Rascal, opinionated and often at odds with the medical profession of his time, playwright Sir George Bernard Shaw once claimed: “A doctor’s reputation is made by the number of eminent men who die under his care.”

Whatever the truth of his bombast at that time, more than half a century after Shaw’s death, general practitioners’ reputations are increasingly likely to be shaped as much by the idiosyncrasies of social media and waiting-room queues as by clinical skill.

Australian GPs enjoy a healthy status in the community and as recently as April, the medical profession as a whole was given the second-highest rating for honesty and ethical standards as part of a Roy Morgan survey about occupations.

But the past 12 months have seen medical defence organisations (MDOs) experience a sharp rise in concerns about growing online threats to individual doctors’ and practice reputations.

So how important is reputation to the business of general practice? What factors can affect a practice’s standing within the community? And what are the best steps to safeguard a good name and the financial goodwill it entails?

Geraldton GP Dr Edwin Kruys frequently sees waiting-time worries, social media and reputation coincide when patients use the regional WA practice’s free WiFi to post complaints about delays on the group’s Facebook page while sitting in the waiting room.

“Service is important. If you have a good reputation for seeing children on the same day and not having very long waiting times, people will come back to you. And if you, as a practice, drop the ball there, then people leave.”

But he says reputation matters more to some patients than others.

“There’s always a group of patients that doesn’t care that much and just want an instant solution and whoever that is, whether it’s a GP or at the emergency department, doesn’t really matter. They just have a problem and it needs fixing.”

“But there’s also a large group that looks for a practice or a GP with a good reputation and, in that respect, reputation is very important.”

Dr Kruys says they have previously had patients switch to other practices when circumstances put pressure on the services he and his colleagues could offer. In one instance, the simple departure of some doctors left the practice short-staffed, thereby lengthening waiting times and damaging the practice’s reputation until the problem was fixed.

Waiting times have been repeatedly identified as a leading factor in the choice of doctor, but a practice’s good name can similarly be hit by cost hikes, mainstream media reports and the manner of staff and doctors.

If these problems are not quickly remedied or addressed by the practice manager or practice GPs, they can go on to affect practice value in the long term when it comes to assessing goodwill.

On the positive side, research has found that word also spreads when it comes to a good bedside manner and lengthy consultation times, helping to put a rosy hue on a GP’s reputation.

Online views
Whether positive or negative, word is spreading faster than ever before.

“The talk of town doesn’t just happen in the supermarkets or in the pub anymore, it happens online”, says Dr Kruys, who was behind the establishment of one of Australia’s first general practice Facebook pages in 2010.

He remains enthusiastic about...
Facebook’s potential for dealing with issues that may affect a practice’s reputation.

“It gives you direct feedback about your service — things that they [patients] might not have told you in person or they may not have used the suggestion box. If you are running an hour late, you can see on Facebook that they’re grumpy about having to wait so long.

“If you’re not online, then I think you miss most of the conversation. You also miss opportunities to show what you do and the services you provide and what your practice stands for.”

MDOs have recently seen a sharp rise in the number of complaints and queries they receive about social media and the risks it poses to reputation.

Avant senior claims manager Sophie Pennington says today’s GPs and practices need to be very careful about both positive and negative comments being posted on their social media platforms such as Facebook and Twitter.

“As the medical practitioner is the one setting it up, they are the ones deemed by the national law as controlling the content and so when other people are putting things on there, then they are responsible for that.”

At the start of the year, the Australian Health Practitioner Regulation Agency (AHPRA) released its revised draft social media guidelines.1

While positive reviews may enhance the practice’s reputation, AHPRA classify them as testimonials, which are prohibited by the Guidelines for Advertising of Regulated Health Services.

Ms Pennington warns that many sites remain non-compliant in this regard and AHPRA is beginning to apply penalties.

“Realise that you are still bound by all of the guidelines that govern your conduct anywhere else.”

Elsewhere, GP reputations are being built and broken on doctor-rating websites such as the US-based RateMDs and Australia’s own Word-of-Mouth-Online, where people can post comments and ratings of doctors anonymously.

A recent defamation case saw Avant work with Telstra, Optus and advanced IT specialists to track an individual who had posted a pejorative comment on one of these forums.

But it was a long process and at the end of the day there was little recompense for the doctor involved because the person responsible for the defamation had few assets.

Such cases raise the spectre of patients potentially being asked to sign “gag contracts” like those now being used by US doctors.

These give the doctor copyright over everything that occurs as part of the patient–doctor relationship, opening another legal avenue to prevent adverse ratings or defamatory reviews online.

Ms Pennington brands the concept as crazy, but says she has already had queries from doctors about such contracts.

“My view is just don’t google yourself, because you’ll probably find something that you don’t like.”

A matter of respect

Earlier this year, the outgoing head of the British Medical Association’s General Practice Council, Dr Laurence Buckman, wryly observed that the standing of British GPs had fallen so low, because of waiting times and performance-related pay, that he had begun introducing himself in “polite company” as a trainee mortician.

