

defenceupdate

Quarterly Magazine of the MDA National Group

Summer 2010

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From the President



Why Do Women Die In Childbirth?

One of the most fascinating and inspirational books that I have read this year is "Half the Sky" by Pulitzer prize winning authors, Nicholas Kristoff and Sheryl WuDunn. It is a passionate expose of one of the most pervasive human rights violations of our era: the oppression of women and girls in the developing world.¹

However, this book is also a timely reminder of "Mother Nature's way" when it comes to childbirth.

In their chapter on "Why do women die in childbirth?", the authors make the observation that "one reason women die in childbirth has to do with anatomy, arising from two basic evolutionary trade-offs. The first is that once our ancestors began to walk upright, too large a pelvis made walking and running inefficient and exhausting. A narrow pelvis permits fast running" and; "The other trade-off is head size. Beginning with our Cro-Magnon ancestors, human skull size expanded to accommodate more complex brains. Larger brains offer an evolutionary advantage once a child is born, but they increase the chance that a larger headed foetus will never emerge alive from the mother".

They also cite a 1984 study of a fundamentalist Christian church in the state of Indiana whose members were affluent, (supposedly) well-educated and well-nourished, yet for spiritual reasons eschewed doctors and hospitals. Although they had some untrained assistance, their maternal mortality rate was 872 per 100,000 live births.² That was twice as high as India, 92 times the standard maternal mortality in Indiana at the time, and around 100 times that of Australia today. And as Kristof and WuDunn further suggest "without C-sections, there is simply no way to save the lives of women" and, "it's difficult to avoid the conclusion that the critical factor for saving mothers is access to doctors in an emergency".

Furthermore, a recent report from the WA Health Department's perinatal and infant mortality committee found that the infant mortality rate for home birth deliveries was 7.81 per thousand which compared unfavourably with the rate for conventional hospital births of 2.03 per thousand.³

Therefore it is most disturbing to read reports that some Independent Midwives are seeking ways around the requirement that they sign collaborative care agreements with doctors.⁴

Indeed, while proponents of midwifery-led births would argue that some adverse outcomes might be avoided with less intervention, low risk births do not equate to nil risk. Thus minimising the potential for serious

adverse outcomes requires early recognition and a willing acceptance by women and their carers that medical intervention might be required.⁵ Therefore, a sound and clear mechanism to instigate prompt referral and assessment by an obstetrician should be an independent midwife's foremost priority.

So quite sensibly the Federal Government, working with the AMA, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Australian College of Midwives have made such collaborative care agreements a requirement for MBS access for midwives. Indeed it is a great credit to those involved, including the AMA Federal President Andrew Pesce, that such measures have been promoted as the preferred route to expand the role of midwives in maternity care.

And while Australian obstetricians have achieved an all time low for maternal and infant mortality, it is distressing to see that the right to timely obstetric care - that is so desperately needed by mothers in the developing world - is now being questioned in the pursuit of greater choice and the desire for a more aesthetic birth experience.

Significant obstetric claims have been declining in recent years, and MDA National believes that this is due to improved risk management, better monitoring of childbirth and more timely intervention by obstetricians. And given such gains, our obstetric colleagues are likely to be reluctant to embrace any new arrangement(s) that place mothers and babies at greater risk.

Hopefully, MDA National will not be asked to defend the rights of a Member in the event that a claim arises through the acts or omissions of a privately practising midwife. However, where a Member is at risk through the acts or omissions of a third party, as always we will work with the Member to ensure that his or her interests are protected. And Members can rest assured that we will continue to monitor and respond to such new health care initiatives in ways that support, protect and promote high quality medical care across Australia.

A/Prof Julian Rait
MDA National President

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- 2 Kaunitz AM, Spence C, Danielson TS, Rochat RW, Grimes DA. Perinatal and maternal mortality in a religious group avoiding obstetric care. Am J Obstet Gynecol. 1984 Dec 1;150(7):826-31.
- 3 Guest, D. State 'in denial' over home-birth risks. "The Australian", November 15, 2010, page 3.
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Notice Board

From The President: Christmas Message

On behalf of your Council, I would like to extend to all Members our best wishes for a happy and peaceful festive season, a refreshing break from clinical work, and a most successful 2011 for all our doctors, students, dentists and their families.

And once again, I would like to extend my gratitude to members of Council, our insurance Board, members of the President's Medical Liaison Council and our management team, staff and various advisors who have again so generously contributed to the success of the MDA National Group this past year.

Annual General Meeting 2010

The 84th Annual General Meeting (AGM) of MDA National was held on 9 November 2010. The President, A/Prof Julian Rait, confirmed that the following Members had been elected to Council for a further term:

Professor Guy van Hazel

Dr David Gilpin

A/Prof Max Baumwol

At the Council meeting held immediately after the AGM, the executive positions of President, Vice President and Chair of Finance were elected from amongst the Council members.

President: A/Prof Julian Rait

Vice President: Dr Beres Wenck

Chair of Finance: A/Prof Max Baumwol

2010 AMA (WA) Awards

Dr Val Lishman and Prof Bruce Robinson were awarded AMA Awards at the AMA (WA) 2010 Awards Night and Charity Dinner in July.

