

Defence Update

Quarterly Magazine of the MDA National Group

Summer 2008

MDA National



Unequal Leg Length After Total Hip Replacement

When to Screen or Not to Screen?

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From the President



As the first Councillor from outside Western Australia elected as your President, I am pleased to acknowledge and pay tribute to MDA National's heritage.

At the heart of medicine in WA is Associate Professor David Watson. David is a renowned physician and has been an inspiring President of the Association. Dr Thomas Fuller, an American Physician once remarked "Great and Good are seldom the same Man". However, I have come to appreciate that David Watson is an exceptional man. He has always been gracious and polite, but has frequently challenged your representatives to engage in "less talk and more action". When Dr John Blackwell passed the Presidency to David in 1997, a new era began. Apart from a brief interlude while David stood aside in 2005, his Presidency spans from that date to last month when David stood down and kindly nominated me to succeed him following our 82nd AGM, a period of nearly 12 years.

During that period, David has overseen MDA National transform from a state based MDO to a national leader in medical indemnity.

Such an achievement highlights the leadership provided by David. A key to our success has been the establishment of our interstate presence through our local Advisory Committees. David has always been ready and willing to travel across the country at very short notice and sometimes leaving and returning on the same day to meet prospective colleagues who were willing to become part of our Advisory network.

The hours and the commitment made, particularly after the medical indemnity industry crisis in 2002, laid the foundations for MDA National to become a significant national player in medical indemnity.

David, on behalf of our Council, I would like to sincerely thank you for your leadership and contribution to our Association. Thankfully you will continue as a Council member and I am sure that Council looks forward to your continuing wisdom and ongoing contribution to risk mitigation and claims management.

I would also like to express my appreciation to my fellow Councillors, to the members of our State Advisory Committees and to our dedicated staff, led by our exceptional Managing Director, Mr Peter Forbes. Our recent internal organisation survey revealed that our people experience a high level of purpose in their work, find their roles interesting and important and continue to care deeply about the success of MDA National in meeting Members' needs.

We are indeed fortunate to have a team of management and staff who share the commitment of your Council to give more than is required to get the job done. On behalf of all Members, I would like to pay our deep respect to them and acknowledge our appreciation for their efforts during 2008.

"The common thread that unites all past Presidents of MDA National has been their commitment to work for the betterment of their colleagues and reinforce the doctor for doctor ethos which, you might agree, has been paramount to the success of our Association. It is a tradition that I intend to continue".

Finally, I understand the great honour and responsibility to be elected to serve and represent MDA National as your President for the coming year. The common thread that unites all past Presidents of MDA National has been their commitment to work for the betterment of their colleagues and reinforce the doctor for doctor ethos which, you might agree, has been paramount to the success of our Association. It is a tradition that I intend to continue.

As this is the final edition of *Defence Update* for 2008, I would like to take this opportunity to offer you all the best wishes of Council for peace and happiness during the festive season. I trust that you will all take appropriate rest from your professional obligations and return to a successful and rewarding 2009.

Associate Professor Julian L. Rait
FRACS, FRANZCO, FAICD

Unequal Leg Length After Total Hip Replacement

"...and strength by limping sway disabled"
Shakespeare. Sonnet 66

Changes in leg length, almost invariably lengthening, are relatively common following hip joint replacement, an operation usually highly successful in relieving pain and improving function in an arthritic joint. In one study the operated leg was a mean of 9mm longer three months after the operation in 62% of patients and 43% were aware of the lengthening¹. Even in patients who do not have significant leg length discrepancy there may be a perception that this is so (apparent leg lengthening). In some cases there may be a period of postoperative perceptual adjustment if a leg previously shortened by hip joint pathology is restored to normal length by arthroplasty. Indeed, in 1979 Sir John Charnley, the father of modern hip surgery, stated that lengthening of up to 10mm was common and acceptable and may actually improve function by slightly tightening the abductor muscles. Lengthening significantly greater than 10mm risks producing a poor functional outcome, with pain due to tissue stretching around the joint, backache due to secondary scoliosis, gait abnormalities and easy fatigue after walking.

