

Defence Update

Quarterly Magazine of the MDA National Group

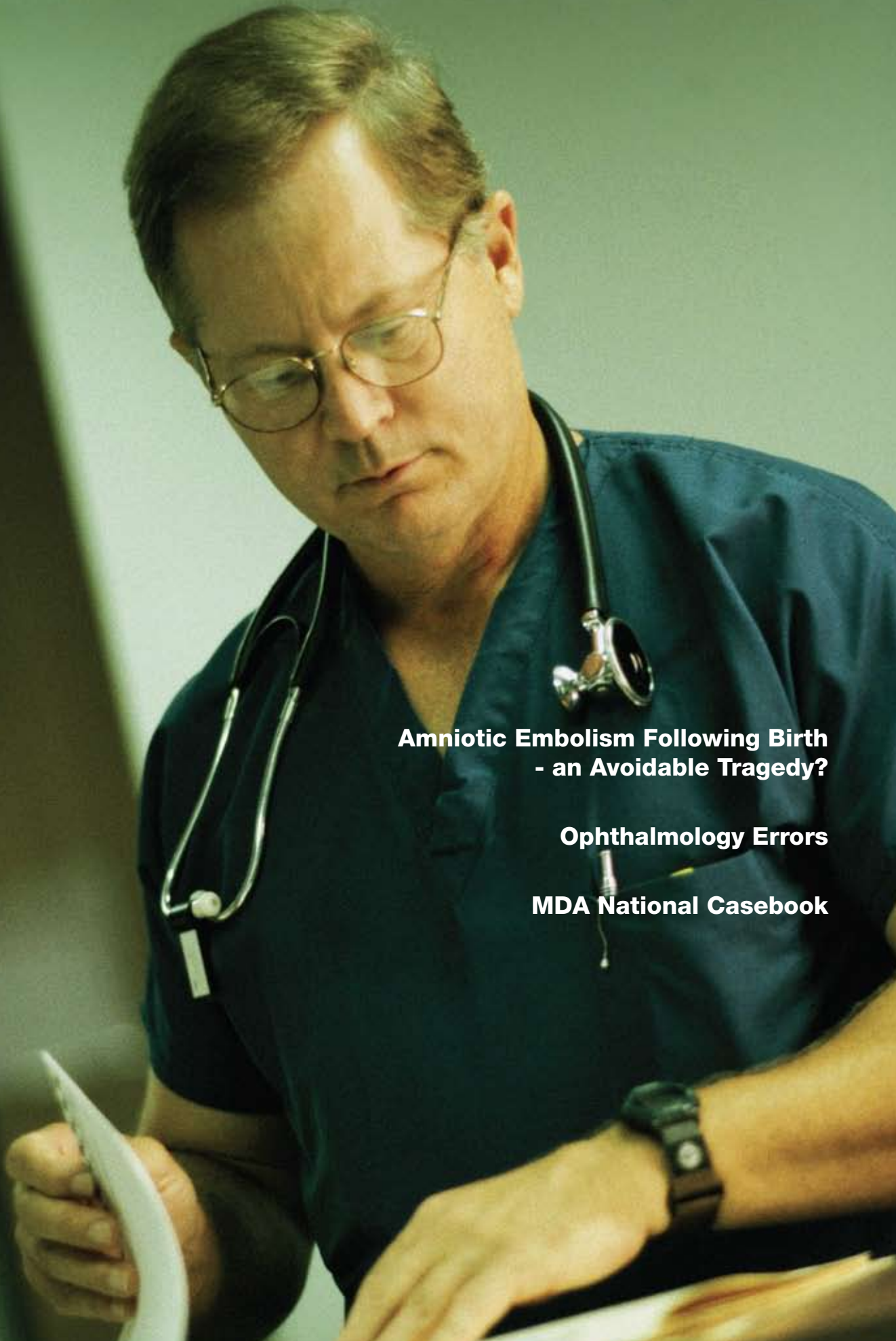
MDA National

Autumn 2008

**Amniotic Embolism Following Birth
- an Avoidable Tragedy?**

Ophthalmology Errors

MDA National Casebook





Member Online Services

Now even more services are available online for MDA National Members.

The Member Online Services (MOS) give you the flexibility to interact with us 24 hours a day, 7 days a week. Since the launch of the first stage in May 2007, we have been working to develop a wider range of online services.

At the times most convenient for you, you can:

- View and update contact details and provider number.
- Renew and pay for the Professional Indemnity Insurance Policy.
- Update policy and payment details in real time.
- Notify an incident online.

The Latest Developments: Certificate of Currency and the Risk Category History.

From time to time you may be asked to provide employers or others with proof of indemnity cover. If you have a current Professional Indemnity Insurance Policy with MDA National Insurance, you can now download and print a Certificate of Currency online.

Additionally, you can also review the risk category history associated with your insurance cover for the past three years.

More Member Online Services

Further important developments will be released in early April 2008. At that time, the Pre Renewal Questionnaire and the application form for the Premium Support Scheme will be available online. As the traditional paper version will also be sent to Members, you will be able to choose the way that you prefer to forward that information.

Online Risk Management

The Risk Management team is looking forward to providing an increased level of support for Members in 2008 through a range of new resources that will be available through the website. The most significant improvement will be an online workshop registration process.

The ever-popular Cognitive Institute Workshops will be provided again in 2008, at no cost to Members. Once the online function is launched, you will be able to search for workshops in your State, register for workshops and receive your confirmation, all online. This will greatly improve the efficiency and ease of registering for MDA National events.

Don't forget, to enjoy the benefits of MOS, you only need to register for a secure online password. Visit our website www.mdanational.com.au to find out how to register.

For more information about MOS visit the website www.mdanational.com.au or contact Member Services on 1800 011 255 during business hours or by email at peaceofmind@mdanational.com.au.

From the President

Welcome to 2008 and the first *Defence Update* for what I hope will be a year free of medico-legal controversies and concerns for Medicine generally and each of us individually.



