Dr Stanley is Counsellor of the NSW Branch of the AMA and President of the Section of Psychiatry. He is also involved with the Ethics and Professional Issues Committees. Dr Stanley is consultant to the Government Health Care Commission and past member of NSW Medical Board. Dr Stanley is on Avant’s Panel of Experts.

Welcome to the sixth edition of Avant Psychiatrist. In this issue we look at the importance of building patient trust.

The issue of trust in Psychiatry and Medicine is absolutely critical for mental health outcomes in our patients. Without patient trust our medical armamentarium is doomed to fail.

This bulletin provides pragmatic advice about dealing with parental disputes over treating children.

Other topics include:
- Pushing professional boundaries.
- Seeking asylum in Australia, an article by Professor Louise Newman.

I hope your find this bulletin informative. Avant welcomes your feedback and ideas on future bulletin topics by emailing editor@avant.org.au.

In this issue:

- Building patient trust
- Producing sensitive medical records
- Pushing the professional boundaries
- Disputes over treating children

Guest writer: Professor Louise Newman
The Doctors’ Health Fund Proposal
We are pleased to announce the Federal Court has formally approved the scheme of arrangement under which Avant will acquire 100% ownership of The Doctors’ Health Fund.

Avant Mutual Group Chair, Dr Stuart Boland, said:
‘Avant Mutual Group looks forward to providing our members and their employees and families with access to The Doctors’ Health Fund’s market-leading suite of health insurance products.’
We expect the transaction to complete in May.

Rewarding your loyalty in 2012
Following the launch of our Loyalty Reward Plan (LRP) in 2010, eligible members are again rewarded for their loyalty in 2012, with premium deductions from 5.5% to 11.0%. Avant’s LRP is a first from an Australian MDO and aims to reward members when Avant’s financial performance is strong.

Not all members are eligible for the Loyalty Reward Plan. Members not eligible include interns, RMO1s and medical students and members who have their professional indemnity policy purchased on their behalf under a corporate group arrangement. For more information please contact member services on 1800 128 268.

DIT research scholarship program
We are delighted to announce the launch of the Avant Doctor in Training Research Scholarships Program. The Avant Doctor in Training Research Scholarships Program has been developed by Avant’s Doctor in Training Advisory Council (DITAC). On offer are two full-time scholarships, to the value of $50,000 each, and four part-time scholarships to the value of $25,000 each. Applications close 5pm on 31 May 2012.
Trust is a key element in the doctor-patient relationship. Patients base trust in their doctor on the belief that their doctor is honest and competent, will act in their best interest, and preserve their confidentiality.¹

Patient mistrust is the result of many things – the media, increased patient autonomy and access to medical information, patients’ social networks and personal experiences, all of which have the potential to impact on patient trust.²

Numerous studies demonstrate that patients with a higher level of trust in their doctor report better health outcomes. This is probably because increased trust and satisfaction in a doctor are associated with a greater willingness to seek care.³ The mechanisms by which trust impacts on health outcomes include compliance, patient disclosure, the placebo effect and doctor’s caring behaviours.³

**Trust and mental health outcomes**

The psychiatrist-patient relationship is vital because the therapeutic relationship can predict long term mental health outcomes and because power and trust have the potential to become imbalanced during the assessment and treatment of the mentally ill.⁴

Research shows if there is a focus on enhancing trust in the psychiatrist-patient relationship, there will be improved information exchange, treatment adherence and mental health outcomes.³⁻⁶

Psychiatric patients emphasise the importance of confidentiality and also report withholding information on substance misuse, dangerous behaviours and non-adherence to medication – all issues of disclosure which may impact on health outcomes.⁴, ⁶ And, when given a choice of treatment, they are more likely to enter treatment and stay in treatment resulting in better adherence – essential for the effective management of psychiatric illnesses.⁴

Mental health patients emphasise the importance of time spent with the psychiatrist and the continuity of care with the same psychiatrist⁶ – greater trust by patients has been associated with a longer duration of treatment with the one psychiatrist and a longer duration of their psychiatrists’ career.⁵

**How to build trust**

Building trust requires paying attention to confidentiality concerns, explaining medication side effects, continuity of care, and consistently meeting patient expectations.⁶ Trust develops over repeated interactions, and as in any relationship takes time to develop.⁷
Trust in a doctor is enhanced:

- with greater duration of the doctor-patient relationship\(^5,\,8\)
- with the perception that effort has been made to understand patient experiences\(^8\)
- when doctors communicate clearly and completely\(^3\).

The Royal Australian College of General Practitioners (RACGP) offers a guide to managing difficult relationships.\(^9\)

The ‘ABCDE’ approach:

A. Acknowledge the problem
B. define Boundaries and seek the patient’s acknowledgement and agreement
C. show Compassion
D. Determine the meaning of the visit - every patient comes with a pre-set belief about what could be the problem and what might be the solution
E. Extend the system – refer or seek second opinion

For psychiatrists, patient trust is not just a lubricant to decrease disputes, prevent possible lawsuits, and increase a patient’s satisfaction, but it also plays a critical role in the one thing doctors are concerned with most – patient health outcomes.

