Avant
By doctors for doctors

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Connect

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Navigating Medicare

We break down the nuances and complexities of Medicare, including tips on staying on the right side and what to do when Medicare contacts you.

In this edition

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Another challenging year

I was dismayed by recent media reports of "widespread rorting" of Medicare by doctors. The profession has provided care to Australians through the most challenging of circumstances during the COVID-19 pandemic, while coping with their own ill health and that of their teams. They are reporting high levels of burnout in the recent Avant member survey, and it was galling to now face these unsubstantiated accusations. It's certainly not Avant's experience in assisting members with Medicare issues.

If there is a silver lining to this episode, it is that it has provided the impetus to take a close look at the framework around MBS billing. And it is clear that doctors are poorly supported in their attempts to navigate Medicare. Our Chief Medical Officer, Dr Michael Wright, discusses Avant's recent survey of members which identifies pain points. Avant has used its knowledge of members' issues to engage successfully with government in the past, on issues such as telehealth, and it is clear that an engagement about Medicare compliance is now needed. Further articles in this edition of *Connect* provide advice on keeping up with MBS billing changes and what to do when Medicare contacts you. Avant regularly updates its educational content on Medicare and more materials can be found on our website, which have been developed around the common queries about the Medicare system.

In a related area, complying with Medicare requirements impacts our incomes in private practice, as private health insurance payments can also be reliant on good Medicare administration. Our Doctors' Health Fund regularly assists patients and doctors in getting reimbursed for care received or provided, and offers some insights into how, as providers, doctors can avoid delays in being paid.

A second theme of this edition is the relationship between doctor and patient. While we try always to do what is best for the patient, this may not be straightforward when the patient has a different view of what is best or is not fully aligned with their practitioner's view. We have two cases that demonstrate how the best intentions resulted in patients complaining about their care.

A further dimension to the doctor patient relationship is when staff, friends and family ask for medical care because you are known and trusted, and it's often more convenient. When the patient is a staff member, there are additional factors to consider before agreeing to such a request, as our case study in this issue discusses.

And then there is the perennial issue of the need to be aware of clinical guidelines as we investigate and manage patients.

One of the case studies in this issue looks at an inquest into a patient death where guidelines were not followed. The case raises the issue of balancing clinical judgement with what's documented in the guidelines. In this case it was complicated by differing views and sets of guidelines.

While trying to meet the needs of our many stakeholders, our own interests can be pushed aside, whether they be personal or professional goals. Our financial services team provide a great example of a member who contacted us wanting to start their own practice. It is a complex and multi-faceted task but, along with our extended legal team and technology division, we were able to help the doctor plan a path forward. We share some of the key aspects to consider when starting a practice that came out of this situation and other experiences our experts have had in assisting doctors.

Our featured member in this edition is Dr Jennifer Green who founded a not-for-profit organisation championing diversity, equity and inclusion in orthopaedics and won the AMA's first ever Diversity in Medicine Award. We congratulate Dr Green and are delighted to see this excellent initiative promoting and implementing diversity equity and inclusion within the medical profession.

We are at the end of 2022 and as I reflect on this challenging year, I am full of admiration for our profession and the care they provide to the Australian people. And I am proud of the role Avant has played in supporting members. Lastly, I want to thank, on behalf of members, the Avant team who are committed to our cause of doctors for doctors.

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

Best regards,

Beverley Rowbotham

Dr Beverley Rowbotham
Chair, Avant Mutual

Diversity in medicine

When Dr Jennifer Green started out as a trainee and was considering orthopaedics as a specialty, there weren't any female orthopaedic surgeons in Sydney.

"I never really thought much about it at the time," Dr Green reminisces. "I knew I wanted to go into orthopaedics, and that's what I did. It wasn't until many years later that I looked back and realised there was a very tiny trickle of women following in our footsteps."

In the two decades since, orthopaedics in Australia has come a long way, even though there is still much work to be done. It wasn't until November 2022 that the Australian Orthopaedic Association (AOA) Orthopaedic Women's Link (OWL) representative on the board of the AOA was given the right to vote.

Women only make up 5% of orthopaedic surgeons in Australia, despite more than 50% of those going to medical school are women. Australia is well behind Canada and Malaysia who have more than 10% female representation in orthopaedics.[1]

"For so many years, women have been isolated from each other and are much less embedded in orthopaedic networks. It is not until recently that we developed a strong network through using a group app to connect."

Leading by example

Earlier this year Dr Green, a Canberra-based orthopaedic hand and wrist surgeon, was the recipient of the Australian Medical Association's first-ever Diversity in Medicine Award, commended on her work in promoting diversity, equity and inclusion in orthopaedics.

> "Putting a power tool in a young woman's hands is a very empowering experience. They realise that they can do this and it's not so far out of their comfort zone.

As the former chair of the AOA's Orthopaedic Women's Link (2018-20), Dr Green's main role was to drive the AOA diversity strategy. During this time, she founded the International Orthopaedic Diversity Alliance (IODA), a non-profit organisation of more than 1,000 members worldwide connecting to champion diversity, equity and inclusion in orthopaedics.

Unconscious bias

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," says Dr Green. "Historically, when joint replacements all 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-specialities to choose from. However, despite these significant changes, the gender diversity of the orthopaedic workforce has remained very low and we now understand the many barriers to diversity and the strategies that are most successful to overcome them."

One significant barrier is the 'hidden curriculum' at medical school, where long-held stereotypes are shared with students by medical faculty, such as 'orthopaedics is a boys' club', which deters women from choosing orthopaedics.

"The most effective tool we have established at AOA to combat this is a workshop program called 'A glimpse into the life of orthopaedics'. These include a 'hands-on' workshop with the opportunity to use drills and plates, practice arthroscopy and apply plaster casts. At these workshops, half of the facilitators are male colleagues who are allies for gender diversity. It sends a very powerful message that women are welcome in orthopaedics."

Fight for equality

While encouraging and supporting diverse students to enter orthopaedics is one tactic, Dr Green knows the fight for inclusion begins from the top down.

"We created a charter we're inviting every national orthopaedic association to sign, stating they will commit to a diversity strategy and strive to include minorities," explains Dr Green.

Dr Green says studies show that if you have more diversity in your organisation, you attract the top talent, you make better decisions and you are more innovative.

"People think diversity is something nice to have but not really relevant," says Dr Green. "But if you don't have a diverse work force, your patients will suffer. Evidence shows there are profound healthcare inequities. A study in Canada a male with severe osteoarthritis in their knee was 22 times more likely to be offered a knee replacement than a woman.[2] There are worse outcomes if parents don't have English as a first language. LGBTQI patients also face barriers because we have so few LGBTQI surgeons in orthopaedics. People that present as gender diverse get lower access to care."

Balancing act

Despite having a full-time practice in addition to her advocacy work, Dr Green still finds time for her husband, two teenage daughters, and dogs. She says it is also key to be proactive in finding time for her own interests and to look after her own physical and mental health.

"I haven't always been good at this, you need to be really deliberate about it," says Dr Green. "It is challenging and I know plenty of people who have struggled, and we are all trying to do better."

Reference

1. Hiemstra, Laurie A. et al. 'Experiences of Canadian female orthopaedic surgeons in the workplace: defining the barriers to gender equity'. *J Bone Joint Surg Am.* 2022 Aug 17; 104(16):1455-1461.
2. Borkhoff, Cornelia M. et al. 'The effect of patients' sex on physicians' recommendations for total knee arthroplasty'. *Canadian Medical Association Journal.* 2008 Mar 11; 178(6): 681-687.

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Navigating the Medicare maze

Medicare has been a cornerstone of Australia's health system for over 40 years, processing over 511 million[1] Medicare items in the last financial year. Keeping up to date and understanding the MBS, can be difficult and can place a significant compliance burden on doctors.

With a budget of $31 billion[2], it's understandable the government acts to ensure the integrity of Medicare. Since the 2018-19 financial year, additional funding has been allocated to increase compliance activity. This is reflected in the increased calls regarding Medicare to our Medico-legal Advisory Service, with compliance activity being the most common reason for members to call.

Survey shows clearer information needed

Our experience and data show that the overwhelming majority of doctors want to do the right thing and bill Medicare appropriately. However, given the complexity, it's not surprising our recent Medicare survey found just under half of respondents felt confident in understanding Medicare billing requirements, which dropped to a quarter for early career doctors.