Dr Val Lishman was recognised for his outstanding contribution to surgical services in regional WA and overseas.

Prof Bruce Robinson achieved international recognition for his work in the field of asbestos-induced cancer and the early detection of mesothelioma.

Junior Doctor of the Year

Dr James Anderson was awarded the inaugural Dr Camille Michener Legacy Award at the AMA (WA) 2010 Awards Night and Charity Dinner in July.

Supporting Doctors in Private Practice

MDA National recognises that running your 'business' is an integral part of your professional lives, and if managed well can also have beneficial effects on your wellbeing and subsequently your patient care. As such, MDA National has recently agreed to participate in an education initiative, The Private Practice, designed to assist doctors by providing advice on the latest practice, financial and lifestyle management ideas such as business structures, personal and professional insurance, managing staff and even marketing and advertising.

MDA National's involvement includes speaking at select workshops and conferences on matters regarding professional indemnity insurance and risk management; as well contributing articles to the quarterly magazine, "The Private Practice", and its website.

Please visit our website www.mdanational.com.au for more information on this new initiative.

Would Your Practice Pass a Health Check?

MDA National recognises that doctors are committed to providing health checks for their patients, but often the health of the practice is overlooked. MDA National is committed to extending our support to assist with the development and maintenance of a healthy practice environment.

With that in mind, we have developed the Practice Self-Assessment Handbook which is quick and easy to use, giving you an instant snapshot of your practice's health in terms of medico-legal risks and areas of vulnerability.

With issues such as patient safety, systems, complaints handling and adverse event management, each topic is introduced by a series of statements for you to consider. Once you identify how these statements apply in your practice, you are given suggestions and strategies for mitigating these risks - to suit your needs and your individual circumstances.

The Handbook includes a tear out Action-Plan that has been designed to:

- Support practice staff in helping you achieve your goals for a healthier medico-legal practice environment.
- Enable you to create a listing of opportunities for change.
- Enable effective delegation of tasks by allowing you to indicate the issue, action required and the person responsible.
- Allow you to clearly view if the issue has been rectified or if it is still outstanding.

The Practice Self-Assessment Handbook has been written in language appropriate for the entire practice team. Selecting the appropriate speciality version for your practice, will assist in a more targeted approach for you and your team to assess the medico-legal health of your practice.

The Handbooks are currently available in four speciality versions:

- Medical Practice
- Surgical Practice
- Anaesthetic Practice
- Obstetric and Gynaecology Practice.

Further speciality versions are currently being planned.

Order Your Free Copy

As part of your MDA National Membership, you can order a copy of the Handbook free of charge by visiting www.mdanational.com.au/risk-management/practice-self-assessment/practice-self-assessment-handbook.aspx or contacting 1800 011 255.

Premium Support Scheme

If you are a recipient of the Premium Support Scheme, completing the Practice Self-Assessment Handbook will assist you in meeting your risk management requirements. For more information visit, www.mdanational.com.au/risk-management/pss-risk-management.aspx

CPD Requirements

Using the Practice Self-Assessment Handbook to consider the health of your practice is not only beneficial for potential reduction in your medico-legal risk, but it may also assist you in fulfilling your continuing professional development requirements in the domains of organisational and legal and professional and ethical roles and responsibilities. Most Colleges and Associations have been notified of the Handbooks and may consider individual applications from Members regarding professional development point allocation. Please contact your College/Association to apply.

If you would like to know more about the Practice Self-Assessment Handbooks or how the Risk Management Team may assist you to improve the health of your practice, visit www.mdanational.com.au/risk-management/risk-management.aspx, email riskmanagement@mdanational.com.au or contact 1800 011 255.

Kim Collins
Education Developer



Medicare Australia and The National Compliance Program

Medicare Australia (Medicare) is responsible for the administration of the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS). Each year Medicare processes about 500 million transactions and pays more than \$30 billion in benefits to providers and the Australian public. The Commonwealth Government has moved to further protect the integrity of the MBS and PBS by enhancing the compliance program which monitors the practice profiles of practitioners operating under the Schemes.

MBS Compliance Program

Under the Increased MBS Compliance Audits initiative, the Government is increasing audits on MBS services to ensure that medical practitioners are fulfilling the requirements of relevant MBS item descriptors. The initiative also sees the expansion of the audits to include allied health professionals and improved coverage of specialists.

Consequently, since 1 January 2009 an additional 2,000 audits each year are being carried out on those who provide MBS services. Proposed legislative changes may also see Medicare's powers increase to enable it to compel the production of records substantiating MBS claims, and introduce new administrative penalties for individuals who are found to be incorrectly claiming.

The MBS Compliance Audits will focus on practice profiles of providers who have unusual trends or patterns in claiming, high or unusual claims, complaints and tip-offs in addition to targeting MBS items with a high risk of mis-itemisation, incorrect claiming or unusual or unexplained growth.

Specific attention is being paid to MBS items at risk of up-coding where a medical practitioner may bill for a more complex and more expensive MBS item than the service provided including, but not limited to, skin lesions, excisions, flap repairs, time based items including attendance items, deep and superficial wounds, general practitioner consultations routinely claimed with practice nurse items, care plans being management plans and health checks.

