

Defence Update

Quarterly Magazine of the MDA National Group

MDA National

Winter 2008



**Insider's Look at the
Claims Department**

**Limitation Periods and
Tort Law Reform - Any Limit?**

**PSS and Your
Risk Management Obligations**

MDA National Casebook

Risk Management Events Calendar 08

DATE	DAY	LOCATION	WORKSHOP TOPIC
August			
2/08/08	Saturday	Perth	Mastering Difficult Patient Interactions
2/08/08	Saturday	Perth	Mastering Adverse Outcomes
9/08/08	Saturday	Sydney	Mastering Adverse Outcomes
9/08/08	Saturday	Sydney	Mastering Your Risk
9/08/08	Saturday	Townsville	Mastering Your Risk
9/08/08	Saturday	Townsville	Mastering Difficult Patient Interactions
16/08/08	Saturday	Brisbane	Mastering Adverse Outcomes
16/08/08	Saturday	Brisbane	Mastering Professional Interactions
September			
6/09/08	Saturday	Perth	Mastering Difficult Patient Interactions
6/09/08	Saturday	Perth	Mastering Patient Expectations
13/09/08	Saturday	Melbourne	Mastering Patient Expectations
13/09/08	Saturday	Melbourne	Mastering Difficult Patient Interactions
17/09/08	Wednesday	Brisbane	Mastering Adverse Outcomes
17/09/08	Wednesday	Perth	Mastering Professional Interactions

All workshops attract CME/CPD points and are free of charge to Members who hold a current Professional Indemnity Insurance Policy.

Please visit our website mdanational.com.au to view full workshop details and to register online.

If you are unable to register online, contact the Risk Management team at riskmanagement@mdanational.com.au or phone 1800 011 255.

Please feel free to check the online calendar of events regularly as more workshops will be added throughout the year.

From the President



Telemedicine: “To be or not to be”, with apologies to Shakespeare.

*“Western Australia is immense: to drive from Esperance in the south to Wyndham in the north is a trip of 3,818km”*¹. Whilst Dobb was discussing a subject other than Telemedicine and his comments apply equally to the remainder of mainland Australia, it is no accident that Telemedicine has developed most rapidly in those parts of Australia where clinicians have to cope with providing services at appropriate standards to people living in remote areas far from major population centres.

It is also evident that Telemedicine has developed where there is support for the technological solutions and a financial incentive to apply those solutions². As Singh & Wachter state, *“risk management in the era of telemedicine and medical outsourcing remains largely uncharted territory”*.

This is no different for MDA National. Our staff has had a close watching brief on Telemedicine for nearly a decade and I venture to say that not a great deal has altered in that time. However, what has changed is both the interest and support of the Commonwealth Government, and the expanding practice of Telemedicine in this country. Radiology (and the RACR) has had a deep interest in the subject, and published again earlier this year³. Kenny & Lau state that *“teleradiology is like a ‘two-edged sword’ that requires careful consideration and balancing, needing uniform standards to guide quality care while ensuring patient safety”*. Smith et al⁴ focus on a quality control issue, providing data from their experience in Queensland comparing telemedicine and face-to-face consultations. This is a different scenario from that which Radiology generally has been developing. The Radiology issues are more those of transmitting images to central reporting areas. Face-to-face consultations are not a feature.

There is another inherent difference in the radiology/clinical consultation comparison: the question of consent. Singh & Wachter state that *“medical outsourcing often occurs ‘behind the scenes’ with patients unaware that certain services may be delivered.....by others”*. In the clinical trials that have been going on in Australia, I suspect that is not the case. Rather, clinicians have been at pains to ensure that patients are very aware of the nature of the consultation.

What is clear from this decade of experience is that Telemedicine is applicable in a wide variety of situations that do not necessarily just apply to rural and remote locations. As well as consultations in Psychiatry, it is of use in Ophthalmology, Otolaryngology and Gastroenterology and embraces procedures as well as “bed-side” assessments. Indeed, the technology should have applicability in any branch of medicine that benefits from the transmission of digital images to and from a remote site.

The issues for Medicine, for organisations such as MDA National, for the Law and Legislators centre on how this technology can be deployed to best advantage in the interests of improved patient care and better quality, particularly for those in more remote areas, allowing better access to services without necessarily having to move to a major centre.

There will not only be technical questions to solve, but cultural, language and other communication hurdles as well as making sure of adequate documentation and retention of that documentation in a form that is tamper-proof and part of a “decentralised” medical record. Implicit in Kenny & Lau’s comments about some of the principles supported by the RACR is a greater need for referring clinicians to provide better information to assist Radiologists interpret images. That implies in all circumstances, but Teleradiology highlights the need.

Telemedicine implies a more team-like approach. Here again there has been some interesting recent local commentary. Evans et al⁵ provide a good outline of how multidisciplinary patient care meetings should be held and documented. They include opinion on documenting dissenting opinion and making sure that there is informed consent. Of interest is their view that the patient does not need to be de-identified during these discussions. As a personal view, I would have thought it was essential they were not. Studdert⁶ states that *“the law aims to promote high-quality care, not retard it. Legal doctrine is neither static, nor vacuum-sealed. As practices change, the law must evolve to accommodate them, without abandoning its commitment to holding providers accountable for substandard care”*.

Here, then is the rub!

The whole implication of Telemedicine and multidisciplinary care is recognition that in the 21st century high quality patient care is a complex set of tasks that has moved beyond the ability of a single individual to deliver it. The “team” approach has existed in some disciplines for half a century. In general these disciplines like cardio-thoracic surgery, intensive and coronary care medicine, emergency medicine and geriatrics are among the safest in a medico-legal sense. It seems the experience of Telemedicine, like any other form of multidisciplinary care, brings with it better documentation as well as improved communication with patients, leading to greater patient and medico-legal safety. It also brings with it a dilution of the “captain-of-the-ship” concept that is the basis of the Tort of Negligence as it affects health care.

Telemedicine is here to stay. It appears to offer distinct advantages in care and documentation likely to improve standards of care and care delivery. The absence of any case law guiding the Profession in this area should not be seen as a barrier to further development of Telemedicine. The basic principles of contemporaneous practice, good communication, sound documentation and informed consent still apply.

Telemedicine offers better, not worse, care.

This information is intended as a guide only and should not be taken as legal or clinical advice. If you are considering commencing Telemedicine remember to contact your indemnity provider for advice relating to your liability for matters covered under your insurance policy.

A/Prof. David O. Watson
President
MDA National

References

1. Dobb G. *National registration will further disadvantage the most at-risk.* Aust Med 2008; 20:14
2. Singh SN & Wachter RM. *Perspectives in Medical Outsourcing and Telemedicine - Rough Edges in a Flat World?* N Engl J Med 2008; 358:1622-1627
3. Kenny LM & Lau LS. *Clinical teleradiology—the purpose of principles (Editorial).* Med J Aust 2008; 188:197-198
4. Smith AC, Dowthwaite S, Andrew J & Wootton R. *Concordance between real-time telemedicine assessments and face-to-face consultations in paediatric otolaryngology.* Med J Aust 2008; 188:457-460
5. Evans AC, Zorbas HM, Kearney MA, Goodwin HE & Peterson JC. *Medicolegal implications of a multidisciplinary approach to cancer care: consensus recommendations from a national workshop.* Med J Aust 2008; 188:401-404
6. Studdert DM. *Can liability rules keep pace with best practice? The case of multidisciplinary cancer care (Editorial).* Med J Aust 2008; 188:380-381

Limitation Periods And Tort Law Reform - Any Limit?

Noah Callan was born on 28 January 1997 at the Bellarine Hospital (“the hospital”). Through his father as litigation guardian, a claim for damages against each of the hospital and the obstetrician alleging that he suffered a brain injury resulting in cerebral palsy as a result of their negligence during the mother’s labour and his birth was commenced on 21 August 2006 and 29 January 2007 respectively.

In their defences the hospital and the obstetrician pleaded that the claims were time barred by the operation of the *Limitation of Actions Act 1958* (“the Act”). The Act had been amended as part of tort law reform with effect from October 2003.

The issues before the Court were:

- (i) Whether the limitation period under the Act as amended by tort law reform had expired to preclude the claim succeeding; and, if so,
- (ii) whether the limitation period ought be extended under section 27K of the Act.