Based on an analysis of Avant's claims data, there are a few item numbers regularly catching doctors out, which are shown in the adjacent table. Understanding the requirements, ensuring services meet them and documenting sufficient details in medical records are all important in ensuring compliance.

Education is the key

A lack of understanding of Medicare can create anxiety and makes non-compliance more likely. As the complexity of the system is unlikely to dramatically simplify, knowing where to get the right information about Medicare item numbers will remain important - although our survey showed that many respondents don't know where to go.

Many survey respondents reported asking colleagues for information and advice about Medicare. With so few doctors feeling confident they understand billing requirements, there is a risk of inaccurate and incomplete information being provided.

After colleagues, MBS Online is the next most commonly used source by members seeking Medicare advice. The AskMBS email service can be a helpful resource to provide information about specific item numbers which, if shown to have been followed, provides a good defence of any billings questioned.

Compliance concerns

Only four in every 10 members responding to our survey felt confident in responding to a Medicare compliance activity. This suggests there is a need for clearer information to allow better understanding of how the compliance system works. Most compliance activity from Medicare is aimed at getting doctors to review and understand their billings in order to encourage current billing.

Support at hand

Receiving compliance communications can be stressful, but you don't need to deal with it alone. There is support available at Avant to help you. We have Medicare experts and you should call us first if you are contacted by the department on a Medicare matter.

Many of you share with us your thoughts and experiences relating to Medicare and the compliance process. These experiences have helped us successfully campaign for members in our discussions with the Department of Health, such as with telehealth item numbers, which were introduced during the pandemic and have since been made permanent. Our advocacy activities continue as we seek to improve the compliance process and the healthcare system.

References

1. Services Australia Annual Report 2021-22
2. Primary Health Care 10 Year Plan – New and amended Medicare Benefits Schedule Listings - Budget 2022-23 factsheet

Avant claims insights

Most common MBS item numbers rendered that did not meet accepted standards or requirements:

General practitioners

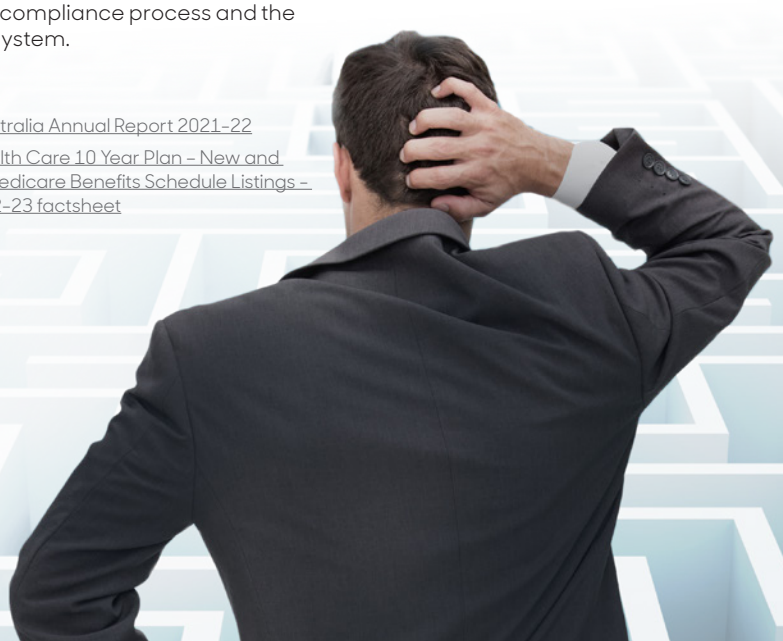
723	team care arrangements
721	preparation of GP management plan
732	review of GP management plan/ team care arrangements

Consultant physicians

132	initial assessment, at least two morbidities, minimum 45 minutes
110	attendance
133	subsequent attendance, at least two morbidities, minimum 20 minutes

Specialist surgeons

104	initial attendance
105	subsequent attendance



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Tips to stay on the right side of Medicare

It can be hard to keep up with Medicare billing requirements and there are several common errors that catch practitioners out. Item numbers change as the ongoing MBS Continuous Review process aims to ensure the MBS continues to support high-quality care and is up to date. Here are our top tips to manage Medicare billings and help avoid compliance issues.

1.

Understand the item number

As the provider you are responsible for claims to Medicare made under your provider number. You need to be sure you are applying the correct item numbers and that your consultation with the patient covers the elements required for you to charge that item number.

If you are using checklists or summaries, make sure you also have a process to check and maintain these against the full item descriptor in case of updates. Check with the government email advice service AskMBS if you are unsure.

Urgent after-hours item numbers are often an area for confusion. If you are using these numbers, it is important to check the requirements of the item number. Make sure your documentation reflects your judgement that the patient did need urgent medical assessment after hours.

2.

Keep careful records

It is a legal requirement when you make a Medicare claim for a service, that you maintain an adequate and contemporaneous medical record that demonstrates the service was provided. Inadequate medical records can result in an audit finding that the benefit for those services should not have been paid, and the government will seek repayment of the full amount of the Medicare benefits paid.

To satisfy Medicare requirements your records need to identify the patient and include a separate entry for each attendance by the patient for a service.

Be sure to record enough details that explain why the service was needed, the clinical input you provided and why the particular item number was billed. Very brief notes such as 'script written' with no record of presenting complaint or patient history or examination are likely to be questioned.

3.

Check all billings made under your provider number

You will be accountable for all services billed under your provider number and you are expected to make the decision about which item numbers to claim.

It can be helpful to have hospital or practice administrative staff submit claims for you but make sure the process allows you to check and approve any claims billed under your number.

If you are concerned that your provider number may have been used to make incorrect claims, contact Avant.

Claims can be audited after you have left your current practice, so keep a copy of all reports of claims submitted under your number for two years in case any are questioned in future.

4.

Be confident the service is appropriate

For example, recent Medicare reviews have focused on item numbers relating to care plans. Professional Services Review committees have expressed concerns about practitioners' unusually high use of care plans, chronic disease management plans and team care arrangements.

It is appropriate to recommend a plan to a patient who you feel will benefit. However, you should not seek to recruit patients to care plans without the appropriate clinical basis. Make sure any plans you create are clearly tailored to the patient, they identify the disease, document a baseline assessment or individualised goals, and document patient consent.

5.

Keep up to date with peers and ask for feedback

Medicare requires that services billed are clinically relevant. One way to be sure you satisfy this requirement is to keep in touch with peers and ensure your practice is in line with commonly accepted standards.

Medicare reviews check for statistical outliers and anomalies. Being aware of your peers' practices can help ensure your Medicare billing is consistent, or that you are aware of and can explain any differences. Also ask practice staff to let you know if they think your practice does not align with their expectations or if they think you have made a mistake.

However, as noted above, check the item numbers yourself and don't rely on hearsay or 'corridor advice' as to what you should be billing.

Avant resource

Medicare: what you need to know

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When Medicare contacts you

Receiving communications from Medicare can be stressful and disconcerting, though few cases are due to sustained non-compliance or inappropriate practice.

The primary focus of compliance activities is prevention and early intervention, but there are other approaches for more serious non-compliance. These are the common Medicare compliance activities and what you need to do, the first being to contact Avant.

Targeted letters

Awareness-raising strategies are used as an early intervention to aid compliance. Letters notifying you that your practice with an item number is different from your peers (often referred to as 'nudge' letters), don't necessarily need you to do anything other than be aware and think about what you do and why. You should have clinical reasons and medical records to substantiate every item number you bill.

Letters requiring you to 'review and act now' may identify you have been billing outside the norm and ask for an explanation. The letter may come with a list of your billings for you to review. You might then consider making a 'voluntary acknowledgment of incorrect payments' if any claims do not meet the criteria.

Medicare audits

Like the tax department, the health department runs random audits. An audit is an assessment that determines whether all the elements required for a particular benefit have been met. The Department of Health conducts audits for the Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Child Dental Benefits Schedule and Incentives Program. Audits do not review the clinical appropriateness of your treatment decisions.

A 'Notice to Produce' explains the department's concern, details of the benefit or service that needs to be substantiated, and the type of information that will help substantiate those services.

If your documentation does not confirm that all elements required for an item number have been met, then you may be required to pay back funds to Medicare.

Practitioner Review Program

The Practitioner Review Program (PRP) monitors Medicare data to identify and examine variations that may indicate you've engaged in inappropriate practice. In the past, statistical packages were simple, but now they are much more sophisticated and can identify statistical and significant differences between practitioners.