It is a New Year for us all in health care. Following the election we have a new and somewhat unknown group sitting on the Treasury benches. That is not to say that as individuals, the members of the Rudd government were unknown in Opposition. In government, as is usually the case, most have taken on portfolios that were not their shadow responsibility. It is in this context as individuals and as a government, they present to us a little unknown. But not necessarily untried.

Ms. Nicola Roxon as the new Minister for Health and Ageing has had her first meetings with her State and Territory counterparts. As might be expected in Health, not all was sweetness and light. A pre-election promise to "fix" the health system and seek to bring it under one tier of government will prove difficult to manage. Notwithstanding health being on the nose for ministers in each State and Territory, it represents a very large part of their budgets and their political reason for existence. Any concerted attempt to remove that responsibility to the Commonwealth will take statesmanship and careful management, even though there is a strong view in many circles that there would be advantages in so doing.

What is also clear is that with Labor governments in every jurisdiction, the Commonwealth and State/Territory governments will face strong pressure on wages and conditions. Hospitals in some states have felt real pain as a result of staff leaving the workplace for better wages and conditions in resource-rich States like WA and Queensland. Attempts to recruit nurses have not only failed but created additional tensions as one State has sought to poach staff from another.

Not only has staff morale been affected, so has the ability to continue to deliver good quality care at the bedside.

The two decade erosion of the role of clinicians in advising hospitals (through their now disbanded boards) on standards of care, appointments and all the other matters necessary to keep complex institutions running, has served as an awful backdrop to this. One of the many features of medical life that has been lost as a consequence is that of loyalty to great teaching institutions and with it the commitment to walk the extra mile. Even without the necessary expansion of teaching and learning for medical students and graduates to peripheral and private hospitals, the loss of commitment to teaching and research in tertiary teaching hospitals is serious.

For MDA National all these changes will continue to be of interest.

At this stage in the life of the new Commonwealth government we have no idea of their attitude to some of the concerns that led to changes in the provision of indemnity for doctors that so concerned the Profession five or so years ago and led to significant changes in many facets of the traditional indemnity arrangements.

On the other side, what about quality and standards of care? Plaintiff solicitors would have it that Tort reform has significantly affected the rights of patients to sue. Virtually everyone (including, I suspect, most plaintiff lawyers) would agree that legal action is no way to get "justice". Notwithstanding that, in a recent publication (*Physician Insurer 2007*, Fourth Quarter: 4-5) in an article headed "*What Patients Want in Response to Complaints: Justice*" the author reported on a survey of 74 US hospitals in relation to complaints regarding care. 74% of those surveyed stated that an explanation of what had happened was more important than an apology. Interestingly, only 32% saw the restoration of the doctor-patient relationship as being important and only 7% "were interested in financial compensation for the incident". The question of "justice" was bound up in being confident that the management systems for complaints was impartial, that there was full disclosure from those managing the treatment and that they could receive an assurance that what had happened could not happen again.

The implication of this final view clearly indicates that complaints management should be tied in to robust systems of improving safety and quality.

Many of these agendas are alive and well in Australia and it is to be hoped that they would have a bi-partisan approach to them. Funding changes to improve safety and quality in our systems of care will always be difficult and more so in times of financial stress or political or professional dispute.

It is to be hoped that the Rudd government will build on the progress of the last few years in developing a more rational approach to improving safety and quality without imposing unnecessary restrictions of those required to provide that care. Resolution of some of the "big picture" items regarding the organisation and funding of health will have to go on. MDA National itself and through the industry body (MIIAA) will take its place at the table to advise and support sensible changes.

A/Prof. David O. Watson
President



Amniotic Embolism Following Birth - an Avoidable Tragedy?

"Too little, too late"¹ is a gross understatement of the circumstances surrounding the death of Piyanat Anna Siriwan (the deceased) who died at 1415 on 1 April 2004 after having given birth earlier that day. The Coroner, Ms. Paresa Spanos, handed down her findings on 25 January 2008 and found: "With competent medical management including more timely and less chaotic decision-making, Mrs Siriwan had a reasonable chance of survival - in that sense I find that her death was preventable".²

An autopsy performed on 6 April 2004 attributed the cause of the deceased's death to "post partum haemorrhage complicating amniotic fluid embolism"³ and this was unchallenged at the Inquest. The major issue for the Coroner's determination was how the death occurred, namely the context within which the death occurred. This required a critical evaluation of the period of approximately five hours from the time the deceased gave birth at 0805 and her arrival at Monash Medical Centre (MMC) shortly after 1300 after transfer from South Eastern Private Hospital (SEPH).

Background

On 31 March 2004 the deceased was induced at forty-one weeks gestation and a healthy baby daughter was born on 1 April 2004 at 0805 at SEPH. Immediately post delivery 400mls of blood loss was noted and the obstetrician left for his rooms at 0815. The midwife's first post delivery observations at 0820 noted the uterine fundus was lacking tone and was therefore "rubbed up", blood pressure was 100/70, heart rate 100bpm and a 200-300mls bright red gush of blood was noted per vagina. At 0823 the midwife pressed the call bell for assistance. The obstetrician was telephoned and gave a phone order for IM Syntocinon 10 units which was administered.

Observations at 0830 showed blood pressure 80/60, heart rate 90bpm and uterus needing to be "rubbed up". The obstetrician was again telephoned and ordered Misoprostol which was administered at

0835. The obstetrician attended at 0840, established an IV line and commenced Hartmann's 1L. Bleeding appeared to have settled and the obstetrician ordered Syntocinon 40 units in Hartmann 1L to run at 250mls per hour over four hours and left. At 0845 the Syntocinon was commenced, blood pressure was 90/70, heart rate 90bpm and heavy blood loss (estimated at 1100mls) including clots, was expelled. Blood loss was continuing at 0855, blood pressure was 85/70 and heart rate 90bpm. A second line was commenced for delivery of Hartmann's 1L. At 0857 the midwife notified the Associate Unit Manager and requested backup.