Medicare engages with professional auditors to undertake detection activities for non-compliance and subsequent data analysis. As a consequence, Medicare is more adept at identifying anomalous claiming behaviour and patterns of practitioners' practice profiles however, it is purely statistical and without regard to the particular clinical setting. Medicare will interview a practitioner where their practice profile is identified as being at a statistical variance to their peers and whilst it may reflect the nature of the practice, it may also indicate "inappropriate practice". It is not until this point that a clinician is involved and review of the particular clinical circumstances occurs that any anomalies and alleged non-compliance might be explained.

The Practitioner Review Program

The program consists of a combination of an interview with a Medicare Medical Adviser to discuss Medicare's concerns, a period of time to enable the practitioner to review his/her practice, and a review by Medicare's Delegate to determine if a request should be made to the Director of Professional Services Review (PSR).

At present, Medicare does not have the power to review a practitioner's medical records and it relies upon the statistical data and factual information given by the practitioner during the interview. Having regard to the proposed legislative changes, this will no doubt impact upon the way in which future interviews are conducted.

Prior to the changes introduced at Medicare, a practitioner was provided with a written, detailed report following the interview setting out Medicare's concerns however, a letter advising whether or not Medicare's concerns have been addressed is sent in lieu of a report. Where Medicare's concerns remain unaddressed, the practitioner is invited to provide written submissions explaining his/her position in relation to those concerns prior to a request being made for review by the Director of PSR.


The Director of Professionalism Services and Professional Services Review Committee (PSRC)

The Professional Services Review Scheme gives the PSR authority to investigate whether a practitioner has engaged in inappropriate practice when providing MBS or PBS services. The test for "inappropriate practice" as defined under the Health Insurance Act 1973 (Cth) (the Act) is wide and non-specific.

The Director of PSR reviews a practitioner's provision of services and, once completed may decide not to take any further action, negotiate and enter into an agreement (ratified by the Determining Authority and deemed final with acknowledgment of inappropriate practice usually resulting in a reprimand, repayment of monies for MBS services and/or disqualification from identified MBS item services for a period of time), or establish a PSRC and refer the practitioner's conduct for determination. The PSRC will decide if a practitioner's medical records meet the prescribed standard and whether the services rendered were clinically relevant. In determining whether a practitioner has engaged in inappropriate practice, regard is given to whether the practitioner has kept adequate and contemporaneous patient records.

Determining Authority

Following a PSRC hearing, a Draft Report is provided to the practitioner for a written submission in relation to the PSRC's preliminary findings before finalisation and provision of the Report to the Determining Authority.



The Determining Authority will invite further submissions from a practitioner in relation to the sanctions it must impose - being one or more of a reprimand, counselling, repayment of Medicare benefits and/or complete and/or partial disqualification for up to 3 years from the MBS and/or PBS.

It is difficult to ascertain the timeframe for completion of Medicare's investigation process in each case, but it can be a protracted and lengthy process once the Director decides to undertake a review of the provision of services in accordance with the Act.

In our experience the most important determinant is the quality of a practitioner's medical records which effectively need to be sufficiently detailed and moreover, contain the necessary clinical evidence to enable a practitioner to justify the professional service claimed. That said, whilst there are many safeguards and opportunities for a practitioner to make written submissions to Medicare during the investigation process, it is advisable that you have professional support at the time Medicare's Medical Adviser seeks the initial interview especially given the provision of a subsequent written report will no longer occur.

We recommend that you contact MDA National on 1800 011 255 for assistance, who will if necessary, refer you for legal advice to assist you through the various stages of Medicare's investigations and review process.

**Andrew Vandervord, Special Counsel
TressCox Lawyers**

Collaborative Care

From 1 November 2010, eligible nurse practitioners and midwives can access the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule, provided the nurse practitioner or midwife:

- has a defined collaborative arrangement in place with one or more specified medical practitioners in relation to the provision of services to patients; and
- meets the required registration standards of the Nursing and Midwifery Board of Australia.

The legislation defines each of the following as a collaborative arrangement for an eligible nurse practitioner or midwife:

- a) the nurse practitioner or midwife is employed or engaged by one or more specified medical practitioners, or by an entity that employs or engages one or more specified medical practitioners;
- b) a patient is referred, in writing, to the nurse practitioner or midwife for treatment by a specified medical practitioner;
- c) an agreement between an eligible nurse practitioner or midwife and one more specified medical practitioners;
- d) the nurse practitioner or midwife has an arrangement in writing which includes, in part, the name of at least one specified medical practitioner who is, or will be, collaborating with the nurse practitioner or midwife in the patient's care and an acknowledgement by the medical practitioner(s) that they will be collaborating in the care. In this situation, if the patient's usual GP is not the named medical practitioner to the collaborative agreement, and the nurse practitioner or midwife refers the patient to a specialist or requests diagnostic imaging or pathology services for the patient, the nurse practitioner or midwife must give a copy of the referral, or results of the services, to the patient's usual GP. A record of the services provided by the nurse practitioner or midwife must also be given to the patient's usual GP. This requirement applies only if the patient consents to the provision of this information to the GP.