Where a practitioner is identified as having unusual billings or prescribing, they are provided with the information and requested to attend an interview with a department medical officer. They discuss the situation and usually give a period (6-12 months) of self-reflection and ask you to address concerns before a second statistical analysis is performed. Nine out of 10 cases terminate at this point.

Professional Services Review (PSR)

Some cases are referred from the health department to the PSR. The Director of PSR will review the evidence and may meet with you to discuss your billings and records before preparing a report. You will have the opportunity to make submissions in response.

From here the Director could:

- decide no further action is required
- enter an agreement with you in which you must acknowledge you engaged in inappropriate practice and likely repay money relating to the services. The Director can also disqualify you from billing to Medicare for a specified period
- refer you to a committee of your peers for a hearing to decide if you engaged in inappropriate practice.

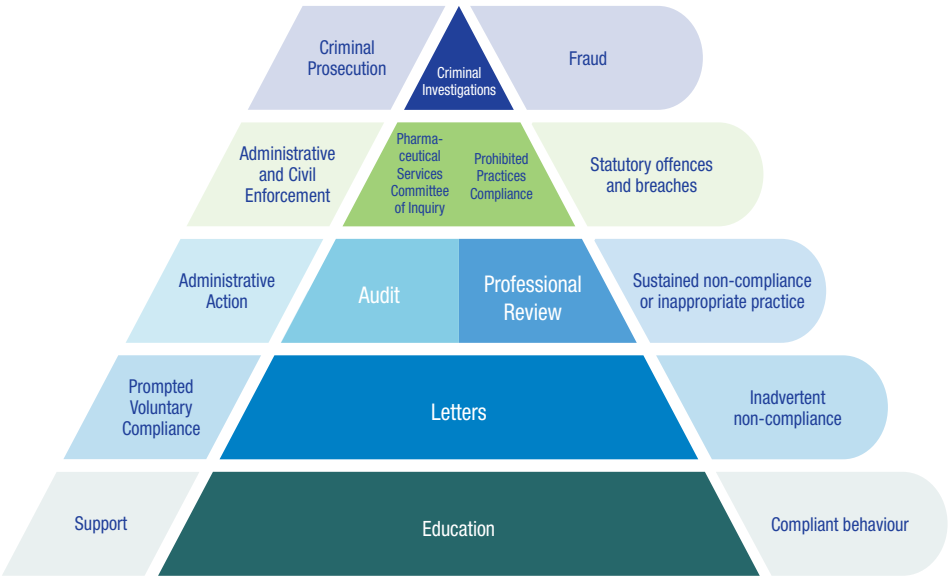
If the Director of the PSR is concerned you haven't complied with professional standards, or you are practising in a way that places your patients at risk of harm, a referral can be made to Ahpra or another regulatory body.

Avant resource

Medicare FAQs

Medicare Compliance Model

Types of compliance based on levels of seriousness



*Note that this is not an escalation model. Responses to instances of non-compliance will correspond with the type and seriousness of the behaviour. Source: Department of Health, Health Provider Compliance Strategy 2021-2022

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Good billing admin pays

Correctly billing services is not only important to meet your obligations as a healthcare provider, it ensures efficient payment of your fees. Having a claim short paid or rejected can add to your administrative time and cost you.

Therefore, it's worth minimising exchanges with Medicare and health funds when looking after privately insured patients. The complexity of the Medicare and private health insurance landscape means billing mistakes happen, so here are some things to look out for.

Compliance with the MBS

Medicare rejections are one of the more common reasons for an unpaid claim. Medicare will reject claims for payment where an item number is not billed according to the MBS requirements. More often than not these are made inadvertently, and can include:

- using out-dated MBS item numbers,
- not adhering to co-claiming limitations,
- not providing additional clinical information where required, and
- billing surgical items in the incorrect sequence.

When a claim is rejected by Medicare, your patient's health fund will follow up with you for more information, until Medicare is satisfied and can process your claim.

The health fund should provide as much information as possible to facilitate this process – although despite best efforts, missing or incorrect information can lead to delays in payment.

Medicare rejections also impact the payment of health fund benefits. Until Medicare pays their 75% portion on a claim for a private patient, the remaining 25% from the health fund, and any additional gap cover payments, can't be paid.

Covering the gap

Choosing to participate in your patient's medical gap cover means abiding by the rules of that cover to ensure the desired billing outcomes. A health fund is unable to cover the gap and will short pay your claim by only paying 25% of the Medicare fee if:

- your registration with their scheme isn't active,
- you haven't identified you're billing your claim according to their scheme when you submit it, or
- you exceed the allowable 'known-gap' fees of that scheme.

The current private health insurance landscape means there are several gap schemes, each with their own billing guidelines. Staying up to date with the terms and conditions of any health fund medical gap cover schemes you intend to participate in, will reduce instances where your claim may be short paid.

Taking time early on to bill correctly means you can spend more time on your most important role of treating your patients.

Services to support your billing

Electronic claiming through ECLIPSE has made billing with health funds faster and more secure. If a claim does get rejected, you can rectify this mistake and resubmit your claim with a much shorter turnaround time.

A growing number of claims are received electronically. We encourage you to implement ECLIPSE claiming into your practice if you haven't already and see how it can help with a smooth payment process.

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Consent in dynamic situations

Some patients have a strong view of the care they wish to receive. This can be challenging when it goes against your advice or when circumstances change.

In the situation below, the capacity of the patient to provide informed consent raises the issue of whether a substitute decision maker should be called upon.

Patient's strong opinion

A 41-year-old woman* was discussing delivery options with her obstetrician at the 28-week antenatal visit. She wanted a 'natural birth' and said she won't require any pain relief for labour. She also expressed a strong desire to avoid a caesarean section.

Towards the end of her pregnancy foetal growth slowed and there were signs of placental insufficiency. The patient refused intervention until 41 weeks when she agreed to an induction of labour. After many hours in labour, the patient said she could not cope with the pain and agreed to try nitrous oxide.

Consent in new circumstances

Eventually the patient became very tired and distressed and the midwives suggested an epidural. She was no longer communicating well but nodded in assent and an anaesthetist attended to assess the patient and obtain consent.

Her partner said he was supposed to stop her from having an epidural or caesarean section "no matter what". The patient was using large amounts of nitrous oxide for pain relief and not speaking to the anaesthetist but would nod or shake her head to answer questions.

Approximately an hour after the epidural was inserted the CTG showed signs of foetal compromise. The obstetrician told the patient and her partner the baby would benefit from an emergency caesarean section if the health of the foetus continued to deteriorate, to which both parents refused.

At this point the doctor contacted Avant for urgent advice.

Consent and capacity

When there is valid consent from the patient, the doctor must act in accordance with the patient's wishes. It's important that the patient understands the consequences of their decision, such as the risk posed to their own wellbeing and, in this situation, the wellbeing of the foetus.

Sometimes the situation changes and the patient's prior position is no longer valid, and it is not possible to have an effective conversation with the patient to gain their consent. In that case, the situation should be discussed with the patient's substitute decision maker. They must make a decision in the patient's best interests and should be guided by what they believe the patient would have wanted, not what the decision-maker themselves might want in the same situation.

For a patient to have capacity to consent, they must:

- understand the information and consequences relevant to the decision
- retain the information and recall the details of the discussion
- use and evaluate the information throughout the decision-making process
- relay their decision and understanding.

These situations can be very difficult, so speak to a colleague about the clinical situation and for support. Consider involving a social worker or psychiatrist to help assess the patient. It may also be beneficial to escalate the matter within the hospital, which may be hospital policy.