Blood pressure at 0859 was approximately 65 systolic and a Code Blue was called and the obstetrician notified to attend immediately. The team arrived at 0900 and commenced Haemacell and ECG monitoring and discontinued the second line of Hartmann's. The obstetrician arrived at approximately 0903 and ordered the Syntocinon infusion to increase to 900mls per hour. The deceased's observations following the Code Blue were blood pressure 90 systolic, heart rate 121bpm, blood loss was settling, oxygen saturation was 99% and the uterus continued to need "rubbing up". At 0915 a second bag of Haemacell was given and the deceased was taken to theatre. An examination under anaesthetic commenced at 0930 with a blood sample taken by the anaesthetist for cross-matching.

During the procedure the anaesthetist and obstetrician became concerned about the deceased's blood clotting capacity and a second sample of blood was taken for clotting studies at approximately 1015.

The obstetrician summarised the procedure which was completed at 1015 as follows: *“Empty uterus, Rx Ergometrine, Syntometrine. Misoprostol 1m. Failure to stop uterine relaxation. Rx 5 vaginal packs into uterus. For transfusion. Opinion Haematologist. RPAO + Intensive nursing”*.⁴

The deceased went to recovery at approximately 1022 and was attended to by two Division 1 nurses and the anaesthetic nurse. The post anaesthetic record reported a patient in a critical and deteriorating condition. The deceased received units of cross matched blood at 1105, 1125, 1140 and 1150. At 1203 an ambulance was called to transfer the deceased to The Valley Private Hospital for an emergency hysterectomy. The ambulance arrived at 1216 however due to reluctance on behalf of both the obstetrician and the anaesthetist to escort the deceased and the obstetrician deciding not to proceed with transfer to a private hospital, (despite Mr Siriwan having conveyed to him that he was not concerned about cost) the ambulance did not depart SEPH until 1255.

Crucially, the deceased continued to bleed. The deceased was accompanied in the ambulance by the anaesthetist and anaesthetic nurse and at some point during the journey to MMC between 1255 and 1304 the deceased went into cardiac arrest. Upon arrival, the deceased was transferred to the resuscitation area for intubation and commencement of CPR with limited response. Despite an emergency laparotomy, immediate hysterectomy, transfusion of substantial amounts of blood, platelets and fresh frozen plasma and ongoing resuscitation, the deceased failed to respond and was recorded as deceased at 1415.

Coroner's Findings

The standard of proof for coronial findings is the civil standard of proof on the balance of probabilities. Applying that standard, the Coroner found no basis for making any adverse findings against the Metropolitan Ambulance Service or Dorevitch Pathology. Similarly, no adverse comment was made against the nursing staff at SEPH.

However, adverse comment was made against SEPH with respect to the transfer of the deceased. The Coroner found there was a need for SEPH to have established and well-rehearsed processes for arranging such transfers with clear role definition and lines of communication. Further adverse comment was made against SEPH to the extent that the doctors' failure to transfuse 'O- Negative' blood immediately the need became apparent arose from the doctors' ignorance of its existence and commented: *“SEPH should ensure that all doctors with practising rights are aware what facilities and resources are available at SEPH”*.⁵

The Coroner noted that adverse comments are not lightly made against professionals, especially medical professionals, however, she found there was compelling evidence to do so against both the obstetrician and the anaesthetist. In summary, the expert evidence found a lack of any clinical plan following the examination under anaesthetic; a failure to treat for haemorrhage in a timely way; the failure to anticipate and attempt to correct developing coagulopathy and the decision to transfer a patient in a critical condition.

The presence or absence of the obstetrician and/or the anaesthetist following the deceased's arrival in the recovery room became a critical aspect of the Inquest. The obstetrician stated in evidence at the Inquest that he left the recovery room at approximately 1040 having satisfied himself that the bleeding seemed to have stopped. This was despite being aware that the deceased's blood pressure was 84/37 at the time. He did not return to the deceased until approximately 1145.

The combined purport of the nursing staff's evidence was that the anaesthetist was in attendance for a short time following the deceased's admission to recovery until approximately 1040, returned at approximately 1110 when blood pressure dropped, ordered Ephedrine, attended to another patient requiring an emergency epidural between 1110 and 1135 and then returned to the recovery room between 1145 and 1200 when the decision was made to transfer the deceased to a tertiary hospital for an emergency laparotomy-hysterectomy.

The Coroner commented in her findings that ultimately it was not so much the actual presence but the value of the medical input of the obstetrician and anaesthetist into the clinical management of the deceased which is germane. She noted: *“It may be that both doctors were unaccustomed to treating patients of such a high acuity. If so, the least that could be reasonably expected was their identification of this mis-match between their capabilities and her clinical needs and the arrangement of a timely transfer”*.⁶

On behalf of the two doctors, submissions were made that, in effect, causation could not be established as there was a strong possibility that the deceased would not have survived in any event. The Coroner accepted the evidence of the independent expert obstetrician and gynaecologist and was satisfied that all that was required for appropriate clinical management was treatment for haemorrhage and/or anticipation of coagulopathy, not a diagnosis of amniotic fluid embolism.

In conclusion, the Coroner noted that it is one thing to say that amniotic fluid embolism is a rare and serious complication of childbirth which may lead to maternal death despite the best management and quite another to contemplate the circumstances surrounding the deceased's death. The Coroner made a recommendation that the Medical Practitioners Board of Victoria considers the circumstances surrounding the deceased's death and takes whatever action it deems appropriate against the obstetrician and anaesthetist. The deceased's widower has initiated a civil action in the Supreme Court of Victoria on behalf of his daughter and himself in a dependency action and a claim for nervous shock against the obstetrician, anaesthetist and SEPH. Exemplary damages are also claimed against the doctors.

Postscript

The deceased's tragedy is compounded by the fact that she was a Thai citizen who elected to give birth in Australia rather than Thailand because of the superior quality of the medical system and facilities in this country.

