SPRING 2026

Defenceupdate

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Medico-legal content

FOR MEDICAL PRACTITIONERS

MDA National

Support Protect Promote

Nerissa Ferrie
Senior Manager
Medico-legal Advisory

Welcome to our Spring 2026 edition of *Defence Update*.

It is easy to become overwhelmed by the sheer volume of content available in the world right now. How we choose to consume media – and knowing whether we can trust the information we receive – is a constant challenge. The way we access information has changed, and although we are saying farewell to the print edition of *Defence Update*, we will continue to produce the clear and concise medico-legal content that has informed generations of MDA National Members.

One of the key benefits of membership in a doctor-owned mutual is the doctors-for-doctors ethos that underpins everything we do. Dr Michael Gannon talks about the value of this clinician-led approach when you need support and advice (page 3). Your membership offers more than reliable insurance cover, and Dr Helena Gawlinska has been kind enough to share her experience of working with Street Side Medics and her passion for giving back in a meaningful way (page 4).

On a practical note, we provide guidance on common medico-legal issues including writing reports for the coroner (page 6), conscientious objection (page 9) and requests for treating doctor reports (page 10). We look at voluntary assisted dying (page 12) and ADHD prescribing (page 8) across the various states and territories, and we take a deep dive into requests for medical records in our Medico-legal Feature (page 13).

Members value case studies that provide practical insight, so in this edition of Case Book we focus on three challenging scenarios: responding to threats (page 18), fitness to drive (page 20), and what to do when you receive a regulatory notification (page 22).

In our First Defence section, we are fortunate to offer our junior segment the benefit of Dr Maria Li's expertise when it comes to social media (page 24). We also take a look at the special mentor relationship between Dr Shev Dias (2026 Rhodes Scholar) and Dr Dror Maor (page 26).

I would like to thank you all for embracing and supporting *Defence Update* over many years. As spring arrives, I hope you enjoy this final print edition of *Defence Update*. Keep an eye out for more informative medico-legal content on our website: **mdanational.com.au**.

In this edition

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We thank all our in-house experts and guest authors for their valuable contributions to this edition.

FROM THE PRESIDENT
A message to our Members

Dr Michael Gannon
President, MDA National

Dear Members,

One of the things that sets MDA National apart from competitors is the deep involvement of medical practitioners across our business. I chair a Mutual Board of our colleagues who come from a variety of medical specialties, spread across four states.

Our two Cases Committees meet regularly, where our in-house legal team receives input and advice from senior specialist doctors. Our Eastern Cases Committee is chaired by General Surgeon Professor Michael Hollands. Our Western Cases Committee is chaired by Anaesthetist Dr Andrew Miller.

I recently participated in interviews to recruit a new Senior Manager within our Clinical Services team. We also have other doctors working part-time or full-time in the office, ensuring medical expertise is readily available to our other staff.

Our Clinical Underwriting Committee chaired by Dr Andrew Perry, an Emergency Physician from South Australia, brings together doctors in practice and our underwriting team. They inform many of the decisions we make about the coverage we offer. In recent months, we have been discussing what good medical practice is, and how it relates to the workings of our doctor-owned organisation.

The Medical Board of Australia defines its code of good medical practice as: *"what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community".*

Most of us know what good medical practice looks like. But as our healthcare system becomes increasingly consumer driven, we have to consider how this impacts on our insurance policies.

When I first joined the MDA National Board, we had levels 1 to 10 of coverage which fitted neatly with different specialist crafts, largely defined according to whether our member was a Fellow of the College of General Practice or another specialist College. An increasing proportion of doctors no longer fall neatly into one of those 10 discrete groups.

With the massive expansion in the number of our medical graduates, and the lack of investment as a nation in general practice and other specialist training positions in our hospitals, more doctors are seeking alternatives to traditional career pathways. We have also seen tremendous growth in the number of international medical graduates working in Australia.

The greatest change is in deciding whether or not to underwrite policies for areas of 'medicine' that do not necessarily fall neatly into the definition of 'medical care'.

For instance, is it up to MDOs to determine that asynchronous internet-based prescription of peptides, sex steroids or cannabis is not good medical practice? Or should Ahpra and the Medical Board decide on standards, leaving us to set a price for every endeavour a registered medical practitioner in Australia might choose?

At the heart of our deliberations is the question: Is it our job to regulate the practice of medicine?

Clearly, we are not the regulator. But it is certainly in our interest to share our insight and expertise to promote safe medical practice. In this way, we protect our Members and also maintain the financial security of our business.

These decisions and conversations are nuanced. We are fortunate to have a large number of skilled and dedicated doctors working at different levels of the business to ensure we remain a strong, robust and well-capitalised organisation. It is one that I remain extremely proud to lead. It is one that our Members should also be very proud of.

Meeting people where they are

Dr Helena Gawlinska and the passion for volunteering

Renata Alves & Marnie Bird
Corporate Affairs & Communication

Dr Helena Gawlinska trained and practised in the UK for almost 30 years before making Australia home in 2009 – a move she has never regretted. Working as a GP, she still enjoys the flexibility and the very human side of her career, including volunteering with a purpose through one of MDA National's key social impact partnerships, Street Side Medics.

How would you describe your day-to-day life as a General Practitioner?

It's always interesting – you never quite know what will come through the door. You see people from all walks of life. A large part of my role is being an advocate for patients, helping them navigate complex health pathways, and coordinating their care. It's important to ensure they're supported in the system and don't get lost, because that can easily happen.

How did you first hear about Street Side Medics, and what made you volunteer with them?

I was actively looking for volunteer medical work, so I did a bit of Google search around 2022 to see what was out there. When I came across Street Side Medics, I immediately felt it aligned with my values. I initially made a donation, and I also put my name down as someone willing to volunteer. I joined at the very start of the Marrickville clinic in early 2023. I really value the outreach model which is taking healthcare to people who might otherwise miss out. It does feel like authentic general practice.

How is your day-to-day experience with Street Side Medics?

I volunteer about one or two sessions a month, and my regular clinic is in Woolloomooloo. I'm always happy to step in if there's a cancellation or a doctor is unwell at short notice. I've now worked across four clinics, and each one is quite different in terms of the community it serves. The team leaders are outstanding. They provide essential clinical oversight and continuity of care, which means patients are known, remembered and supported. Our volunteers and support staff do so much of the work that breaks down barriers – building relationships, encouraging people, and creating a safe space where patients can be seen; even if they don't have a Medicare number, or feel uncomfortable sharing their real name. In a traditional setting, those people might be turned away.

What are the challenges of volunteering with Street Side Medics?

I think a lot of it is around the uncertainty. These challenges rarely exist in isolation, so you have to prioritise what you can help with in that moment. It's about understanding what matters most to the patient, building trust over time, and staying non-judgemental, open and encouraging. That's very different from routine general practice, where the concerns can sometimes be relatively minor; whereas here, patients often have multiple significant health and social issues happening all at once.

Is this something you've always wanted to do? Have you volunteered before?

Yes. I've always had a strong urge to volunteer. On the medical side, I've been on a couple of short-term missions: one to Vanuatu, working on a boat; and another to Fiji. Outside of medicine, I volunteered with OzHarvest for about eight years here in Sydney. I started by helping with their *Cooking for a Cause* program, usually about twice a month, mostly washing up... and honestly, I'm not very good at it!

When you think about social impact on healthcare, what does that look like for you?

It's about meeting people where they are. It means putting judgement aside and offering respectful, compassionate care – which is exactly what I see everyone at Street Side Medics doing. The impact happens in small, steady steps. A big part of it is restoring trust; helping people feel healthcare is safe, supportive, and there for them.

Have you ever needed support from MDA National – for example, calling for advice, or any interactions with the team?

Yes. Since joining MDA National – I think about seven years ago – I've called a couple of times for advice. Thankfully, I haven't had any complaints (touch wood). But whenever I've needed guidance, the team has always been very good, helpful, sensible, and easy to talk to.

A COMMITMENT TO SOCIAL IMPACT

MDA National launched their official partnership with Street Side Medics in May 2025, undertaking the combined goal of bringing healthcare directly to communities that need it while contributing to a broader vision of a better future for all.