The Facts

On 27 January 1997, Mrs Callan was admitted to the hospital at approximately 0900 for induction of labour at 41 weeks for the birth of her second child. The 28 year old was seen by her obstetrician at approximately 1800 and was sent home to await events. Around 0100 the next morning she was re-admitted, in labour. The obstetrician was notified, but did not attend. By about 0130, CTG monitoring showed evidence of foetal heart rate deceleration. The obstetrician was again contacted around 0510 and given a report of “profound foetal bradycardia”. The obstetrician attended and unsuccessfully attempted a ‘Ventouse extraction’, before Noah was delivered around 0547 with the assistance of forceps. Noah required resuscitation immediately after birth and a paediatrician was called. Noah developed neonatal seizures over the first few hours of life and required anticonvulsants during the first week. Mother and babe were transferred to the Geelong Hospital and discharged when Noah was 10 days old.

When Noah was approximately 1 month of age his paediatrician told his parents that he suffered from athetoid cerebral palsy and would have a permanent level of disability. However, Noah had been socially interactive since birth and his parents were reassured by the paediatrician advising them that Noah might possibly be only mildly affected.

Around this time his parents also consulted the obstetrician and asked what had happened during the birth as Mrs Callan “felt” or “sensed” that the management of her labour was the cause of Noah’s condition. The obstetrician informed the Callans that his review of the medical file indicated that the medical management of the birth was within acceptable standards.

Noah started receiving occupational therapy and physiotherapy at the age of about 2 months. His parents obtained a written report dated 8 May 1998 from the paediatrician which noted one of his problems as “*Cerebral Palsy – mixed - spastic quadraparesis with some diplegia and athetoid elements*”.

When Noah was about 16 months old his parents, at the urging of family members, consulted solicitors who correctly advised as the law then stood, that Noah would have until 6 years after his 18th birthday to pursue any claim. The Callans decided in mid 1998 not to pursue a legal claim at that time and moved to Japan.

It was around Noah’s 4th birthday on 28 January 2001 that his parents first realised that he would not attain normal developmental milestones and would have serious physical disabilities for the rest of his life. However, believing that Noah had until the age of 24 to do so it was not until 17 November 2004 when Mrs Callan contacted her solicitors via email from Japan and advised that upon her family’s return to Australia in the next 12 to 18 months they would like their assistance as by then they knew that Noah would require extensive lifelong care. The solicitors responded and informed Mrs Callan of amendments to the Act which meant, in their opinion, a proceeding would be statute barred however an extension might be granted. The Callans responded promptly stating that they would like to proceed in bringing a possible claim.

There was a slight delay in obtaining Noah’s medical records and a Writ was not issued until 21 August 2006 following receipt of an independent expert obstetric opinion dated 27 September 2005. This opinion reported that Mrs Callan’s labour was not monitored appropriately. A medico-legal opinion was also sought from a paediatric neurologist and in his report dated 12 April 2006 that expert opined that Noah’s diagnosis of a dyskinetic athetoid type of cerebral palsy was highly likely to be due to birth asphyxia.

The Relevant Law

Pursuant to the tort law reforms which took effect in Victoria from October 2003, the amending legislation reduced the limitation period for a personal injury action brought by a minor who is a person under a disability.



At relevant times after 1 October 2003, section 27E of the Act provided:

- (2) *“An action in respect of a cause of action to which this section applies shall not be brought after the expiration of whichever of the following periods is the first to expire –*
- (a) *the period of 6 years from the date on which the cause of action is discoverable by the plaintiff;*
- (b) *the period of 12 years from the date of the act or omission alleged to have resulted in the personal injury with which the action is concerned.”*

Section 27F of the Act prescribes a cause of action as being ‘discoverable’ by a person on the first date that the person knows or ought to have known of all of the following facts:

- (1) ...
- (a) *“The fact that the death or personal injury concerned has occurred;*
- (b) *the fact that the death or personal injury was caused by the fault of the defendant; and*
- (c) *in the case of personal injury, the fact that the personal injury was sufficiently serious to justify the bringing of an action on the cause of action.”*

Section 27K of the Act makes provision for a court to grant an extension of the limitation period if it decides it is just and reasonable to do so. In exercising this power, a court shall have regard to many factors including:

- whether the passage of time has prejudiced a fair trial of the claim;
- the nature and extent of the plaintiff’s loss; and
- the nature of the parties conduct.

Applying the applicable law to the facts in this case, the limitation period is 6 years from the date the cause of action was “discoverable” by either of the Callans as Noah’s capable guardians. That is, the date either of them knew or ought to have known that Noah’s personal injury occurred, was caused by the fault of the hospital and the obstetrician and was sufficiently serious to justify the bringing of the cause of action.¹

The Callans conceded that Noah’s cause of action was “discoverable” under s. 27F (1)(a) and (c) by about 8 May 1998, the date of Mr Hewson’s report. The issue before the Court however was when the cause of action was discoverable within s. 27F(1)(b) i.e. when either of the Callans knew or ought to have known that Noah’s injuries were caused by the fault of the hospital and the obstetrician.

The Decision

Justice Williams was persuaded that before the Callans were aware of the expert obstetric opinion on 27 September 2005, neither of them knew or ought to have known that Noah’s personal injury was caused by the fault of either the hospital or the obstetrician within the meaning of Section 27F(1)(b) of the Act. Thus, in Her Honour’s view, the causes of action were not ‘discoverable’ before 27 September 2005 and thus each of the limitation periods therefore extend to 2 September 2011. Accordingly, Her Honour struck out the pleading of the claim being statute barred within the hospital’s and obstetrician’s defences.

In passing, Her Honour indicated that even if she had concluded that the limitation periods had expired because the causes of action were discoverable earlier, she would have been persuaded by Noah that it was just and reasonable to exercise the Court’s discretion to extend the limitation periods.

The Significance

This case is yet another example of the courts exercising a liberal interpretation of the provisions of a Limitation Act. The most significant finding is that even if Her Honour found against Noah in relation to the limitation period provision applying, she would otherwise have exercised her discretion to extend the limitation period. In the absence of demonstrable prejudice, beyond mere lapse of time, there is a real risk that courts will extend time in cases of this nature.

**Philip Rowell/Anne-Maree Hunt
Monahan + Rowell Lawyers**

References

- 1 Section 27F(1)(a)-(c) Limitation of Actions Act 1958 Vic.



Insider's Look at the Claims Department

I was asked recently how much of a Member's claim will be handled by us here at MDA National and whether we are simply an agency who refers your problem to external lawyers, like a car insurer sends you off to a panel beater.

I was taken aback that the doctor was not aware of our in-house claims team, and how they handle the vast majority of the work in relation to all our claims. As many of our Members will fortunately not have the need to contact us more than once or twice in their career, and those who do have claims may prefer not to discuss the issue with their colleagues, perhaps I should not have been surprised at the query.

In fact only approximately 50% of actual claims will require external legal input, and even then our in-house team retain an important role in coordinating conduct of a claim. We must not undervalue our external lawyers who retain a pivotal role in claims handling and litigation, but Members should be aware of just how extensive the in-house service is, to place it in perspective.

Nationally, we have twenty Claims staff members who are responsible to the Head of Claims, Allan Tattersall, for managing all aspects of incident handling. Allan, an MBA Accountant and Economist by training, came to us from a general insurance background, where he had gained wide experience with companies such as GIO, NRMA and AMP before becoming a consultant for Trowbridge Deloitte. He is an industry leader with his experience in coordinating management of medico-legal claims. His staff include doctors, lawyers and support personnel.

When a Member calls about an incident or an issue, the matter will initially fall into one or more of the following categories.

Advice – the Member needs information on medico-legal issues. Every year we receive thousands of such calls for assistance. For example, where do I stand if my employer wants me to undertake telemedicine consultations? Most often these can be handled by a Claims staff member, who may consult with other lawyers, doctors and the in-house insurance, underwriting and risk management experts to frame a response (See Dr Sara Bird's article in this issue for a wider exploration of the type of Advice Calls we handle.)

Incident – notification of an event that we consider is unlikely to lead to a claim. For example, a patient has developed a recognised complication from appropriate treatment, and will likely recover without permanent problems.

Likely Claim – a notification of an event that we consider is likely to lead to claim. For example, the patient has had wrong site surgery, or a plaintiff lawyer has requested information in relation to an adverse outcome.

Claim – where any verbal or written demand for compensation has been made against a Member by the patient or a third party. This is the writ, statement of claim or letter of demand that arrives on your desk.

Investigation – a Member has received notice of an inquiry by a State Health Complaints body or the Medical Board or Coroner.

Management of a Claim

The Claims Manager will gather information from the Member and, if the matter is more serious or complex, seek guidance from a Medical Manager who will be a member of one of our Cases Committees, and seek to obtain expert medical reports.

At times it will be obvious that a matter should be settled rather than defended and we will move to do so on best terms in an expeditious fashion. Generally an outcome can be reached where there is a confidential settlement with no admission of liability.