References

Case study: Producing sensitive medical records

Georgie Haysom – Special counsel Medico-legal Advisory Service/Health law

Subpoena requested

We recently assisted a psychiatrist member with an application to set aside a subpoena for production of medical records relating to a patient. The patient, K, was asked to be a witness in a criminal trial. K had been a patient of our member for several years, having first been referred following a traumatic incident unrelated to the issues in the trial. The diagnosis was of mood disorder. K had given evidence at the committal hearing which led to an exacerbation of K’s symptoms. By the time the trial was due to take place, K’s condition had deteriorated to such an extent that in the opinion of our member, K was unfit to give evidence in court, and would remain so for the long term. Our member provided a medical certificate to the court to this effect. Based on our member’s opinion, the prosecution team sought to rely on K’s evidence at the committal hearing and a previous statement rather than call K to give evidence at the trial.

The accused’s lawyers issued a subpoena to our member seeking production of medical records relating to K. K was extremely distressed by the prospect that our member’s medical records would be released to the accused and the accused’s lawyers. As a result, K felt unsafe seeking treatment from our member and advised our member that the therapeutic relationship could not continue.

On behalf of our member, we filed an application to set aside the subpoena on the grounds that it had no legitimate forensic purpose and that the production of the medical records would be detrimental to K’s psychiatric condition. The application was supported by an affidavit from our member.

Extensive legal argument on the issues was unnecessary because the prosecution decided not to call K as a witness in the trial. Consequently, there could be no legitimate forensic purpose for production of the medical records, and the subpoena was withdrawn.

Medico-legal advice

Members often express concern about producing medical records in response to a subpoena where the records contain sensitive material. Frequently, this concern is expressed in the context of psychiatric records, often in family law proceedings, but also in civil and criminal trials. Usually these issues arise when one party seeks psychiatric records relating to the opposing party, but as our case study shows, the records of witnesses can also be sought on subpoena.

In our experience it is difficult to have subpoenas for production of medical records set aside on the grounds that the material is sensitive. Generally the party issuing the subpoena need only establish there is a legitimate forensic purpose for the subpoena and that is sufficient.

However, various other mechanisms may be used to protect the sensitivity of the material – for example, orders may be sought to limit access to the documents to legal advisors only. Where the records sought are those of a party in the proceedings, the party’s lawyers are the ones who would usually apply for orders limiting or prohibiting access to the clinical records. Failure to comply with a valid subpoena is a contempt of court, so if you are concerned about the production of sensitive material, seek advice from Avant’s medico-legal advisory service on 1800 128 268.

Avant Psychiatrist Issue 06 – May 2012
Pushing the professional boundaries – financial interactions with patients

Michael Wade – Special Counsel, Medicare

It is generally well recognised by psychiatrists that sexual boundary violations are unethical and will amount to professional misconduct. The ‘zero tolerance’ policy of the RANZCP provides that sexual relationships between psychiatrists and their current and former patients are always unethical. Psychiatrists are alert to indications of ‘transference’ and ‘counter-transference’ which may lead down the slippery slope of intimacy towards a sexual boundary violation, but how does one assess the risk of non-sexual boundary transgressions occurring?

What might give rise to a boundary transgression of a financial nature? We pose some hypothetical questions and answers for your consideration.

Case one

A patient tells his psychiatrist he is moving interstate and is selling his home. The patient’s care will be transferred to an interstate colleague. The patient is keen to find a buyer for his house, a beautiful old home in a great location – exactly what the psychiatrist and her family have been looking for. Following their final consultation, the psychiatrist expresses to the patient an interest in purchasing the patient’s home.

Is the psychiatrists’ conduct appropriate?

Does it matter if the home is publicly auctioned or sold privately? Does it matter whether the psychiatrist actually purchases the house?

The RANZCP Code of Ethics states ‘exploitation of patients, whether physical, sexual, emotional, financial or through other benefits is unacceptable; the trust embodied in the doctor-patient relationship must be respected’.²

Is this exploitation? Given the psychiatrist waited until the therapeutic relationship with the patient had ended, the psychiatrist’s expression of interest in the property may be unlikely to affect the patient’s future treatment but that can not be discounted completely. Significantly, there remains a power imbalance which could influence the patient in her negotiation of the sale and which opens the psychiatrist up to an assertion of impropriety.

Financial transactions go bad for many reasons. Property prices can suddenly rise or fall, or there can be unexpected ‘discoveries’ made by a purchaser which may necessitate an ongoing interaction between purchaser and vendor or legal action. Even if the sale of the property has no affect on this patient’s on-going treatment, a dispute with her former psychiatrist may. That risk exists whether negotiation of the sale is private or by auction.