Philip Rowell and Anne-Maree Hunt Monahan + Rowell Lawyers

1. Dr Emlyn Williams in cross examination on 28 March 2006. Coroner's Court. Transcript of Proceedings Pg 134
2. Record of Investigation into Death. Case No. 1137/04. Pg 16
3. Dr Matthew J. Lynch, Forensic Pathologist, Autopsy Report.
4. Dr Lichter's Operation Theatre Notes dated 1 April 2004. Coroner's Court. Transcript of Proceedings. Pgs 32-33
5. Record of Investigation into Death. Case No. 1137/04. Pg 14
6. Record of Investigation into Death. Case No. 1137/04. Pg 15

How to Manage the Stress of Claims and Complaints



Reactions of Doctors to Medico-legal Issues

A claim or complaint against a medical practitioner causes emotional and physical stress, regardless of the outcome. Research has shown that the threat of a medical negligence claim is one of the most severe sources of stress in medical practitioners' working lives¹. It is not uncommon for medical practitioners to experience a range of differing emotions as a claim or complaint proceeds. Symptoms may last for only a short period, recur with each step in the process or persist throughout the entire claim or complaint.

A recent Australian survey examined the differences in psychological morbidity between general practitioners who have experienced a medico-legal matter and those who have not². Those practitioners with a current medico-legal matter reported increased levels of disability in work, social or family life and higher prevalence of psychiatric morbidity, compared to those with no current matter. Those respondents with a history of past medico-legal matters reported increased levels of disability and depression subscores. Male respondents with a current or past medico-legal matter had significantly higher levels of alcohol use than male respondents with no experience of medico-legal matters.

When faced with a claim or complaint, medical practitioners may experience the following emotional reactions:

- distress;
- anger;
- feeling attacked;
- feeling guilty;
- loss of confidence;
- feeling ashamed; and/or
- wanting to give up medicine³.

Strategies to Manage the Stress of Claims and Complaints

The ability to cope with stress is highly individual and medical practitioners need to reflect on their own means of coping. There are a number of strategies that medical practitioners can use to deal with the stressful nature of a claim or complaint. Effective coping responses include both problem solving and emotionally focused coping. Practitioners need to learn to switch, when appropriate, between coping responses. Problems can arise if medical practitioners try to apply the wrong response in a given situation; for example, trying to solve an unsolvable problem.

One of the first steps in coping is to obtain sufficient information about the process in which the medical practitioner is now a participant, albeit an unwilling one. MDA National's claims managers can provide detailed information about the particular medico-legal process that a Member is involved in. Additionally, medical practitioners need to understand what can be expected psychologically and, throughout the process, they need to observe their emotional and physical reactions. If any symptoms develop, such as depression, physical illness or substance abuse, Members should consult their general practitioner. Self medication should be avoided, even if faced with the common symptom of insomnia.

For most medical practitioners, a feeling of being 'out of control' pervades the onset of the claim or complaint process. Medical practitioners often feel like they are on a roller coaster ride, with alternating feelings of confidence and loss of self esteem, of assurance and self doubt. Regaining a sense of mastery and control is important. Medical practitioners often have difficulty identifying their strengths but are well practised in identifying their weaknesses. By identifying strengths, medical practitioners are then in a position to develop them and look at shaping their life and work to feed those strengths. Engaging in activities that make the practitioner feel in better control of their personal and professional lives will assist in restoring a sense of balance [see Table 1].

Further research has shown that medical practitioners who were the subject of a medical negligence claim described the following reactions:

- 96% of medical practitioners acknowledged an emotional reaction for at least a limited period of time.
- 39% experienced depression, including symptoms such as depressed mood, insomnia, loss of appetite and loss of energy.
- 20% experienced anger, accompanied by feelings such as frustration, inability to concentrate, irritability and insomnia.
- 16% described the onset or exacerbation of a previously diagnosed physical illness.
- 2% of medical practitioners engaged in excessive alcohol consumption.
- 2% experienced feelings of suicidal ideation⁴.

Table 1 - Some Strategies for Coping with Claims and Complaints⁵

Social Support
<ul style="list-style-type: none"> • Discuss your feelings with a trusted person - a colleague, family member, friend, GP and/or your claims manager.
Restore mastery and self esteem
<ul style="list-style-type: none"> • Ask your claims manager to describe each step of the process. • Clarify the anticipated length of time required to conclude the matter. • Take an active role in the preparation of the case, including participating in the choice of any medical experts. • Put aside necessary time to deal with the case. • Prepare yourself for the unpredictability of the process. • Identify areas of your practice that cause anxiety or feelings of 'loss of control' and find ways to diminish them. • Engage in activities that increase your sense of competence eg teaching, CME activities. • Review the amount of time spent on professional and family activities and make appropriate changes. • Participate regularly in physical and other leisure activities.
Change the meaning of the event
<ul style="list-style-type: none"> • Review your career objectively and reinforce your sense of competence. • Seek the advice of trusted family members, colleagues, friends and professionals about your feelings and the progress of the case.

Role of MDA National

When dealing with a medico-legal issue, MDA National's aim is to obtain the best possible outcome for our Member. Unless the Member is well and able to cope with the process, then the best result for that Member cannot be achieved. Therefore, providing support to our Members is an integral part of MDA National's role. All of our claims managers have extensive experience in supporting Members throughout the course of a claim, complaint or other medico-legal process.

Every Member will have their own individual needs, depending on their personality and the nature of the matter they are dealing with. Some Members find it relatively easy to implement strategies to cope with the stressful nature of the process, while others may be reluctant or unable to obtain the support that they need.

In order to ensure that our Members are provided with an appropriate level of support when dealing with a medico-legal issue, we have introduced two additional programs to provide support to Members:

Doctors for Doctors Program

- The aim of this program is to provide understanding and support to a Member and enable the Member to share their experience with another doctor during the course of an incident notification, claim, complaint, investigation or other process
- The claims manager will discuss the program with the Member and provide a prompt referral if the Member would like to use this service at any stage during the case
- The program complements the role of the claims manager and offers the Member additional support from a colleague during the course of the case

Professional Support Service

- The aim of the Professional Support Service is to provide a Member with direct access to a psychiatrist who can give professional support to the Member during the course of an incident notification, claim, complaint, investigation or other process
- This service is completely confidential and details of any discussions between the psychiatrist and Member will not be disclosed to MDA National
- MDA National will pay for the cost of up to 10 consultations per membership year.

If you are faced with a claim or complaint, please take the opportunity to discuss these additional support programs with your claims manager. We are here to assist, advise and support you throughout the process, to ensure that the best possible result is achieved.

