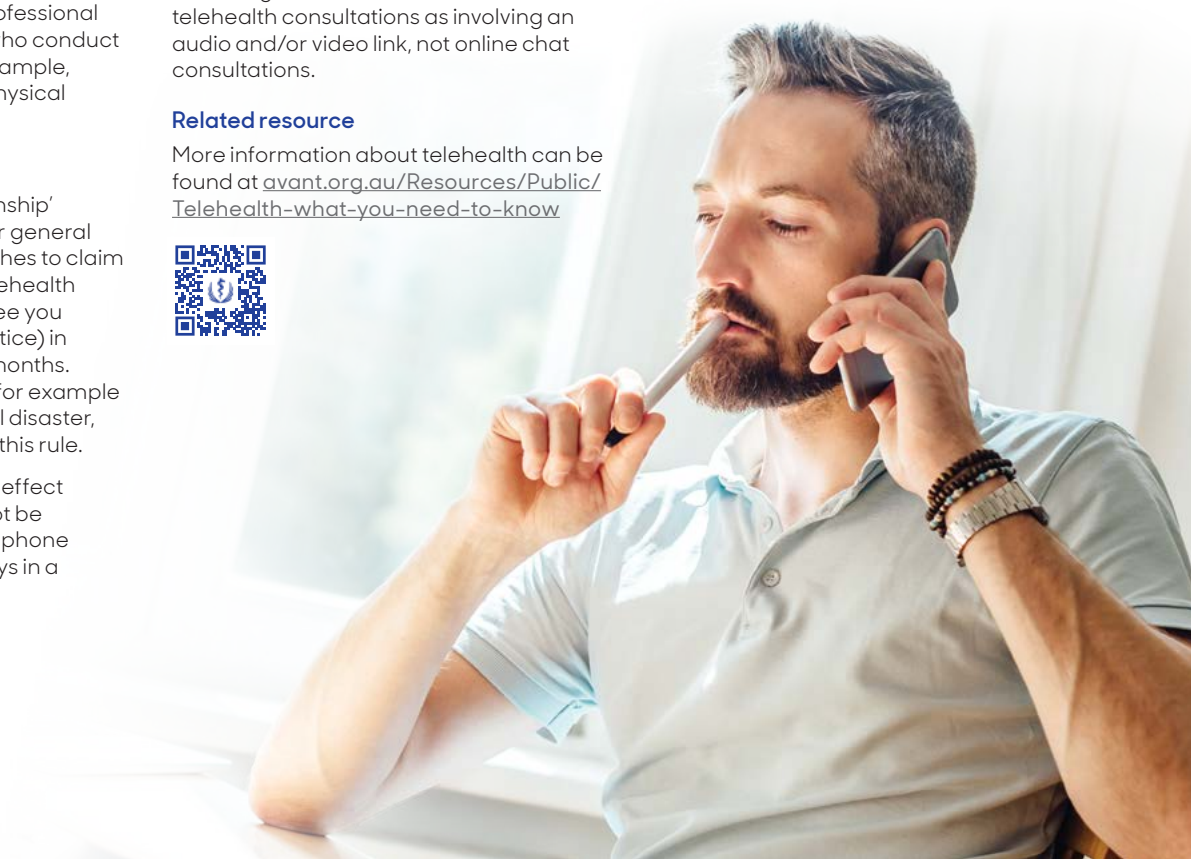
More information about telehealth can be found at avant.org.au/Resources/Public/Telehealth-what-you-need-to-know

What is the 80/20 rule?

Legislation stipulates that when a doctor bills Medicare for more than 80 professional attendance services per day for 20 or more days over the course of a single year, they will be deemed to have engaged in inappropriate practice and will be reviewed by Medicare's watchdog, the PSR.

Doctors should monitor the number of daily professional attendances and ensure all items billed under their Medicare provider number align with Medicare Benefits Schedule (MBS) requirements. The number of professional attendance services is often greater than the number of patients seen.

For more information visit health.gov.au/resources/publications/prescribed-pattern-of-services-the-8020-rule



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Managing patients' new expectations

Having a normal day is not something many doctors have felt for some time. Adapting to the changes brought about by COVID has also meant patients are seeing things differently.

Telehealth has become a convenient way of delivering healthcare for both patients and doctors. Not having to wait days for an appointment or having to hang around in reception areas are huge benefits to patients. Expectations of on-demand care and the convenience offered by telehealth need to be managed as we establish the new normal. Convenience does not necessarily align with better medicine.

Quality care trumps convenience

Doctors recognise the convenience for patients but are often frustrated by the quality of care telehealth provides.

Patients may have come to expect that if they report their symptoms, and they 'know' what is wrong, they will receive treatment without the need for an in-depth evaluation and consideration by their doctor. But doctors are not vending machines and risk being seen as just another online service, rather than as professionals providing healthcare. To avoid the risks of 'retail healthcare', it is essential the doctor takes a full history, rather than simply supplying patients with whatever is on their shopping list.

There's no getting away from the fact that telehealth also provides convenience for doctors. However, when using telehealth, even basic things, like seeing a patient with a sore throat, require a level of assumption rather than having the benefit of a physical examination. Requiring patients to undergo a telehealth consultation when it is their preference for face to face similarly needs to be managed.

Hybrid consultations

Face-to-face visits may sometimes be logistically difficult and cumbersome for patients, so they need to be aware of the benefit of having them when required. Relatives of older patients may expect things can be done by telehealth, when the doctor who knows their patient realises that face-to-face consultations are far more appropriate.

Shortcuts that were necessary during waves of the pandemic should not be the ongoing standard of care for permanent telehealth consultations. One size doesn't fit all when it comes to consultations. Some patients may have fully embraced telehealth, whereas others may be reluctant to have the consultation even over the phone

To integrate telehealth more regularly into your practice, communication will be key. Offering a hybrid system where you initially see the patient face to face for new health issues and suggest follow-up appointments over telehealth, might be an appropriate compromise.

Prepare the team

So as not to be on the back foot when you see the patient and be met with a litany of reasons why they are not happy with a particular form of consultation, make sure the practice staff are all delivering a consistent message.