GPs here continue to have a much healthier community status, but when the profession’s reputation does come in for a battering, Dr Simon Willcock, professor of general practice at the University of Sydney, says it’s important to bring it back to self-respect.

“In the days of social media, it’s harder than ever to isolate those sorts of things but if you value yourself and like what you do, then you carry that into the environments that you go into and you invariably garner that respect.”

“Within your community you’ll be very much judged by your own personal characteristics.

“If you contribute and you’re recognised to be ethical and interested in people in the community, your personal standing should be quite independent of whatever those trends are.”

And regardless of Bernard Shaw’s barbs, that standing is good not only for the health of a practice, but also for the health of its GPs and ultimately their patients.

Annabel McGilvray


“... don’t google yourself, because you’ll probably find something that you don’t like.”

Sophie Pennington
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Brain the lure for “Prof Switzerland”

Professor Helen Chenery is a speech pathologist keeping a large group of neurosurgeons, engineers and ethicists on track as they research deep brain stimulation’s role in making patients’ lives better.

Helen Chenery’s colleagues call her “Professor Switzerland”.

“It’s a moniker she bears with a smile and, one suspects, not inconsiderable pride.

As director of the Asia–Pacific Centre for Neuromodulation (APCN) at the University of Queensland’s Centre for Clinical Research in Brisbane, Professor Chenery must corral a pool of diverse talent engaged in groundbreaking research and innovation.

It is a task not unlike herding cats, but she does it with alacrity.

“It’s a significant leadership role”, she tells the MJA.

“There are about 40 to 50 people presently engaged in research with us. A lot of them have day jobs in other centres, other universities. So it’s quite a task pulling together such a disparate group of smart people”, she says.

The group at the APCN includes neurologists, neurosurgeons, neurophysiologists, even engineers — biomedical, electrical and mechanical — health economists and neuroethicists, as well as allied health practitioners such as deep brain stimulation (DBS) nurses, psychologists and psychiatrists.

DBS is the APCN’s main focus, working with patients with Parkinson disease, Alzheimer disease, Tourette syndrome and obsessive–compulsive disorder (OCD), among others.

The day Professor Chenery spoke with the MJA, she was working on a grant application for a new joint venture between the APCN and the CSIRO.

“In collaboration with CSIRO we are developing a remote patient monitoring device which will allow us to monitor Parkinson’s patients in their home using passive sensors which send information to their smartphone”, Professor Chenery says.

“How do you measure quality of life? You can sit someone down in the doctor’s surgery and ask them how they are, using a subjective rating scale, but then you see performance effects and all kinds of biases.

“This device will provide an objective measurement of the severity of a person’s Parkinson’s in their everyday life, as well as their response to treatment, focusing on all the characteristics of the disease — their movement, their mood, how they’re communicating.”

Professor Chenery concedes the device raises all kinds of ethical questions around the patient’s privacy, but argues that in the age of “quantifiable me”, the benefits outweigh the negatives.

“We have to look at the balance between privacy and being more open to have a better health outcome”, she says.

Among her colleagues Professor Chenery is the exception rather than the rule.

She is a speech pathologist, graduating from the University of Queensland (UQ) in 1978 before completing her Masters (1987) and PhD (1994). She has a storied 33-year clinical career assisting people who have lost the ability to communicate as the result of a sudden neurological injury such as stroke or head injury or who have a slowly progressive neurological condition such as Parkinson disease or Alzheimer disease.

Her teaching career spanned 20 years, progressing from senior tutor to deputy executive dean (academic) of the Faculty of Health Sciences at UQ until the middle of last year when she took up her current post at the APCN.

“It didn’t take very long into my training for me to realise that the brain was where it was at”, Professor Chenery says.

“The brain is so intricately precise. In terms of communication it defines so much of who we are and how we relate to our world. It’s a mirror to our soul.”

DBS has had its fair share of detractors, but Professor Chenery is more than happy to accept and learn from those criticisms.

“The detractors keep the debate warm — hot, sometimes — but it’s a debate that has to be had”, she says.

“We never resile from that debate. The worst thing would be to pretend that negative outcomes or controversies or different opinions don’t exist. The best thing is to let the light shine on them and bring the critics into the collaboration.”

“Professor Switzerland” says her status as a speech pathologist gives her an advantage when heading up a team of clinicians.

“I don’t bring a lot of baggage in terms of territoriality”, she says, citing a problem that can dog disparate groups of clinicians. “I try not to cut the baby in half to solve a problem, and I find that a lot can be achieved with goodwill and communication.

“We can’t be a good DBS centre if we don’t see it as an episode in a really long journey for these patients.

“The patients in our matched control groups, who aren’t receiving deep brain stimulation — they are living with Parkinson’s or OCD or Tourette syndrome as well — their journey can be lonely and troubled. We always try to keep that in mind”, Professor Chenery says.

For now, at least, she says she has found her dream job.

“It’s so rewarding. And busy. And tough”, she says. “This is a rapidly moving space. The technology develops so quickly so the granting agencies and publishers are needing to think of different and faster ways to keep pace.

“But there is so much goodwill and I feel like this is the right place at the right time for me.”
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