Where there is doubt about the Member's liability, however, a matter will be defended. Material provided by the complainant will be analysed along with our own expert reports and the matter will be brought to Cases Committee for discussion when appropriate. The management have available to them two Cases Committees, one based in Perth and the other in Sydney. These are populated by doctors from a wide range of backgrounds, all with expert medical experience. The Committees offer guidance to the Claims Managers on the medical areas of a claim that need exploration and interpret the many complexities of expert reports where required. There is sometimes spirited debate and testing of propositions, and the benefit of wide ranging discussion between a variety of specialists has many times contributed a great deal toward a successful resolution of a claim for a Member. The primary decision is whether in all the circumstances the standard of care was reasonable.

The Claims Managers are responsible for keeping the Member concerned briefed on the progress of the matter. They often spend many extra hours providing support for Members during what is a stressful time. A recent development has been the formal promulgation of Member support services so that resources are available for referral and counselling if that is required.

Claims staff also need to interact with our reinsurers in regard to claims that will or might require payments that access our reinsurance treaties which are in place to cover large losses. Dr Rod Moore, Chairman of the Western Cases Committee, and the staff spend a great deal of time presenting information so that the reinsurers understand the cases that may involve them.

Additionally, Claims staff have an important role passing information on to our Risk Management professionals for use in our educational activities. They also inform the Underwriting division and refer Members who require assistance in reviewing or improving an aspect of their practice to Risk Management for support and advice.

Claims against doctors are our fundamental business. The evolution of the excellent in-house claims handling system of MDA National will continue, in concert with support from our external solicitors who are chosen for their proven skills in defending medical negligence claims.

Dr Andrew J Miller MBBS LLB FANZCA FACLM
Councillor, Medical Claims Manager

Protecting Root Cause Analysis in NSW Private Hospitals

How do we learn from, and prevent further, adverse outcomes? A helpful and much used tool has been a root cause analysis (“RCA”). Most Australian States have in place legislation to facilitate a RCA – some apply only to public hospitals. However RCAs currently conducted at NSW Private Health Facilities are not afforded privilege or protection from disclosure, for example, under subpoena by a patient making a claim. This absence of adequate protections for the participants has hindered transparency and arguably weakened the process and quality of the RCA report. When it comes into force, the NSW Private Health Facilities Act 2007 (the Act) will mirror, in private facilities, the root cause analysis (RCA) process and protections that currently exist in public hospitals. Those who have been involved in the public hospital RCA will appreciate the benefits afforded by this protection. Moreover the formalisation of the process enables participants to understand their role better, as well as the outcomes and consequences of the process.

The new Act requires private facilities to create RCA teams if a “reportable incident” occurs. Although this is not yet defined under the Act, it is likely to adopt the definition in the NSW Health policy directive “Reportable Incident Definition under section 20L of the Health Administration Act” http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_634.pdf. A reportable incident is one with serious or major clinical consequences (as defined) which has a frequent or likely chance of recurrence.

The RCA team must focus on systemic change and is not permitted to investigate the competence of an individual. However, this does not prevent the team from acting on identified issues in regards to below standard care. If the team considers the incident might involve professional misconduct or unsatisfactory professional conduct, or indicate that a person suffers from an impairment, they must notify the licensee of the facility and the chair of the medical advisory board. If the incident involves unsatisfactory professional performance that does not reach the level of possible professional misconduct or unsatisfactory professional conduct, the team has a discretion to make a notification.

When conducting the investigation, the team must abide by the rules of natural justice. In general, the rules of natural justice include informing affected persons about the investigation and giving them a reasonable opportunity to respond to any adverse comment, and considering the response; making reasonable enquires and ensuring any findings are based on sound reasoning and relevant evidence; acting fairly and without bias; and investigating without undue delay.

At the end of the process, the team must provide a written report describing the incident, the reasons they think it occurred and any recommendations for changes to practice or procedure. The Director-General of NSW Health receives the report. In the absence of consent, the report must not name an individual who provided or received health services, and, so far as is practicable, should not contain information that would permit an individual to be identified. The report cannot be used as evidence in any proceedings to show that a practice or procedure was careless or inadequate.

Members of the RCA team must not disclose any information they obtain as part of the investigation, except to exercise their functions and provide a report. A member cannot be compelled, in any forum, to disclose information or produce documents which they have solely because of their role in the RCA team. Only the final RCA report may be disclosed. Team members also have protection from defamation for statements made in writing or orally as part of the RCA process.

This legislation echoes similar moves in other states to found legal protection for RCAs conducted in both public and private facilities. By way of example, in 2008, Queensland amended the *Health Services Act 1991* to establish a protected RCA process in public and private hospitals for ‘reportable events’. Unlike NSW, an RCA is not mandatory and a facility should only conduct an RCA after considering whether an investigation of the event would benefit from the non-disclosure protections provided by the Act. In addition, the legislation specifically provides that the RCA report, or information from the report, may be provided to someone with a “sufficient personal or professional interest” in the event.

In South Australia, the Health Services Act 2008 creates RCA processes in both public and private hospitals. The RCA provisions are yet to come into force. Features of the South Australian legislation include a specific statement that disclosure to an RCA team of information, including confidential information, will not constitute a breach of any law or rule of professional ethics. RCA teams must prepare two reports, one dealing only with objective facts and recommendations and another with more detail, including causal statements. Only the more limited report may be released publicly with the detailed report available only to specified classes of people.

RCA legislation in each state and territory is different and doctors should seek specific advice, if necessary.

The new NSW Act encourages full and frank participation by creating a confidential RCA investigation process. While the focus, as in other states, is on systemic change, the team can notify concerns about individual health professionals to be investigated elsewhere, if necessary. Some facilities may choose to disclose the final RCA report as part of an open disclosure policy and we note that NSW public hospitals have adopted this practice. We expect the Act will commence this year.

The process as it has developed in the NSW public hospital environment provides clear benefits to those required to participate. It is not a perfect process nor does it provide absolute protection – it is, however, an improvement. Even so a practitioner can expect their conduct, or misconduct, will be scrutinised and acted upon where concerns are identified.

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Kerrie Chambers
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Risk Management Events Registration Now Online

It is now even easier for Members to register for Risk Management events such as the ever-popular Cognitive Institute Workshops.

Starting from July 2008, Members will be able to select from a range of Risk Management Event topics and locations. In recognition of our expanding Membership, new workshop locations include: Townsville, Hobart, Adelaide and Canberra.

To register for an event, Members can simply:

- Go to “Risk Management” on the MDA National Home Page
- Click on “Workshops”
- View the calendar of events
- Follow the prompts to register through Member Online Services using your Member number
- Register there and then with confirmation as easy as a click of your print button

Alternatively, Members can register directly through Member Online Services. Events will become available for registration three months prior to the date of the event.



Workshop Topics

MDA National Members will have the chance to participate in workshops that address many of the key medico-legal challenges facing doctors today including: managing adverse outcomes, understanding and managing patient expectations and difficult patient interactions, mastering shared decision making and improving professional interactions. These workshops are evidence-based and presented by doctors for doctors.

Mastering Adverse Outcomes

A patient's decision to initiate a claim can be influenced by the degree to which the doctor is able to effectively manage the patient's disappointment and expectations following an adverse outcome.

In this workshop you'll learn how to increase the ease and comfort of talking with angry and upset patients about perceived and actual adverse outcomes.

This workshop will also provide guidance on:

- What patients want from you after an adverse outcome.
- How to empathise without compromising your legal position.
- Why you want to be the first person to talk to the patient.

Mastering Professional Interactions

Doctor to doctor communication is an integral part of patient safety and continuity of care. However, many doctors have experienced:

- Having to act on a referral with scant information.
- Accepting a patient back without a discharge summary, results of investigations or current medication list.
- Being asked to pick up care for a patient over a weekend, having little information about history or ongoing planned treatment.
- A significant difference of opinion with a colleague about the diagnosis or management of a patient.

This workshop is about reducing these risks through improvements in inter-professional communication.

Mastering Patient Expectations

This workshop helps participants find ways to reduce risk and prevent patient disappointment by exploring the theory around expectations and teaching skills and techniques for eliciting patient expectations before proceeding with an intervention or treatment.

The workshop then teaches communication skills for realigning and correcting expectations, while avoiding conflict, building trust and portraying your decision/actions as in the patient's best interest.

All doctors have experienced being pressured by patients to undertake procedures or prescribe specific treatments they would prefer not to. This workshop also addresses negotiation skills to work towards a mutually acceptable solution, and how to say 'no'.