Dr Sara Bird Team Leader Advisory Services

1. Schattner PL, Coman GJ. *The stress of metropolitan general practice*. MJA 1998; 169:133-137.
2. Nash L, Daly M, Johnson M at al. *Psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter: cross sectional survey*. Aust N Z J Psychiatry 2007; 41:917-925.
3. Bark P, Vincent C, Olivieri L, Jones A. *Impact of litigation on senior clinicians: implications for risk management*. Quality in Health Care 1997;6:7-13.
4. Charles SC, Wilbert JR, Kennedy EC. *Physicians' self reports of reactions to malpractice litigation*. Am J Psychiatry 1984; 141:563-565.
5. Charles SC. *Coping with a malpractice suit*. West J Med 2001; 174:55-58.

MDA National Insurance Expands into Dental Indemnity

In 2007 the MDA National Council set down the Strategic Parameters under which our Group's current and future business model should operate. A fundamental principle of those parameters is that we should continue to focus on our core business, the provision of secure professional indemnity to our medical members. However, where appropriate, we would offer professional indemnity to other classes of health care professionals providing it does not compromise our fundamental core business of medical indemnity.

In the last quarter of 2007, MDA National's wholly owned insurer, MDA National Insurance Pty Ltd received unsolicited approaches from two groups representing the dental profession; namely ADA WA and Dental Protection Limited (DPL), a division of the Medical Protection Society of the UK (MPS).

In summary, MDA National had been selected by both organisations as the preferred insurer for dental indemnity for their respective members.

The MDA National Council agreed that dental indemnity fell within our Group's Strategic Parameters and endorsed MDA National Insurance investigating the expansion into dental indemnity.

I am pleased to report that after several weeks of negotiation including due diligence and regulatory approval, MDA National Insurance will be offering dental indemnity insurance contracts to both ADA WA and DPL members in Australia with effect from 1 July 2008.

I should note that under this arrangement only medical practitioners and medical students will continue to be members of MDA National. The arrangement is one of provision of insurance contracts only to dentists. MDA National will remain 100% doctor owned.

The addition of another class of professional indemnity is an exciting development as it allows economies of scale and is another step in the development of MDA National via accelerated growth and in turn an expanded capital base.

From an historical perspective, this is not an entirely unknown class of indemnity to MDA National. Several of our claims staff and myself, have had an extensive involvement with the dental profession over the years and we look forward to establishing and enhancing our forthcoming business relationship for the advancement of your organisation.

Peter Forbes
Managing Director
MDA National Insurance

Changes on the MDA National Insurance Board



Dr Dennis Hayward

Following the retirement of Dr John Blackwell in November 2007, Dr Dennis Hayward was elected as Deputy Chairman of the MDA National Insurance Board. Dr Hayward has been a non-executive director of MDA National Insurance since 2002, he assumed the Deputy Chairmanship from 12 December 2007.

Dr Hayward holds an MBBS from UWA and a Master of Insurance from Deakin University. He is a Fellow of the Australia and New Zealand College of Anaesthetists, a Member of the Australian Institute of Company Directors and a member of the Australian and New Zealand Institute of Insurance and Finance.

Additionally, Associate Professor Julian Rait has been appointed as an Alternate Director to Dr Tom Hugh, a director on the MDA National Insurance Board.



A/Prof. Julian Rait

A/Prof Rait is an Ophthalmologist in Melbourne and joined Council in June 2004. He is an Associate Professor of Ophthalmology at the University of Melbourne, a fellow of RACS and RANZCO and a member of the International Association for Research in Vision and Ophthalmology.

A/Prof Rait currently serves as the MIIAA representative on the competence and performance working party of the Royal Australasian College of Surgeons.



Ophthalmology Errors

Surgical confusions, including wrong sided procedures, operating on the wrong patient, or inserting the wrong implant are some of the worst imaginable events for patients and the surgical team. Bilateral organ symmetry creates the potential for wrong-sided anaesthesia and surgery¹ and large surgical volumes set the scene for mistakes, especially where there are last minute changes to the order of operating lists.

That intra-ocular lens errors are a common source of patient dissatisfaction has long been known to ophthalmic surgeons. However, a recent study in Archives of Ophthalmology² reveals just how commonly these mistakes occur. Simon and his co-authors from the Department of Ophthalmology at the Lions Eye Institute in Albany New York, have recently published a sobering review of two large databases: the New York Patient Occurrence Reporting and Tracking System (NYPORTS) and the closed cases of the Ophthalmic Mutual Insurance Company (OMIC). They discovered that the wrong intra-ocular lens implant was the main source of error in eye surgery, accounting for 63% of the 106 cases examined. Wrong eye or wrong eye blocks were the next most common errors with an incidence of 14% and 13% respectively while the wrong patient or procedure was involved in 7% of all cases identified.

Given the retrospective nature of the study and that mandatory reporting systems (such as NYPORTS) suffer from significant under-reporting, the observations in this paper are almost certainly subject to bias. Nevertheless, even if the absolute number of errors are under-representative, an incidence of 69 errors per million procedures is still unacceptably high when compared to modern manufacturing standards, where the accepted rate is no more than 6 errors per million. Furthermore, when compared with other specialties, Ophthalmology is foremost in inserting the wrong prosthesis into patients. However, this really reflects the very high number of lens implants now performed and that cataract surgery is the leading surgical implant procedure performed in the world today.

Of course, Ophthalmologists are painfully aware of their own and other surgeons' mistakes in the implantation of an incorrect intra-ocular lens either through measurement or calculation error or simply because the wrong lens was inserted at the time of surgery. But there are some unique cognitive challenges for

eye surgeons. Ophthalmologists grow accustomed to "their right" being the "patient's left" when examining the patient at the slit-lamp. This situation is altered during eye surgery when the Ophthalmologist usually sits behind or at the side of the patient's head. Multiple intra-ocular lenses of varying powers and more recently specific astigmatic axes, need to be implanted. Confusion can easily occur especially as some surgeons are probably genetically unable to consistently distinguish right from left in themselves and in others³.