Since commencement of the joint venture, MDA National has extended support beyond the linear financial realm. We are assisting Street Side Medics in reaching potential volunteers through our membership base, as well as facilitating access to established educational resources and medico-legal expertise when required.

As part of our broader Environmental, Social and Governance (ESG) Strategy, MDA National is highly committed to strengthening communities where we live and work, with an important key focus on partnering for healthier communities and Indigenous reconciliation.

For MDA National, making a long-term impact starts here and now.

Writing a report for the coroner

Daniel Spencer
Case Manager (Solicitor)

Dr Sarah Taylor
Clinical Support Adviser

Reports prepared for the coroner play a critical role in the investigation of reportable deaths in Australia. Medical practitioners are frequently required to provide reports that assist the coroner in determining the identity of the deceased, the cause of death, and the circumstances surrounding the death.

The coronial process

Coronial systems in Australia operate under state and territory legislation, commonly titled the Coroners Act.

The primary function of the coroner is to:

- determine the identity of the deceased;
- establish how, when and where the deceased died and the medical cause of death; and
- make findings and recommendations aimed at preventing future deaths.

While specific provisions vary by jurisdiction, the fundamental role of the coroner is consistent – to investigate certain categories of death, including unexpected, violent or unnatural deaths, and deaths occurring in custody or care.

The primary aim of the coronial process is not to look to blame specific parties for the death. The process is geared to explore potential systemic issues that may have contributed to the death, and to make recommendations to prevent future deaths.

That said, the coroner can, and does, report medical practitioners to Ahpra in circumstances where a practitioner's conduct or performance may have fallen below accepted professional standards.

Medical practitioners may be required to provide clinical records of the deceased and/or a report when they were involved in the clinical care of the deceased, when they attended the deceased prior to death, to clarify medical issues relevant to the death, or when they are involved in death certification where cause is uncertain.

Where will the request come from?

A request for a report or a statement may come from the coroner directly or from a police officer acting on behalf of the coroner. Who the request is sent by does not impact on a doctor's duty to cooperate.

You should always contact MDA National for advice when responding to a request for records or a report.

Consent from the executor of the will of the deceased, or from family of the deceased, is not required when providing records or a statement. Privacy legislation does not override coronial powers.

The obligation to cooperate with the coroner is set out in paragraph 10.11.3 of the Medical Board Code of Conduct:

Good medical practice involves:

10.11.3 Assisting the coroner when an inquest or inquiry is held into a patient's death by responding to their enquiries and by offering all relevant information.

Where do I start?

A coronial report/statement should generally include:

- an introduction, setting out your name, professional address, and who has requested the statement;
- a summary of your qualifications and experience;
- a summary of the care provided to the deceased (including the period in which you saw them), presenting complaints, medications prescribed, specialist referrals made, and your last contact with the deceased. Where care has been provided by other practitioners, this should be noted. If the outline of the care set out in the statement has been limited to a specific period of time (at the request of the coroner), this should be acknowledged in the statement;
- a response to any specific questions asked by the coroner;
- an expression of condolence to the family of the deceased; and
- a declaration that the contents of the statement are true to the best of your knowledge and belief.

If you are not provided with a proforma by the hospital, or there is no other prescribed form or document you are asked to use, you can access a general proforma at: **mdanational.com.au/writing-coroner-report**.

The length and detail of your statement will vary according to the extent of your involvement in the care of the deceased. MDA National can assist you to determine the level of detail appropriate for your statement. Often, you might be one of several doctors providing a piece of the puzzle; it is part of the coroner's role to piece the entire story together.

Do I need access to the medical record?

When preparing a statement, it's important to refresh your memory from the medical records. You should never prepare a statement without having access to the records.

In most cases, the coroner is not a medical professional but usually has a legal background. Therefore, the statement should not just explain what medical care occurred but should also seek to explain why certain decisions were made. Medical jargon and abbreviations should be avoided or, if necessary to use, explained in layman's terms.

When will I hear further?

Once a statement has been provided to the coroner, you may not receive any update for up to (and sometimes more than) a year due to significant backlogs at coronial offices nationwide. If the patient's cause of death is determined and issued to the deceased patient's next of kin, you may not hear anything further at all.

The majority of matters in which statements are provided are usually finalised at the investigation stage. Less than 5% of deaths reported to the coroner proceed to an inquest. Inquests are usually held when:

- the death raises public safety concerns;
- there is uncertainty or controversy; or
- systemic issues warrant further examination.

For further information about the coronial process, please see the articles below on our website and contact our Medico-legal Advisory Services team for advice:

Coronial matters involving hospital doctors

When the coroner calls

When should I report a death to the coroner?

ADHD prescribing

Dr Karen Lam
Clinical Support Adviser

Michelle Nguyen
Medico-legal Adviser

Attention deficient and hyperactivity disorder (ADHD) has doubled in diagnosis, with an increase of 300% in stimulant prescriptions over the past ten years.[1] Demand has outpaced patient access to psychiatric review for diagnosis and treatment, prompting significant reforms to ADHD prescribing across several jurisdictions.

Stimulant medications such as dexamfetamine, methylphenidate and long-acting versions are used to treat ADHD, although non-stimulant treatment options exist. Stimulant medications are schedule 8 (s8) medications and subject to different state or territory regulations governing authorised prescribers, maximum doses, patient age restrictions and mandatory approvals, authorisations or permits.

PBS prescriptions

Practitioners issuing PBS prescriptions are subject to PBS requirements governing clinical, patient population and treatment criteria, which vary between stimulants. These are distinct from s8 state and territory regulations. All PBS stimulant prescriptions require a PBS authority number.[2] There are maximum allowable specific quantities, doses and frequency of repeat prescriptions under the PBS.

Real-time monitoring systems

Prescribers in Victoria,[3] South Australia,[4] Queensland,[5] Northern Territory[6] and Tasmania[7] must use real-time monitoring systems when prescribing stimulant medications. Prescribers of schedule 4 (s4), s8 and other monitored medications in Western Australia must be registered with ScriptCheckWA, effective since 12 June 2025.[8]

Impact on fitness to drive

ADHD can impair a patient's driving ability due to deficits in planning and prioritising tasks, sustaining and shifting focus, and emotional regulation;[9] and its impact is individualised. The type of vehicle and licence class also informs this. Patients must report a diagnosis of ADHD and any associated medication use to the relevant road traffic authority. Practitioners must make a report when a medical condition can affect their patient's driving ability in some jurisdictions. Specific requirements are detailed in Austroads national driver medical standards.

New state and territory regulations

Prescribers should be aware of these additional requirements in addition to jurisdiction-specific requirements. Queensland, Western Australia, South Australia, New South Wales, Tasmania, Victoria and the Australian Capital Territory have announced significant regulatory changes. These reforms enable specialist general practitioners (GPs) to initiate and continue managing stimulant medications for treating ADHD, subject to completing additional training. Specialist GPs who have not completed this training must continue abiding by the regulations governing shared care or co-prescribing.

Medical practitioners have been able to initiate, titrate and prescribe stimulants for ADHD treatment in Queensland with no additional training requirements since 1 December 2025. This includes psychostimulant prescribing without prior approval by non-specialist medical practitioners.

All prospective stimulant prescribers must be aware of all applicable regulatory requirements that impact their prescribing. See our online article (**mdanational.com.au/adhd-prescribing**) for details of legislative requirements across various states and territories.

Approvals, authorisations or permits

Stimulant prescribers in some states[10] and territories[11] must obtain approvals or authorisations in certain circumstances. This includes prescriptions exceeding maximum permissible daily doses[12] or age limits.[13]

Interstate prescribing requirements apply

Interstate prescribing requirements vary between jurisdictions. Interstate stimulant prescriptions are valid in certain states or territories,[14] while others are not.[15] Prescriptions may require ongoing approval or authorisation requirements.[16]

View the references online: **mdanational.com.au/adhd-prescribing**

Conscientious objection in medicine

Doctors are entitled to hold their own personal beliefs and morals. But what happens when there is a conflict between your values and your professional and legal obligations to a patient?