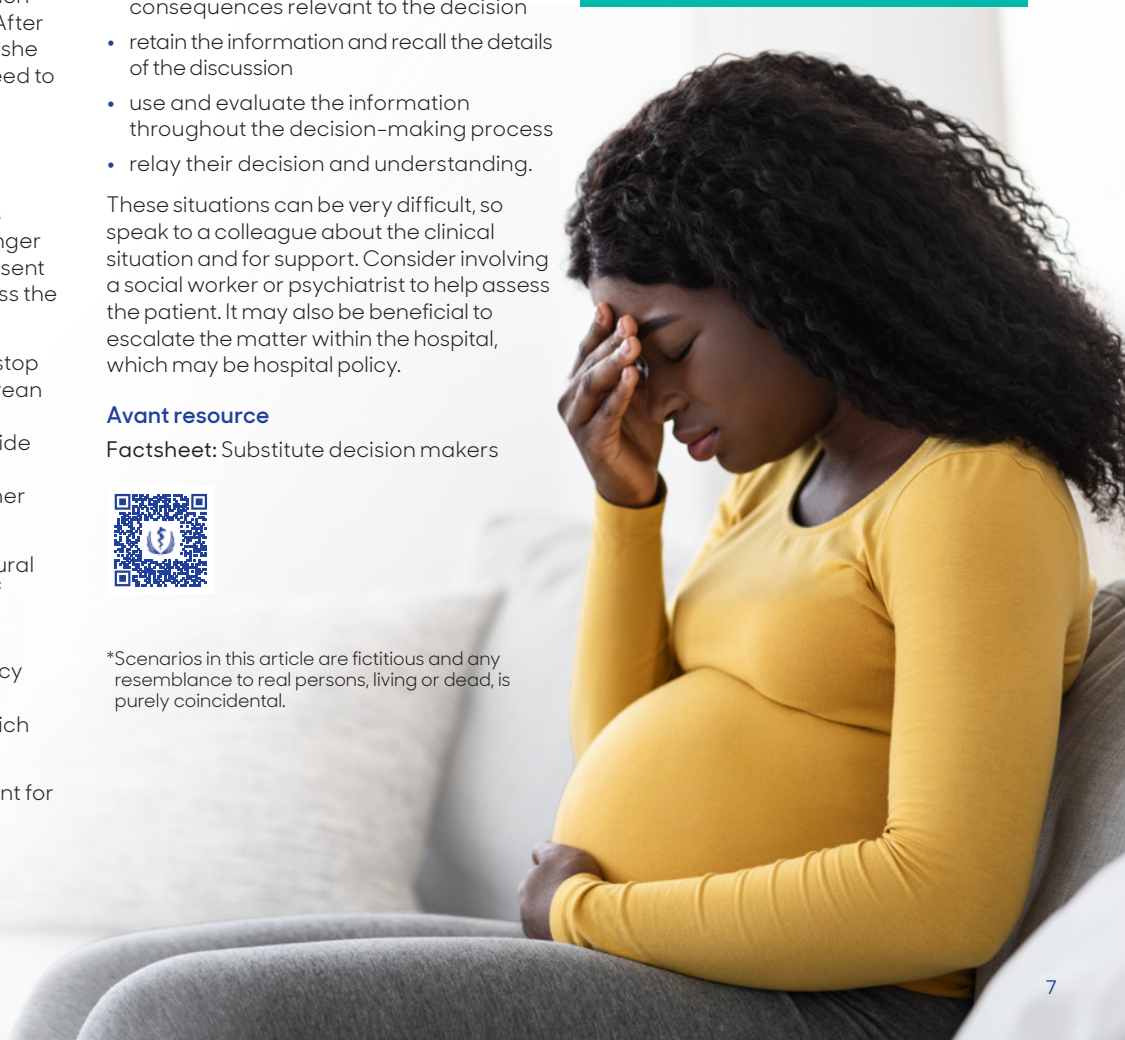
Avant resource

Factsheet: Substitute decision makers

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

Key lessons

- A patient with capacity has the right to refuse treatment, even if the doctor disagrees with the patient's decision.
- If the clinical situation changes, this should be discussed with the patient including an explanation of the likely outcome for the patient and the foetus.
- If the patient loses capacity, the discussion should occur with their substitute decision maker, who should be guided by the patient's wishes or their best interests.
- All discussions should be well documented in the clinical notes.
- Involve senior clinicians and/or escalate the situation to hospital management if needed.



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Inquest highlights role of guidelines

Doctors often face a delicate balance between slavishly following guidelines and using their clinical judgement. The tragic death of a young woman due to deep vein thrombosis (DVT) after minor surgery, reinforces that all patients should be assessed for venous thromboembolism (VTE) and the role of clinical guidelines.

The coroner said it was clear at the time of the inquest that the assessment and prevention of VTE was marked by "controversy and uncertainty". From a medico-legal perspective, VTE is a foreseeable complication. Guidelines can assist doctors to navigate competing risks and can also be used when discussing the risks and benefits of treatments with patients.

Risk factors complicate fracture treatment

A 21-year-old female patient presented to a district hospital with a fractured and grazed left ankle after dancing in high heels.

The patient was a non-smoker and overweight, with a body mass index of about 35kg/m^2. She was also taking an oral contraceptive pill. She was given a tetanus booster and analgesics and started on intravenous antibiotics before being transferred to a tertiary hospital.

Her leg was considered too swollen for surgery, so a below-the-knee cast, analgesia and elevation were provided. Antibiotics were continued and the anticoagulant enoxaparin was administered for three days for DVT prophylaxis. She was transferred to another hospital for the swelling to reduce and enoxaparin and her contraceptive pill were continued.

At the time, the patient's father told a staff member about his history of blood clots in the lungs and that he had been prescribed ongoing warfarin. He asked if his daughter would be given blood thinners and was told she was receiving them each night.

About two weeks later, she was transferred back to the tertiary hospital for surgery.

Discharged without anticoagulant

The patient's surgery was allocated to an orthopaedic registrar to perform an open reduction and internal fixation of the fracture. The patient was not given enoxaparin before surgery, and her chart shows she received enoxaparin in the evening following her surgery.

The inquest heard the usual practice at the hospital is that the orthopaedic surgeon who performs the surgery provides the post-operative instructions. As the usual practice was to consider a patient's need for ongoing thromboprophylaxis at discharge, it was not surprising that the post-operative orders didn't mention thromboprophylaxis.

A day after surgery, an on-call registrar reviewed the patient and discharged her after checking the post-operative instructions, which did not mention enoxaparin or aspirin. The patient was not asked about her family history of VTE or prescribed an anticoagulant.

Her father asked a doctor, who introduced himself as one of his daughter's surgeons, whether she would be sent home with blood thinners. He was reportedly told, "No, her heart is good, she is young and strong like an ox."

Cause of death

A month later, the patient saw her GP with shortness of breath, pleuritic chest pain and vomiting. She was sent to the emergency department of a general hospital, where she collapsed and suffered a cardiac arrest in the waiting room. Tragically, despite resuscitation efforts, she couldn't be revived.

The coroner attributed her death to pulmonary embolism (PE) associated with DVT in her injured leg.

Inconsistent hospital guidelines

At the time, the hospital had two guidelines for thromboprophylaxis for lower limb trauma:

- The hospital's guideline for fracture with immobilisation recommended enoxaparin starting six hours after surgery for the entire period of immobilisation.
- The orthopaedic department guideline, developed by the department based on the relevant literature, recommending the use of enoxaparin the morning after surgery, followed by 150 mg aspirin on discharge for patients with restricted weight bearing. For high-risk patients, enoxaparin was recommended six hours after surgery and warfarin for six weeks from the day after surgery.

The events involving this patient highlighted the discrepancy between the two sets of guidelines. At the time of the inquest, the hospital was taking steps to align the guidelines.

Differing views on DVT risk

Evidence presented at the inquest highlighted the challenge of managing patients with a moderate risk of DVT, and disagreement over whether the patient had a moderate or high-risk of DVT.

Expert evidence said risk factors for DVT included the oral contraceptive pill, lower limb fracture and being immobile. Family history was also very important and should always be considered during a risk assessment.

The expert opined that if the TIP (trauma, immobilisation and patient characteristics) risk score had been applied to the patient, she would have been classified high risk. Furthermore, enoxaparin would have reduced her risk by 60 to 80% and aspirin by 20 to 30%.

Coroner's recommendations

Ultimately, the coroner accepted the decision not to prescribe prophylaxis was an omission rather than a failure of the guidelines.

However, while the coroner noted there was no guarantee the patient's VTE would have been prevented had she been given prophylaxis, she was not treated in accordance with the hospital's own guidelines. This exposed her to a much higher risk of developing a PE than would otherwise have been the case.

The coroner recommended implementing an effective assessment process throughout the state's hospitals to prevent the risk of VTE, as far as practicable, and suggested considering the TIP score as part of this system.

The hospital's reforms included introducing a VTE risk assessment eForm and developing a VTE information leaflet to give to all patients at risk of VTE.

Clinical guidelines and decision-making

As this inquest demonstrates, guidelines often come into play when experts are divided on what should have been done.

When deciding whether a doctor acted in a manner 'widely accepted' by peer professional opinion as competent practice, guidelines are important evidence of what was known and accepted at the time the care was provided.

The legal position is clear that 'widely accepted' does not mean 'universally accepted.' Widely held peer professional opinions can differ on what care should have been provided, yet still be viewed as competent and appropriate.