Mastering Shared Decision Making

This workshop explores the communication skills that can assist in eliciting patient ideas and values to ensure the "right" healthcare decision is made.

Enhancing doctors' skills in assisting patients to make decisions is an important risk reduction strategy, whether it be to reduce "failure to warn" claims or complaints where important patient expectations and personal factors were not adequately considered in developing a treatment plan.

Mastering Difficult Patient Interactions

This workshop gives participants new insights and practical skills to improve the ease of dealing with difficult patient interactions.

Participants will learn:

- What causes difficult interactions.
- How to look past words and emotion to understand patients' motivations and meaning.
- Words to communicate professional and personal boundaries.
- Practical skills for handling difficult interactions and negotiations.

Mastering Your Risk

This workshop provides doctors with a thorough grounding in risk management and introduces practical preventative skills and techniques doctors can implement immediately to reduce exposure to litigation.

The workshop delivers techniques to improve communication skills and patient satisfaction. This workshop is recommended to those doctors who are attending a Cognitive Institute Workshop for the first time, but is also a great refresher for all doctors.

How to Register

In order to make the events work well for our Membership as a whole, we would like to remind Members about our professional courtesy expectations for attendance at Risk Management Events:

- Register online as early as possible.
- If you register for an event, be sure that you are able to attend – these events are very popular and numbers are limited. If you don't arrive for the scheduled event, another Member has been prevented from attending.
- If you have to cancel, do so as early as possible – this allows us to let another Member attend. You can de-register from an event easily online by visiting the 'My Events' section or by calling Risk Management on 1800 011 255.
- As a mark of respect to our presenters and other Members, please endeavour to arrive on time. This will allow all participants to gain the most from the Workshop.

As a reminder to Members, future editions of *Defence Update* will include a risk management calendar of events. Members are encouraged to register for these events online for ease of access and speed of confirmation. However, if you are unable to register online, phone Risk Management on 1800 011 255.

PSS and Your Risk Management Obligations

The Premium Support Scheme (PSS) is a Federal Government program designed to help eligible doctors with the costs of their medical indemnity insurance. The medical indemnity insurers administer the program on behalf of the Government.

Among the obligations placed on our Members who are recipients of a PSS payment is the requirement to complete an activity that MDA National considers to be appropriate and designed to assist Members to identify risk and implement appropriate risk management strategies. In essence, the risk management requirement is based on the premise that if doctors receive publicly-funded subsidies to assist them in paying for their private indemnity insurance, then the public/Government should reasonably expect some accountability for that public spend. As the PSS was introduced to assist in reducing the cost of premiums to these doctors and the cause of higher premiums is the cost of claims then it follows that doctors receiving the payment should be taking steps to actively reduce their risk of attracting a complaint or claim. Of course all doctors (PSS eligible or not) should be doing this and the vast majority are. However, the voluntary nature of requesting PSS assistance places a positive obligation on these doctors to participate in risk management.

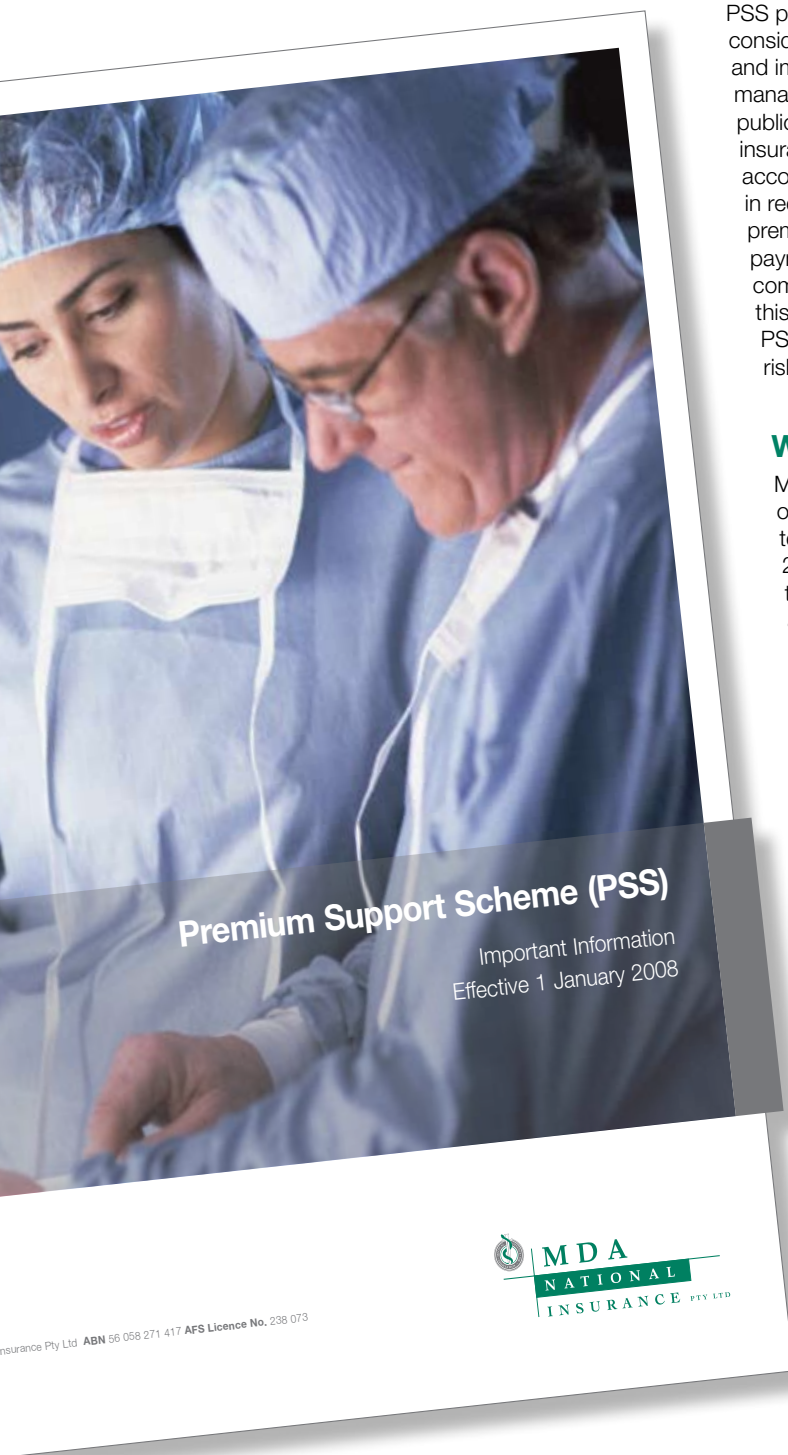
What is meant by Risk Management?