Kate Rowan-Robinson
Medico-legal Adviser

Conscientious objection is generally not defined in legislation. In a medical context, it is commonly considered to be an action that occurs when a doctor declines to provide legal medical treatment (or a procedure) due to a sincerely held conflict with personal beliefs, values or morals. Doctors are not obliged to provide or participate in medical care to which they hold an objection; however, certain requirements must be upheld to avoid regulatory complaints or legal action.

The Medical Board Code of Conduct requires doctors to ensure their patient's access to medical care is free from bias and discrimination. Doctors need to be aware of any conscientious objections they hold, and ensure their patients (and if relevant, their colleagues) are informed of their objection. A conscientious objection cannot be used to impede patients' access to legal healthcare, and doctors should be aware of any legislation that may require them to refer a patient (or take certain steps) if they do not wish to participate in a certain type of medical care.

For example, doctors who conscientiously object to termination of pregnancy may be required to provide information on how the patient can locate an appropriate practitioner, or immediately refer the patient to another doctor who can provide the service. Personal beliefs should not be expressed by the doctor in a way that may cause a patient distress or fracture the therapeutic relationship.

Additionally, conscientious objectors must not obstruct or delay a patient's access to medical care by ordering unnecessary tests or referring the patient to a service that does not provide the relevant medical treatment. It may be useful for doctors to know colleagues who will be able to provide the relevant health service to the patient.

For doctors who hold a conscientious objection, consideration also needs to be given to their employer and ongoing management of health services. Steps should be taken to inform employers of a conscientious objection and to minimise disruption to health service delivery when an objection is invoked. In a medical emergency, doctors still have a duty to provide appropriate treatment, even if they hold a conscientious objection.

Doctors can uphold a conscientious objection, but should be aware of legislative, regulatory and professional standards when providing medical care. While doctors may not be required to provide a health service they object to, they may be required to provide information, refer the patient to a suitable practitioner, or provide emergency medical treatment.

Employers can assist with managing conscientious objections and minimising disruption to patients and health services. Taking these steps can allow doctors to hold their own beliefs and protect themselves from legal or regulatory action.

The Medical Board Code of Conduct requires doctors to ensure their patient's access to medical care is free from bias and discrimination. Doctors need to be aware of any conscientious objections they hold, and ensure their patients (and if relevant, their colleagues) are informed of their objection.

View the references online: **mdanational.com.au/conscientious-objection**

Reports from treating doctors

Dr Julian Walter
Career Medical Officer

A request for a medico-legal report from a treating doctor is a normal, albeit time-consuming, part of medicine. Knowing what sort of questions are best left to others is an important strategic consideration. Responding to unnecessary or inappropriate questions can take up valuable time.

Do I have to provide a report at all?

If you have been involved in the care of a patient, obtained relevant consent, have access to suitable records, and a reasonable fee is offered for your time, it will generally be appropriate for you to provide a report which summarises your care of the patient. Failure to provide a report can result in regulatory complaints, particularly if there is no other appropriate care provider who can produce the necessary information.

If agreement on fees cannot be reached, or no other suitable treating doctor is able to assist, then one option is to suggest that records can be made available (with relevant consent) for the requesting party to brief an independent expert to provide a report. Consider seeking advice from MDA National if declining to provide a report where no other alternative is available.

Independent expert versus treating doctor

Treating doctors are not 'independent experts'. A treating doctor report will provide a relevant factual chronological history, and historic clinical opinion (diagnoses, prognosis). The report may also draw on information in the medical records from other health practitioners, including specialists and allied health.

If the information sought is outside the expertise of the treating doctor (and not contained in medical information on the file), then it may be appropriate to suggest that the requesting party seek a separate report from other treating specialists who are in a better position to provide an opinion.

If you provide an opinion, make sure it is clear what facts underline your findings. While opinion evidence can be given by treating doctors, there are many circumstances where this isn't appropriate. Information sought on some issues is better provided by an independent expert – for example:

- causation (did the health outcome arise from a specific situation, or did other issues outside of your knowledge contribute to the injury);
- where you are asked to critique the care of others, or your own care;
- apportionment (what percentage of the health outcome is attributable to a specific cause); or
- the assessment of permanent impairment (a very specific assessment skill).

In addition to the guidance provided by our previous article (*How to write a medico-legal report*),[1] you should indicate early in the report that you are providing the information in your capacity as a treating doctor, not as an independent expert. You should also make reference to any information you don't currently have access to, which might better inform your conclusions.

List the question you are answering so your report can be read as a standalone document. Some questions may be difficult to answer. If asked about prognosis, for example, the best answer may be: "at the present time, the prognosis is guarded". You may be reluctant to respond when the question is outside of your knowledge or expertise, in which case it may be best to decline and suggest the question be posed to a specialist.

View the references online: **mdanational.com.au/treating-doctor-reports**

All doctors have professional obligations under section 10.9 of the Medical Board Code of Conduct when providing reports, certificates and evidence. These include being honest and accurate, making reasonable steps to verify content, clearly indicating the limits of your knowledge (and not giving opinions beyond this), not misleading, and not omitting relevant information deliberately.

This professional obligation can be relied on if you need to set boundaries around patient requests to withhold or include specific information you do not agree with. It is vital that you communicate the source of information throughout the report and restrict your opinion to medically relevant details.

Be careful of stating information in a way that looks like you are the source of the information, or that it is an established fact (short of a judgment, court order or official finding) when dealing with collateral information. You otherwise risk a complaint from others impacted by your report.

What if a treating doctor is provided with information for the report?

Most information provided would be clinically relevant and would therefore need to be stored in the patient file (to which the patient has a right of access). This additional material should be referred to in the report.

If you are provided with material (e.g. surveillance footage) but you are directed to not share this material with the patient, seek early advice from MDA National before you review the footage.

What information should not be provided?

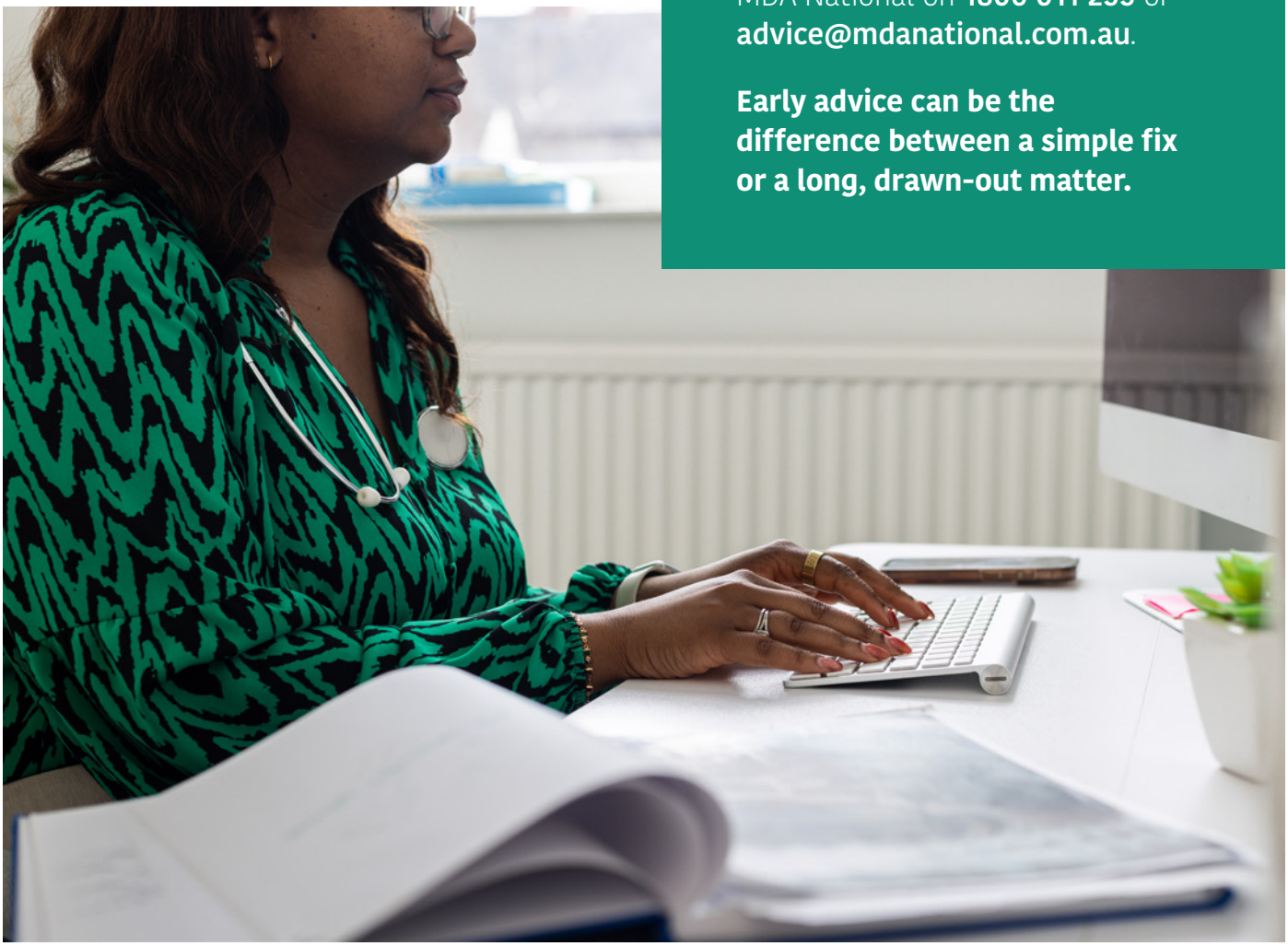
Treating doctor reports should generally be limited to factual and opinion clinical evidence. It is not a doctor's role to conduct an investigation into issues which may later be the subject of a finding of fact in court.