Simon and his co-authors also acknowledge that the surgical confusions identified in their study account for only 2% of malpractice cases in Ophthalmology. Less common but more devastating events such as intra-ocular infections more often result in claims. Nevertheless, this article acts as a timely reminder to Ophthalmologists of the imperative to improve their systems and embrace new measures to reduce some avoidable and harmful mistakes.

A/Prof. Julian L. Rait
Vice-President, MDA National
Associate Professor of Ophthalmology, University of Melbourne

1. Selden S and Barach P. *Wrong sided anesthetic and surgical procedures: Why do they continue to happen?* In Tartaglia R. Healthcare systems ergonomics and patient safety. Taylor & Francis 2005, pp 13-15.
2. Simon JW, Ngo Y, Khan S, Strogatz D. *Surgical confusions in ophthalmology.* Archives of Ophthalmology. 2007 Nov; 125 (11):1515-22.
3. Storfer MD. *Problems in left-right discrimination in a high-IQ population.* Percept Mot Skills. 1995 Oct; 81(2):491-7.



The Pros and Cons of Electronic and Paper Records

Whether paper or electronic, medical records are essential for effective communication and good clinical care. In a busy practice the medical records can sometimes be given low priority and be poorly maintained. Nonetheless, many doctors want to know the best way, from a medico-legal perspective, to keep medical records. There is, of course, no “right” way to keep medical records. We do know from experience that hybrids, which are a combination of paper and electronic records, continue to be the most commonly used method by medical practitioners.

The following fictionalised, but based on real-life, story of Dr Brady, provides an example of how well good record-keeping can work:

Dr Brady is a specialist orthopaedic surgeon who had a claim against him for a failed procedure after performing an open reduction and internal fixation of a fractured tibia and fibula on Mr Roderick.

When presented with the claim, Dr Brady disputed the facts, saying that Mr Roderick had been non-compliant with his recommended post-operative treatment.

During the course of his treatment of Mr Roderick, Dr Brady had written in his notes on each review visit about advice given. Mr Roderick was advised not to weight bear on his leg for at least 6 weeks. Dr Brady noted in his records that Mr Roderick continued to weight bear against advice.

Dr Brady also noted that he had advised Mr Roderick not to smoke, as this would delay the healing of his wound. Again Dr Brady recorded that Mr Roderick continued to smoke against his advice.

Dr Brady's practice manager had also noted in Mr Roderick's file the details of conversations she had with Mr Roderick, indicating his weight bearing on entering the rooms and his discussions with her about smoking.

Dr Brady's Medical Defence Organisation provided Mr Roderick's medical records to the plaintiff lawyers. Upon review the claim was withdrawn, as it was likely that the patient would not succeed in his claim given the documented evidence of his non-compliance with treatment recommendations, among some other factors.

'Easy' Electronic?

Electronic records have many advantages. They are always legible, easy to link to other information and have the capacity for automated recalls, flags and alerts. There is always the ability to find out when the record was last accessed.

Electronic records, of course, have their vulnerabilities, such as 'crashes' and lost information. With electronic records, it is essential to have a system for back-ups. These are best completed daily with a copy of the back-up kept off-site.

There is another area of risk with electronic records. The practice of summarising documents in an electronic health record (then destroying the paper record) may lead to relevant information being omitted, altered in context and/or misinterpreted.

Current legislation does not specify the format of medical records. Occasionally, original paper documents can have forensic value if required at trial. This aspect needs to be weighed up against the need for rationalisation of storage space. There are concerns with destruction of medical records after scanning.

MDA National recommends:

- Keeping all original paper documentation received and created by the medical practice for the minimum periods currently recommended by your state.
- In the event that this is not possible, the original, complete documentation should be promptly scanned and saved into the patient's electronic health record. The original paper document should then be securely destroyed.
- Quality scanning to allow a complete and legible hard copy to be reproduced from the electronic copy as required.
- Not to summarise original paper documentation in the electronic health record.

A medical practitioner's position may be compromised in defending any claim or investigation arising from patient management based in any part on summarised information. This may even be in circumstances where original documentation has been kept.

Plain Old Paper?

It is easy to imagine that going back to the "good old" paper records might be the answer. However, there are also risks with these more familiar paper records. Back-up of paper information is not feasible. Furthermore, paper records are at risk of being subject to the ravages of the elements, the risk of fire, flood or other physical damage.

Privacy of faxed information can often be overlooked. Faxed private information can languish exposed in an open office in-tray. Additionally, with electronic, there is always a record of who has accessed the record - with paper, this is not possible. Paper records make error correction an area of risk.

MDA National has made the following recommendations about error corrections in paper medical records:

If, in the normal course of patient management, you need to make a correction to the medical records, it is quite acceptable to rule across the mistaken entry (without deleting it) and initial the correction, including the date that the correction was made. If information relating to a particular incident is received at a later date one may insert an entry but clearly mark it "Additional" and include the date and time it was made and sign this entry.

Hybrid Health?

Even health information professionals, who once thought that medical practitioners were simply "resistant to change" when it came to computers, now embrace hybridisation of medical records - albeit as a step toward eventual full electronic health records¹.

With hybrids, there are also risks, in particular information "gaps and overlaps". These risks are best managed with a systematic approach. These strategies can assist:

- All versions of patient information should be available to the Medical Practitioner at the time of consultation with any patient.
- Agreed procedures on what will be paper and what will be electronic.
- Clear policies for staff about how referrals and results are documented and progressed.
- Clarity around how test results are receipted and followed up.
- Safeguards in place to avoid 'missing' data.
- Clear conventions about care documentation for each contributor to the record.
- Constant vigilance, such as regular audits, of medical records to identify inconsistencies, gaps and unnecessary duplication.