It should also be noted that midwives can only have a collaborative arrangement with:

- an obstetrician; or
- a medical practitioner providing obstetric services; or
- a medical practitioner employed or engaged by a hospital who has been authorised by that hospital to participate in a collaborative arrangement.

Am I covered if I decide to enter into a collaborative arrangement with a nurse practitioner or midwife?

You should contact our Member Services Department if you are thinking about entering into a collaborative arrangement so that we can ensure that you are in the correct risk category and we can understand better the particular circumstances of that arrangement. MDA National is committed to working with our Members to ensure the potential risks are understood. At this stage, we will consider each request individually, as we anticipate that there will be a variety of ways that collaborative arrangements will be implemented.

Do I have to agree to enter into a collaborative arrangement if asked to do so by a nurse practitioner or midwife?

No, you are not obliged to enter into a collaborative arrangement with a nurse practitioner or midwife if you do not want to do so.

What should I do if I receive a test result from a nurse practitioner or midwife about one of my patients and I am not involved in the collaborative arrangement with that practitioner?

If a GP receives a test result or other information about one of their patients (even if the GP has not ordered the test) then that GP does have a legal duty to consider this information to determine if any action needs to be taken. The action required, if any, will depend on the individual circumstances of the case. For example, a normal cholesterol result would not require any specific action but an INR of 12 would.

MDA National is working with other groups, including the RACGP and the AMA, to clarify the medico-legal implications, so that we can provide consistent advice about how best to manage this type of situation to minimise any risk. Members are encouraged to contact our 24 hour Medico-legal Advisory Service on 1800 011 255 for advice about any specific situation which arises in their practice.

More Information

Additional information about collaborative care is included in the AMA's 'Collaborative Arrangements: What you need to know'. Available at <http://ama.com.au/node/6071>

Dr Sara Bird
Manager, Medico-Legal and Advisory Services



Scientific Investigation: Infallible or Flawed?

Many people see scientific investigation as an infallible means of finding answers to medical questions when in reality it is an inherently complicated and often flawed process. It is important for us as medical professionals to realise that these flaws often manifest themselves within the studies we use to make clinical decisions every day.

Understanding some of the reasons behind the shortcomings of scientific investigations can serve to assist us in ultimately making better clinical decisions for our patients.

Evidence for shortfalls in medical investigation has been effectively demonstrated by Dr. John Ioannidis, Professor of Epidemiology at the University of Ioannina School of Medicine in Greece. His landmark paper entitled "Why Most Published Research Findings Are False" was published, appropriately, in the open-access Public Library of Science (PLoS) in 2005. This paper shows, through a detailed mathematical analysis, that problems such as bias, flawed research techniques, and a tendency to inappropriately focus on more exciting topics confounds researchers and leads to them reaching the wrong conclusions most of the time.

Another study from Dr. Ioannidis, published in JAMA in 2005 entitled "Contradicted and Initially Stronger Effects in Highly Cited Clinical Research" further demonstrated problems within medical research. In this paper, he scrutinised 49 heavily indexed articles from journals including The New England Journal of Medicine, JAMA, and The Lancet (as well as medical specialty journals) published between 1990 and 2003. 45 of these 49 articles demonstrated some sort of effective medical intervention. Ioannidis then further searched the literature to see if any of these interventions had been retested in a more rigorous study. What he found was that the results in 41% of the original studies were either wrong or had been significantly exaggerated. This is a particularly significant finding, especially in the eyes of a medical professional putting their full faith in a well-respected medical journal, taking for granted an appropriate peer review process, and when using those results to make a clinical decision.

Ioannidis' research suggests an underlying dysfunction in the process of scientific investigation itself. (It should be noted that these problems are not endemic to medicine, such discrepancies can be found in all scientific fields, from economics to physics). He cites problems with bias (particularly researchers looking for an intended result with a study) and its effect on the subsequent research technique. A specific culprit of this type of bias can be seen in drug company trials, which have the added corruptor of a financial conflict of interest. An article in the November 2010 issue of The Atlantic quotes Ioannidis as saying "Researchers headed into their studies wanting certain results - and, lo and behold, they were getting them. We think of the scientific process as being objective, rigorous, and even ruthless in separating out what is true from what we merely wish to be true, but in fact it's easy to manipulate results, even unintentionally or unconsciously."

Research aims looking for specific answers may be partially the reason why you can find an evidence base (albeit small) for such alternative therapies such as magnet therapy, homeopathy, acupuncture, and even prayer. Such therapies may show benefit in some trials, but a close look at the research technique may show that bias or a confounder has provided a result that might not fit with what is generally accepted as standard medical practice.

As a medical professional using evidence-based medicine we must always remember that a tenet of EBM is to employ "conscientious, explicit, and judicious use of current best evidence" in our clinical decisions. Understanding that the process of scientific investigation is one that is commonly flawed can only help us use available scientific evidence conscientiously and judiciously. This, when coupled with our own clinical expertise (as well as that of our colleagues), can only help us make the best and most well informed clinical decisions for our patients.