Agree among the staff the roles of face to face and telehealth consultations and how to communicate to the patient what's best for a particular situation. This allows those on the front desk to effectively triage appointment requests and manage patients' expectations and concerns. Make the position on telehealth clear on the website and notices in the practice. A key message is to carefully inform patients that there is a reason they need to be seen face to face if they haven't been in the past 12 months.

Risk of infection has been a common concern for patients, so have a clear message of what is being done to keep them safe. Patients may take some persuading, but the bottom line is that we want to deliver quality care.

Emma Winch
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Coroner highlights fixated thinking behind tragedy

Doctors are often required to make calls in stressful situations, but sometimes important clinical signs are missed. The unexpected death of a toddler during anaesthesia underscores being mindful of fixated thinking within treatment teams.

In a recent case, an anaesthetic team working in a high-pressure operating theatre faced an emergency situation while providing a general anaesthetic to a 19-month-old child, before minor surgery.

Minor incident leads to surgery

The toddler and her parents had presented to a regional hospital after a cockatoo bit her finger at a wildlife park. Surgical debridement, washout and repair was recommended as examination of the wound revealed a deep de-gloving laceration to her right middle finger.

Dr A, an anaesthetic registrar member, obtained a detailed medical history, noting the toddler was slightly underweight for her age (9.4kg measured at autopsy), but otherwise healthy. He informed her parents of the plan to use general anaesthesia and explained the common risks.

Dr A discussed the anaesthesia plan with Dr B, the on-call anaesthetic consultant. Dr B proposed using a rapid sequence induction (RSI) form of anaesthesia with fentanyl and propofol and placing a cuffed endotracheal tube (ETT) into the trachea to support breathing.

Intubation attempts

The anaesthetic team comprised Dr B, who was to administer the medication, Dr A, who would manage the toddler's airway, and an anaesthetic nurse. Dr C, a consultant anaesthetist member, was asked to remain on standby.

During the toddler's anaesthetic care, two intubation attempts were performed. Dr C was called to provide assistance shortly after the first intubation attempt due to her low oxygen saturation levels. The ETT was then removed and observed to have blood on it.

Although the ETT was replaced by Dr B, the toddler's oxygen saturations continued to decrease, her stomach remained distended, and an audible air leak remained. After Dr B suggested the toddler may have bronchospasm and anaphylaxis, she was treated with salbutamol and for possible anaphylaxis. The anaesthetic was also deepened, and a muscle relaxant administered to improve ventilation.

A short time later, her heart rate and oxygen saturations fell dramatically. A cardiac arrest was declared but, despite prolonged resuscitation efforts, the toddler could not be revived.

Cause of death

Reinforcing the forward-thinking and preventative focus of inquests, the coroner was not critical of any individual doctor, finding the cause of death was unrecognised oesophageal intubation.

The coroner determined that the decision to perform surgery under general anaesthesia using the induction technique and ETT was appropriate. However, he found a constellation of signs as to the reversible cause of her deterioration were present, but not recognised. Consequently, appropriate treatment to preserve her life was not provided.

Fixated thinking factors

The coroner noted it was the "collective failure" of the anaesthetic team to recognise the misplacement of the first and second ETT in the oesophagus, rather than the trachea. Based on the evidence, the coroner also noted dislodgement could have occurred when the laryngoscope was removed, or the cuff was inflated.

Dr B also gave evidence he believed the rise and fall of her chest and rising oxygen saturations indicated correct placement of the ETT. However, expert evidence noted that, unlike in adult patients, it is possible to provide some degree of oxygenation in infants and small children without the ETT being in the trachea. While not considered optimal, a degree of oxygenation may occur if an ETT is above the vocal cords.

The coroner concluded the key signs that should have alerted the anaesthetic team to the misplacement were the absence of persistent, high amplitude $ETCO_2$ waveforms with an audible air leak, coarse and harsh breath sounds in the upper airway and a distended stomach.

"Recognition of ETT misplacement required the synthesising of various indicators in an environment that was challenging and with a patient that was clinically deteriorating," the coroner said. "...no such synthesis occurred and instead the anaesthetic team became anchored in their thinking and fixated upon reversable causes of [her] deterioration."

The coroner observed that three factors had contributed to the fixated thinking:

- An environment the anaesthetic team described as "controlled chaos" and not conducive to "calm thinking".
- The anaesthetic team's understandable reluctance to consider ETT removal in circumstances where Dr A and Dr B were confident they had seen both ETTs pass through the vocal cords.
- The anaesthetic team were unaware of the possibility that a misplaced ETT could still allow for a degree of oxygenation of a paediatric patient.

Given the cause of her deterioration was recognisable and reversible, the coroner concluded her death was preventable.

In the wake of the toddler's death, the hospital implemented changes, including developing guidelines on the provision of anaesthesia care to children, stipulating that paediatric patients can only undergo anaesthetic care if they weigh at least 10kg. Given these reforms, the coroner did not believe any recommendations were necessary or desirable.

Support throughout inquest

Noting the heartbreaking circumstances, Avant Law, an Avant claims manager and one of our medical advisers assisted Dr A throughout the coronial process and provided critical collegial support.

This involved communicating with the police on Dr A's behalf during the initial investigation and helping him prepare a statement for the coroner regarding his treatment of the toddler.

Once Dr A was called as a witness at the inquest, we assisted him in understanding the coronial inquest hearing process and to prepare for the hearing.

The solicitors also met with Dr A regularly to update him on the evidence as it emerged during the hearing and to discuss the coroner's findings once the inquest had closed.

Anaesthetist's perspective

Dr Amanda Smith
MBBS, FANZCA, Senior Medical Adviser, Avant

While it's easy to look back in hindsight and be falsely reassured that you would not have found yourself in the same position, it's worth remembering that all doctors are vulnerable to fixation errors. The speed with which critical incidents occur and tension during surgery can impair thinking and lead to a decision a doctor may question for the rest of their life.

Many doctors will find themselves involved in a coronial investigation and your care may be open to criticism. Rather than avoiding discussions about these cases, it can be more constructive to acknowledge how difficult they are for the doctors involved and to keep the lessons in mind if you are faced with a similar situation.