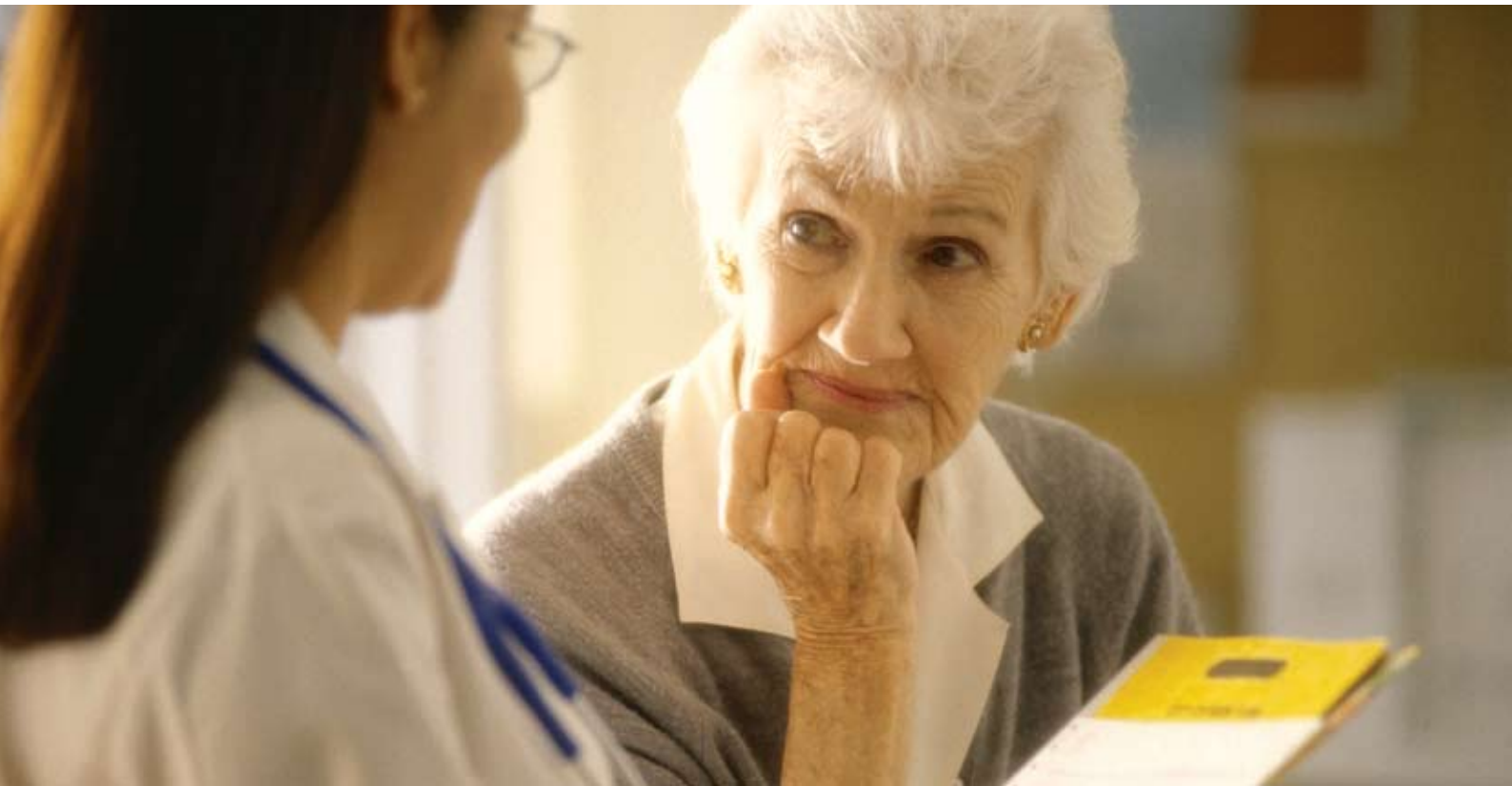
Most doctors are already involved in risk management activities as part of their professional or employment obligations, but it may not always be termed 'risk management'. To find out more, MDA National surveyed our 2007/08 cohort of PSS recipients to gain a greater understanding of the types of risk management activities that they are already participating in and those they would consider participating in. We had a good response (53%) to the survey which showed that within the past 24 months:

- 67% of respondents had participated in a MDA National risk management activity.
- 68% of respondents had participated in a non-MDA National activity (of those listed on the survey instrument).
- 23% of respondents had participated in both types of activity.
- 19% of respondents had participated in no activity (of those listed on survey instrument).

One of the difficulties for a significant proportion of PSS recipients revealed by the survey responses is that they are involved in limited private practice. Fifty percent of the 2007/08 PSS recipients are in the lowest income bands (range: \$1 - \$100K gross annual billings) and this factor may impact on their ability to participate in relevant risk management. These doctors are for instance in salaried positions – practice, research and teaching, in part-time practice, on maternity leave, in training etc. At the other end of the scale there are a small number of full-time Obstetricians and Gynaecologists and Neurosurgeons that are eligible.

For this reason we needed to think carefully about what we would ask our Members to do in order to meet their PSS risk management requirements. We wanted our requirements to be both relevant to their particular circumstances and feasible.





We went back to basics and thought about what we believe risk management to mean. We define risk management as the culture, processes and structures that are directed towards the effective management of potential adverse effects. It involves identifying, analysing, treating and monitoring risk and is an ongoing process. From a medical indemnity insurer's perspective, we are concerned with reducing the potential for patient harm and patient dissatisfaction and, hence, the risk to the Member of a complaint, claim or investigation.

Reducing these risks is dependent on a number of factors, including: doctor factors (personal well-being, ongoing training and skills development, judgement); their relationship with others (peers, members of the health care team, staff) and their relationship with patients (effective communication and behaviours, expectation management). It is also dependent upon the systems, procedures and communication mechanisms used to provide a continuum of care to patients, which should be appropriate, safe and timely.

What are our Requirements?

MDA National is of the view that the vast majority of its Members already incorporate risk management in their professional lives and that individual Members are in the best position to determine what their risk management requirements are. By the same token, MDA National remains committed to providing a range of risk management resources and tools that may assist Members in identifying and mitigating risks in their practice.

For the 2008/09 Policy Year we have developed a range of risk management options from which Members can choose. Members can participate in one of the existing MDA National sponsored or developed activities. Alternatively, they can provide us with a report of an 'external' risk management activity they have undertaken. The choice is theirs to make.

The completion of an 'external' risk management activity will be accepted by MDA National as meeting the PSS risk management requirements provided it meets the following criteria and the Member can provide evidence of completion of the activity. The criteria were developed to ensure the chosen activity was in keeping with the spirit of the PSS objectives.

Criteria:

1. Directly relevant to risk management in your particular area of professional practice.
2. Relates to an identified risk in your practice.
3. Involves analysing potential contributory factors.
4. Involves implementing changes (if needed) to mitigate this risk.
5. Includes evaluating or measuring the changes on the risk (where possible.)

To assist Members in deciding on an appropriate 'external' risk management activity we developed a report template which guides Members through the risk management 'process' or 'way of thinking' from MDA National's perspective. To further assist, we have provided examples of how the risk management process can be applied to an identified practice risk. More details are available to Members on our website.

We will continue to monitor the participation and success of the various risk management activities and will make changes or refinements as necessary. As always, we invite feedback from our Members on the choice of activities, how these were communicated to them, the ease of understanding the requirements and their suggestions for future activities.

We want to assist all of our Members who have received a PSS payment to meet their risk management requirement as failure to do so will result in the Member being deemed ineligible and any PSS payments received will need to be repaid.

The details of the PSS obligations and risk management requirements can be found on our website. It also provides the contact details of MDA National staff who can assist you in both understanding your requirements and meeting them!



A Call a Day Keeps the Solicitor Away...

MDA National's Medico-Legal Advisory Service

One of the benefits of Membership of MDA National is access to immediate, expert medico-legal advice. Our medico-legal advisory service is available 24 hours a day, seven days a week and is staffed by advisers who have medical and/or legal training.

This article provides an overview of the medico-legal advisory service, including the:

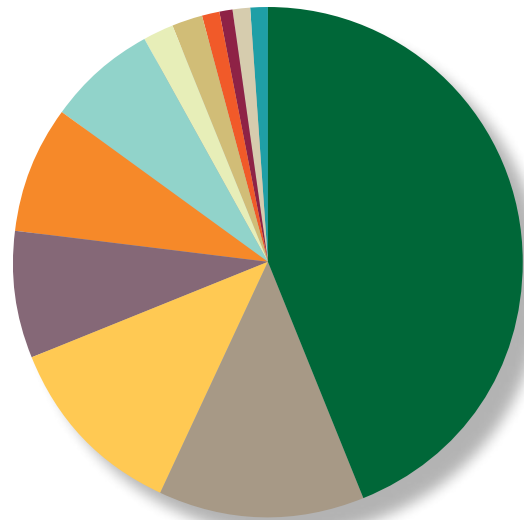
- nature and frequency of the medico-legal calls, and
- answers to some of the common medico-legal questions and issues which arise during these calls.

An analysis of the medico-legal calls received in April 2008 was undertaken to provide a 'snapshot' view of the advisory service. Approximately 300 new medico-legal phone enquiries were received from our Members in April 2008. Of these calls, 60% involved the provision of general medico-legal advice and 40% related to new incident notifications, claims, complaints, coronial matters and other investigations.

The specialties involved in the calls are outlined in Figure 1 at right.

General medico-legal advice calls covered the following issues:

- Provision of medico-legal reports to patients, insurers, police, solicitors and other third parties.
- Dealing with requests for medical records from patients, solicitors, insurers and other third parties, including obtaining appropriate patient authority to release the records.
- How to give evidence in court.
- Retention of medical records.
- Concerns about a colleague.
- Questions about legal obligations and legislation, including mandatory reporting requirements with regard to child abuse.
- Dealing with subpoenas.
- Termination of the doctor/patient relationship.
- Confidentiality.



- 44% GP
- 13% JMO
- 12% Surgeon
- 8% Psychiatrist
- 8% Anaesthetist
- 7% Physician
- 2% O & G
- 2% Radiologist
- 1% Student
- 1% Paediatrician
- 1% Pathologist
- 1% Other

Frequently Asked Questions

Is my patient entitled to obtain a copy of their medical records?

The short answer to this question is yes. Under the amendments to the *Privacy Act*, which were introduced on 21 December 2001, medical practitioners are obliged to provide patients with a copy of their medical records, if requested, unless certain defined exceptions apply. The definition of 'medical records' is broad and includes all specialists' letters and reports, pathology and other test results which are contained in the patient's medical records. Patients can request part of their medical records, for example a specialist's letter, or ask that their records be sent to a third party, such as their solicitor or insurer.