However, while guidelines provide recommendations for best practice, they should not replace clinical decision-making as they can vary and don't always provide a clear consensus on treatment.

Ideally, guidelines are a tool doctors can use to help navigate competing risks such as the potential risk of VTE versus the risk of bleeding from VTE prophylaxis. They can also be used to assist in communicating the material risks and benefits of a treatment to patients to support informed consent and shared decision-making discussions.

Departing from guidelines

While courts recognise there may be a good reason for considered and rational departure from guidelines, if something goes wrong, the practitioner's clinical reasoning will be scrutinised.

Generally, doctors who depart from standards of care based on their own unique views about treatment that are not supported by their peers, are more likely to fall foul of courts and tribunals.

In situations where you do depart from relevant guidelines, keep the following in mind:

- Consider whether your peers would agree that departing from the guidelines is appropriate in the patient's circumstances.
- Carefully document your clinical reasoning for not following the guidelines in the records.
- If in doubt, consult your peers for their opinion.

Related resources

Guidelines: The Australian Commission on Safety and Quality in Health Care's *Venous Thromboembolism Prevention Clinical Care Standard (2020)* and *Implementation Guide: Venous Thromboembolism Prevention Clinical Care Standard*.

Avant article: Court finds following guidelines "not irrational"

Key lessons

- From a medico-legal perspective, VTE is a foreseeable complication of significance to the average patient.
- All patients should be assessed for VTE risk, given anticoagulant treatment if appropriate and provided with information about the potential risks of VTE and the risk of severe bleeding from VTE prophylaxis. These discussions should be documented in the patient's clinical record.
- When deciding whether a doctor acted in a manner 'widely accepted' by peer professional opinion as competent practice, courts will rely on guidelines as evidence of what was known and accepted at the time the care was provided.
- Clinical guidelines are not a replacement for appropriate clinical decision-making and courts recognise there may be a good reason to depart from guidelines. In situations where you depart from the guidelines, carefully document your clinical reasoning in the records.

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Good intentions, lost in translation

Doctors generally face a broad spectrum of patient personality types, including ones who could misconstrue a practitioner's delivery style as threatening or coercive.

In this case, a misunderstanding between a general practitioner and a patient led to a complaint to the regulator. It highlights the importance of effective communication, particularly when discussing sensitive topics and with more challenging patients.

Communicating on the same page

The general practitioner consulted with his young, female patient about pregnancy and contraception on multiple occasions. One of their initial consultations involved the patient reporting some bleeding after removing her IUD herself and advising that she had resorted to using condoms, but only intermittently.

There were several more consultations where the patient reported pregnancy scares and made ambivalent statements about whether she currently felt ready to be a parent.

The general practitioner had a lengthy consultation with the patient where he gave her information on the various methods of contraception available, educated her with information about the menstrual cycle and discussed the pros and cons of each of the options available, including the published efficacy rates for each of these options. He felt confident at the end of the consultation that they had come to an agreement with respect to which contraceptive option the patient would pursue.

Having come to this agreement, the general practitioner ended the consultation by asking the patient to shake his hand to indicate she would follow through with the agreed option.

Responding to the complaint

The patient subsequently lodged a complaint with Ahpra, alleging she felt pressured and threatened by the general practitioner to agree to the contraceptive option he considered she should have.

Avant's medico-legal team helped the general practitioner submit a response to Ahpra to clarify that at no time had he meant to cause the patient to feel pressured or threatened. He was simply trying to provide her with information about the contraceptive options available to her and ensure she made the most appropriate decision for her circumstances.

The patient also complained that the general practitioner forced her to agree to a birth control method by injection and that he threated to tell her mother if she did not agree.

The general practitioner offered an apology to the patient for his part in the misunderstanding that occurred between them. He responded that he offered to invite her mother into the room in the hope the patient would feel more comfortable with her mother present, as her mother had accompanied her during a previous consultation. The general practitioner stated that this was in no way a threat to the patient and reassured the Medical Board that he would never disclose a patient's confidential health information without their consent.

The patient also alleged the general practitioner was trying to "scare her with statistics", which she felt were exaggerated. This was in reference to the information on efficacy rates set out in the brochures provided by Sexual Health & Family Planning Australia, that the general practitioner had given the patient during their consultation.

Finally, the patient felt that by being asked to shake the doctor's hand as a form of agreement that she would follow through with the contraceptive options, she was coerced to do so.

The general practitioner admitted he routinely employed this tactic with patients to confirm lifestyle-related decisions, such as quitting smoking or cutting back on drinking. He had not realised it could be interpreted as a forceful method.

Reflection assists outcome

Having had the opportunity to respond to the allegations and reflect on the response of the patient, the general practitioner was dismayed that the patient had walked away with the impression she did.

This experience has prompted him to re-evaluate his approach with patients, his delivery style, and how he handles sensitive topics to ensure that a misunderstanding like this does not happen again.

Avant's medico-legal team provided the general practitioner with a course of education in relation to communication, as he was motivated to improve his practice in this respect.

The general practitioner also sought further education on communication with patients and handling sensitive issues with care and completed an online course on improving his practice.

The Medical Board considered the explanation provided by the general practitioner and, taking into account his reflection and educational activities, determined that no further regulatory action was required.

Avant resources

Effective communication:
avant.org.au/Effective_communication

Article: Informed consent and communicating information

Key lessons

- While patients need to be provided with relevant information about their reproductive choices, remember to communicate this without judgement.
- Remind your patient that their doctor is there to assist and support them to make an informed decision, rather than to make a decision for them or coerce them in any way.
- Clear communication with patients is one of the most important aspects of general practice and is often at the root of patient complaints to the regulator.
- Practitioners are encouraged to be clear in their communication that the decision is the patient's to make, particularly when discussing potentially sensitive issues such as sexual health and family planning.
- It is important that a practitioner's communication style could not be interpreted by the patient as judgemental, threatening or coercive.

How to respond to an Ahpra notification

Acknowledge the concerns raised
and try to understand the perspective of the notifier.

Acknowledge any errors that may have occurred
and offer an apology if appropriate.

Clarify what has been done
to address the concerns.

Provide supporting documentation
for any additional training or CPD you have done since.

How concerns are managed by Ahpra and the National Board

Receive a concern about a practitioner, speak to notifier

↓

Review information and regulatory history about practitioner, assess risk

↓

Speak directly to practitioner to gather information about practice setting and context

↓

Validate steps taken by practitioner and/or their workplace to manage any risk to public

↓

Take regulatory action when practitioner is not sufficiently managed by individual and/or organisation risk controls

Source: www.ahpra.gov.au/Notifications/Has-a-concern-been-raised-about-you/What-to-expect

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GP cautioned over telehealth consult after patient complains

Telehealth services have become an essential part of healthcare delivery for doctors and patients alike. However, as one GP member was reminded, doctors must adhere to the same standards as a face-to-face consultation. This includes always taking a full medical history and documenting the discussions, especially when seeing a new patient.

Video telehealth consultation

In this case, the GP was conducting a telehealth consultation through a national mobile app service. The patient, based interstate, was required to complete a health summary which included their personal details, medical history, current medications and presenting symptoms via the app for the GP to review ahead of the consultation.

In terms of her medical history, the patient said she had undergone breast surgery, had asthma and allergies to latex and codeine. She also stipulated she was not taking any medications.

Using the chat function, the GP and patient exchanged messages before the consultation, and the patient advised that she had gained 25 kg in a year despite having a reasonably good diet and doing physical activity.

The GP asked the patient if she had seen a dietician. The patient said no but indicated that she ate well. He asked for her height and weight and calculated her BMI to be 30-31.

Still via the chat function, with the information provided, the GP suggested she could try the appetite suppressant, Duromine. The patient researched the medication and said that she wanted to try it.

The GP then started the video telehealth consultation and went into more detail about Duromine, explaining that combined with a good diet, it could help reduce her BMI. He told her to take it for a few days to see how she tolerated it and provided one month's supply with a starting dose of 30mg. He also advised the patient not to drink alcohol while taking the medication and strongly recommended she see a dietician.