Key lessons

- Be mindful of making assumptions when treating patients and consider alternative diagnoses.
- If you are in a stressful environment and having trouble thinking rationally, take a brief time out to synthesise the information at hand and go back to basics if necessary.
- If something does not look or feel right, speak up – you may not be the only one who thinks something is wrong.

Related resource

Factsheet: Coronial investigations and inquests – avant.org.au/Resources/Public/Coronial-investigations-and-inquests

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Faxing error leads to privacy breach

A case where multiple medical records were faxed to a wrong number, reminds both doctors and practices to move away from less secure methods such as fax, when sending patient information.

A medical practice had intended for patient referrals to be faxed to a psychologist. Unfortunately, the wrong number was programmed into the fax machine. The number belonged to a member of the public who continued to receive the referrals for the next two years.

Faxing error goes unnoticed

The man who received the faxes did not contact the practice as he did not want to alarm the patients but, as the faxes continued to arrive, he decided to contact a newspaper with his story.

He estimated he had received the documents of approximately 10 patients over two years, most of which he disposed of straight away. These included detailed medical histories and mental health plans for patients diagnosed with severe anxiety, depression and sleep disorders. The documents also contained personal information including names, birth dates, Medicare numbers and addresses.

The practice discovered the data breach had been caused by human error. This involved mixing up the digits of the fax number when the psychologist's contact details were put into the fax machine's address book.

The error went unnoticed as the GP gave a hard copy of each referral to the patient to take to the psychologist. Therefore, the psychologist didn't realise they were missing the faxes.

Avant support for the practice

Avant Law assisted the practice by assessing the data breach, notifying the Office of the Australian Information Commissioner (OAIC), and in taking remedial action. Our team also reviewed the practice's privacy and information security policies and liaised with the privacy regulator on the practice's obligations under the Privacy Act. With this support, the practice was able to satisfy the OAIC that this was a singular event, and their remedial action meant no further action needed to be taken by the regulator. As such, the practice avoided any fines or sanctions in respect of the data breach.

As part of the remediation and review of the data breach, Avant's risk advisers also reviewed the practice's existing data protection and privacy protocols and provided targeted risk education for all the staff on privacy and information security.

If you or your practice experience a data breach, it's important to notify Avant immediately*.

From the time the data breach is identified, the person or practice has 30 days to assess the breach and make a notification, if required, to the OAIC. Subject to the terms and conditions of your policy, Avant can assist you to assess whether the data breach must be notified to the OAIC. This applies to breaches that are likely to result in serious harm to individuals and where remedial action is not considered to prevent the likelihood of harm.

> Privacy laws state that you can use any method of communication as long as you take reasonable steps to protect the privacy of the patient and the security of their health information.

Secure email for sending patient information

According to an OAIC report released last year, human error is second only to criminal attacks as the main reason for data breaches. Information being sent to the wrong recipient (by email, post, or other means) due to human error is the primary cause of data breaches.

The RACGP supports phasing out faxed communication, calling it "dated technology". The *RACGP position statement:* Safe and effective transfer of information to and from general practice, advocates for the use of secure messaging systems because they are the safest, most secure and most efficient communication method. These are explained in the position statement: "Every effort should be made to secure [information] as much as possible, through the use of password protection, encryption software, or via a secure website with passwords requiring multi-factor authentication."

Privacy laws state that you can use any method of communication as long as you take reasonable steps to protect the privacy of the patient and the security of their health information.

Practices should use the most secure messaging delivery system available to it to send patient information. The benefits of sending sensitive information via secure messaging and encrypted email are that they are more secure than fax.

Furthermore, if there is an error in the email address, it is more likely the email would 'return to sender,' rather than being sent to a random recipient and the content would not be accessible.

Ideally, the most patient-centred approach would be to discuss with your patient the best method of communication. However that may be difficult to implement in practice for all patients. If this is the case, you can send information by unencrypted email after making the patient aware that this is not a secure form of communication.

Related resource

Factsheet: Data breaches: all you need to know – avant.org.au/Resources/Public/data-breaches-all-you-need-to-know

Key lessons

- Transmission protocols required to send faxes are very outdated. If you are communicating patient information, it should be sent via email using password protection, encryption software or via a secure website.
- When updating contact information always verify the contact number or email address, to avoid information ending up in the wrong hands.
- Do not use auto populated options for email addresses.
- If you or your practice experience a data breach, ensure that you conduct a timely and thorough assessment of the breach.
- Consider drafting a data breach response plan, which should include a communications plan that covers how to deal with media inquiries.
- Notify Avant immediately so an assessment can be performed and the OAIC notified, if necessary, within the 30-day period.

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General Manager, Medical Advisory Services
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'Strange examination' results in patient complaint

While physical examinations may be necessary for a correct diagnosis, they can be uncomfortable for the patient and can lead to a complaint.

An obstetrician found herself facing such a situation when a female patient complained that a routine internal exam 'felt different' and that she was 'touched for too long'.

Patient's version of consultation

The patient presented to the emergency department at a rural hospital, complaining of abdominal pain caused by endometriosis and heavy period issues. Her hospital notes had shown a history of chronic pelvic pain and she had since developed vaginal pain.

The member explained to the patient that she needed to perform an internal examination. She offered to examine her vaginal area to see if they could find the reason for the pain, which the patient consented to. The patient later complained to the Office of the Health Ombudsman (OHO) that the examination had felt intimate, and the doctor had touched her for too long.

Nurse corroborated doctor's version of events

Upon commencing the examination, the member requested that a registered nurse be present as a chaperone. The nurse was able to provide a signed statement, stating that she witnessed the member perform the exam in a sensitive and appropriate manner and with the patient's consent.

The member denied the exam was out of the ordinary and alleged the pelvic exam lasted for approximately 15 seconds, which the nurse was able to verify.

Clinical care and communication

There were two issues investigated by Ahpra; the first related to the clinical care involving an inappropriate examination, and the second was failure to communicate openly, honestly and effectively.

The need for the examination should always be explained to the patient and they should be made aware that the examination can be stopped at any time. Their consent must also be obtained and recorded in the contemporaneous medical record.

Since the patient complained of pelvic pain and new vaginal pain, the need for an examination was clinically indicated.