Unfortunately, patient dissatisfaction is a potential concern when there is significant postoperative leg inequality. It is not acceptable to some patients to be told postoperatively that they need to wear a raised shoe on the previously normal opposite limb. As a result, unexpected lengthening of the operated leg is now one of the most common reasons for litigation against orthopaedic surgeons in the United States. A similar frequency of claims for leg inequality may be emerging in Australia. Over the past three years approximately 20% of MDA National Insurance's orthopaedic incidents and claims related to total joint replacement surgery arose as a result of postoperative leg length inequality. However, the numbers are still too small to be able to measure the trend accurately.

What causes leg lengthening?

The cause of postoperative leg lengthening is multifactorial. The surgical task in hip arthroplasty calls for a balance between tissue tension and stability of the prosthesis in order to restore normal biomechanical function and achieve a good range of pain-free movement, while at the same time aiming for final leg length equality. These multiple goals are sometimes conflicting. Additionally, scar tissue contraction and abductor muscle action, factors beyond the surgeon's control, may sometimes cause early postoperative lengthening, which resolves in the majority of patients.

If the prosthesis feels loose or dislocates easily in flexion and internal rotation when first inserted the surgeon needs to adjust for this by increasing the neck length of the modular prosthetic hip, thereby tightening the soft tissues and imparting stability, but almost certainly at the cost of lengthening the leg.

Intraoperative judgment of leg length is easier and clinically more accurate if the patient is supine, when length can be measured from the iliac spine to the level of the ankle malleoli or the knees. But this is not the most common operative approach. Most hip replacements are performed through a posterolateral or sometimes direct lateral approach, with the patient in the lateral position, when accurate tape measurement of leg length is not possible.

How do we manage the risk of lengthening and avoid postoperative complaints?

Consent

Fully informed preoperative patient consent is very important. Patient expectations of the operation should be anchored in reality. Because leg length equality can never be guaranteed after hip joint replacement it should be fully discussed as a potential complication. Those discussions should be carefully documented.

The patient's preoperative leg lengths should be measured and recorded in the patient's notes; common methods involve tape measurement from the anterior superior iliac spine to the medial ankle malleolus, or by progressively inserting blocks under the foot of the standing patient until the pelvis is level. In most preoperative patients with arthritic hips the legs still feel of equal length to the patient.

True preoperative shortening may occur with:

- congenital dislocation;
- severe acetabular dysplasia;
- as a result of Perthes disease;
- avascular necrosis or collapse of the femoral head;
- post-traumatic arthritis; and
- rarely as a result of a previous osteotomy.

Apparent shortening may be secondary to:

- idiopathic or degenerative scoliosis of the spine;
- fixed pelvic obliquity; or
- flexion and adduction contractures of the arthritic hip.

In such cases restoring leg length to normal will cause initial apparent lengthening but this should settle by 6 to 12 weeks postoperatively.

Paradoxically (and rarely) an arthritic hip may stiffen and cause preoperative apparent lengthening because of fixed hip abduction due to contracture of the capsule and the gluteal muscles.



Preoperative planning

This is essential in achieving length equality and entails:

- Measurement of leg length difference clinically, accepting that observer error may be up to 10mm,
- Estimation of the correction needed to achieve equality,
- Good quality radiographs – AP pelvis, including both hips and upper half of femora,
- Templating with overlays to gauge the predicted desirable level of the femoral neck osteotomy and offset, as well as
- Ensuring the components to be used have the modularity to restore as closely as possible normal anatomy.

However, digital images are now variable in magnification or reduction. Although templates (usually visualised radiologically with a 10% magnification factor) cannot be absolutely accurate at least they provide some guidance.

Fixed neck-shaft angle stems with limited neck lengths will not accurately fit every patient. The surgeon needs to be particularly careful of the patient with a long femoral neck and significant femoral offset. If the offset is not corrected, achieving stability will inevitably lead to lengthening, often to an unacceptable extent i.e. 15mm or greater.

Intraoperative management

- The patient should be carefully positioned and ideally held with a frame or supports to fix the position of the hips perpendicular to the table if the most common lateral/posterolateral approach is used.
- Intraoperative X-rays are sometimes recommended if the patient is supine. i.e. in an anterolateral approach, but are very difficult with the more common lateral approach.