In any circumstance, involvement in a financial relationship with a current or former patient – particularly one as significant as the sale of a house – permits of confusion between the financial and professional relationships and an allegation of exploitation.
Case two

A psychiatrist treats a director of a large public company for acute depression. The patient reveals in the course of treatment that the cause of her current stress is dealing with a potential takeover offer that is likely to be made for the company. Unknown to the patient, after the consultation, the psychiatrist invests in the company.

Has the psychiatrist acted appropriately?

The psychiatrist’s actions are unknown to the patient so are unlikely to affect the patient’s perception of the therapeutic relationship or to lead to a complaint by the patient. There is no improper financial relationship between the patient and the psychiatrist.

However, the psychiatrist’s actions are blameworthy for two reasons:

• The psychiatrist has used information for his own benefit which was provided by the patient in confidence for the purpose of facilitating treatment and in so doing has breached the patient’s privacy – and possibly breached securities law.

• By introducing the distraction of profit into his treatment of his patient the psychiatrist has blurred the boundaries of the professional relationship and could open the psychiatrist up to an allegation of exploitation of the therapeutic relationship for their own benefit.

Financial dealings of all types involve risk, both foreseeable and unforeseeable. By allowing confusion to arise between the boundaries of the professional relationship and a financial one, psychiatrists expose themselves to unnecessary and often unforeseeable risk to their professional practice.

References


Dealing with parental disputes over treating children

Andrew Took – National Manager Medico-legal Advisory Service

An inquiry we receive (not infrequently) from psychiatrists involves disputes between parents over the treatment of their child.

In such circumstances the parents are often separated and have an acrimonious relationship. Once they learn of the proposed treatment (usually from the child on the next occasion they spend with that parent) they contact the psychiatrist demanding that treatment be modified, or a medication be ceased. In one recent example a child had been receiving treatment for attention deficit/ hyperactivity disorder and our psychiatrist received an email threatening legal action unless the prescription of psychostimulants ceased.

So … how do you proceed when you’re faced with conflicting demands from parents?

The basics

In all states and territories a child is defined as a person under the age of 18 years.

Depending on the circumstances, consent to medical treatment for a child may be given by:

1. the child – a child or young person can give valid consent to treatment when the child has achieved a sufficient understanding and maturity to enable them to understand fully what is proposed. This is known as ‘Gillick competence’ or the ‘mature minor’ doctrine. The onus is on the treating medical practitioner to establish that the child or young person has sufficient maturity to consent to treatment.
2. a parent or guardian
3. the court.

In general, a guardian of a child – usually a parent – has the authority to consent to or refuse medical treatment and procedures provided it is in the best interests of the child, unless:

- the child has the capacity to make decisions themselves – a ‘mature minor’
- court authority is required – e.g. gender reassignment
- the procedure is illegal – e.g. female genital mutilation
Both parents have authority to consent to treatment for their child unless there is a parenting order of the Family Court. Consent of either parent will generally be sufficient and a psychiatrist is entitled to assume that there is no issue concerning which parent is responsible for the care of the child. However, if it is brought to your attention that the parents are separated or divorced, it is often prudent to enquire whether there are any parenting orders giving authority to one parent. The rights of the parents to consent to treatment diminish as the child grows towards emotional, cognitive and chronological maturity.

**Between a rock and a hard place ...**

As a psychiatrist you can find yourself in the middle of an acrimonious situation where one parent consents to treatment and the other objects. In our experience it is important in these circumstances to communicate with both parents and set clear ground rules to avoid an impasse developing which may put the child’s health at risk. This might include involving one or other parent in any consultation by telephone. In cases involving serious communication breakdown between parents, perhaps even where threats of legal action may have been made against you, we recommend you turn to Avant for assistance. In situations such as these we have drafted letters on behalf of our psychiatrist members asking the parents to obtain resolution of their disagreement over treatment decisions for their child by court direction.

As with adult patients, a medical practitioner can treat a child without their consent or the consent of the parent or guardian wherever there is an imminent risk of death or serious injury, or where the treatment has been authorised by a court order or legislation.

As always with situations of this type, sensitivity and common sense go a long way towards helping to resolve the issue. If you find yourself between that rock and a hard place, don’t hesitate to seek our assistance. Call our Medico-legal Advisory Service on 1800 128 268. We have plenty of experience!