How Avant helped

After the patient made the initial complaint, the member received a notification from the OHO. The member contacted us for assistance, and a solicitor from Avant Law was allocated to the matter. The solicitor explained how the process of a notification from the OHO and an investigation by Ahpra works. The member was assisted in preparing a response to the complaint and provided with details on how to contact Avant's Doctors' Support Service.

Having considered the member's response to the complaint, the Medical Board noted that given the patient's presenting complaints of pelvic pain and new vaginal pain, it was appropriate for the member to perform an examination of the genital region. The Board acknowledged the patient felt violated but since she couldn't participate in the investigation, the Board was unable to form a reasonable belief that the communication, consenting process and performance of the exam were inappropriate or inadequate. Therefore, there was no further action taken.

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The need for the examination should always be explained to the patient and they should be made aware that the examination can be stopped at any time.

Good practice for physical examinations

- Communicate what the examination will involve and why it is necessary.
- Explain your actions as they happen to reassure the patient.
- Be alert to indications of concern by a patient and address those concerns immediately.
- Respect the patient's dignity.
- Document discussions and examinations.
- Establish rapport through good communication.

Related resource

Fact sheet: 'Observers: Chaperone protect and reassure' – avant.org.au/Resources/Public/Observers-chaperone-protect-and-reassure

Good record keeping

- When the patient's version of events does not align with those of the doctor or the chaperone, documentation is a vital element of the evidence considered. Sub-optimal documentation can also form the basis of a complaint. Keeping detailed and contemporaneous notes can be challenging for clinicians working in real-world hospital environments, where multiple teams are involved in care, handovers occur and shifts change.
- Keep in mind that the most important goal of documentation is to support optimal patient care.
- Efforts should be made to document well to ensure effective communication with others in the clinical team.
- Important information, including from handovers, should be documented.
- All documentation should aim to minimise the risk of losing important elements of the history, findings, diagnoses, decisions and management plans.

Key lessons

Obtaining consent

Intimate examinations can be sensitive topics, as they require a high level of trust in the doctors who perform them. Australian law and medical practice recognise that individuals have the right to make informed decisions about their medical treatment, therefore, consent should be obtained prior to every examination.

Communicating effectively with the patient

The duty to disclose information to patients is part of the overall duty of a medical practitioner to exercise reasonable skill and care. Even though consent was obtained by the member and a chaperone was present, the patient still felt that she did not give consent for a vulva examination to take place.

Continue to be thorough in your approach

A fear of an allegation of inappropriate conduct can sometimes deter a doctor from conducting a clinically indicated examination, which places them at risk of misdiagnosis. This fear should not interfere with good practice.

Ruanne Brell
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Avant

GP suspended after ignoring prescribing red flags

Complex legal requirements when prescribing drugs of dependence and pressure from patients can create the perfect storm for doctors. Refresh your knowledge to sharpen your prescribing practices and provide these medications safely.

The Pharmaceutical Regulatory Unit found the GP had prescribed drugs of dependence in a prohibited way and without the authority required.

The Medical Council of NSW suspended the doctor's registration following a hearing. This led the Health Care Complaints Commission (HCCC) to investigate the complaint on disciplinary grounds. The allegations centred on her prescribing of oxycodone, alprazolam, fentanyl patches and flunitrazepam to eight patients.

It was found the doctor knew, or should have known, the patients were drug dependent, and she prescribed the Schedule 8 drugs for a continuous period of more than two months without obtaining the proper authority. Expert medical evidence was strongly critical of her prescribing practices. Some of the concerns included:

- providing prescriptions without assessing the patient, for example in response to email requests and requests from a patient's family member
- prescribing oxycodone in excessive quantities and to patients being treated for opioid dependence
- continuing to prescribe drugs of dependence for patients identified as prescription shoppers
- continuing to prescribe for patients who failed to follow the doctor's recommendations to engage with specialist services
- failing to obtain a past medical history from patients about diagnoses prior to prescribing drugs of dependence
- ignoring red flags and drug-seeking patient behaviour and continuing to prescribe for those patients.

The Civil and Administrative Tribunal (the tribunal) agreed with the expert's opinion regarding management for all patients.

Patient confidentiality and documentation

The tribunal also found the doctor breached patient confidentiality while treating two patients, a married couple who had recently separated. Patient A told the doctor about an extramarital affair, which she disclosed to Patient B without Patient A's consent or any therapeutic justification, and no legal or public interest reason to explain the disclosure. When told of the affair, Patient B disclosed incidences of self-harm and threats to the person with whom Patient A had been having the affair.

The tribunal highlighted the Medical Board of Australia's *Code of Conduct* which states patients have the right to expect their information will be held in confidence by doctors or practice staff, unless it is legally required or permitted to be released.

The doctor said she disclosed the information because she thought it would reduce Patient B's risk of self-harm or harming others. However, the tribunal found this represented a "total lack of understanding" of the obligation of patient confidentiality.

The tribunal also found her failure to properly assess Patient B or make any referral for specialist treatment or develop a management plan, concerning.

> If prescribing for a drug dependent patient, a doctor must obtain a permit or authority from the relevant state or territory pharmaceutical services unit.

The doctor's lack of documentation during the consultations was also strongly criticised. This centred on a failure to document any information given to the patients about the purpose, importance, benefits or risks of the medication prescribed. The tribunal found this was below the standard for record keeping under the RACGP's *Standards for general practices*.

There was also an absence of record keeping for Patients A and B. This included no record of counselling sessions or ongoing assistance to Patient B, and no documentation of a mental health care plan, assessment, or further clinical review.

Ultimately, the doctor was found guilty of professional misconduct and unsatisfactory professional conduct.

In the disciplinary proceedings, the doctor's registration was cancelled, and the tribunal directed she could not apply for re-registration for two years.

Prescribing requirements

Drugs of dependence often present unique challenges for doctors who must be satisfied the medication they prescribe is clinically indicated. Additionally, there are strict legal requirements which vary across states and territories, and according to whether a patient is considered drug dependent or not.

To determine if your patient is drug-dependent before prescribing, take a comprehensive medical history and assessment, and if necessary, confirm the information from other sources if you do not know the patient. It's also important to check the real-time prescription monitoring system if it is mandatory in your state or territory.