Patient complaint

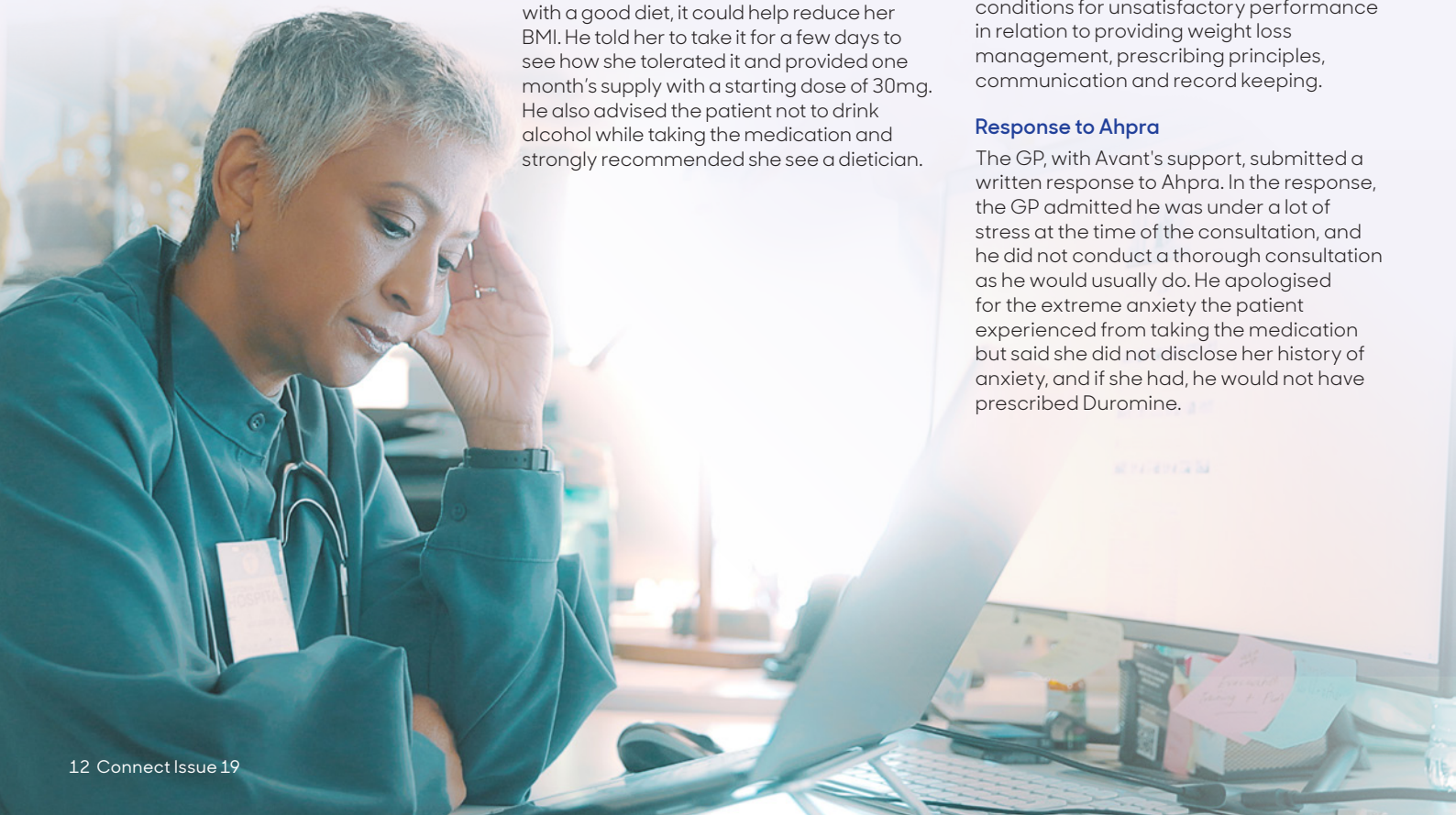
The GP did not see the patient again and later received a complaint notification from Ahpra.

The patient had complained, claiming the GP did not perform a proper assessment and she should not have been prescribed Duromine due to her history of anxiety. She stated her mental health suffered significantly, experiencing panic attacks and ruminating, obsessive paranoid thoughts, and developed behavioural symptoms, including picking her skin and pulling her hair.

Ahpra acknowledged the patient's dissatisfaction with the treatment the GP provided and recognised that the experience was disappointing for her. They proposed a caution and mentoring conditions for unsatisfactory performance in relation to providing weight loss management, prescribing principles, communication and record keeping.

Response to Ahpra

The GP, with Avant's support, submitted a written response to Ahpra. In the response, the GP admitted he was under a lot of stress at the time of the consultation, and he did not conduct a thorough consultation as he would usually do. He apologised for the extreme anxiety the patient experienced from taking the medication but said she did not disclose her history of anxiety, and if she had, he would not have prescribed Duromine.



The GP also reflected on his practice and sought ways to improve it. He completed eight hours of education on weight loss management, prescribing principles relating to weight loss, and communication and record-keeping.

The final decision

Ahpra found the GP's performance during this telehealth consultation fell below the expected standard and was unsatisfactory because:

- He failed to take the patient's full medical history.
- He did not write a referral to a dietician himself.
- The messages between him and the patient were brief, and he did not perform a complete assessment before deciding a prescription for Duromine was appropriate. Instead, this was suggested as the first line of management and no other options were explored.
- There was a lack of any medical records.

Ahpra upheld their decision to caution the GP and imposed conditions on his registration for six months, requiring him to undertake mentoring on comprehensive patient assessment and communication.

Avant resource

Telehealth – what you need to know

Key lessons

- Doctors must adhere to the same standards as if conducting a face-to face consultation.
- You are required to keep an appropriate record of the consultation.
- If you are seeing a patient for the first time, and you don't have access to their medical records, take a full medical history and probe for more information before offering treatment options.
- Communicate with your patient to ensure the proposed treatment is not contraindicated. This particularly applies when you have no prior knowledge or understanding of the patient's condition(s) and medical history or access to their medical records.
- When considering prescribing a medication, ensure your patient has no contraindications, is fully aware of the side-effects and advise them of any alternatives.
- If appropriate, write a referral to another healthcare practitioner, don't just suggest the patient see one.
- The Medicare Benefits Scheme item numbers define telehealth consultations as involving an audio and/or video link, not online chat consultations.

Telehealth cover changes

Avant's Practitioner Indemnity Policy cover for telehealth activities is changing from 1 January 2023, to exclude telehealth consultations based on online questionnaires and/or text-based chat.

The change is due to concerns about the quality of services where there is no real-time face-to-face, video or telephone consultation, and where the practitioner lacks access to the patient's medical records from a previous in-person medical consultation. It is not intended to apply to pathologists or radiologists.

Login to check your renewal documents, or visit **avant.org.au** for details.

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Why treating staff members can be problematic

Doctors are reminded to avoid treating colleagues after a GP faced an Ahpra complaint from a staff member who had been provided with medical care.

A staff member at a practice booked an appointment with the doctor while at work, complaining of chest pain. The doctor agreed to see him in case emergency care was required.

The doctor took a medical history, conducted an examination and reviewed the staff member's ECG, which was normal. After documenting the consultation, the doctor advised him to follow up with his regular GP.

A few days later, the doctor called the staff member to provide him with his blood test results. The doctor advised that if his symptoms didn't improve in three weeks, then a referral to a cardiologist should be considered. The doctor also reiterated the need for the staff member to attend with his regular GP for any future care.

Further appointments booked

The staff member booked another appointment with the doctor regarding his ongoing chest pain, saying he was unable to see his regular GP that week.

The doctor saw the staff member and arranged for him to see a cardiologist the next day. The cardiologist advised the pain was unlikely cardiac, possibly muscular in nature, and recommended simple analgesia.

The doctor discussed the results of the investigations with the staff member and provided him with a copy of the results. The plan was for any further follow-up to be with the regular GP.

Instead of seeing his regular GP, the staff member made appointments to see another GP at the practice, again insisting the care was urgently required and could not be provided by his regular GP. The practice eventually had to advise the staff member they were unable to book further appointments and offered to transfer records to his regular GP.

The staff member resigned and then submitted a complaint to Ahpra expressing concern that the doctor had inappropriately influenced the decision of the practice not to provide further appointments. The complaint also aired workplace grievances and alleged bullying conduct and privacy breaches.

Defending the doctor

We assisted the doctor to prepare a response to Ahpra and were able to explain the doctor's actions with reference to the Medical Board of Australia's Code of Conduct and the practice's policy on treating staff and their families, which incorporated the guidance from the Code of Conduct.

The Code of Conduct says: "In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient."

However, the guidelines provide that in situations where providing care to those close to you is unavoidable, good medical practice requires recognition and careful management of these issues.