The patient and their legal representatives will typically capture non-clinical information in a witness statement or an affidavit (the workplace injury, the alleged assault, the motor vehicle accident, etc).

Providing detailed and non-clinically relevant information in a report (and even recording it in the notes) can expose the patient to a finding of a prior inconsistent statement, if the non-clinical details are different to what has been reported elsewhere.

For complex matters, contact our Medico-legal Advisory team at MDA National on **1800 011 255** or **advice@mdanational.com.au**.

Early advice can be the difference between a simple fix or a long, drawn-out matter.



Voluntary Assisted Dying

A year in review

Nicole Golding
Senior Manager, Dental Claims & Investigations (Solicitor)

Voluntary assisted dying (VAD) has become an established part of end-of-life care across Australia, with all states and territories now offering legal pathways for eligible individuals to access this option. The past 12 months have marked a significant period of consolidation and expansion as states and territories refine their approach and share their learnings.

Common themes across all jurisdictions include the importance of care navigator roles, ongoing training for medical practitioners, and the need for clear communication about eligibility criteria. Debate continues around specific requirements such as residency periods and the role of telehealth in assessments – particularly for rural and remote communities.

The past year has also seen increased focus on data collection and transparency, with most jurisdictions publishing regular reports on VAD usage, demographics and outcomes. This information is valuable for ongoing policy refinement and public education.

As VAD becomes more embedded in Australia's healthcare landscape, attention is turning to ensuring equitable access, supporting healthcare workers, and maintaining the balance between autonomy and protection that defines all Australian VAD schemes.

The coming years will likely see continued evolution as each jurisdiction learns from experience, and one another.

Victoria, which pioneered VAD legislation in Australia when it came into effect in June 2019, continues to lead in terms of experience and data collection. The state has seen steady uptake of the scheme, with hundreds of Victorians accessing VAD annually. In 2024-25, the VAD Review Board received an unprecedented 837 requests for VAD.

Western Australia's VAD scheme, operational since mid-2021, has similarly matured over the past year. The state has reported consistent usage patterns. In 2024-25, the number of deaths from VAD increased by 63.8% compared to 2023-24.

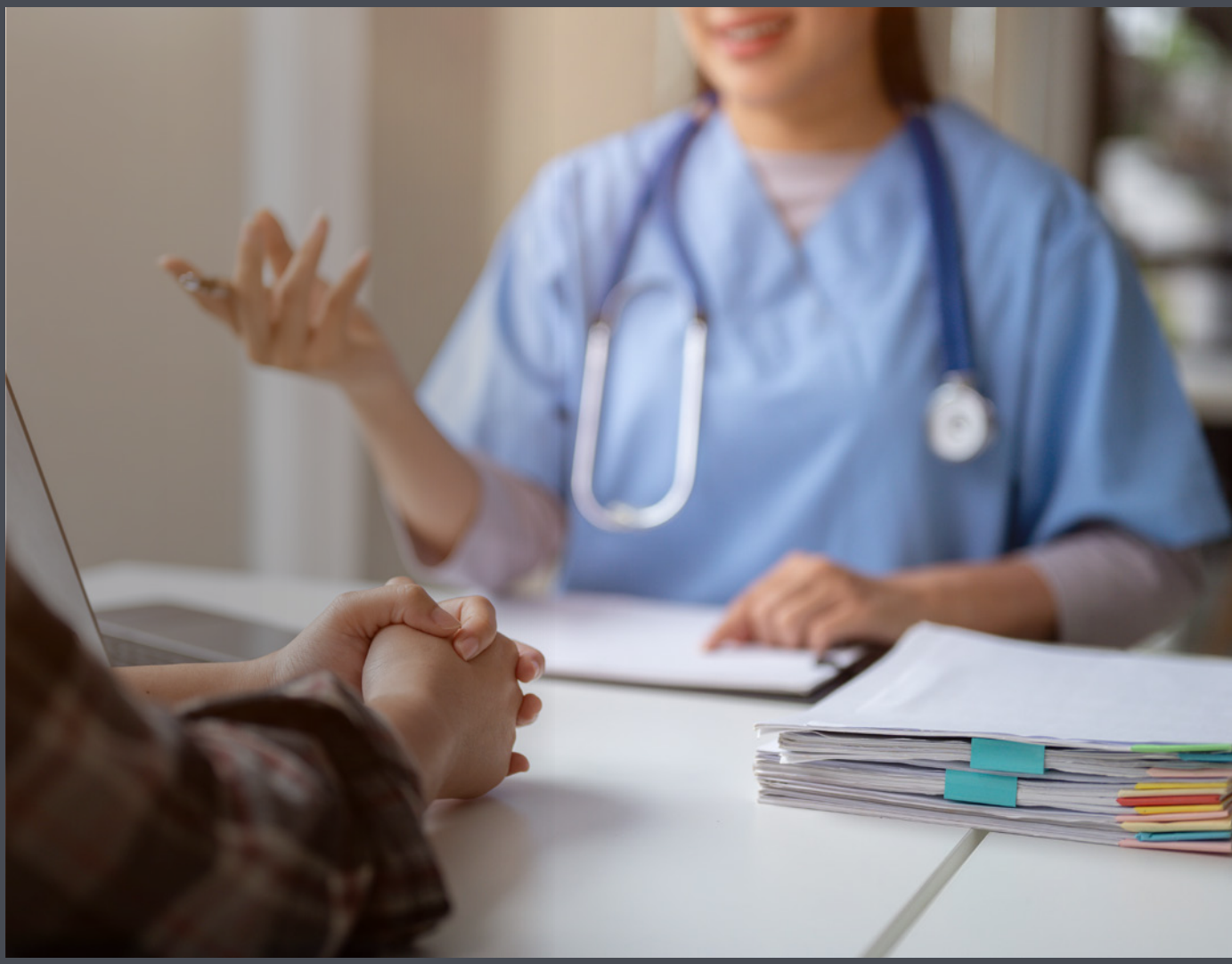
Tasmania's scheme, which began in October 2022, has continued to evolve, with ongoing efforts to balance accessibility with appropriate safeguards.

Queensland's legislation, which commenced in January 2023, has now accumulated more than a year of operational data, providing insights into uptake patterns and implementation challenges in Australia's third-most populous state. From 1 July 2024 to 30 June 2025, a VAD substance was administered to 1072 people.