What are the situations in which I can refuse to provide access to the medical records?

There are a limited number of situations when a patient's request for access to their medical records may be denied. These include:

- Access would pose a serious threat to the life or health of any individual, including the patient or a member of their family (this may include physical or mental harm).
- Privacy of others may be affected.
- The request is vexatious or frivolous.
- Information relates to existing or anticipated legal proceedings. Information that would not be discoverable in those proceedings may be withheld.
- Access would prejudice negotiations with the patient.
- Access would be unlawful.
- Denying access is required or authorised by law.
- Law enforcement and national security.
- Commercially sensitive evaluative information.

If information is withheld, the patient must be given reasons for the denial of access, unless such a disclosure would prejudice an investigation against fraud or other unlawful activity.

Can I charge a fee for providing a patient or a third party with a copy of the medical records?

A fee may be charged to cover the cost of providing access to the medical records (e.g. photocopying, printing and administrative costs), as long as the fee is 'reasonable' and does not discourage a patient from accessing their records. The Privacy Commissioner suggests that medical practitioners should consider the patient's individual circumstances and capacity to pay for access when considering what fees may apply. It should be noted that it is unlawful under the *Privacy Act* to charge a patient a fee for requesting access to their medical records.

How long should I keep my medical records?

There is legislation in NSW, ACT and Victoria (NSW *Medical Practice Regulation 2003 Sect 7*, ACT *Health Records (Privacy and Access) Act 1997 Schedule 1* and Vic *Health Records Act 2001 Schedule 1*) that prescribes the minimum period of time for which medical records should be kept:

- For an adult – seven years from the date of the last entry.
- For a child – until the age of 25 years.

Ideally, medical records should be kept indefinitely. However, from a practical point of view, storage problems often dictate the length of time that records are retained. MDA National recommends that medical records should be retained:

- For an adult and deceased patients –
 - in WA, 10 years from the date of last entry;
 - in all other states and territories, 7 years from the date of the last entry.
- For a child –
 - in WA, until 30 years of age;
 - in all other states and territories, until 25 years of age.
- In certain circumstances medical records should be retained indefinitely; for example: legal proceedings, patients with brain damage or other disability.

Should I terminate the doctor/patient relationship? If so, how do I terminate the relationship?

There are a number of different situations in which Members seek advice with regard to possible termination of the doctor/patient relationship. These include the 'lovelorn' patient, the abusive patient and the 'difficult' patient. While each case has to be considered individually, in general terms, medical practitioners do not have a legal obligation to see a particular patient, except in an emergency situation.

If the medical practitioner decides that it is appropriate to terminate the doctor/patient relationship, as a general rule it is preferable not to enter into a long discussion with the patient about the reasons for terminating the relationship. Advising the patient that it is in their best interests to seek care from another medical practitioner (which invariably it is) and offering to promptly provide a copy of the patient's medical records to the new treating doctor is the most appropriate way of managing this situation. As always, Members are encouraged to discuss a particular case with MDA National.

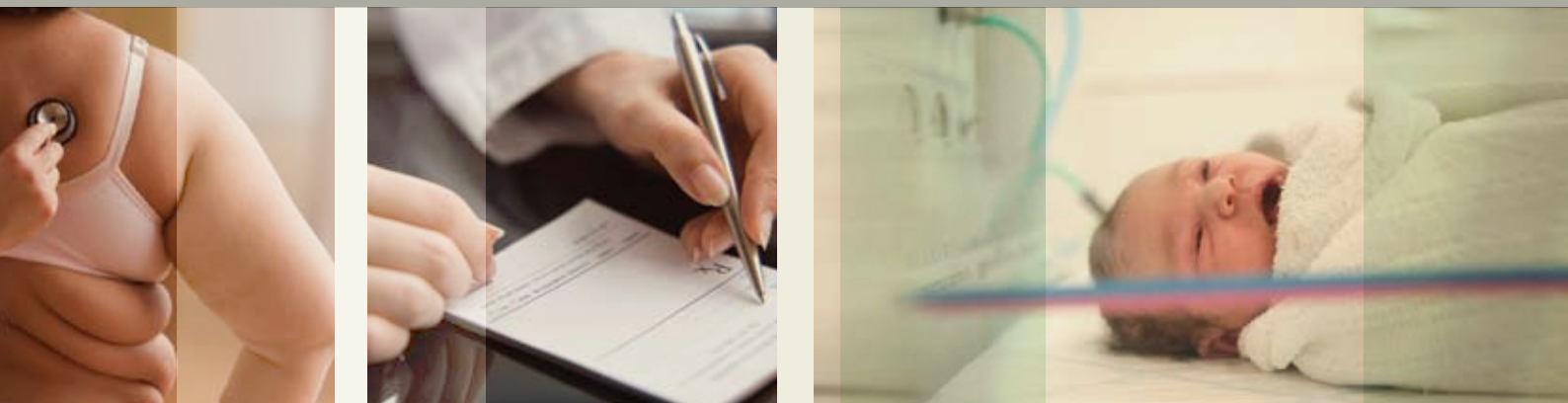
Conclusion

The provision of timely and accurate medico-legal advice is an important part of the service provided by MDA National. We welcome your calls and invite you to contact us for advice about any issues of medico-legal concern.

Dr Sara Bird
Medico – Legal Claims Manager
MDA National

MDA National Casebook

The following cases have been prepared by Members of the medico-legal team. 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 authors to ensure the anonymity of the parties involved.



Anaesthesia for Patients who have previously had Bariatric Surgery

Case History

Dr McQueen anaesthetised the 42 year patient for an abdominoplasty and breast reduction surgery on 22 February 2006. The patient had cancelled her booked pre-operative anaesthetic appointment in Dr McQueen's consulting rooms due to her work commitments and therefore she was seen in the hospital on the day of surgery.

Of note in her pre-operative assessment was a history of laparoscopic gastric banding in October 2002. The patient denied any adverse gastric emptying symptoms since the surgery and told the anaesthetist that she had no reflux except when she lay down immediately after a meal. She was otherwise healthy, having come down from 110kg to 80kg over the four years.

The patient informed the anaesthetist that she had taken nil orally since 2300 the night before surgery. The procedure commenced at 1500, after some 16 hours fasting.

After routine intravenous induction of anaesthesia including administration of Rocuronium, Dr McQueen commenced mask ventilation while the patient became paralysed, prior endotracheal intubation. During this brief period she suddenly became difficult to mask ventilate and, on inserting the laryngoscope, Dr McQueen found her mouth to contain a significant amount of clear fluid. He immediately suctioned her mouth, positioned her head down, intubated her and then further suctioned her airway via the endotracheal tube. On auscultation there were widespread crackles and wheezes and her airway pressures were elevated. Dr McQueen made the diagnosis of pulmonary aspiration but, despite this, her oxygenation remained good.

The anaesthetist administered salbutamol via the circuit and her airway pressures and wheezing decreased significantly. Over the next few minutes her condition improved significantly, to the extent that a decision was made to proceed with surgery.

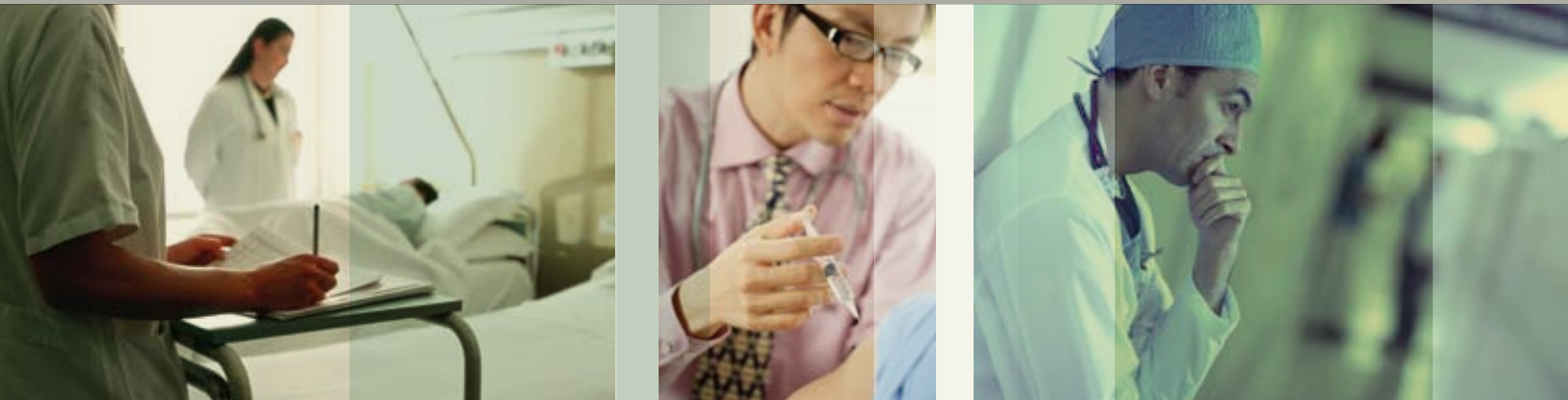
Throughout the three hours of anaesthesia, the patient's oxygenation and airway pressures were satisfactory and he extubated her successfully on completion of the surgery.