It is strongly suggested that prior to dislocation and femoral neck transection a measuring device be used. Simply palpating the level of the patella or using the diathermy lead to estimate leg length is not sufficient. Similarly, palpating the tightness of the anterior capsule or feeling how much give or “shuck” occurs on traction with trial components is not accurate even in the hands of an experienced orthopaedic surgeon.

Computer navigation may eventually lead to more accurate cup and stem positioning but currently the most reliable gauging method is to use a pin in the pelvic brim, a second pin in the greater trochanter and a frame device as shown, which is tightened and set aside for estimation after the trial components are positioned. This provides the best possible estimate of leg length and offset.

Failure to document some reasonably accurate method of intraoperative leg measurement may make defence of a leg lengthening claim more difficult.

What is acceptable lengthening?

Even with use of an intraoperative leg length guide, lengthening of up to 10mm is common at 6 weeks postoperatively due to scar and abductor tightness and will usually resolve over 6 to 12 weeks and will not require any shoe modification. At 3 months, even if x-rays suggest offset and length are within 10mm of equality, if the patient feels the leg is functionally longer that perception is likely to be permanent.

A leg lengthening of greater than 15mm may cause tightness, possible pain, a limp and long-term low back pain, with a significantly poorer overall functional status². An allegation that this outcome is due to negligence is difficult to defend if preoperative warnings were inadequate or not documented, if there is no documentation of any preoperative leg length inequality and if there is no record of intraoperative measurement to estimate as closely as possible leg length equality and stability of the hip prosthesis.

Summary

- Preoperative informed consent should include documented discussion of leg length inequality as a possible complication.
- Careful preoperative leg measurements should be recorded.
- It cannot be assumed that one type of joint component or prosthesis fits all patients.
- Preoperative planning is essential.
- Recognition that more modular prosthetic components, particularly in regard to length and angle of femoral neck and therefore offset, may be needed.
- Intraoperative measurement prior to dislocation of the hip joint should lead to greater accuracy in postoperative leg length equality.

Postoperative patient dissatisfaction should be lessened by such means and claims for alleged negligent or inappropriate treatment in what is generally regarded as a highly successful operation may be minimised.

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MDA National Insurance

References

- ¹ Konyves A, Bannister GC. *The importance of leg length discrepancy after total hip arthroplasty.* J Bone Joint Surg (Br) 2005;87(2) :155-7.
- ² Wylde V et al. *Prevalence and functional impact of patient-perceived leg length discrepancy after hip joint replacement.* Int Orthop. Published online 25 April 2008.

When to Screen or Not to Screen?