Legislation in most jurisdictions includes a definition of a 'drug-dependent person'. While the definition varies between states and territories, generally it's a patient who:

- exhibits impaired control or drug-seeking behaviour
- is likely to experience withdrawal symptoms of a mental and/or physical nature as a result of stopping the medication
- has consumed prescribed medications contrary to, or in excess of, prescribed instructions.

If prescribing for a drug dependent patient, a doctor must obtain a permit or authority from the relevant state or territory pharmaceutical services unit.

For non-drug dependent patients, a drug of dependence cannot be prescribed for more than two months (this time frame includes prescribing by previous doctors) without approval in most states and territories. This applies to drugs listed on Schedule 8, and some listed on Schedule 4, of the Poisons Standard by the Therapeutic Goods Administration.

In Queensland, approvals for prescribing drugs of dependence are not required unless the patient is on the Queensland Opioid Treatment Program, or in other limited circumstances.

Related resource

Factsheet: Prescribing drugs of dependence – avant.org.au/Resources/Public/Prescribing-drugs-of-dependence

Key lessons

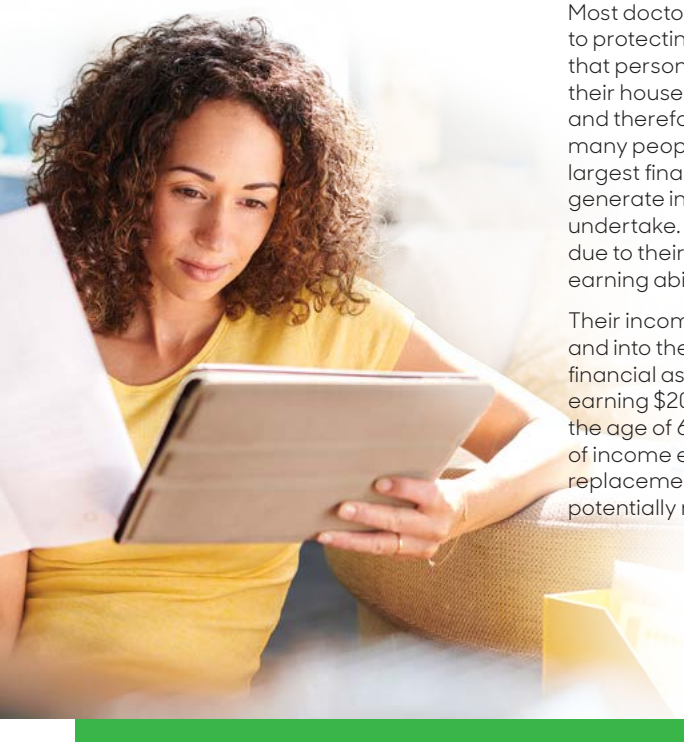
- Obtain all relevant authorities and consider any concerning drug-seeking behaviours before prescribing drugs of dependence for a patient.
- Document all treatment and prescribing decisions in the patient's records. This includes any information or advice given to the patient about the purpose, importance, benefits or risks of the medication prescribed.
- Always comply with your professional obligations around patient confidentiality.

A version of the article was first published in the *Health Law Bulletin* as: R Brell Professionalism, prescribing and privacy: (2021) 29(5&6) HLB 85.

Michael Loughman
BBus
CEO, Avant Financial Services

Don't let a natural disaster be a financial one

If the past two years have taught us anything, it's the value in being prepared for any event. This includes financial preparedness, as the financial consequences can be just as stressful as the events themselves.



Bushfires, COVID and floods have impacted many people both directly and indirectly, often with life-changing consequences. While it is hard to individually prevent such events, you can prepare for them, and other unexpected incidents, to minimise the impact.

Build financial resilience

Most doctors are prudent when it comes to protecting their assets. They understand that personally taking on the risk of losing their house or their car is not a good idea, and therefore insure these assets. However, many people fail to realise that one of their largest financial assets is their ability to generate income through the work they undertake. This is especially true for doctors due to their higher than average income earning ability.

Their income and its cumulative value, now, and into the future, is often their largest financial asset. For example, a 30-year-old earning $200,000 per annum through to the age of 65, and assuming a 3% increase of income each year and an insurable replacement income of 70%, would potentially receive over $12.6m payout over that period. When you consider that doctors' incomes generally rise much faster and higher than this example, it is clear that protecting this asset is just as important as insuring your most prized possessions.

Even for doctors who have been practising for some time, not being able to generate income can have a serious impact on lifestyles and limit choices, and even delay retirement.

COVID has demonstrated that there are many unexpected ways in which your ability to work could be impacted. The good news is that protecting your income is relatively simple and when compared to the size of the asset you are protecting, represents good value. Selecting the right insurance is critical as there is significant differentiation in terms offered, which has been magnified over the past few years in response to significant regulatory change. Avant Financial Services is experienced in helping doctors in this and would welcome the opportunity to help you in securing your income for the first time, or in providing you information to make a comparison to what you already have in place.

> As the cash rate starts to climb, interest rates will rise across the board. This will come as a shock to millions of Australians and you don't want to be caught out.

Adapt to the changing environment

After many years of not hearing the word 'inflation', it has recently become one of the most talked about areas in the global economy. Official statistics confirm what many doctors already know that costs are rising. Headline inflation is 3.5%, its highest in over 10 years. Underlying inflation (which excludes food and energy costs) is running at 2.6%, and has reached the level at which the Reserve Bank of Australia (RBA) has stared to lift the official cash rate[1].

It is expected that the RBA official cash rate will continue to increase, and this signals higher interest rates for borrowers. In fact, lenders have begun to push their loan rates higher[2]. This may come as a shock to many people as it has been 11 years since the RBA has increased rates. In a recent statement the Governor of the RBA stated that over 1.1 million mortgage holders in Australia have never experienced a rate rise.

Economic change doesn't occur in a vacuum and growing costs coupled with the potential for higher interest rates can bring additional uncertainty for doctors, on the back of two very uncertain years. It's fertile ground for stress and anxiety that can spill over from the professional arena into personal lives. The good news is that with the right support, paying higher and higher interest rates isn't inevitable. Utilising fixed rates can insulate you against future rate rises. Many people fix all or part of their loans so they have certainty over cash flow required to service their debt for the period of the fixed rate. This certainty alone can be a tremendous stress reliever.