**Dr Christopher Baughman MBBS
MDA National PMLC Member (SA)**

The Hazards of Being a Doctor

If you are a male, were trained in Australia and work in solo practice, you are more likely to drink at hazardous levels. If you haven't taken a holiday in the past year and work long hours, you are more likely to suffer from depression and anxiety.

You are also more likely to suffer psychiatric problems if your personality traits tend towards introversion or neuroticism.

As a male doctor, you are at a 26% higher risk of committing suicide than the general population, and if you are a female doctor, the risk is 146% higher than the general population.¹ Although you may drink less alcohol, you will take more benzodiazepines, especially if you are in emergency medicine or a psychiatry resident, and you will often self-prescribe these medications.

If you are a male and work long hours, you are more likely than others to be the subject of a claim or complaint. Those working in procedural specialties such as obstetrics and surgery are more likely to be involved in a medico-legal matter: claim, complaint or coronial inquiry.

Not only this, if you are the subject of a complaint or claim, you are more likely to experience psychiatric problems, to drink more than you usually do, to take antidepressants, to have disturbed sleep, and to feel more stressed, anxious or depressed.

Recent Australian research has found all of the above to be statistically valid assertions.² Does even reading this make you anxious?

Don't let these statistics put you off. If you ask most doctors, they wouldn't trade their chosen profession for anything. The rewards of the job far outweigh the pitfalls. And what aspect of life is free from setbacks and challenges? The life of a professional of any calling has its hazards. The key to surviving them is to be prepared for them, to understand them, to seek professional assistance and personal support when you need it. The other key is to know and understand yourself: what personality traits you bring to the job, how they have benefited you in getting this far and knowing when they can make you more vulnerable to stress.

Be mindful of your own characteristics: are you a high achiever who thrives on stress or who suffers from distress, do you have good collegiate support or work better in solo, are you so indispensable that you can never take a holiday, do you work long hours because there is too much to do or because you cannot let go?

MDA National's Partnering Your Professionalism program aims to cultivate an awareness of one's self as a professional in relationship to others and one's environment, at all stages of your career, from student to retirement. This awareness will mitigate the potential for adverse impacts on your performance and wellbeing during setbacks.

Personal or internal factors include personality, psychosocial factors, beliefs and attitudes, career choices, self-care, relationship with peers, commitment and leadership skills.



External factors include changes in community values and expectations, how government policy can impact on health service provision, your own obligations and duty of care when resources are restricted, the medico-legal environment and processes and the regulatory framework in which doctors practise.

The program is offered to groups in hospitals, in the medical community or as an individualised service. For more information about the program or the research please email the Partnering your Professionalism team at PyP@mdanational.com.au.

Elizabeth van Ekert
Program Manager and Professional Services Adviser (PyP)

References

- 1 beyondblue Mental Health of Doctors Literature Review, August 2010
- 2 MJA 19 October 2009, 2 August 2010 and other paper by Nash, Kelly, Walter, Willcock, van Ekert et al.

MDA National CaseBook



The following cases have been prepared by the Claims and Advisory Services Department. They are based on actual medical negligence claims or medico-legal referrals; however certain facts have been omitted or changed and all names changed by the author to ensure the anonymity of the parties involved.

Lost Without Translation

Case Study

The patient was using a nail gun when he was struck in the left eye by a piece of metal.¹ The patient was of non-English speaking background and was fluent in Spanish. One day after the accident, the patient attended a general practitioner for review. An onsite interpreter was not used during the consultation. The patient claimed that he tried to inform the GP that he had been using a nail gun at the time of the accident and that a piece of metal had struck his left eye. However, the GP's medical records included a notation that the patient had previously been hit in the eye by a wood chip. The patient was diagnosed as having a corneal abrasion and he was treated with antibiotic eye drops. By the next day, the patient's condition had deteriorated and he attended a hospital emergency department. At this time, an X-ray was performed which revealed a metal foreign body in the eye. The patient subsequently underwent urgent surgery but the vision in his left eye remained very poor.

The patient subsequently commenced legal proceedings against the GP alleging that the lack of an interpreter resulted in his impaired vision. The claim proceeded to trial in Oregon, USA.

The patient alleged the standard of care required the general practitioner to immediately refer him to a hospital emergency department ED if there was a history of using any type of power tool at the time of the injury, as was the case in this instance. The patient claimed that if he had been able to communicate appropriately via an interpreter, the details of the mode and extent of his injury would have been conveyed to the GP. The patient's expert testified that if the surgery had been performed earlier, the patient's sight could have been saved. The jury returned a verdict in favour of the patient in the amount of US\$350 000, less contributory negligence of 35% because the patient did not seek medical attention until 1 day after the injury.

Discussion

Evidence suggests that the use of interpreters with patients of non-English speaking background is associated with improved quality of care, better health outcomes and greater patient satisfaction. Yet, surveys of Australian general practices reveal that the use of interpreters is uncommon. Over two-thirds of surveyed general practices have never used the free 'Doctors Priority Line' telephone interpreting service and over one-third were unaware of the existence of this service. Of concern, almost one-third of practices reported that they would not arrange an interpreter even if asked to do so.²

Criterion 1.2.3 of The Royal Australian College of General Practitioners Standards for general practices states:

'Our practice provides for the communication needs of patients who are not proficient in the primary language of our clinical team and/or who have communication impairment'.