O’Gorman v Sydney South West Area Health Service

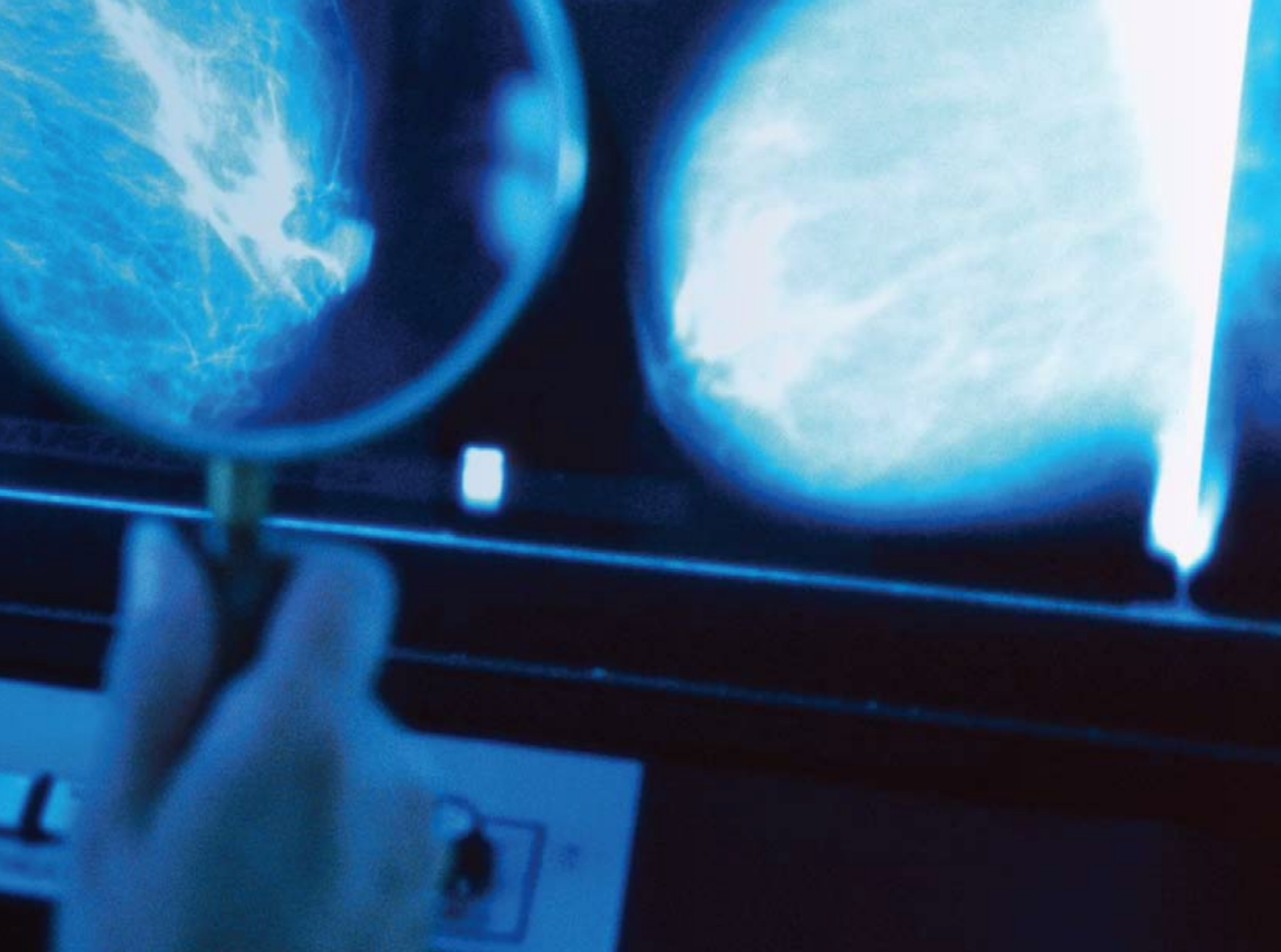
On 29 October 2008, Justice Hoeben delivered judgment in the matter of *Christine Ann O’Gorman v Sydney South West Area Health Service* with a judgment in favour of Ms O’Gorman (aged 57) (“Ms O’Gorman”) in the amount of \$405,990.00. Ms O’Gorman alleged that BreastScreen NSW Sydney South West (“BreastScreen”) failed to recall her for further investigation following a screening mammogram on 23 February 2006 having had mammograms with BreastScreen every two years from 1996. In January 2007 she was diagnosed with breast cancer which has subsequently metastasised into her lungs and brain. Ms O’Gorman is likely to die before the end of 2008.

Ms O’Gorman’s 2006 mammogram was performed by BreastScreen as part of its breast cancer screening programme. BreastScreen receives \$4.8 million in State and Federal Government funds to provide free breast screening mammograms to women aged 50-69 years – these can be repeated, at no charge to the patient, every two years. Ms O’Gorman admitted that she did not attend her GP for annual breast examinations but did self checks on a monthly basis.

BreastScreen called evidence to distinguish between a screening and diagnostic mammogram. In his evidence, Prof Osborne, State Radiologist BreastScreen Queensland, said that screening mammograms concentrated on mass population screening on asymptomatic women to detect unsuspected lesions – the screening was largely a lineal comparison of changes on each woman’s sequence of films. By comparison a diagnostic mammogram was used to diagnose actual breast changes or abnormalities that have been detected through self examination and/or clinical examination. There was clear and detailed evidence of the screening process provided at BreastScreen – it differed in significant respects to a diagnostic process. It was submitted that BreastScreen’s budget did not allow for diagnostic examinations which would require a recall of between 30 to 40 percent of patients as opposed to only 5 percent in the screening program. Prof Osborne gave evidence that had the 2006 mammogram been Ms O’Gorman’s first screening mammogram the features observed on the film would have suggested a recall was necessary. However, the changes when compared with the 2004, or 2002, films appeared consistent with a benign cyst.

Ms O’Gorman did not accept the validity of the distinction between a screening and diagnostic mammogram. His Honour, however, said that there is proper and valid distinction between diagnostic and screening mammograms where screening is performed as part of lineal sequencing as was conducted by BreastScreen.