Equally important to the cost of your funding, is having the certainty of funding.

The last thing you need to worry about during difficult times is access to money. Security of funding is vital, yet the catch is that during times of economic strain, access to debt can become difficult. This makes it essential to secure your debt position now, with lines of credit set up in a way that is tailored to your individual situation. This is particularly relevant for doctors, as the majority of lenders do not understand the varied ways doctors are paid and find approval outside the straight-forward difficult during these times.

Acting now to protect against higher interest rates doesn't have to be limited to personal borrowings. At a time of rising costs, it makes good financial sense to adopt a holistic approach and review commercial borrowings.

Plan ahead

Getting your finances in order now will ensure you are best prepared for whatever challenges the future may hold.

In the same way your patients come to you for expert advice, seeking professional advice on your finances can have a valuable impact. Having a trusted expert who understands doctors and is across your financing and wealth protection needs can help you navigate the labyrinth of different terms and conditions and highlight the risks and benefits of the options available.

Our purpose at Avant Financial Services is to help doctors gain peace of mind through financial security and freedom of choice. Should you wish to have a confidential discussion around your personal and professional finances, please do not hesitate to contact us on 1800 128 268.

avant.org.au/financial-services

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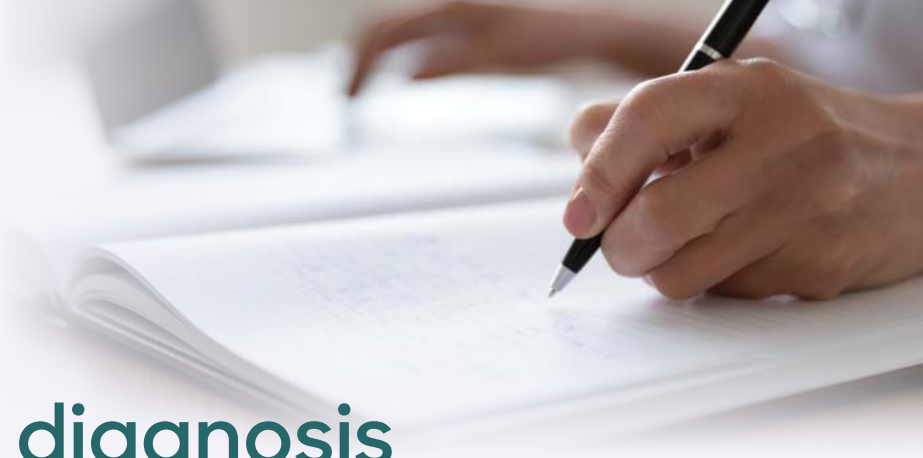

Making a good diagnosis

Wrongly diagnosing a patient is one of the biggest concerns for doctors. These concerns are understandable considering an estimated 140,000 people have medical issues misdiagnosed in Australia every year, resulting in 4,000 deaths – three times the number killed in road accidents[1].

Listening to patients is key

Taking a medical history forms the basis of starting the diagnostic process, but are you spending sufficient time on it?

A world-first study[2] led by researchers at the Australian National University (ANU) and the University of Melbourne, looked into what causes doctors to arrive at a false diagnosis. It found doctors who spend less time learning about their patients' medical histories and put greater emphasis on physical symptoms, misdiagnose patients at higher rates.

In 2018, a paper[3] was published that showed only around a third of doctors elicit the patient's agenda. In seven out of ten occasions, it was only a median of 11 seconds before the patient was interrupted.

Senior researcher for the ANU study, Dr Mary Dahm notes, "Communication is a common and significant factor in diagnostic error, with the predominant focus on organisational rather than interpersonal communication when things go wrong. Listening is really important. Research shows patients will initially talk only for about 90 seconds before stopping[4], and everything they say to that point was useful."

Signs of diagnostic uncertainty

Where doctors are uncertain, it shows in their communication. "In addition to less time on history taking, doctors spend more time on delivering the diagnosis. The diagnosis is typically provided with false starts and self-repairs where doctors go back and re-phrase the message to make it easier for the patient to understand. This can be a problem if it starts taking over, with stammering and changing language coming across as uncertainty, which can result in patients losing confidence," says Dr Dahm.

Another sign of uncertainty is using 'shields' such as talking in the third person or presenting lots of evidence.

These signs should be triggers for supervisors or colleagues, that there is uncertainty and the diagnosing doctor may be going down the wrong track and could benefit from further diagnostic input and discussions.

Embracing uncertainty

Diagnosis in medicine is difficult and admitting uncertainty can be hard when it is not expected by patients and colleagues. Right from the start at medical school there is always an answer to clinical case problems and students don't experience uncertainty. But when doctors begin practising they quickly realise there is more grey and less black and white.

Dr Dahm sees "diagnosis not as a simple linear process, it is a meandering, evolving one. Doctors intuitively know this, but they don't make it explicit to patients".

Managing patients' anxiety around diagnostic uncertainty requires open communication to increase their awareness of the nature of diagnosis as a process rather than an isolated event. Dr Dahm believes adding empathy to the delivery of diagnostic uncertainty helps maintain trust with patients[5]. "Acknowledging, understanding and exploring patients' concerns rather than dismissing them when you don't agree, not only benefits the diagnostic process. By using listening and patient-centred strategies it is less likely that the patient will complain or make a compensation claim."

Acknowledging and managing uncertainty in the diagnostic process may also help foster a safety culture in which all diagnostic team members can openly discuss, challenge, and collaborate to refine clinical reasoning. Diagnostic possibilities could be explored in self-reflection, and in interactions with colleagues and with patients. Embedding differential diagnosis in medical records and using language expressing uncertainty can also help avoid the diagnostic team discounting other diagnostic possibilities.

Uncertainty doesn't need to be perceived as a threat to expertise or professionalism. On the contrary, doctors who openly encourage and engage in discussions of uncertainty without blame or penalty, demonstrate good diagnostic processes.

Key points for diagnostic excellence

Diagnostic errors are a common patient safety blind spot and often involve communication breakdowns. Uncertainty is ubiquitous in the diagnostic process. Clear, accurate and open communication is the lynchpin of correct, timely and safe care.