South Australia's VAD legislation came into effect in January 2023, running parallel to Queensland's implementation timeline. The state has focused on building robust support systems for both patients and healthcare providers. In 2024-25, South Australia experienced a 61% increase in VAD deaths.

New South Wales represents one of the more recent additions to the VAD landscape, with its scheme commencing in November 2023. The past year has seen the state navigate its first full year of implementation, establishing care navigator services and training healthcare professionals to ensure safe and compassionate access.

The **Australian Capital Territory** (ACT) and **Northern Territory** (NT) have also moved forward, with the ACT's scheme becoming operational on 3 November 2025, and the NT having restored its ability to legislate on VAD after decades of federal prohibition. The VAD legislation in the NT is expected to be enacted in mid-2026.



RELEASING MEDICAL RECORDS

Requests for medical records are a common feature of the medico-legal landscape. Here are some key things to keep in mind before you release the notes.

Requests for medical records

Sam Coten-Frigerio
Medico-legal Adviser

Requests for medical records might come directly from a patient, a lawyer, an insurance company, or another interested third party. There are also other legal mechanisms in place (such as a summons or a subpoena) which compel the release of specific records.

Patients have a right to access their own health information, and they can delegate this authority to a third party. It is important to facilitate this access in a timely manner to ensure compliance with Australian health and privacy law.

While each request for records is different, here are some common considerations.

Who should respond to the request?

The person who receives the request should acknowledge receipt as soon as possible and advise how the request will be handled. This task will often fall to practice staff, who will generally liaise with the patient's treating practitioner about the request before deciding next steps.

If the request is sent directly to the practitioner, the practice will often be involved at an administrative level, because the practice is usually the custodian of the notes.

Although this is the general principle in a standard practice–practitioner relationship, arrangements may vary according to business arrangements and contractual obligations.

Can you release the notes to the person requesting them?

Before releasing any records, you must ensure that you have the patient's consent. This may involve confirming the identity of the patient if they are requesting a copy of their own medical record. A request from a lawyer, insurance company or other third party should always be accompanied by a (recent) signed patient authority.

Patients can withdraw prior consent; so if you have any concerns at all, you should advise the patient of the request and confirm their authority to release the notes. If you obtain the patient's verbal consent, this should be recorded in the medical record.

According to the *Guide to Health Privacy* published by the Office of the Australian Information Commissioner (OAIC), you should respond to a request for records within 30 days of receiving the request. Do not leave the request sitting until the last minute, because some requests can be quite complex to process. This is particularly the case with the records of deceased patients, and where family law disputes are afoot.

Deceased patients

Patients are still entitled to confidentiality after death, and requests of this nature require delicate handling.

A bereavement discussion with the next of kin shortly after the patient's death is very different to a request for a complete copy of the deceased patient's medical record a year down the track.

Some legal instruments, such as an enduring power of attorney or guardianship, die with the patient. They have no legal standing once the patient is deceased.

Obtaining a copy of a deceased patient's medical record usually requires a legal authority such as a subpoena, a grant of probate, or letters of administration.

In some states, being the named executor is sufficient in the absence of any known disputes over the estate. It is important to consider these requests carefully, and we recommend you contact MDA National to discuss the situation in more detail.

Is there anything that should not be released?

Under the *Privacy Act 1988* (Cth), there are grounds on which you can refuse to comply with a request for records. Two of the most common bases for refusal is where you *"reasonably believe that giving access would pose a serious threat to life, health or safety of any individual, or to public health or public safety"*, and where *"giving access would have an unreasonable impact on the privacy of other individuals"*.

While the practice usually maintains custody of the records, it is important to seek input from the patient's treating clinician, where possible, to ensure none of the exceptions apply. You should also consider whether it is appropriate to refuse access to the entire record, or whether any information should be redacted before the record is provided to the patient.

If you are relying on one of the exceptions under the privacy legislation, there is a process that needs to be followed – so please refer to the *Guide to Health Privacy* or contact MDA National for advice.

Can I charge a fee for the release of records?

You can charge the patient a 'reasonable administrative fee' for the production of records, although you should consider the patient's individual circumstances when considering what would be reasonable.

The OAIC provides guidance on the factors to consider when raising a fee, but they make it clear that the cost should not be excessive or discourage a patient from obtaining their medical records, and flat fees are not generally appropriate.

Remember

The medical record is not just the progress notes made by doctors in the practice. It can include tests results, referrals, specialist reports, and notes obtained from the patient's previous practice.

Requests for medical records: family disputes

Separated parents

One particularly complex scenario is a request for records where the separated parents of children are requesting access to the notes – or objecting to the other parent accessing the notes.

The default position, in the absence of court orders to the contrary, is that either parent can consent to treatment, and either parent can access the child's medical records.

When such a request is made, you should acknowledge receipt and ask the parent requesting the records whether there are any custody arrangements or court orders in place which might affect your ability to provide these records.

Once this has been confirmed, you should seek the views of the other parent as to whether there is any reason the records should not be released (for example, it might be necessary to redact third-party information such as this parent's address or contact information).

It is important to respect both parents' rights to access their children's medical records, unless there is a legal basis that prohibits access.

There is also an exception based on serious risk of harm as detailed earlier. If you are getting into this territory, we strongly advise you to seek advice from MDA National.

Family disputes are often complex and difficult to navigate.

Our Medico-legal Advisory Services team has experience in these matters, so please contact us for advice.

Protected confidences

A relatively new concept which intersects the family law and medico-legal space concerns amendments to the *Family Law Act 1975* (Cth), which introduced the notion of a 'protected confidence'.

As a medical practitioner, sensitive information you collect while providing care can be the subject of a protected confidence order (PCO). Essentially, a PCO prohibits disclosure or use of particular sensitive information, if the Court decides that the likely harm from this use or disclosure outweighs the benefit of being able to use the information.

Any information held in a patient's medical record can be the subject of a protected confidence. While you, as the practitioner (or 'confidant', in the language of the Act), can make an application for a PCO, we would generally advise against this. It is up to each party, or their legal representatives, to make an application to the Court.

If you have concerns about a patient's welfare or the information held on their file, you should still comply with the subpoena or summons and produce the material to the Court (as not doing so can constitute an offence), but you can alert the Court to the sensitive information you are concerned about. This will allow the Court to consider whether it is appropriate to make a PCO on its own motion.

Alternatively, you can reach out to the patient and explain you have received a subpoena and intend to comply with it. If they have concerns about the records being provided to the Court, you can suggest they either seek independent legal advice or contact the Court registry for advice on steps they can take to protect their sensitive information.

Learn more about medico-legal risks and your obligations while you earn CPD points

Make the most of the resources available through your MDA National membership to assist in meeting your CPD obligations for the year. Our CPD-accredited on-demand webinars and eLearning modules are available 24/7, and they deal with the most common medico-legal issues affecting doctors.

On-demand webinars

- Medicare Updates 2025 – What You Need to Know **NEW**
- Medico-legal Challenges of Prescribing Medicinal Cannabis
- A Health Practitioner's Guide to Social Media
- AI in Record Management for Doctor Consultations

eLearning modules

- GLP-1 Self Audit **NEW**
- AI Scribe Tools in Record Management **NEW**
- Introduction to Open Disclosure
- Prescribing Opioids
- Informed Consent Challenges
- Noteworthy: The How, What, Where and Why of Medical Documentation

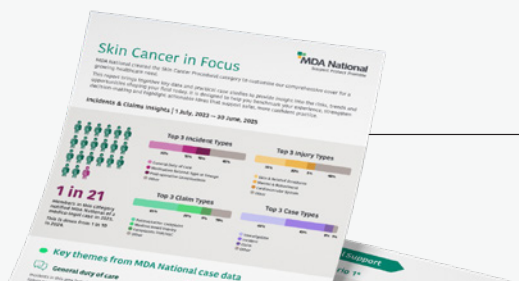
Scan the QR code to learn more and enrol, or visit **learn.mdanational.com.au**

New resources: specialties in focus

These concise reports bring together key data and practical case studies to provide insight into the risks, trends and opportunities shaping your field today. They are designed to help you benchmark your experience, strengthen decision-making, and highlight actionable ideas that support safer, more confident practice. Our data and insights reports include:

- Anaesthetists
- Emergency medicine
- General practitioners
- Gynaecologists
- Minor cosmetics
- Neurologists
- New to Private Practice
- Obstetrician & Gynaecologists
- Ophthalmologists
- Paediatricians
- Psychiatry
- Radiology
- Skin cancer
- Surgeons combined

Scan the QR code to access these specialty reports, or visit **mdanational.com.au/specialist**



Responding to threats

Sam Coten-Frigerio
Medico-legal Adviser

Case study

Mark is a 39-year-old patient with a known history of depression who presents to your GP clinic seeking a script for his regular anti-depressant medication. He usually sees one of your colleagues, but you're comfortable providing a repeat script after confirming Mark's mood has been stable.