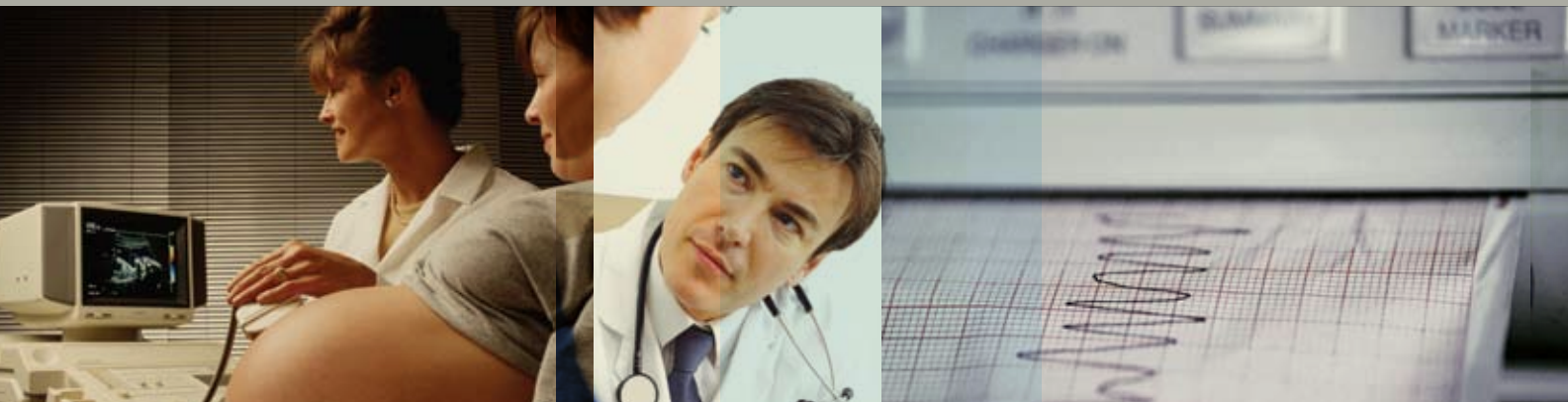
Regardless of method, good systems with comprehensive, legible and accurate medical records are often the key to successfully finding the facts and/or defending a claim or a complaint - as was the case with Dr Brady and Mr Roderick. Claims often involve a dispute of the facts. Where there is little or no supporting documentation, the medical practitioner is at risk. It is best not to rely on your memory - be sure and write it down or key it in!

Susan DeVries
Education Developer

1. Chavis, S (2006) HIM's finest blend For the record; 18 (25):14 accessed 05 Feb. 08 at: http://www.fortherecordmag.com/archives/ft_12112006p14.shtml

MDA National Casebook

The following cases have been prepared by members of the Claims Department, Dr Jane Deacon and Ms Julie Brooke-Cowden. 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.



“More is Missed by Not Looking than by Not Knowing”

(Thomas McCrae, 1870-1935)

Case History

Mrs Brown, a 39 year old woman, consulted Dr A for the first time on 1 February 2003 (the first consultation). The patient stated that she was three months post-partum. This was her third baby, with her other children aged 8 and 3 years. The patient had recently moved to the state capital from a regional centre and felt isolated and lonely. She was not sleeping well, was teary and felt she was not coping with the children.

Dr A took a full history and discussed at length with the patient the possible diagnosis of post-natal depression. They decided that antidepressants were not necessary at this stage and the patient was given the contact details of a nearby post-natal depression support group and other supports. At the end of the consultation, the patient seemed happier and reported that she would come back to see Dr A in a few weeks to report how she was progressing. By this time the consultation had taken well over the allotted 15 minutes and Dr A was running late.

As the patient reached the door on the way out of the consulting room, she paused and turned back towards Dr A and said “I’ve been having some pain from my bottom when I go to the toilet since my baby was born. I suppose it’s nothing to worry about and I think something similar might have happened when my 3 year old was born.” Dr A then made some clinical notes for the consultation regarding the possible post-natal depression. He also wrote “? Fissure (anal)”.

The patient presented to the doctor two weeks later on 15 February 2003 and again on 15 March 2003. At both these consultations, the

patient’s post-natal depression was discussed. At neither of these consults did Dr A ask about the progress of the fissure and the patient did not volunteer any information about it.

About four months later, on 6 June 2003 (the second consultation), the patient again presented to Dr A. This time she had come for a repeat of her oral contraceptive pill. She also mentioned that she was still having discomfort in her bottom. She stated that the pain occurred when she used her bowels and during sexual intercourse. It also made it uncomfortable for her to sit at times and the pain was radiating down her leg. Dr A did not examine Mrs Brown. He felt her symptoms were most likely due to a persistent anal fissure. He recommended that the patient use Proctosedyl ointment. He asked her to come back for review if the Proctosedyl ointment was not improving the situation. He did not make a note of that advice but recorded ‘anal fissure - trial Proctosedyl’ in his clinical notes.

Dr A did not see Mrs Brown for about three months. She next presented on 2 September 2003 (the third consultation). On this day the patient told Dr A that she was experiencing persistent and increasing anal pain and Dr A referred her to a surgeon.

The surgeon, Dr B, was unable to perform a thorough rectal examination because the patient had severe pain. He arranged for her to have sigmoidoscopy, EUA and excision of fissure the following week. She was found to have an indurated fissure in ano at 10 o’clock with copious granulation tissue around it giving a mass of about 2 cm in diameter. Clinically he felt that it was likely to be a tumour. It was biopsied and found to be a basaloid anterior anal canal carcinoma.



Medico-Legal issues

Some time later the patient commenced proceedings against Dr A, alleging a delay in diagnosis. Expert opinion was obtained from a GP as to whether Dr A's standard of care of this patient was appropriate.

The GP commented on the difficulties encountered when the patient pauses as they are leaving the room, their hand on the door handle and the patient introduces a completely new symptom or complaint. Often this concern is significant to the patient but they have delayed it to the end of the consultation, either because it is too embarrassing or too worrying for the patient to raise earlier in the medical consultation. The GP is then faced with the difficult decision as to whether to bring the patient back into the room and deal with that complaint at that consultation with the risk of running significantly behind time and annoying other patients who are waiting in the waiting room. The alternative is to invite the patient to make another appointment so that this concern can be dealt with properly. Obviously sometimes the patient will introduce very urgent problems at the door, eg chest pains, which must be dealt with on the day. Rectal pain, although not immediately life-threatening, is a symptom that should be taken seriously and followed up.