The practice's policy followed the Code of Conduct, including stipulating that doctors should avoid treating practice staff and their families as far as possible, except in emergencies.

In this case, the Medical Board of Australia decided to take no further action.

Why doctors should avoid treating staff

Treating a staff member can be driven by an intrinsic desire to help or pressure from the employee to be treated. However, there are many reasons why providing care to staff can be inappropriate.

Lack of objectivity

Maintaining objectivity in this situation can be challenging. You may find it awkward to, or refrain from, asking sensitive questions, or the patient might find it difficult to disclose sensitive information to you, so you may miss vital information.

Obtaining a complete history or full physical examination may be uncomfortable for you or the patient and may lead to you not completing a full assessment.

What you know about the staff member outside of the consultation room may also influence your management.

A lack of objectivity may also mean you don't follow up on appropriate investigations or referrals, which can result in a missed diagnosis.

Discontinuity of care

A lack of continuity of care can also arise, particularly if a staff member persuades a doctor to provide a repeat script or referral or perform a 'corridor consultation.'

In these situations, documentation may be informal or non-existent, and there may be no proper handover or follow-up, which can compromise patient care.

Privacy

Other staff may be able to access the medical records of a colleague or their family. Without a clinical need to do so, this may be a privacy breach and would be exacerbated if this information is discussed with other people.

Complete and accurate records

You might be tempted to mask a record (for example, by using a false name), or exclude sensitive information, (for example, information about a mental health issue) to protect your colleague's privacy.

Conflict of interest

Where the doctor is also the employer or manager, a conflict of interest may arise. Your knowledge of the medical history or personal circumstances may impact your management of the employer-employee relationship and could lead to concerns, for example, about discrimination.

If a working relationship breaks down, this could also compromise the treating relationship.

It is generally recognised that it is in a patient's best interests to obtain their medical care outside of their workplace.

Avant resource

Factsheet: Treating family members, friends or staff

Tips when it's necessary to treat a colleague

If you find yourself in an emergency situation, or an isolated setting where you do need to provide treatment to a colleague, keep these tips in mind:

- Ensure consultations occur in a proper setting and they are thorough.
- Set boundaries and expectations about the treatment you will provide.
- Have appropriate systems in place to protect against privacy breaches.
- Where treatment is provided in an emergency, hand over care to another doctor once the emergency has been dealt with.
- Ensure appropriate medical records are made of the treatment provided.

Michael Loughman
BBus
Chief Executive Officer
Avant Financial Services

How do you start a practice?

Dr Singh* dreamed of 'financial freedom' and had business objectives she wanted to achieve but did not know where to start. "I got to a point where I was sick of working for other people," Dr Singh explained, adding that she wanted to start a multi-room consultancy but had no idea how to run a business.

A career in medicine means a life dedicated to helping others, but it doesn't necessarily mean you need to be working for others. For many doctors, this means aspiring to own your own practice and being closer to obtaining financial freedom. Being clear on what you want to achieve on a business level allows a path to be mapped out for the journey.

Here are some important aspects to address early on in the process.

1. What business structure is best?

This depends on how much control you want. Dr Singh was also interested in having other specialists,physicians and allied health professionals in the area that could join, which could be done as a partnership or set up as an incorporated company or a trust. The pros and cons of each can be weighed up by discussing them with a solicitor who understands corporate law and an accountant, who can provide the relevant tax-related guidance.

2. Buy or lease

You may prefer to own a commercial property with a mortgage, as opposed to leasing it and being subject to vacancy at any time. The legalities and finances associated with each could impact your decision. For example, purchasing a property requires conducting a great level of due diligence and searches for your desired location. However, if you take the option of leasing the property, having a written lease in place which appropriately protects your interest is just as important.

3. Financing the practice

A good understanding of the options and steps required in obtaining the most appropriate finance can save both time and money. Commercial property funding is not the same as funding a personal property and you will also need to consider how to finance inventory and equipment. Depending on your circumstances, it might be beneficial to refinance existing debts or home loans to optimise your capital and assets.

Protecting your assets and insuring against the additional risks is imperative as it could open you to a catastrophic financial situation. Not only should you consider business insurances, but it would be wise to consider your personal insurance and estate planning.

4. Staffing the practice

Having the right team is essential and once resourcing is determined, the nature of the arrangements needs to be finalised for contractors and employees.

Employment laws are complex and can have implications on payroll tax and indemnity liabilities. It will also be necessary to establish policies and processes to ensure staff understand how the practice should operate.

5. Get expert advice

These are just a few of the many factors to consider when establishing a practice. It may be daunting as well as exciting, but you don't have to be alone on your journey. Avant has helped many doctors in similar situations, and it was rewarding to see our wide range of expertise used to address Dr Singh's needs to her satisfaction. "I left the meeting feeling confident and much more relaxed, that Avant can help make this a reality," said Dr Singh.

Download our handbook on *Owning Your Future for more information about starting, acquiring or buying into a medical practice.*

*name has been changed to maintain member confidentiality

How Avant can help your practice

Building Practice Efficiency

Navigate the complexities of practice ownership and reduce time and cost on critical practice management tasks.

- Manage your practice policies, procedures and accreditation with PracticeHub.
- Access to quality medical supplies through Team Medical.
- Understand and manage your employer obligations with advice from Avant Law.

Managing Practice Risk

Understand and manage risk in your practice to give you confidence your obligations are being met.

- Insure your practice for claims and complaints, cyberattacks and damage to property through Avant insurance offerings.
- Proactive risk management support through the Risk Advisory Service.
- Quick access to legal and medical experts for advice and guidance on practice issues.
- Support with workplace disputes and claims from Avant Law.

Confidence to Grow

Make the most of new opportunities to grow and build practices.

- Financing for property, equipment and fit outs through Kooyong, Avant's finance and lending team.
- Advice on business structuring, leasing and purchasing from Avant Law.

Renovate or relocate?

Are you thinking about updating your home due to an expanding family, needing more space for guests or the need for a makeover? The decision to 'renovate or relocate' is best made when well-informed about the many factors, challenges and benefits each option presents.

Sell up and move

At first glance, selling your home and moving into a house that ticks your dream home boxes can appear to be the easier option. The upsides of relocating to a property that doesn't require additional work, and the potential profit you could make selling your current home, can be appealing.

However, there are several factors to consider, including that if you are selling and buying back into the same suburb, the profits are likely to go directly into your next home. In addition to the purchase price, there are other costs to look into, including: stamp duty, repairs, agent's fees, marketing cost, home staging, building and pest inspections, legal or conveyancing fees, removalists and rates and taxes post-settlement.

You will also need to decide if you prefer to sell before or after you've found a new home. If you buy first, there is a chance you will need a bridging loan to help finance two properties until your current home has sold.

Bridging finance can be complex and only a handful of banks offer this specialised home loan product, with some only willing to provide assistance to existing customers. You will need to find out if your bank offers it, what their policy is and if they are willing to issue bridging finance without your current home being sold, or if you need an unconditional sale contract first.

When searching for your next property, you can avoid wasting time or money on one that doesn't suit your needs by having clear criteria and getting background information on the property.

Stay put and improve

The top reason to remain in your current home is often that owners love where they live and there isn't an option to move within your neighbourhood. However, upsides to renovating include the potential to increase the value of your home and fully customise what you want to make it perfect for your needs.

When drawing up the budget, there are less obvious costs not to be overlooked, such as design and surveyor fees, permits, inspection reports, asbestos or tree removal and insurance. And be sure to factor in rental costs if you will need to live elsewhere.

Builders are currently over pricing jobs due to high workload and uncertainty on the supply of building materials. If you are undertaking construction and need funding, tell your lender as they may want to review building contracts and might require the builders' financials and prior tax returns. They may also ask for the contract deposit to be held or provided by alternative means.

If you've built up equity from paying down your home loan, you could use it to fund the renovations with a home loan top up. Other finance options include refinancing your current home loan, using a redraw facility, or applying for a construction loan.

Knowing the current value of your existing house before you decide to go ahead with a renovation, will help ensure you don't overcapitalise.

Knowledge is power so gaining as much insight as possible is the key to making the right choice.

Use a Kooyong Property Report to gain valuable insight into your property's estimated sale value and full transparency of the properties you are considering.

Justin Fung
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Cyberattack: are you prepared?

Imagine receiving a phone call from your IT team or service provider, informing you there's been unauthorised access of the entire patient record by an unknown party. Unfortunately, this is a situation many practices have faced recently and is a reminder for practice owners to be across their cyber security.