Mark seemed a little edgy during the consultation and you're not sure if this is normal for him. You proceed with the consultation and give Mark his repeat script.

Mark makes a passing comment under his breath as he's walking toward reception muttering, *"It would be easier if I just topped myself..."*.

The comment takes you by surprise, and you're not sure how to respond because the next patient is already making their way into the consultation room. You carry on seeing patients, but Mark's comment is still playing on your mind.

Medico-legal discussion

One of the most challenging components of medical practice is often the 'people' part. In the heat of the moment, it can be challenging to read a situation and respond effectively, particularly in circumstances where you fear the wrong response could provoke the patient.

Threats by patients (against themselves, you, or others) can present in different ways, and it is important to be prepared to respond to these threats as effectively as possible.

Breaching confidentiality

Under Australian privacy law, you can disclose health information where *"it is unreasonable or impracticable to obtain consent to the use or disclosure of that health information, and you reasonably believe the use or disclosure is necessary to prevent a serious threat to life, health or safety of any individual, or to public health or safety"*. This may include a call to the police to undertake a welfare check on a patient or report a potential crime.

Threat assessment

Having a few 'go to' lines can be a handy way of gauging risk and de-escalating the situation. This allows you time to think through your options, or to obtain advice from a colleague or MDA National.

It is important to remain calm and measured to ensure you can clearly assess the situation and any potential risk the patient might pose. Asking the right questions could alleviate your concerns, particularly if the patient is just blowing off steam. De-escalation skills come with practice, and situations like this can be very uncomfortable, particularly if patients start to swear or become irate.

Personal safety is paramount – so if you don't feel safe you should remove yourself from the threat, alert practice staff, and call the police. Avoid heated arguments and physical contact. These situations can be very stressful, and it might take some time to process your thoughts. Once the immediate threat has passed, call MDA National to debrief and seek advice on next steps.

General de-escalation tips

- Try and use the patient's name, stay calm, and attempt to bring the temperature down.
- Offer the patient a break in the consultation, but use this technique with caution; the patient may leave the practice in a heightened state without any resolution or safety plan in place.
- Use open questions and don't be afraid to clarify points made by the patient if you have ongoing concerns.
- Avoid blocking entrances or exits, or trying to restrain the patient, as this can escalate the tension and lead to a physical altercation.

No two cases are the same, but we've set out examples on how you could respond to some of the tricky situations you might come across:

"I'm so angry, I could stab someone!"

- *"Hey, can we talk a bit more about that?"*
- *"If you genuinely mean that, I may have an obligation to alert the police."*

"I wish she was dead."

- *"Please don't joke about things like that. What do you mean?"*

"You know I've got a gun at home?"

- *"What are you suggesting?"*
- *"Do you intend to use the firearm on yourself or someone else?"*

"Just give me some more codeine and nobody gets hurt!"

- *"Who do you intend to hurt?"*
- *"I can't provide you with care if you're going to threaten me. Let's talk about your current symptoms and then we can discuss appropriate treatment."*

"Don't you dare push me over the edge!"

- *"I'm here to help you; can we talk about what's making you feel that way?"*

"It doesn't matter..."
(if you ask the patient to repeat what they've said)

- *"I'm doing my best to help you – can you repeat what you said?"*

Case study - outcome

During a break between patients, you call the contact number on file for Mark and he answers your call.

"I was a little concerned about a comment you made as you were leaving the consultation today – I just want to check that you are okay."

Mark apologises and confirms he was having a bad day; he is not suicidal or making any plans to harm himself; and he is grateful for the follow-up call.

Fitness to drive

Finbar O'Reilly
Medico-legal Adviser

Case study

Dr Powell became involved in the care of Andrew, a long-term patient of the practice and previously under the care of Dr Powell's colleague. Andrew recently turned 75, and Dr Powell's colleague noted changes to his cognitive function.

Andrew was referred to a geriatrician for a review of his cognitive function and memory. The geriatrician's report outlined cognitive impairment, low RUDAS score, visual-spatial impairment, and a lack of insight regarding the decline.

Andrew holds a heavy-vehicle licence. While he does not own a heavy vehicle, he hires them to teach learners how to operate them. Andrew also recently disclosed he was thinking of buying a car.

At Andrew's next consultation, Dr Powell discussed the results with him and advised that his ability to drive had likely been impacted.

Dr Powell encouraged Andrew to contact Transport for NSW to disclose the condition and undergo a practical driving test.

Andrew became very aggressive, claiming his driving was fine and that he would continue teaching learners. He also confirmed he had purchased a new car and was driving it.

Andrew threatened to sue Dr Powell if he notified Transport for NSW. Dr Powell was also concerned about breaching privacy laws with his disclosure to Transport for NSW.

Medico-legal discussion

Medical professionals play a vital role in helping patients understand the impact their medical conditions have on their day-to-day functioning, including fitness to drive.

Unfortunately, some patients disagree with their doctor's clinical advice and continue to drive. A question often arises about whether the medical practitioner has a legal obligation to notify their relevant state driving authority about the patient's impacted fitness to drive.

Notification

Each state has slightly different legislation addressing the issue of notifying the state driving authority.

The first thing to recognise is that all states impose an obligation on the patient to self-notify to the relevant driving authority if they have a certain health condition.

The legislative wording differs between states, but the general principle is that if a patient suffers from a condition, classified as a long-term or permanent physical or mental condition, injury or disability that affects their ability to drive and may endanger the public, they must notify the state authority.

Examples include:

- vision/eye conditions
- cardiovascular conditions
- sleep disorders
- substance misuse
- dementia and cognitive impairment
- psychiatric conditions
- seizures and epilepsy
- age (in NSW, patients over 75 must undertake a fitness-to-drive assessment).

Most states do not have a mandatory reporting obligation to report a patient whose condition impacts their driving. Exceptions are the Northern Territory (NT), South Australia (SA) and the Australian Capital Territory (ACT).

If a medical practitioner in the NT or SA believes a patient has a long-term or permanent physical or mental condition, injury or disability that affects their ability to drive and may endanger the public, they must notify the relevant authority. The ACT is slightly different, as discussed in more detail below (under 'Heavy or commercial vehicles').

The doctor's role

A doctor's primary role is to assess a patient's fitness to drive and to advise patients on how the condition may impact their ability to drive. Part of this discussion may include advising a patient of the requirement to self-notify to the driving authority and/or assist them in the completion of an online medical report.

It is useful for patients to understand that a notification does not automatically mean their licence will be suspended. They may instead receive restrictions or conditions on the licence. For example, they may be allowed to only drive during the day.

While there is not always a mandatory reporting obligation, you may have an ethical obligation to report the patient's condition and fitness to drive. This will often arise when a patient lacks insight or judgement due to their condition, or they disregard clinical advice to self-report which places the public at risk of harm. In this case, you should consider reporting the patient to the state driving authority.

If a patient poses an immediate risk to the public (or themselves) due to a serious condition, then the police can be notified. Conditions applicable to this circumstance include driving under the influence, suicidal ideation, and severe mental or physical impairment.

If you believe a patient needs to be reported to the state driving authority or the police, you can contact MDA National for advice.

Heavy or commercial vehicles

Patients who operate heavy or commercial vehicles are required to meet a higher health standard due to the increased risk to the public associated with operating these vehicles.