What then is the duty of care owed by BreastScreen to users of its programme? His Honour rejected a standard that would apply to those participating in diagnostic mammography. He said that BreastScreen “...had an obligation to provide a level of care and skill in the interpretation of mammograms to be expected from a reasonably competent radiologist in the context of a mammogram screening program...” (our emphasis). To establish a breach of duty by BreastScreen Ms O’Gorman had to establish that the changes identified on her 2006 screening film were so suspicious as to raise the possibility of malignancy and warrant recall. It was the opinion of Ms O’Gorman’s expert radiologist, Dr Kitchener, that although there was no clear indication of the presence of a cancer in Ms O’Gorman’s 2006 mammogram, the culmination of signs was such that a real suspicion existed as to the presence of a malignancy which required that Ms O’Gorman be recalled for further assessment. Furthermore, it was Dr Kitchener’s opinion that when one measured the dimensions of the mass in the 2006 mammogram and compared its size with the same mass in the 2004 mammogram, it had approximately doubled in size.



Justice Hoeben accepted and preferred the opinion of Dr Kitchener, over that of Prof Osborne. He found that given that the mass did so increase Ms O’Gorman should have been recalled and the breach of duty was established.

Turning to issues relevant to an appropriate assessment of loss/damages some interesting findings and analysis were displayed.

His Honour found as a fact that had an ultrasound been carried out in March 2006 the tumour would almost certainly have been discovered. He assessed this likelihood at 90%. His Honour found that the risk of Ms O’Gorman’s breast cancer metastasising between March 2006 and January 2007 increased by approximately 10% - the experts were in agreement on this issue.

Just how one applies this 10% ‘loss of a chance’ to a fair assessment of loss and damage was hotly contested. BreastScreen submitted that a proper application of the principles required that Ms O’Gorman be entitled to damages calculated on the loss of no more than a 10% chance of a better outcome, i.e. a 10% chance of avoiding the metastases that occurred. By comparison Ms O’Gorman lawyers submitted that as the delay in diagnosis of the cancer by BreastScreen materially contributed to and increased the risk of metastases, which in fact had occurred, BreastScreen should be liable for all of the damage that flow from the cancer metastasising. His Honour accepted Ms O’Gorman’s argument and awarded her full damages.

What message can we gain from this decision which will undoubtedly cause consternation for organisations and practitioners who are involved in the provision of screening programmes – when is the screening service safe? For legal practitioners there is as much interest in His Honour’s rationale for assessing full damages on what is arguably no more than a 10% loss of a chance of a better outcome.

We understand that an appeal is being considered by BreastScreen which, if it transpires may provide further guidance on the medicolegal implications of this decision.

Brit Mainhoff
Senior Associate – Health
HWL Ebsworth

Risk Management

Shared Decision Making – Improve Your Skills

Patients increasingly expect doctors to respect their autonomy in decision making and to facilitate effective conversations that will assist them to make informed healthcare decisions. Progressively higher standards of disclosure of medical information to patients by doctors are also being set. Whether in the consulting room or hospital ward, doctors are faced daily with the difficulty of meeting patient and community expectations in this area.

Doctors are required to not only provide information such as the risks and benefits of any treatment interventions they are proposing in an appropriate and comprehensible manner, but also to take into account the patient's own ideas, values and personal characteristics.

The process of 'shared decision making' is being advocated as the most effective methodology to respond to these pressures. This shared decision making model seeks the middle ground between the often unworkable paternalistic 'doctor knows best' and 'consumerist' models; and to be effective requires that doctors possess a particular set of skills.

MDA National has previously offered the successful Cognitive Institute's 'Mastering Consent' Workshop which outlined basic communication skills to reduce the specific medico-legal risk involved in undertaking formal consent processes with patients.

Responding to the increased risk being identified around all clinical decision making processes involving patient choice and selection, the new 'Mastering Shared Decision Making' workshop:

- examines the nature of and pre-requisites for effective decision making;
- revises basic principles outlined in the 'Mastering Consent' workshop; and
- offers advanced communication techniques and support strategies.