In the recovery room, however, the patient required significant amounts of supplemental oxygen to maintain adequate oxygenation, and a chest x-ray revealed bilateral pulmonary infiltrates consistent with aspiration. The anaesthetist explained the situation to the patient and her family and admitted her to the intensive care unit (ICU).

Initially the patient's condition improved rapidly, with decreasing supplemental oxygen requirements. The ICU staff planned to transfer the patient to the general ward the next day. Unfortunately, her hypoxia again worsened prior to the planned transfer, eventually necessitating reintubation, ventilation and nitric oxide therapy for a number of days. Interestingly, the nursing staff in the ICU noted pieces of partially digested food matter in the patient's mouth on a number of occasions. These had refluxed from the patient's stomach despite her not having eaten any food for several days previously, suggesting very poor gastric emptying.

After extubation the patient was transferred to the ward under the care of a respiratory physician. He noted that she remained significantly hypoxic and ordered a CT scan of her thorax. This showed appearances consistent with an organising pneumonia, probably secondary to the initial aspiration event. The patient was commenced on intensive therapy with rapid symptomatic and physiological improvement.

The patient was discharged from hospital two weeks after her surgery. She had made a good recovery from a surgical perspective and it was anticipated that her respiratory function would return to normal.



Medico-Legal Issues

The anaesthetist visited the patient on a number of occasions during her hospital admission. He did not refund her pre-paid anaesthetic fees but, after discussing the matter with MDA National, waived the amount still owing. The patient expressed concern that there would be significant extra hospital costs for her time spent in the ICU. The anaesthetist advised the patient that he would ask a staff member from the hospital's accounts department to discuss this issue with her.

There were no further medico-legal developments.

Discussion

It has long been accepted that Bariatric surgery poses significant medical risks, including a 10-15% risk of major complications and a 0.5-2% risk of mortality¹. The increase in the performance of bariatric surgery has been accompanied by a concomitant increase in incident notifications and medical negligence claims against the medical practitioners who are involved in the care of these patients. MDA National has received reports of morbidity and mortality of patients undergoing bariatric and subsequent surgery. It seems that subsequent anaesthesia in these patients even after they have had significant weight loss probably also carries increased risk, especially of aspiration, particularly if they still have an inflated gastric band in situ.

Risk Management Strategies

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) has suggested that poor pre-operative assessment and a lack of planning have been identified as key issues for anaesthetists involved in bariatric surgery and in subsequent procedures. Patients undergoing bariatric surgery often have an increased risk of surgical complications due to co-morbidities. Multidisciplinary input can optimise the care of patients with diabetes, asthma, hypertension and obstructive sleep apnoea, all of whom may benefit from pre-operative intervention. Ensuring that procedures are performed in hospitals with appropriate facilities is also important.

The VCCAMM state that:

"Airway management is of prime concern to the anaesthetist, with the risk of reflux on one hand and difficulty in securing the airway on the other. Thus a thorough and unhurried pre-operative assessment must include careful evaluation of the airway enabling adequate planning for a difficult or failed intubation.

*Pulmonary aspiration occurs most commonly during induction and laryngoscopy when sub-optimal conditions, including multiple attempts at intubations contribute to the risk. The role of cricoid pressure in the prevention of aspiration has been questioned, as it has been suggested that it may be ineffective and impede ventilation and intubation. It is, however, essential that first class assistance is always available to help in securing the airway. The incidence of oesophageal reflux is high with a direct correlation between body mass index and reflux. There is also a different pathophysiology in the obese with hyperacidity, hiatus hernia, raised intra-abdominal pressure as well as vagal abnormalities. Gastric banding itself may cause reflux (especially with slipping or erosion of the band). In patients undergoing band revision or gastroscopy it must be assumed that there is a full stomach. Removal of fluid in the band is also recommended for all patients undergoing elective surgery"*².

As this case history illustrates, patients who have previously undergone bariatric surgery probably remain at higher risk of anaesthetic complications, particularly aspiration.

Dr Sara Bird
Medico – Legal Claims Manager
MDA National

References

1. Kaufman AS, McNelis J, Slevin M et al. *Bariatric Surgery Claims – A Medico-Legal Perspective*. *Obesity Surgery* 2006; 16:1555-1558.
2. Carden J. *Hazards of Anaesthesia for Laparoscopic Banding*. *The ANZCA Bulletin*, October Issue 2007.



Do Doctors Make the Worst Patients?

Case History

Dr Brown was a 39 year old GP working in a regional centre. She consulted her own GP, Dr John, on 27 November 2003 about a lump she had recently noticed in her thyroid gland. Dr John examined Dr Brown and agreed that there seemed to be a mass in her thyroid gland. Dr John ordered an ultrasound to further investigate the lump.

The ultrasound demonstrated a 3cm mass in the thyroid and an FNA under ultrasound control was recommended. Dr Brown then obtained a request for this procedure from Dr John, but unfortunately had lost this request form by the time she arrived for the FNA. Dr Brown wrote another request for herself but did not disclose the involvement of Dr John. The radiologist, Dr X, performed the FNA and referred the cytology slides together with his own request form to Dr Path (Pathologist). On this new referral form, received by Dr Path, Dr X was the referring doctor, and there was a request for copies of the report to be sent to Dr Brown (the patient), and Dr Cut, the local surgeon.

Dr Path issued a formal pathology report on 1 December 2003 making an unequivocal diagnosis of malignancy. Copies of this report were sent to Dr X, one of Dr Brown's practice addresses (as stored in the pathology practice data base) and Dr Cut. Dr John telephoned the pathology practice and the clerical staff added Dr John to the distribution list and faxed a copy of the report to him. Dr John did not speak to Dr Path and the pathology practice staff did not inform Dr Path that Dr John had been added to the distribution list or that he had been sent a report.

On 2 December 2003 Dr Brown again consulted Dr John and discussed her results. Dr Brown was very upset that she had cancer of the thyroid and was keen to have surgery as soon as possible. Dr John had the faxed copy of the pathology report and arranged a referral to Dr Cut (the local surgeon) the following week.

On the 2nd and 3rd of December a quality review of the slides was performed and three of Dr Path's colleagues reviewed the slides and disagreed with Dr Path's original report. They were of the opinion that the appearances were no worse than atypical/suspicious. After discussion with his colleagues Dr Path amended the original report, including a recommendation that definitive surgery should not be performed without further investigations, and copies of this amended report were automatically sent to the doctors on the distribution list, i.e. Dr X, Dr Cut, Dr Brown (unfortunately to Dr Brown's old practice address) and to Dr John (he received an electronic copy only). Dr Path then telephoned Dr Cut to inform him of the amended report, as he seemed to be the treating doctor according to the referral form. Dr Path was still not aware that Dr John was the patient's GP.

Meanwhile, Dr Brown decided that she should travel to another town for treatment, as her family lived there and would be able to provide her with support while she had her surgery. She managed to obtain an appointment with the second surgeon very promptly, and she left town on 4 December 2003. Prior to her leaving she phoned Dr John and informed him of her plans. By this time Dr John had received 2 electronic copies of the pathology report, the original and the amended, but he did not open the second report as he assumed that it was a copy of the first.

Dr Brown saw the second surgeon as arranged and a total thyroidectomy was performed on 15 December 2003. Unfortunately there were complications with the surgery and Dr Brown developed a significant wound infection.

The pathologist reporting on the thyroid specimen did not find any malignancy and requested from Dr Path the original slides. On 6 January 2004 Dr Brown spoke to her surgeon and was informed that no malignancy was found, that the original slides which also showed no malignancy had been reviewed and that an amended report had been issued.

Dr Brown was shocked and horrified that she had undergone a total thyroidectomy unnecessarily. She rang Dr John to inform him. He stated that he was aware that she had undergone a thyroidectomy, but was unaware of a change in the initial report. In perusing his records, he discovered that he had two cytology reports in his pathology downloads and that he had disregarded the second one as he presumed that it was a copy of the first.