1. Listening is a key activity. Take time gathering full patient histories and exploring patient concerns.
2. Explicitly and empathetically share diagnostic uncertainty with patients.
3. Reimagine diagnostic uncertainty as positive and routinely embrace it in clinical care and education.
4. Explicitly acknowledge, manage, and communicate uncertainty to promote a robust diagnostic safety culture.

Dr Mary Dahm (PhD) is a Senior Research Fellow, Institute of Communication in Health Care, ANU

Related resource

Factsheet: Missed or delayed diagnosis – avant.org.au/Resources/Public/Missed-or-delayed-diagnosis

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Private health insurance after a pandemic

As we look towards what life might be like once COVID is no longer at pandemic proportions, the private health industry must stay alert to the opportunities and responsibilities that lie ahead.

Healthcare that was put on hold to make way for critical pandemic responses is now our focus, and a proactive and coordinated approach is key to effectively handling this into the future.

Private health to help take the pressure off

Our public hospital system continues to operate under significant pressure, with predictions that it will take years to reduce the record-breaking waiting lists that have built up for a range of procedures.[1] For instance, the number of patients waiting over a year for their elective surgery has more than doubled, with the greatest increase occurring for total knee replacements and septoplasties.[2]

Maintaining high participation rates in private health insurance is crucial to relieving some of this pressure on our already stretched public services. Pleasingly, in the last year the participation rate in hospital and extras cover have both increased by 1% to 44.9% and 54.7% respectively.[3]

Ongoing government reform plays a key role in aiding this participation by making private health insurance accessible and affordable for more Australians.[4] We must keep in mind, however, that the uptake of low-quality health cover is not the solution to ensure participation and affordability. This includes policies that allude to the security of private health cover but fail to deliver due to the minimal coverage they actually provide. These affordable 'junk policies' that remain in the market not only confuse consumers and treating practitioners and erode the community rating principle of private health insurance, they do little to remove the burden on the public system. We have and continue to add our voice to rethinking this aspect of policy settings.

A growing focus on mental health

It has been widely reported that the toll the pandemic has taken on mental health will be felt for many years to come.[5] There have been calls for an integrated, cross-sector policy approach to address this,[6] with private health insurance having an opportunity to play a bigger role in helping to increase service access.

A large focus of the mental health challenge ahead will be on sufficient resourcing for community-based care. To supplement this, it is vital that health funds continue to promote the mental health benefits that are available to their members and uplift this access where possible, including looking at more innovative funding models to ensure targeted access is provided to groups of concern.

At Doctors' Health Fund, we've been cognisant of the role the pandemic has played on doctor burnout and stress. Benefits for mental health services were increased across all extras products in 2020 and in collaboration with Avant, we've provided tailored health cover to early career doctors that provides access to essential health services, especially mental health.

Healthcare trends ahead

The pandemic's lockdowns and social distancing measures caused non-COVID related healthcare to be put on hold in many cases. Health insurance utilisation has felt the flow-on effects of this delayed care, with COVID destabilising once largely predicable claiming patterns.

The industry is being guided by regulators to be proactive and prudent in their financial approach, providing confidence to members during a time of significant uncertainty. As part of this proactive approach, most health funds have returned surplus profits that resulted from lower claiming, through unprecedented initiatives such as deferring premium increases, premium refunds and financial hardship support.

It will take some time, likely years, for claiming patterns to re-stabilise and a long-term view must be taken. The outlook will become clearer once we return most of our focus to non-COVD related care post pandemic.

Many doctors work across both public and private healthcare systems and the combined strength has been on display throughout the course of the pandemic. As we look ahead, this duality is essential for a strong and sustainable healthcare system in the years to come.

References on request.

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Doctors are not invincible

Medicine is a uniquely high-pressure occupation, and doctors are no strangers to experiencing burnout and struggling with attaining a work-life balance. The COVID pandemic has only exacerbated these issues and there is emerging evidence that the impact of the pandemic is creating even more mental health concerns[1].

Reluctance to admit anything is wrong, the stigma around mental health issues, and fear of mandatory reporting add to the complexity of an already challenging situation experienced by many doctors.

Alarming statistics

A recent review led by the Black Dog Institute and UNSW Sydney that was published in *The Lancet* alarmingly highlighted doctors are at increased risk of suicide and, in their early years of training, one-quarter to one-third reported significant mental ill-health. Female doctors are a particular risk, with a suicide rate that is significantly higher than women in the general population.

The review also revealed depressed doctors make six times more medication errors than healthy doctors, with mental ill-health or substance misuse a common cause for impairment inquiries by medical regulators[1].

Myth busting

In March 2020, the mandatory reporting laws and guidelines were amended. The aim was to make it clearer when a notification was required and encouraged doctors to seek treatment without the fear of being reported.

The truth of the matter is, if you seek treatment for an illness, your treating doctor is only required to report you if they reasonably believe you will put the public at substantial risk of harm by practising with an impairment.

If you are managing your condition by getting treatment, taking leave or a break from practice, which reduces the risk and severity of harm, there is no reason to report.

Ahpra has stressed there is a high threshold for reporting, and an illness that is treated and well managed would rarely require notification.

The right help, at the right time

Patients seek our advice when they're not well. We comfort them with our expertise and are trusted to perform life-saving procedures in high-risk scenarios[1] – but we are not invincible.

Help is there from many sources and it's important to seek it before a situation becomes unmanageable. At Avant, we have a team of medical advisers who can provide resources and support, and doing so will not impact your premiums.

As a general practitioner, I know first-hand the challenges that doctors are dealing with, particularly at the moment. Also as a Medical Adviser at Avant, I speak with doctors on an almost daily basis, and I am hearing from them the impact these stressors are having on their mental and physical wellbeing. I encourage them, as I am encouraging you, to reach out and seek assistance and support.

A positive that has emerged from these uniquely challenging times is a growing awareness and acceptance that anyone can be susceptible to mental health challenges, and it is okay to admit you need help. It is also recognised that a healthy medical workforce is essential to providing safe patient care.

If you're struggling for any reason, please contact any of the health services specialising in supporting doctors; Doctors' Health Advisory Service (in your state), Drs4Drs, Hand-n-Hand peer support or an Avant medical adviser.