This workshop will outline the model's likely benefits (particularly in the areas of medico-legal risk, patient outcomes and patient satisfaction), examine the specific skills required by the doctor, offer possible solutions for the difficulties encountered and provide an opportunity to rehearse some of the most important skills.

Key communication skills that enhance the discussion with patients are the ability to:

- provide accurate information about associated risks and benefits of any interventions proposed in an appropriate and comprehensible manner;
- elicit information preferences from your patient – how much, what form, how delivered;
- clearly discuss options with reference to patient characteristics, values and concerns;
- respond empathically to your patient's ideas, concerns and expectations;
- build a partnership with your patient; and
- provide an atmosphere that facilitates patients asking questions.

By skilfully facilitating this discussion, doctors are not only assisting patients to act with autonomy, but also are increasing the likelihood that patients will feel ownership of and follow through with any decision reached.

Being confident and competent in this critical medico-legal area is recognised as a real need; hence MDA National will be providing 11 of these workshops for our Members between February to June 2009. We encourage all Members to attend these workshops which will be available in all Australian States and the ACT.

You will be able to register for one of the 'Mastering Shared Decision Making' workshops (and others) on-line via MDA National's website, www.mdanational.com.au. Registrations are open three months prior to each workshop. Just follow the prompts via the risk management pages.

We look forward to seeing you in 2009!

Risk Management Team

Risk Management Workshops



The first series of Risk Management Workshops for 2009 has been announced.

Registration can be completed online through the Member Online Services section of the MDA National website or by contacting Risk Management on 1800 011 255. Numbers are limited for these sessions so make sure that you register early to ensure your place. Please note that registration is not available until 3 months before the date of the workshop.



Date	Day	Time	City	Workshop
21/02/2009	Sat	9am-12pm	Perth	Mastering Shared Decision Making
21/02/2009	Sat	1pm-4pm	Perth	Mastering Shared Decision Making
21/03/2009	Sat	9am-12pm	Hobart	Mastering Adverse Outcomes
21/03/2009	Sat	1pm-4pm	Hobart	Mastering Shared Decision Making
4/04/2009	Sat	9am-11.30am	Adelaide	Mastering Your Risk
4/04/2009	Sat	12.30pm-3.30pm	Adelaide	Mastering Shared Decision Making
22/04/2009	Wed	6pm-9pm	Brisbane	Mastering Shared Decision Making
29/04/2009	Wed	6pm-9pm	Sydney	Mastering Shared Decision Making
2/05/2009	Sat	9am-12pm	Perth	Mastering Shared Decision Making
2/05/2009	Sat	1pm-4pm	Perth	Mastering Adverse Outcomes
16/05/2009	Sat	9am-12pm	Brisbane	Mastering Shared Decision Making
16/05/2009	Sat	9am-12pm	Melbourne	Mastering Shared Decision Making
20/05/2009	Wed	6pm-9pm	Melbourne	Mastering Adverse Outcomes
27/05/2009	Wed	6pm-9pm	Sydney	Mastering Shared Decision Making
27/06/2009	Sat	9am-12pm	Canberra	Mastering Shared Decision Making
27/06/2009	Sat	1pm-4.30pm	Canberra	Mastering Difficult Patient Interactions

Full descriptions of the workshop topics can be found in the Risk Management section of the MDA National website.

All workshops attract CME/CPD points and are free of charge to Members who hold a current Professional Indemnity Insurance Policy. If there are no workshops currently listed that are convenient for you, make sure that you check the online calendar regularly as more will be added for the remainder of 2009.

For Medical Students....

MDA National has a significant presence among medical students across the country. Support is provided for social and academic activities at all medical schools. In addition, we offer support directly to students by way of some competitions based around their studies and humanitarian goals.

Student Elective Essay Competition

The Elective Essay Competition has been held for a number of years to assist student Members of MDA National with funding for their elective program.

This year, students were asked to write a short essay on the following topic:

"The elective term is a central part of the medical degree in Australia. With regards to your chosen location, discuss how the medical elective adds value".

The winner, Katie Fletcher (University of Queensland) received \$2,000 to help fund her elective with the Queensland Ambulance Service - Aeromedical Retrieval & Pre-Hospital Care Team.

First runner up, Tim Sullivan (University of Sydney) won \$1,000. Tim will be undertaking his elective in South Africa. Second runner up, Ruella D'Cruz (University of NSW) won \$500 to help her travel to Tanzania and the Northern Territory for her elective placements.