Unfortunately the significant wound infection took a prolonged period to heal leaving Dr Brown with unsightly scarring around her neck.

Sometime later Dr Brown commenced proceedings against Dr John, Dr X and Dr Path alleging that she had undergone surgery unnecessarily.

Medico-Legal Issues

The allegations against Dr Path (a Member of MDAN) were that not only did he negligently arrive at the original diagnosis and also failed to take reasonable steps to ensure that the patient was informed of the contents of the amended report - he had failed to forward a copy of the report to Dr Brown's correct address and failed to telephone Dr John.

Expert opinion from a pathologist discussed the usual protocol when issuing an amended report. He stated that pathologists virtually never discuss results with patients, even if the patient is a doctor, and that all contact is usually through the referring doctor. In this case, Dr Path considered that he had done this, as he had spoken to Dr X, the referring radiologist, and Dr Cut, the local surgeon. He was quite unaware that Dr John was the treating doctor and quite unaware that Dr Brown had decided to seek treatment in another town. The situation was further complicated by Dr Brown completing her own referral form.

Expert opinion was obtained from a GP with regard to the failure of Dr John to review and act on the amended pathology report. The expert was critical of the pathology company for not telephoning Dr John to alert him to the fact that an amended report had been issued. The expert also noted that the pathology company used a most unfortunate method for setting out the amendment. The amendment is written at the bottom of the page. If a practitioner scans the results, it would be understandable for the reader not to appreciate that this was in fact a new or amended result. Although the report is identified as amended, the report reads as it was before, until one reaches the end of the page. Nevertheless, a competent GP should review every diagnostic result forwarded to him in a timely fashion. Upon receipt of such a significant result a GP should make every effort to contact the patient as soon as possible.

The case was found to be indefensible. The matter was eventually settled, with a 50% contribution from the pathologist and 50% from the radiologist and the GP combined.

Discussion

There were a number of opportunities in this case for the doctor-patient to be informed of the amended report. Unfortunately due to a number of separate errors and omissions the patient did not receive the report in time to prevent the unnecessary surgery. The patient herself contributed to the errors by completing her own referral form and omitting to note her GP as the treating doctor. However the main burden of responsibility for ensuring that the patient was informed of the amended report fell to the pathologist and it was felt that he did not make enough attempts, given the seriousness of the misdiagnosis.

The GP also faced some criticism for not checking the second report, and this is a timely reminder that special care needs to be taken when reviewing electronic reports. It cannot always be assumed that the second report is a duplicate, and sometimes

important information is at the end of the report. This is of greater importance now that some doctors receive all pathology and radiology reports electronically and have dispensed with the hard copy.

Being asked to provide medical care to other doctors is recognition of competence by one's peers, but it also presents some unique challenges which should be acknowledged. Anxiety in doctor-patients may be greater than in non-medical patients¹. In this matter, anxiety may have prompted the doctor-patient to seek a surgical opinion and undergo surgery more expeditiously than most non-medical patients could have arranged.

Doctors treating doctors should clarify the doctor-patient relationship and discuss diagnostic and treatment plans in detail. If the doctor-patient assumes the 'VIP syndrome' administrative matters may be circumvented and short cuts taken with the usual history examination, explanation and follow up of the patient. It requires special awareness, insight and skills to take on the role of a doctor's doctor².

Dr Jane Deacon
Medical Advisor
MDA National

References

1. Schneck SA, *Doctoring Doctors and Their Families* JAMA 1998; 280:2039-2042
2. Osmond H, *Doctors as Patients* The Practitioner 1977; 218:834-839



Treatment Refusal

Case History

A thirty five year old patient was admitted to hospital early in the morning for a major orthopaedic procedure which it was anticipated would involve large volume blood loss. He had been seen in the anaesthetic preoperative assessment clinic six weeks prior and had consented to general anaesthesia, invasive monitoring, epidural pain management and blood transfusion if required. This had been done in the presence of family members who acted as partial translators as English was his second language. He was not a suitable candidate for autologous pre-donation of blood. Once in the anaesthetic room adjacent to the operating theatre an intravenous line was inserted and preoxygenation commenced. He removed the mask and requested that he not be given any blood products during the procedure. Upon further discussion it transpired that he had two weeks prior become engaged to be married and converted to the Jehovah's Witness faith. Due to the time required to explore the issues surrounding this change in consent and the non-emergency nature of the operation, the procedure was cancelled and a follow up appointment with an interpreter arranged.

Medico-Legal issues

The legal position can be summarised as follows:

1. Blood transfusions administered against the expressed wishes of a Jehovah's Witness may constitute an assault, including blood transfusions which take place in an emergency, when it is known that the person is a Jehovah's Witness and that they do not wish to receive a blood transfusion.
2. Even in emergency and life-saving situations, blood transfusions should not be administered when the patient's wishes to refuse treatment with respect to blood transfusions are known.
3. Where the patient is competent to discuss the issues, a senior member of the health care team should:
 - Discuss the rationale/benefits regarding the proposed treatment.
 - Discuss the potential side effects/risks of the proposed treatment.
 - Discuss the potential risks of **not** receiving the proposed treatment.

- Discuss the patient's reasons for declining/refusing treatment, to determine whether alternative strategies which are acceptable to both the patient and clinic staff, are available. There may be instances where a Jehovah's Witness patient will indicate (usually when there are no family members or members of the faith present) if it is necessary to preserve their life, that they will agree to receive blood products. A practitioner should keep any such consent by a patient in the strictest confidence as it is likely that the patient will not want family members or other members of the faith to know.
4. In an emergency, where a person is unable to express their consent to medical treatment, a medical practitioner may provide treatment:
 - To save the patient's life.
 - To prevent serious damage to the patient's health.
 - To prevent suffering or continued suffering from significant pain or distress.

However, a medical practitioner cannot provide emergency treatment when they know that the patient does not wish to receive that treatment.

Consent where a patient's wishes are unknown can be sought from next of kin and guardians but practitioners should seek advice from hospital administrators or MDA National in these circumstances.

5. There are laws that apply specifically to emergency treatment of children in similar circumstances. Doctors should seek advice if it is likely that the parents or guardian will not agree to a treatment that is viewed as essential by the medical staff, such as emergency blood transfusion. Generally the opinion of two medical practitioners is required in these circumstances.

Discussion

It is important for a practitioner not to impinge their own personal beliefs upon the patient's care. The acceptance or refusal of blood or blood products or indeed any treatment is the competent patient's decision.

MDA National can provide advice specific to the clinical circumstances if you find yourself in an analogous situation.

Philippa Nash LLB
Solicitor, Claims Manager

Dr Andrew J Miller MBBS LLB FANZCA FACLM
Councillor, Medical Claims Manager

Member Details

Full name
Membership number (if current Member)

Patient Details

Name	
Address	Postcode
Employment	
Date of birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status	No. of dependents
Treatment given	
Outcome	
Patient type <input type="checkbox"/> Private <input type="checkbox"/> Public <input type="checkbox"/> Public with private consultation <input type="checkbox"/> 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.
Do not send originals of medical records – send copies only if relevant to the notification. Please ensure your original records are preserved and kept separate from any correspondence with MDA National Insurance. If this matter develops into a claim, they will become critical to your defence. Attach any correspondence relevant to the notification. Attach additional comments on separate pages if necessary.

Signature _____ Date _____

<p>Policy holders based in WA, NT, SA and overseas Please post or fax the completed form and related documents to: Claims Division, MDA National Insurance PO Box 1557, Subiaco WA 6904 Fax: (08) 9415 1492</p>	<p>Policy holders based in all other states Please post or fax the completed form and related documents to: Claims Division, MDA National Insurance Level 5, 69 Christie St, St Leonards NSW 2065 Fax: (02) 9460 8344</p>
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Please notify us now...

Do not forget to let us know, as quickly as possible, of any incidents that may give rise to a claim. In some cases a claim can be minimised or even avoided altogether where we have immediate notification.

It is also a condition of your MDA National Insurance Professional Indemnity Insurance Policy that claims or circumstances are notified in writing as soon as practicable.

Don't wait for a complaint or adverse outcome to become a claim before you notify us of the incident concerned.

Please use this form to notify us of any incidents. It is a good rule of thumb that if you are worried about an outcome, you should report it.

To quickly notify us of an incident you can also log-in to our secure Member Online Services at www.mdanational.com.au to complete and submit the form online. If you require assistance logging into the secure section of the website, please contact Member Services on 1800 011 255 during business hours.

Remember – the sooner we know about an incident, the quicker we can help.

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