In the ACT, there is a mandatory reporting requirement that patients holding or applying for heavy-vehicle licences must be reported to Access Canberra within seven days if they have a permanent or long-term condition that impacts their ability to operate the vehicle safely.

Protection against disclosure

Andrew's threat of litigation, and Dr Powell's concerns about breaching privacy, are common considerations when a doctor is faced with the prospect of reporting a patient to the driving authority. All states allow anonymous reporting and provide protection from civil and criminal liability, when the report is made in good faith.

Unsolicited third-party information

Information about a patient's condition can often be provided by a friend or relative without the patient's knowledge. Unsolicited collateral information, while often well-meaning, can have privacy implications if the third-party declines to allow the doctor to discuss those concerns with the patient. For more information, see our article: *Managing unsolicited patient information from third parties*.[1]

If you are not permitted to discuss the concerns raised, you can inform the third party to directly contact the driving authority, invite them to attend a consultation with the patient, or make your own independent enquiries about the patient's fitness to drive as part of your ongoing therapeutic relationship.

View the references online: **mdanational.com.au/fitness-to-drive**

Following receipt of a notification, Ahpra may contact the practitioner for a brief discussion. It is prudent to advise Ahpra that you wish to first speak with your medical defence organisation before providing a verbal response.

Receiving a notification

Daniel Spencer
Case Manager (Solicitor)

Case study

Dr Patel is a general practitioner working in a suburban mixed-billing practice, servicing a diverse patient population with high appointment demand.

He receives an Ahpra notification from a 32-year-old female patient who attended the practice on three occasions over a two-month period for ongoing abdominal discomfort, bloating, intermittent diarrhoea, and persistent fatigue.

The patient works full-time and reports significant disruption to her daily functioning. Each consultation was booked as a standard 15-minute appointment, and Dr Patel was managing a full clinic on each occasion.

In the notification, the patient alleges that Dr Patel failed to appropriately investigate her symptoms and did not take her concerns seriously. She states that she repeatedly described worsening fatigue and difficulty concentrating, but felt these concerns were minimised and attributed to stress and lifestyle factors without adequate explanation.

Concerns were also raised about his communication style – describing Dr Patel as rushed, using medical terminology without clarification, and not providing clear advice about when to return or what symptoms should prompt further review. She reports feeling dismissed, and leaving consultations uncertain about the management plan.

The patient later consulted a different general practitioner, who ordered a broader panel of investigations including iron studies and coeliac serology. These tests indicated iron-deficiency anaemia and coeliac disease, and she was referred to a gastroenterologist for further management.

In her complaint, the patient states she believes the investigations should have been initiated earlier, and the delay contributed to ongoing symptoms, anxiety, and reduced trust in medical care. She seeks acknowledgement of her experience and reassurance that similar issues will not occur for other patients.

Medico-legal discussion

The word 'notification' can make your heart sink, but there are plenty of practical steps you can take if one comes your way.

Anyone can lodge a notification with Ahpra about a medical practitioner, and Ahpra receives it on behalf of the Medical Board. Most notifications are made by patients or family members. Although the National Law imposes mandatory reporting obligations on health practitioners, employers and education providers, most notifications are voluntary.

Following receipt of a notification, Ahpra may contact the practitioner for a brief discussion. While this may seem benign, it is prudent to advise Ahpra that you wish to first speak with your medical defence organisation before providing a verbal response. Your case manager at MDA National can then consider the pros and cons of a verbal response versus a written response, and can advise you accordingly.

Ahpra may also offer you the opportunity to have a case discussion which can generally be in lieu of, or in addition to, a written response. Again, advice should be sought from MDA National on the best way forward.

While the Medical Board can decide to take no further action in relation to a notification without obtaining a practitioner's response, this is not common. A response will generally be sought from a practitioner at the outset, irrespective of whether a notification appears to have any proper grounds.

Understandably, this can be a source of great frustration for doctors who can feel unfairly targeted and perhaps perceive Ahpra to be "taking sides" with the notifier. This is not the case. It is generally simply Ahpra providing a practitioner an opportunity to respond in accordance with the requirements of procedural fairness.

Most notifications end with the Medical Board taking no further action and closing the matter. Where a notification raises concerns about a practitioner's conduct, the way they practise, or their health, the Board may decide to investigate or ask the practitioner to complete a performance or health assessment.

A considered and reflective response to the notification is invariably a doctor's best opportunity to defend their performance or conduct. Despite the understandable dissatisfaction of being the subject of regulatory scrutiny, there are invaluable opportunities to learn from the experience. We receive consistent feedback from Members that further education offered by us and voluntarily completed by them has helped them in their broader practise of medicine.

Outcome

In responding to Ahpra, Dr Patel focused on providing a factual, reflective and professional response. He outlined his clinical reasoning at each consultation, acknowledged that alternative investigations could reasonably have been considered earlier, and reflected on how his communication may not have met the patient's expectations. He avoided defensive language and expressed insight into how a patient might perceive brief consultations as dismissive, even when the clinical care is appropriate.

Dr Patel also identified steps taken since the complaint, including improving documentation of shared decision-making, allowing additional time for complex presentations, and undertaking further training in patient-centred communication. He completed several online courses offered by MDA National and provided certificates of completion to Ahpra with his written response.

Dr Patel was relieved to receive a letter from Ahpra acknowledging his response and advising that no further action would be taken in relation to the notification.

Seek advice

If you are the subject of an Ahpra notification, call our Medico-legal Advisory Services team on **1800 011 255** or email **advice@mdanational.com.au** so we can provide you with support and expert advice.

Ahpra and the Medical Board: Facts and Figures

Extracted from the Medical Board of Australia's Annual Report 2024/25

- 12% increase in notifications about medical practitioners in 2024/25 – compared with a 14% increase across all registered health professions.
- 6.1% of medical practitioners were the subject of a notification in 2024/25.
- 61% of notifications closed in 2024/25 resulted in no further action.
- A slight decrease in the number of medical practitioners subject to mandatory notifications, from 27.4 per 10,000 medical practitioners in 2023/24 to 26.6 per 10,000 in 2024/25.
- Wide variation in mandatory reporting across states and territories, with a 160% increase in NT, a 127% increase in ACT, and a 17% decrease in SA.
- The Medical Boards took "immediate action" 374 times – down 11% from 2023/24. The biggest decrease was in NSW, where immediate action was taken 3 times, down from 10 in 2023/24.
- 73% of "immediate actions" led to regulatory action – such as conditions, undertakings, or suspension of registration.
- 97% increase in notifications received about boundary violations nationally, with NT having a 1,200% increase.

Social media is media

Dr Maria Li (MDA National Member)
General Practitioner
Host of *The Safe Practice Podcast*

Social media is a public platform. It's a powerful tool, but not one without risk. Doctors who confuse familiarity with privacy do so at their peril.

More doctors than ever are using social media to educate, advocate and connect. Social media is a public stage. And, like any regulated profession, doctors are accountable for how they show up on it. There's no rulebook stipulating that doctors must use social media a certain way. Many of our colleagues successfully use these platforms in ways that align with their unique voice and personality.

But there is a catch: if a doctor's online content or conduct is found to not meet certain professional standards, there are real consequences – such as reputational damage and potential regulatory scrutiny. That's why understanding not just the rules, but the principles behind them, is essential for every doctor with a social media presence.

Case study

Liam* was a subspecialty registrar who built a sizeable social media following. He started out posting general health tips, but soon realised what drew people in were his strong personal opinions and his unfiltered sense of humour.

So, he leaned in. His posts became more personal and candid — sharing his negative experiences with medications and some vaccines; and his blunt and often humorous takes on the health system. His followers loved it.

But not everyone did.

Complaints started coming in to his employer and Ahpra. Some flagged his unprofessional tone. Others accused him of spreading health misinformation.

The Therapeutic Goods Administration caught wind of his testimonials on therapeutic goods.

Under scrutiny, Liam shut down his accounts. His career, once enhanced by his online presence, was now overshadowed by it.

*Liam is a fictional character based on real examples of online behaviour.