The indicators for this criterion are:

- (a) Our clinical team can describe how they communicate with patients who do not speak the primary language of our staff or who have a communication impairment.
- (b) Our practice has a list of contact details for interpreter and other communication services including the Translating and Interpreting Service (TIS).

The standards note that 'qualified medical interpreters should be the interpretation medium of choice. The use of patients' relatives and friends as interpreters is common. This is acceptable if it is an expressed wish of the patient and the problem is minor. However, further consideration should be given to the following:

- whether friends and relatives will put their own interpretation into the translated communication
- the use of friends and relatives in sensitive clinical situations or where serious decisions have to be made may be hazardous
- the use of children as interpreters is not encouraged³



Risk Management Strategies

In 2000, the Doctors Priority Line was introduced by the Australian government through the Translating and Interpreting Service (TIS) National, which is part of the Department of Immigration and Citizenship (see Resources). The service provides medical practitioners with access to an interpreter 24 hours a day, 7 days a week, for the cost of a local call. General practitioners can use the Doctors Priority Line when providing services that are:

- claimable under Medicare Australia
- provided in private practice
- provided to a non-English speaking Australian citizen or permanent resident.

Calls on the Doctors Priority Line are given priority and an interpreter will generally be available within 3 minutes for common community languages.

When working with an interpreter, consider the following strategies:

- a standard phone handset is appropriate if you use interpreters for emergencies or occasional use only, however if you use the service regularly, consider using a hands free phone
- introduce yourself to the interpreter, describe the phone you are using and state where you are (e.g. private rooms or hospital)
- brief the interpreter about relevant words and concepts before the interview whenever possible
- while interpreters are used for their language expertise, you may also be able to use their cultural expertise, by asking the interpreter before the interview for information on any cultural factors that might affect the interview. Be aware of gender, class, disability and other issues (e.g. political, religious) that may impact on the interview. Seek the patient's permission if you need to obtain additional cultural information from the interpreter during the interview
- introduce the interpreter to the patient
- sit facing the patient
- speak naturally but clearly so the interpreter can hear you
- use plain English where possible
- when complex issues are involved remember to summarise periodically
- talk to your patient, not to the interpreter. Always use the first person, for example: 'How are you feeling?' Do not say (to the interpreter): 'Ask her/him how she/he is feeling?'
- do not try to save time by asking the interpreter to summarise

- pause often to allow the interpreter to speak
- be aware that it may take more or fewer words than those you have spoken to convey the message in another language
- try not to let the interpreter's presence change your role in the consultation. It is not the interpreter's role to conduct the interview
- use nonverbal communication such as smiling
- if the consultation takes a long time, give the interpreter a short break after 30 minutes
- clearly indicate when the consultation has ended.⁴

Resources

- Doctors Priority Line
- Department of Immigration and Citizenship www.immi.gov.au/tis

Acknowledgment

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Dr Sara Bird Manager, Medico-Legal and Advisory Services

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MDA National CaseBook

Medication Errors: Insulin

Case History

Mr F was an 81 year old man with a number of medical co-morbidities, including CCF, PVD, COPD, CRF and insulin dependent Type II diabetes. Following a one month hospital admission for management of pneumonia, he was admitted to a nursing home on 20 September 2006.

Since early 2000, Mr F had been looked after by a GP, Dr H, who had made regular house calls to him. Following Mr F's admission to the nursing home, Dr H was contacted. Although the nursing home was not within his area for home visits, Dr H agreed to continue Mr F's care in view of his longterm relationship with the patient.

Mr F was seen by Dr H at the nursing home on 21 September 2006 at about 3pm. Dr H spent about one hour with Mr F and, as part of his visit, completed the nursing home medication chart. Mr F was on 15 medications, including Mixtard 30/70 8 units mane and 6 units nocte. Dr H recorded the doses on the medication chart as 8 and 6 followed by a circle with a dot in it (see copy of medication chart, top right of this page).

At about 4:30pm on 21 September 2006, the nurse administered 6 units of insulin to Mr F. She was aware of the correct dose of insulin to administer because she had read the hospital discharge summary the day before.

On the morning of 22 September 2006, the nurse noted that the morning dose of insulin for Mr F was 80, with a dot inside the zero. The nurse had once before seen a zero with a dot in it to indicate units of packed cells. She therefore interpreted the medication chart as requiring 8, rather than 80, units of insulin.