Reference

1. newsroom.unsw.edu.au/news/health/doctor-mental-health-concerns-increase-covid-surge-hits-hospitals

A positive that has emerged from these uniquely challenging times is a growing awareness and acceptance that anyone can be susceptible to mental health challenges, and it is okay to admit you need help.

Professor Kumar Visvanathan is Chair of the Department of Medicine at the University of Melbourne and Consultant Infectious Diseases Specialist at St Vincent's Hospital.

The pneumonia checklist

Prof Kumar Visvanathan and his research team received the Avant Foundation grant in 2018 for his application on investigating the accuracy of pneumonia diagnosis in ED.

Initial research had shown the rate of pneumonia misdiagnosis was astoundingly high – at 35.4%.

"In a lot of diagnoses, especially common disorders, a mistake like this could mean extra hospital days, increased hospital admissions, not to mention morbidity and mortality for the patient when you don't get the right diagnosis," said Prof Visvanathan.

"Potentially, if the person didn't have pneumonia and they were getting antibiotics when they didn't need it, it could lead to antibiotic resistance."

Developing the checkbox system

The intervention stage comprised a 'checkbox system', where the clinician will be required to identify that a series of symptoms associated with pneumonia are present to ensure diagnostic accuracy.

"Similar to what pilots go through – they have a checklist to make sure everything's secure before they fly. In the same way, having a checklist for diagnosing pneumonia is a way to ensure everything is done properly."

Prof Visvanathan is confident that correct identification is key to improving misdiagnosis.

"I don't think there's a lack of clinical ability. The checkbox system is another way of ensuring people did the right things and steps are not missed along the way."

The COVID factor

The project was forecasted to take approximately two years to complete. After commencing the research and analysis, his team was about to begin the intervention phase when COVID made its way to Australia in 2020.

Not only did COVID disrupt the healthcare system, but the research had to be put on hold.

"COVID did two things. First, it completely jammed up our emergency department and we couldn't possibly put another burden on them at the time. But secondly, it gave another cause of pneumonia," explained Prof Visvanathan.

"COVID adds a layer of complication because pneumonia can be a complication arising from the virus. The research may also need to be revisited at a later time because the baseline is now likely altered."

Prof Kumar Visvanathan

Looking past COVID

Prof Visvanathan is optimistic that the research could apply to other common diseases that have a high misdiagnosis rate.

"What's interesting is that we can extrapolate this to other diseases," says Prof Visvanathan.

"There's a big focus on medical error and things that are acute, but this is much bigger in terms of error. The misdiagnosis error is something we haven't really concentrated on, especially in common disorders."

Prof Visvanathan and his research team are waiting for the pandemic to subside before they can undertake the last phase of their research.

Healthcare for the homeless

When Young Australian of the Year, Dr Daniel Nour, had a chance encounter outside a busy London train station, it was the following events that he says changed the course of his life.

He recalls rushing to help a homeless man having a seizure. After speaking with the man's friends, they indicated the man – who didn't drink or do drugs – had several seizures in the past few months. Not once had he gone to a clinic or seen a GP.

"This helped me realise that for this population, health at times takes a back seat to other priorities like food security, shelter, money or companionship. As a result, healthcare was often neglected," explained Dr Nour.

After returning to Sydney, Dr Nour did his research to see what other health services were on offer for people experiencing homelessness. While these services exist, there are barriers such as prohibitive costs, Medicare requirements, lack of transport, stigma and distrust, that prevent people from accessing them.

Dr Nour's solution to the problem was starting Street Side Medics, a not-for-profit organisation that delivers a mobile primary healthcare service to people who are vulnerable or experiencing homelessness.

Same time, same place

Each clinic provides a range of medical services including health assessments and examination, care plans, vaccinations, pathology services as well as minor surgical procedures including wound debridement, abscess incision and suturing.

Street Side Medics operates out of a custom-fitted medical van and is 100% volunteer-run. The clinics have taken place in Woolloomooloo, Manly, Brookvale, and Parramatta at the same time every week since its inception in mid-2020.

"Despite surges in COVID cases and living through lockdowns, not a single clinic has been cancelled," says David Ballhausen, CEO of Street Side Medics.

"This is truly a testament to the commitment of our team of highly skilled volunteers – GPs, doctors and nurses – who have been stretched to the limit during this extremely challenging time and yet maintained their commitment to our patients during their limited time off."

> Many suffer illnesses in silence, many die of conditions which could have been treated. Many avoid interventions which could have improved their quality of life or prolonged their life.
>
> Dr Daniel Nour

Organising the organisation

What kept Dr Nour up at night were potential legal consequences, such as what would happen in the event of a needle stick injury. Would the team immediately know what process to follow?

With over 380 volunteers on its books, including doctors, nurses, allied health professionals and admin staff, it was important to define and implement a quality and compliance framework that works within the context of a transient medical workforce.

Setting up a new practice meant being aware of medico-legal risks and adhering to clinical governance and practice policies and procedures.

Avant's PracticeHub assisted by providing the clinical governance framework required to cover all operational processes of running the practice, including:

- a comprehensive and current set of policies and procedures
- a learning management system useful for inductions and educating new starters
- automated alerts related to any changes to Ahpra registration for all of the healthcare medical staff
- end-to-end management of the certificates of insurance, including alerts and reminders
- registers with automated due date reminders and expiry alerts for the vaccine fridge, the ultrasound machine and vital insurances.

Dr Daniel Nour, Young Australian of the Year 2022
Credit: Street Side Medics

Dr Clement Chao
Credit: Street Side Medics

Volunteering with Street Side Medics

Street Side Medics recently launched new clinics in Blacktown and Hornsby, which has seen 40 new volunteers get actively involved in the delivery of these clinics. It has plans for further significant growth within NSW as well as interstate.

If you are interested in volunteering with Street Side Medics, please visit **streetsidemedics.com.au/take-action**

Doctors' Health Fund

Health cover designed for doctors

YOUR CHOICE

Who treats you and where you want to be treated should be your decision. It shouldn't matter where your doctor chooses to practise, or which allied health provider you wish to visit for extras.

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