The misconception of informality

Social media feels casual and personal. Your followers feel like your tribe. The algorithm serves you people who support you. It's easy to forget you're not just chatting to friends.

However, platforms like Instagram, Facebook, LinkedIn and TikTok aren't private domains. Unlike a tearoom conversation, social media is public, permanent, searchable and shareable.

A comment made in jest, frustration or vulnerability can be screen-captured, shared and interpreted in ways you didn't expect. What you say can — and often does — travel far beyond your intended audience.

When you post on socials, you are publishing.

What if I don't tell people I'm a doctor?

It doesn't matter. In the age of Google, LinkedIn, and online provider directories, it's not hard to figure out who someone is and where they work. Whether or not you declare your profession, you'll still be seen, and judged, as a doctor.

What the regulator says

Ahpra's guidelines are clear: the standards expected of doctors in face-to-face professional interactions also apply online. That means your social media presence is held to the same expectations as your conduct in work settings.

If you wouldn't write it in a letter to the editor, don't write it in a comment on Instagram. If you wouldn't say it in a television interview, don't put it on TikTok.

Before you share on social media, ask yourself: *Would I be comfortable seeing this on the front page of a newspaper, with my name and photo next to it?*

Real consequences

This isn't just theory.

In one high-profile case, a Victorian GP lost his registration after posting content that was critical of vaccines, minorities, the LGBTQI+ community, and other health professionals. His conduct was deemed below acceptable professional standards for a medical practitioner.

No need to log off

If, at this point, you're thinking about deleting all your accounts and going silent on socials — there is no need.

Doctors have a valuable role in online conversations. Social media is a powerful tool for health promotion, advocacy and connection — so much so that the World Health Organization has created a global taskforce of healthcare influencers to spread credible, evidence-based messaging.

But with that visibility comes risk, and we must approach our online presence as carefully as we would any public statement.

Applying caution

Before you post, comment or share, take a pause and ask yourself: *Would I be comfortable seeing this on the front page of a newspaper, alongside my name and photo?*

If you're unsure whether something is appropriate to post:

- run it by a colleague;
- call your medical defence organisation; and
- re-read Ahpra's guidance.

If you're still unsure, don't post. Because, at the end of the day, social media is media — as doctors, we forget that at our peril.

This article is an edited extract of an original article published in MJA InSight+ on 14 April 2025: ***https://insightplus.mja.com.au/2025/14/social-media-is-media-a-crucial-reminder-for-doctors****.*

Mindset & mentorship

Renata Alves
Corporate Communications Specialist

When we first met Dr Shev Dias, he was halfway through medical school – humble, busy, and quietly determined. Since then, the junior doctor has become everything we imagined he would, and more: a 2026 Rhodes Scholar, a Doctor of Medicine graduating with Distinction, and an emerging leader who is already influencing the culture around him.

Shev's career journey stands out for achieving his goals with discipline, perspective, and commitment to his community. This mindset mirrors the influence of his key mentor, Dr Dror Maor – an orthopaedic surgeon whose own path was also shaped by mentorship, including guidance from the late Dr Sol Levitt, MDA National's former Chair. Dror went on to build an international career in orthopaedics, working alongside organisations such as FIFA, the Royal London Ballet, Chelsea Football Club, and the Australian Wallabies.

For both Dror and Shev, orthopaedics was a natural choice sparked by a shared love of elite sports and the practical, purpose-driven work of helping people move and lead a healthy and fulfilling life.

Shev doesn't sugar-coat his Doctor of Medicine degree, a highly demanding journey. But he is grateful for the pressure that came with purpose and rewards. He describes the hardest part as pushing for strong results and becoming a capable doctor, while still growing into himself outside medicine – all at once. The supportive environment and the friendships formed along the way were the foundation that helped Shev stay steady during his time at the University of Western Australia, through long weeks and shared resilience.

It all comes to mindset

Having a balanced approach to his medical course was a key success factor for Shev. While working through exams and placement hours, he also leaned into advocacy and community work through organisations like Dr YES, via the AMA (WA), and the Western Australian Medical Students' Society; and all that balanced with national ultimate frisbee competitions and part-time work.

That combination gave Shev the tools to manage pressure and his mental health, and stay disciplined when time was tight – skills that matter in medical school and hospital wards.

But mindset alone isn't enough. In medicine, support networks are vital, especially for junior doctors still developing their confidence. Shev credits senior practitioners and broader professional networks for creating the kind of environment where learning from failure is possible, and where it's safe to ask for guidance.

Under Dror's guidance, Shev has immersed himself in placements, research and studies. Mentorship has played a central role in shaping his career path. "Having someone like Dror who invests in you, challenges you, and leads by example makes all the difference," he says.

In 2024, Shev received the Third Prize for a presentation on *Calcaneal Osteotomies for Talocalcaneal Coalitions* at the Australian Orthopaedic Foot & Ankle Conference, with Dror's mentorship and support. In October 2025, Shev was awarded a Rhodes Scholarship (Australia at Large) and is heading to Oxford this year to pursue a PhD in Musculoskeletal Sciences. He aspires to become a renowned orthopaedic surgeon, just like his mentor, Dror. He says he is accomplishing his goals "simply by doing things I enjoy and striving to be the best version of myself".

Putting yourself first

Looking back at his medical school journey, Shev says he wouldn't change a thing. He explains that he put himself first, and medical school second, without neglecting either. Even with the tough workload, he built a full life alongside study: engaging in sports and fitness, volunteering for causes he cares about, leading a fulfilling social life, publishing papers, presenting at conferences, and travelling the world.

Shev frames his graduation with Distinction as the outcome of his balanced approach, adding that lows mattered just as much as the highs – making his achievements possible, and even more special.

A mentorship success story: Dr Dror Maor & Dr Shev Dias

Even after decades of experience, Dror treats every orthopaedic surgery as individual, reviewing notes the night before and actively thinking through what is unique about the operation and how to get the best possible outcome.

He speaks openly about those moments of doubt, saying he constantly reflects on his performance to ensure best outcomes for patients.

The prominent Perth orthopaedic surgeon speaks warmly about Shev's strengths across research and patient interactions, and the balance of being upbeat while knowing when to be serious, with professionalism and a bubbly personality – a great quality for any doctor to have.

Looking back at his own journey, Dror believes the early years are critical to building a gratifying career.

This success story is anchored in mentorship. In a highly demanding profession, having people who help you stay grounded, raise your standards, and back you with encouragement can make all the difference.

Dror and Shev's journey is a strong reminder of that.

> *I like to think I'm someone who performs well and does well under pressure, but it all comes from the mental strength training you do in preparation for it. It's important to recognise that it's your mindset that affects all that, more than anything.*
>
> Dr Shev Dias

> *Regardless of what you choose to do, it's important to say 'yes' to everything at the beginning and enjoy the experience of being a student and a doctor. The more experience you get, the more enjoyable and well-rounded a doctor you'll be down the track.*
>
> Dr Dror Maor

Practical resources to support your development

Watch our *Lifeline* medico-legal video series, designed to build your confidence when it matters most.

Lifeline video series

Latest topics include:

Open Disclosure

Learn about open disclosure and the process for an adverse event, where a patient has experienced harm.

Confidentiality

Find out about your legal and professional duty to practise confidentiality, including after a patient's death and when exceptions apply.

Medical Certificates

Legal document obligations and responsibilities when writing and signing medical certificates.

Medical Reports

Understand your obligations and responsibilities when writing and signing medical reports.

LIFELINE
A MEDICO-LEGAL SERIES

Scan the QR code to watch these videos, or visit **learn.mdanational.com.au**

NEW EDUCATIONAL RESOURCE

GLP-1 Self Audit

Assess your patient data to better manage your prescribing practices

- Prescription medication in weight-loss management is a rapidly developing field with widespread adoption.
- The ongoing monitoring of your patients is critical to their care and to your medico-legal protection.
- Audit your practice with this tool to gain insight into your decision-making process and identify areas to optimise.

This self-audit explores the prescription of GLP-1 agonist weight medication for patients.

It covers:

- best practice for prescribing GLP-1 weight-loss medication
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