At about 4pm on 22 September 2006, the nurse checked Mr F's BSL and found it to be 3.8mmol/L. She waited for Mr F to have something to eat and drink and, at about 5pm, she administered 60 units of insulin, misreading the medication chart to read 60 rather than 6 units. At about 7pm, the nurse was reviewing Mr F's file and came across the hospital discharge summary. She realised that the incorrect dose of insulin had been administered and that Mr F had received 10 times the amount of insulin prescribed. She notified the RN in charge and completed a medication drug error report.

| MEDICATION ORDER | | MONT |
|----------------------|---------------------|---------------------------|
| PLEASE PRINT CLEARLY | | DATE |
| DRUG/DOSE | MIXTARD 30/70 | TIM |
| FREQUENCY | 80 mane 60 nocte | |
| ROUTE | 9c | |
| Date Ordered | 2. 9.00 | Date Suspended & Dr. Sign |
| Dr Sign | [Signature] | 21/9/06 [Signature] |
| Dr print | | |

Mr F's BSLs were monitored on an hourly basis thereafter and were found to be:

| | |
|----------------------------|--|
| 20:00 | 4.6 |
| 21:00 | 3.4 (given Glucodin) |
| 22:00 | 3.6 |
| 22:35 | 5.3 |
| 23:50 | 4.2 |
| 23 September 2006 00:45 | 1.6 (given Glucagon IMI and ambulance called) |
| 01:25 | 8.3 |



Mr F's consciousness deteriorated soon after midnight on 23 September 2006 and his BSL at 00:45am was found to be 1.6mmol/L. Glucagon was administered intramuscularly by the nursing staff and an ambulance was called. On arrival, the ambulance officers noted Mr F to be alert but he was agitated, tachypnoeic and peripherally cyanosed. Mr F arrived in ED at about 1:55am on 23 September 2006. After review by the RMO, and discussion with the patient's daughter, a decision was made to provide palliative care only. Due to Mr F's agitation, he was given 2.5mg morphine IV at 5:15am and again at 8:45am. Mr F was declared dead at 9:50am and the cause of death was recorded in the medical records as cardiorespiratory arrest and respiratory failure. As a result of concerns about the incorrect dose of insulin that was administered at the nursing home, Mr F's death was reported to the coroner.

An autopsy was performed which revealed evidence of extensive bronchopneumonia and severe IHD. The pathologist noted that post-mortem analysis of glucose levels were of limited value and any assessment of whether or not the dosage of insulin administered on the evening of 22 September 2006 was likely to have played a significant part in Mr F's death would be reliant on the medical history.

Medico-legal Issues

The matter proceeded to an Inquest in October 2008 and the coroner's findings were handed down on 25 September 2009.

The issues considered by the coroner included:

Did the incorrect dose of insulin contribute to Mr F's death?

At the Inquest, evidence was heard from Mr F's treating geriatrician and the hospital RMO who saw him on the morning of 23 September 2006. Independent expert reports were obtained from two endocrinologists, a clinical pharmacologist and a cardiologist. In his final report, the coroner noted that: "Although all the expert witnesses agreed that Mr F suffered very serious chronic health problems around the time of his death, there was conflict about the impact of the hypoglycaemia on Mr F."

The treating geriatrician believed that the excess insulin dose "could have had an effect" on Mr F's deterioration, stating that the deterioration in his condition at the nursing home appeared to have been noted at the same time as the BSL was recorded as 1.6.

One of the endocrinologists reported:

"The final trigger, having improved from a critical illness, in my opinion, undoubtedly is the hypoglycaemia produced by that excessive dose of insulin. This development causes considerable impairment of cardiac function, the cardiac muscle needed glucose for its appropriate metabolism, and its response to circulatory demands... He was shown to be fibrillating at a rate of 128 beats per minute on arrival at hospital, a situation with the myocardium of that order which is little short of disastrous."

The other endocrinologist stated:

"It is highly improbable that Mr F died as a result of the large insulin dose nor that this dose had any material effect on his death... Mr F died as a result of severe hypoxia, as a result of widespread bronchopneumonia affecting 4 out of 5 of the lobes of the lungs and from congestive cardiac failure due to his previous heart disease, which in turn, is related to his diabetes... The extensive bronchopneumonia would have been present for at least 24 hours prior to Mr F's death and possibly even longer. It could not have developed from the time of Mr F's evening injection of 60 units of insulin... In summary, Mr F's bronchopneumonia was so extensive, coupled with his cardiac failure, that it is unlikely that he would have survived a further 24 hours."

The clinical pharmacologist reported:

"Severe hypoglycaemia is usually a non-fatal event, particularly in otherwise healthy persons. Mr F had severe intercurrent illnesses and it would have been a contributing factor to his death."

The cardiologist stated that:

"While there is a temporal relationship between the administration of extra insulin on the evening of 22 September and Mr F's deterioration, I believe this is an association only, and not necessarily a causal association. I cannot exclude the possibility that a brief period of hypoglycaemia "tipped the balance" in this case, but I consider it unlikely."

Based on this evidence, the coroner concluded in his final report that "the evidence does not support a conclusion that the incorrect dose of insulin contributed to the death of Mr F."

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continued...

Should Mr F have been transferred to hospital as soon as the error in relation to the dose of insulin was discovered?

The treating geriatrician reported that as soon as the error in the dose of insulin had been discovered, Mr F should have been transferred to hospital where his condition could have been monitored with frequent glucose measurements and a dextrose or glucose infusion could have been administered to try and maintain his blood sugar levels.

Did the treatment Mr F received at hospital, on 23 September 2006, contribute to his death?

The coroner concluded that the care Mr F received in hospital on 23 September 2006 was entirely appropriate. At the time of his hospital admission, Mr F's oxygen saturation was 56% on oxygen via a mask. The only option available at that time was intubation. The coroner reported that the RMO's decision, supported by the geriatrician and the patient's daughter, that "it was appropriate not to intubate him and to administer morphine to reduce Mr F's distress" was correct and he concluded that "no criticism should be made in relation to the treatment Mr F received at the hospital".