If Dr A did not feel that there was time to adequately deal with it on that first appointment, the GP expert was critical that he did not make a more definite plan to follow up. Doctors should be aware of this situation and have a strategy to deal with it and if possible make a note in their records that the patient has been advised to return to discuss the issue properly.

In addition, when the patient mentioned the problem for the second time, on 6 June 2003, opinion from the GP was firm that on this day, the patient should have been examined. Despite many patients' natural reluctance for intimate examinations, it is always the doctor's responsibility to indicate to the patient that the relevant body part should be examined. Whether it would have changed his therapy is speculative, because one cannot predict what he would have found at the time, but it may have made this matter easier to defend.

Oncology opinions were sought as to the effect of the delay in diagnosis on the patient's prognosis. Although it was felt that this was a slow growing tumour and the delay may not have caused a significant difference to her prognosis, Dr A's failure to perform a physical examination at the second consultation deprived the patient of the chance of a better outcome.

Accordingly it was felt that this case could not be defended and it was settled.

The importance of accurately documenting follow-up instructions given to a patient is highlighted by this case. As the GP had written extremely comprehensive notes regarding her discussions with the patient, she was able to prove that she had discussed the patient's CT scan results with him, her reasons for initially recommending a conservative approach to treatment, and the follow-up instructions provided to the patient.

A Pain in the Back

Case History

On the 6th of August 2004 a 29 year old man presented to the GP, complaining of lower back pain. According to the patient, the pain was radiating both up to his neck, and down to his knees. On examination, the GP observed that the patient's straight leg and lumbar flexion was limited. The GP provided the patient with referrals for an x-ray, CT scans of his lumbar spine and a referral for physiotherapy treatment. He was asked to return with the results of his radiological investigations.

The patient returned to the GP on the 10th of August 2004. The GP noted when she was reviewing the films, that there was a mild disc bulge at the L3/4 level, and a moderately large right-sided disc prolapse at the L4/5 level. The GP recommended that the patient's back pain be managed conservatively, and asked that he return if his symptoms did not improve with physiotherapy. Although the patient was subsequently seen on 2 occasions in October 2004, he made no mention to the GP of any back pain. The patient did not return to the GP's practice after October 2004.

On the 3rd of November 2005, the patient experienced the onset of back pain while he was at work. He sought treatment from an after hours clinic and was given anti-inflammatory medication for an acute flare-up of lower back pain.

A week later, on the 10th of November 2005, the patient presented to the Emergency Department of his local hospital. When examined by the CMO, the patient was complaining of severe back pain, numbness in his bottom, thigh, back, and right leg. The CMO noted that the patient appeared to have difficulty walking.

The patient was subsequently reviewed by the Neurosurgical Registrar. After undergoing a CT scan, the patient was discharged by the Registrar with a diagnosis of right sided disc bulge at the L4/5 level.

However, the patient was brought to hospital by ambulance the following day, with severe abdominal pain, urinary frequency and dysuria. An IDC was inserted, and almost two litres of urine was drained. An MRI scan was urgently performed. This was reported as showing an L4/5 disc sequestration, with cauda equina compression. Although the patient underwent urgent laminectomies and discectomies, he was left with bowel and bladder incontinence, and significant weakness of his right leg.

Medico-Legal Issues

In December 2006, the patient commenced legal proceedings against the hospital. The patient alleged in his Statement of Claim that the hospital was negligent in:-

- Failing to adequately consider the patient's history of sacral numbness and bilateral leg sensory symptoms on the 10th of November 2005;
- Failing to perform an MRI scan when it was clinically indicated;
- Failing to diagnose an incomplete cauda equina lesion;
- Inappropriately discharging the patient home.

The solicitors instructed on behalf of the hospital wrote to the GP in March 2007. They stated that the hospital would be seeking a contribution from the GP, with respect to any damages awarded to the patient. The GP sought advice from MDA National.

An expert neurosurgeon instructed on behalf of the patient was extremely critical of the decision to discharge the patient home on the 10th of November 2005. The Neurosurgeon expressed the view that if a diagnosis of incomplete cauda equina syndrome had been made on the 10th of November 2005, and the lesion had been surgically decompressed, the patient would most likely have maintained normal bowel and bladder function.

The hospital served a report of a General Practitioner, which was extremely critical of the GP's care. According to the hospital's expert, the sudden onset of unexplained back pain in a fit and well 29 year old male was a red flag indicator of a potentially serious condition, thereby warranting further investigation. The failure by the GP to refer the patient to a Neurosurgeon, or to arrange for an MRI scan to be performed in the expert's opinion constituted an unacceptable departure from usual practice.

However, the GP expert instructed by MDA National on behalf of the GP was most supportive of the patient's management. The expert was of the view that appropriate investigations had been performed by the GP, and that a conservative approach to the management of lower back pain (which resolved without intervention in late 2004) was appropriate.

The hospital subsequently withdrew the claim for contribution against the GP.

Discussion

The importance of accurately documenting follow-up instructions given to a patient is highlighted by this case. As the GP had written extremely comprehensive notes regarding her discussions with the patient, she was able to prove that she had discussed the patient's CT scan results with him, her reasons for initially recommending a conservative approach to treatment, and the follow-up instructions provided to the patient.

Ideally, the GP would have followed up the patient's back pain during his subsequent consultations in October 2004. However, the parties agreed that it was unlikely the patient would have failed to mention his back pain to the GP in October 2004 if he had been experiencing significant symptoms at this time.

Member Details

Full name

Membership number (if current Member)

Patient Details

Name

Address Postcode

Employment

Date of birth / / Male Female Marital status No. of dependents

Treatment given

Outcome

Patient type Private Public Public with private consultation Not yet known

Other Practitioners Involved

Name

Address Postcode

Name

Address Postcode

Name

Address Postcode

Incident Details

Location of incident

State of occurrence Date of incident / / Date you became aware of incident / /

Your medical specialty at time of incident

Brief Summary of Incident

Include details of patient presentation, diagnosis, treatment and outcome.
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