**References**

1. See for example section 45 Crimes Act 1900 (NSW)
2. The Family Law Act 1975 (Cth) states that each parent has parental responsibility (that is, all duties, powers, responsibilities and authority which, by law, parents have in relation to children) for their children (section 61C).
3. The Family Court may make parenting orders that may alter parental responsibility, by conferring duties, powers, responsibilities or authority in relation to a child on either parent or another person, but only to the extent provided for in the order (section 61D). A parenting order relating to responsibility for the long-term or day-to-day care, welfare and development of a child is termed a ‘specific issues order’ (section 64B). Medical or paramedical treatment would fall within the scope of a specific issues order. Other orders that may be made by the court are contact orders, residential orders and child maintenance orders.
Mandatory detention of asylum seekers who arrive by boat to Australia continues to provoke debate and concern.

Provision of health and mental health services in detention centres, many of which are in remote areas, is a major challenge. The asylum seeker population is one of high risk with common pre-migration experiences of persecution, exposure to conflict and violence, traumatic loss and torture. Children and adolescents are particularly vulnerable with loss of carers and traumatic exposure. Around half of child asylum seekers in Australia are unaccompanied without adult carers.¹

Detention in off-shore and remote facilities has raised issues about the impact on detainees and difficulties for staff and clinicians. Mental health and outbreaks of self-harming behaviour and protest have raised concerns about the potential harm of detention.

Psychiatrists and mental health professionals have played a major part in raising clinical and ethical concerns around detention and its impact on vulnerable groups. Since 2000 psychiatrists and child psychiatrists have undertaken research and clinical work with detained asylum seekers, contributing to the body of evidence about the prevalence of mental disorder in these groups and the impact of detention. Unsurprisingly, mental disorder in asylum seekers is related to both pre-migration experiences and experiences during flight. Detention, particularly if prolonged, is related to mental deterioration. Lack of resolution of refugee status and uncertainty about the future are associated with persistent anxiety, depression and increasing hopelessness.² Suicidal behaviour and self-harm are common, with five deaths within detention centres since September 2011 under Coronial enquiry.³

Clinical and ethical dilemmas

Working with detained populations raises complex clinical and ethical issues for psychiatrists. First, the capacity to treat psychiatric conditions arising in detention is limited. Psychiatrists have little control over the length of detention, lack of status resolution and conditions of the detention environment. If systemic and environmental factors contribute to mental deterioration then traditional clinical approaches lose efficacy. Some symptomatic relief may be given but this does not prevent ongoing problems. Responding to self-harm and protest is also complex and understanding this behaviour as a result of distress and frustration is important.
For clinicians, advocacy is a core component of professional ethics and practice and this is particularly difficult with asylum seekers and has become highly politicised. Major health bodies have stated that reform of immigration law and the policy of mandatory detention are necessary and have called for community placement and treatment of vulnerable groups.

For mental health clinicians the detention context challenges the traditional model of trauma and self recovery. The model of post-traumatic stress disorder applied to individuals has less utility when talking about trauma across a whole community or group. Cultural variations in the expression of distress and experience of trauma prompt exploration in frameworks which are broader than western diagnostic approaches. Socio-political interventions potentially transcend the individualistic psychological models of western psychology.

Research on detained populations is inseparable from consideration of the appropriateness of detention. Thus research cannot be value free – a strong argument supports making explicit the values that underlie and influence the research agenda. Researchers may strategically highlight the predicament of detained asylum seekers by documenting mental health impacts of detention and critiquing detention policy and practice. Such findings are vital to discussion about policy reform and better practice. Issues of informed consent in detention and possible negative consequences to participants are serious and complex: individuals need to be fully aware of the research questions and process and consequences of participation.

Déjà vu

Immigration detention has once again become a key political issue following a period of relative calm in the system. Increasing numbers of boat arrivals have prompted a political debate about factors influencing asylum seeking and those which might deter it. In the face of increasing numbers of detainees, many with a history of torture and trauma and significant numbers of unaccompanied minors, concerns have again been raised about the mental damage caused by detention and the impact on children. Attempts to provide psychological support and increase mental health services confront the problems of treating in a damaging environment. Increasing numbers of ‘failed’ asylum seekers and long stay cases will have a major impact on the operation of detention centres and the rates of protest, disturbance and mental disorder. Attempted suicides and suicidal behaviour are endemic in detention centres and are related to increasing despair and hopelessness. The challenge appears to be one of re-creating some level of psychological and empathic understanding of the plight of the asylum seeker and of the impact of mandatory detention. The sense of déjà vu is strong for those who have been involved in these issues over the last decade or more.

References


3. Coroners cases still before the court.


Please refer correspondence to Professor Louise Newman: louise.newman@monash.edu
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Risk Management Toolkit

Avant's online Clinical Risk Management Toolkit is designed to educate and support members on contemporary practice issues including related topics in this bulletin:

- Difficult doctor-patient relationships
- Complying with subpoenas
- Boundary violations
- How to proceed when ‘consent’ is unclear – treating children and young adults

Visit www.avant.org.au and login to the Members Only section using your User ID and password. Then click on ‘Risk Management’ and ‘Tools and Resources’ factsheets.