While the barrister for Mr F's family asked that the coroner make recommendations in relation to Dr H's use of a non-standard abbreviation, the coroner reported that he was unable to do so because he found no causal link between Mr F's death and the dose of insulin he received. Nevertheless, in his statement to the coroner, Dr H stated: "I wrote up a number of medication orders for Mr F, including an order for insulin (Mixtard 30/70) to be taken 8 units in the morning and 6 units at night. I used a shorthand for writing units of insulin which is a nought with a dot in the middle. I acquired this practice when I was working as an RMO in the Renal Unit... However, since Mr F's death, I write "units" in accordance with the National Inpatient Medication Chart Guidelines".

Discussion

Medication errors are one of the most common causes of avoidable harm to patients in health care organisations. A majority of the medication errors which result in death or serious patient injury involve a small number of specific medications. These include insulin, opiates and narcotics, injectable potassium chloride or phosphate concentrate, intravenous anticoagulants and sodium chloride solutions above 0.9%.¹

Several common errors are known to occur with the prescription and administration of insulin. These include:

- Prescribing or administering the wrong named insulin – pharmaceutical companies giving very similar names to insulin with different pharmaceutical properties e.g. Humalog and Humalog Mix 25, NovoRapid, NovoMix 30 and Mixtard 30;
- Selecting the wrong insulin vial/cartridge;
- Using a syringe not designed for use with insulin – this can result in incorrect doses being given;
- Incorrect abbreviations being used for insulin e.g. "U" – the U can be mistaken for a 0 leading to overdoses; or "IU" for International Units – the I can be mistaken for a 1, leading to overdoses such as 6IU being misread as 61 units;
- Using incomplete names e.g. Humulin without specifying the exact preparation, Humulin S or Humulin I;
- The use of the symbol "/" to separate doses e.g. 10/5 units (meaning 10 units in am and 5 units pm) could be interpreted as 10 units in the morning and 15 units in the evening, or even 1,015 units;
- Confusion about the meaning of the term "sliding scale".²

Between August 2003 and August 2009, the UK National Patient Safety Agency (NPSA) received 3,881 wrong dose incidents involving insulin. These included one death due to a 10 times error from the use of the abbreviation of the term "unit". Three deaths were also reported where an intravenous syringe was used to measure and administer insulin. Two of these deaths involved junior medical officers who were unaware that 1ml of insulin measured in an IV syringe did not correlate to a 1 unit dose, or that insulin syringes should be used when administering insulin.³



Risk Management Strategies

On 16 June 2010, the NPSA released a Rapid Response Report on the safer administration of insulin. The recommendations included:

- All regular and single insulin (bolus) doses are measured and administered using an insulin syringe or commercial insulin pen device. Intravenous syringes must never be used for insulin administration.
- An insulin syringe must always be used to measure and prepare insulin for an intravenous infusion. Consideration should be given to the supply and use of ready to administer insulin infusion products.
- The term “units” is used in all contexts. Abbreviations such as “U” or “IU” are never used.
- A training program should be put in place for health care staff expected to prescribe, prepare and administer insulin (an e-learning program is available at www.diabetes.nhs.uk/safe_use_of_insulin).³

Dr Sara Bird
Manager, Medico-Legal and Advisory Services

References

- 1 'High - alert' medications and patient safety. International Journal for Quality in Health Care 2001; 13(4):339-340.
- 2 Safe and Effective use of Insulin in Hospitalised Patients. Available at www.diabetes.nhs.uk
- 3 National Patient Safety Agency, Rapid Response Report NPSA/2010/RRR013: Safer administration of insulin. June 2010.

MDA National Risk Management Workshops

Cognitive Institute Workshops Calendar

February 2011

Mastering
Work/Life Balance
Wednesday 9
6.00pm - 9.00pm
Sydney

Mastering
Work/Life Balance
Wednesday 23
6.00pm - 9.00pm
Perth

March 2011

Mastering
Work/Life Balance
Wednesday 2
6.00pm - 9.00pm
Brisbane

Mastering
Work/Life Balance
Wednesday 16
6.00pm - 9.00pm
Melbourne

May 2011

Mastering Shared
Decision Making
Saturday 7
9.00am - 12.00pm
Sydney

Mastering Difficult
Patient Interactions
Saturday 7
1.00pm - 4.30pm
Sydney

Mastering Shared
Decision Making
Saturday 21
9.00am - 12.00pm
Perth

Mastering Difficult
Patient Interactions
Saturday 21
1.00pm - 4.30pm
Perth

Registration can be completed online through the Member Online Services section of the MDA National website or by contacting Risk Management at riskmanagement@mdanational.com.au or 1800 011 255.

Full descriptions of the workshop topics can be found in the Risk Management section online.

All workshops attract CME/CPD points and are free of charge to doctors who hold a current Professional Indemnity Insurance Policy. Please check the online calendar regularly as more workshops will be added throughout the year.

Numbers are limited for these sessions so make sure that you register early to ensure your place.

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