The recent Optus and Medibank cyber security incidents are high-profile instances of an increasingly common type of cyberattack using ransomware. This is a type of malware that works by locking up or encrypting files so they can't be accessed until the victim pays the ransom.

Check your preparedness

When was the practice's cyber security last assessed? Practices grow and their operations become more complex over the years, which can introduce new areas of risk. Automated activities that should be occurring regularly need to be checked to ensure that they are still performing properly, otherwise important back-ups and file transfers may not be there to use when you need them (including in the context of a cyberattack).

Long gone are the days when patient records have been stored in hard copy format in filing cabinets, as these records have likely migrated to a cloud-based platform hosted by third-party providers. These third-party providers often employ cyber security experts, however, it is good to understand how they are looking after sensitive patient data in the practice. Knowing how your business collects and handles patient data is essential and requires having the right expertise to advise the practice on privacy and IT security matters.

Signs that risks might increase

Turnover among IT staff could affect the way the business' cyber security systems are audited. This may also affect whether the latest updates to IT platforms are in place.

Are practice employees receiving unusual emails and pop-up messages requesting information? Do they know what to do if they receive a suspicious email? Employees need training and regular reminders on this to avoid complacency, and so they know what to do and how to report potential cyber threats. The majority of cyberattacks start from phishing (email by someone posing as a legitimate institution to obtain sensitive data), which means that every staff member is an essential part of the practice's first line of defence.

Consequences and costs of an attack

The cost to organisations to rectify the impacts of a ransomware attack can be in the millions of dollars. There are the direct costs of items such as the ransom, people's time, lost revenue due to downtime, IT and other consultants, hardware and network costs. In addition, there are the indirect costs of damage to the practice's brand and reputation.

Health sector a prime target

According to a report issued by IBM Security X-Force Threat Intelligence Index, ransomware was the top attack type in 2021 and comprised 21% of all cyberattacks. The health industry was the top sector affected by ransomware, as reported to the Australian Cyber Security Centre[1]. The health sector is a prime target for cyber criminals due to the following:

- Services delivered by the health sector are often critical to the community. Where there's a potential threat to human life, cyber criminals that target health also assume organisations are considerably more likely to pay a ransom.
- Given the general sentiment of trust communities place in medical professionals, cyber criminals anticipate that health organisations are most inclined to do 'whatever it takes' to restore business continuity as quickly as possible.
- Bigger practices operating cloud-based platforms hold sensitive data of many patients. The increased centralisation of data has made it attractive for criminals to target these bigger practices.
- As healthcare organisations are focused on delivering care to patients, cyber security can move down the priorities and practices may gradually become more vulnerable to lower levels of cyberattacks.

Reference

1. Australian Signals Directorate & Australian Cyber Security Centre, Ransomware in Australia, October 2020

Manage your risks of a cyberattack

- ✓ **Are you running up-to-date** end-point security and anti-virus software for all your digital communication and messaging platforms?
- ✓ **How often are you backing up** all of the patient records and related data?
- ✓ Have you **implemented anti-phishing campaigns** and does your business have systems in place to screen, block and restrict websites which may potentially be malicious?
- ✓ What tools do you have in place to continually **monitor for potentially malicious activity** across your systems?
- ✓ Are there **internal protocols and controls** governing who can access certain types of information with different levels of sensitivity?
- ✓ **Are your staff (especially those on the frontline) being regularly trained** and tested on their ability to identify potential concerns and promptly report unusual activity through to the correct channels?
- ✓ Have you got a **business continuity plan** which sets out clear processes and procedures to be implemented in the event of a cyberattack?
- ✓ Do you have **appropriate reporting and governance structures** in place to ensure that key stakeholders are apprised of potential vulnerabilities and relevant regulatory authorities are notified?

Avant resource

Download our Cyber security checklist

Protecting members' data

Avant views member data in the same way doctors and practices view patient data. Protecting your data is a top priority involving people, processes and technologies, including:

- 24/7 security monitoring of the Avant systems landscape
- Annual audits to test the effectiveness of the security controls
- Use of industry leading technologies to create an external defence
- Regular external and internal cyber testing of systems
- Annual cyber security compliance training for staff
- Security management of vendors
- Regular reviews of the types of data stored and for how long.

As the cyber landscape is constantly evolving, Avant is always on high alert to secure and protect your data.

We need your help too. If you become suspicious of a message from Avant, contact us on 1800 128 268.

Privacy breaches and cyber incidents can happen despite your best efforts

Avant Practice Medical Indemnity Insurance^ includes **Cyber Insurance**⁺, protecting against:

- cyber extortion
- privacy liabilities
- damage to digital assets.

Protect your practice, your staff and your data today.
Visit avant.org.au/practices

^Cover is subject to the full terms, conditions, exclusions and limits set out in the Policy Document and policy schedule. Avant Practice Medical Indemnity Policy is issued by Avant Insurance Limited, ABN 82 003 707 471, AFSL 238 765. ⁺Avant Cyber Insurance cover is available up until 20/03/2023 to eligible Avant Practice Medical Indemnity Policy holders under a Group Policy between Liberty Mutual Insurance Company, ABN 61 086 083 605 (Liberty) and Avant. Practices need to consider other forms of insurance including directors' and officers' liability, public and products liability, property and business interruption insurance, and workers compensation. Any advice here is general advice only and does not take into account your objectives, financial situation or needs. You should consider whether the product is appropriate for you and the Policy Document and the Policy Schedule for the relevant product, available by contacting us on 1800 128 268, before deciding to purchase or continuing to hold a policy. Information is only current at the date initially published.

Avant Foundation funds analgesia research

As a seasoned intensive care medicine specialist for over 20 years, Dr Andrew Casamento is passionate about the way sedation and analgesia is provided to his patients.

"It's clear to me that the way we provide sedation and analgesia to our patients is quite random," explains Dr Casamento.

"This can be institutional dependent and within an institution, it can be doctor and nurse dependent."

Dr Casamento's KALME study aims to determine whether ketamine infusion will decrease opioid use in patients. Among other secondary outcomes, they are also assessing if ketamine can decrease the diagnosis of in-hospital delirium and decrease the long-term use of opioids following hospital discharge.

Worsened outcomes in patients

Dr Casamento's previous study published in 2021, the ANALGESIC trial, examined 681 mechanically ventilated patients. It showed that fentanyl was associated with slightly less time in ICU, but otherwise, there was very little difference between the morphine and fentanyl.

"What we did find was that over 40% of patients in this study had a diagnosis of delirium or were prescribed anti-psychotic medications during their hospital stay," says Dr Casamento.

"Delirium has been associated with worse outcomes including prolonged hospital stay and, in some studies, increased mortality."

In addition, the study found that about 6% of patients were still on opioid medications six months after hospital discharge. These patients were not on opioids prior to hospital admission.

Help with analgesia and sedation

Ketamine has a long history of being used as an adjunct for analgesia in conscious patients and has been shown to decrease narcotic requirements in non-ICU patients.

With several feasibility outcomes which are currently being assessed, if the KALME study is found to be feasible, it is likely there will be a plan for a larger, multi-centred study of ketamine for mechanically ventilated patients. Currently, the trial is randomised and consists of ketamine given by infusion versus placebo.

"If ketamine can decrease opioid consumption in our mechanically ventilated patients, then adverse events such as delirium and long-term opioid use may be decreased," says Dr Casamento.

Finding better alternatives

Patient sedation and the use of analgesic agents are not based on large amounts of high-quality clinical data. By studying alternative therapies to minimise unpleasant experiences, the objective is to uncover alternative, positive outcomes.

Adverse effects from fentanyl and opioid use, such as long-term anxiety, depression and post-traumatic stress disorder, will hopefully decrease. As a result, this can mean improved patient care, less risk of delirium and opioid dependence.

"If we can prove that ketamine is beneficial with few side effects, it is likely that I will use ketamine to aid with analgesia and sedation in mechanically ventilated patients more frequently," says Dr Casamento.

Despite a delayed start, the trial commenced in early September 2022 with plans to enrol 120 patients in 12 months.

Lead researcher:
Dr Andrew Casamento
Dr Casamento is an intensive care physician and enrolled part-time in a doctorate program at the University of Melbourne. Dr Casamento is the lead researcher in this study carried out by Austin Health and Northern Health with funding from the Avant Foundation.

> Up to 80% of patients who were ventilated can remember painful experiences in the ICU.
>
> It is possible that these experiences can contribute to long-term anxiety, depression, and post-traumatic stress disorder.

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