This year, there were close to 80 entries for the competition, with a high standard from students who intend to complete their electives both in Australia and overseas.

If you would like to view the winning essays please visit our website www.mdanational.com.au

Good Cause Elective Photo Competition

The Good Cause Elective Photo Competition was held for the first time this year. Students were asked to provide a journalistic snapshot representing significant experiences during their elective. The photos submitted covered a range of themes from poignant to witty and demonstrated a high level of creativity among Australia's future doctors.

Instead of receiving a grant for themselves, the winner was able to donate the prize money to the medical charity of their choice. Winner, Jake Parker, donated the \$1,000 to the Hamlin Fistula® Relief and Aid Fund.

The top three photos are shown at right.



Winner: Jake Parker, University of QLD - India.



First runner up: N Lau, Monash University - India.



Second runner up: P McGiffin, University of QLD - Fiji.

MDA National Casebook



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

Follow Up of Test Results After Hours

Abstract

This article examines a recent Coronial inquest in which the Coroner made recommendations regarding the process of notification by pathology practices of abnormal and life threatening results to general practitioners (GPs) and the response to such notifications by GPs. An addendum to the Standards for general practices provides guidance for GPs and their staff on the systems to manage the follow up of test results outside normal general practice opening hours.

Case History

The 34 year old patient attended a Medical Centre on 25 March 2004 complaining of low retrosternal and epigastric discomfort. The pain was worse when the patient was lying down and she often had a bitter taste in her mouth. There was no past, or family, history of any significant illnesses. Physical examination was normal, apart from some tenderness in the epigastrium. An ECG was performed which was normal. The GP made a provisional diagnosis of 'hyperacidity with mild oesophageal regurgitation'. The patient was given a prescription for Losec. She was asked to re-attend for review in one week or earlier if she experienced any additional symptoms. The patient returned at 10am on 26 March 2004 and saw another GP at the Medical Centre. She complained of epigastric discomfort and vomiting overnight. Physical examination was normal, apart from the previously noted tenderness in the epigastrium. Another ECG was performed which revealed sinus bradycardia of 60 bpm, but no other abnormality. The GP ordered blood tests including cardiac enzymes. The patient was asked to return to discuss the results of the tests or to re-present if the symptoms worsened. The blood tests were reported at 8.35pm on 26 March 2004 and the results were faxed to the Medical Centre by the pathology practice at 8.37pm. The results revealed an elevated troponin. The test results were placed in the GP's in-tray but were not seen by the GP until he was next on duty on 28 March 2004.

In the interim, the patient had actually presented to the local Emergency Department (ED) at 12.51pm on 26 March 2004. She complained of chest pain, stating that she had suffered burning pain in the chest since 22 March 2004. The patient advised the triage nurse that the pain occurred mainly at night and was non radiating. She gave a history of having vomited on three occasions over the preceding 12 hours. The patient said she had had an ECG which was normal and the Losec she had been prescribed had been ineffective. The patient's blood pressure was noted to be 122/86, her pulse rate was 86 bpm and her temperature was 37.2. The patient was triaged category 3. At 2.30pm the patient's name was called by one of the ED medical officers. The patient did not answer and the file was marked 'Did not answer call'. At approximately 2.45pm the patient was found dead in the toilets in the waiting room of the ED. The death was reported to the Coroner. An autopsy revealed that the patient had died from an acute myocardial infarction (AMI).

Medico-legal Issues

In November 2005, the case proceeded to a Coronial inquest (hearing)¹. The Coroner was not critical of the consultations by the two GPs at the Medical Centre. He opined that the GPs were entitled to form the view that the pain was gastrointestinal in origin, having taken a history and performed a physical examination and an ECG. However, the Coroner was concerned that there was a delay in reviewing and taking appropriate action by the Medical Centre upon receipt of the pathology results which were suggestive of an AMI. The Coroner concluded that there was a failure in the systems in place at the Medical Centre for the patient's test results to be accessed, assessed and appropriate action taken, although he noted that in this case the failure had not made any difference to the outcome for the patient. At the inquest, one of the GPs gave evidence that systems had since been introduced into the practice to ensure that there was some follow up of pathology results.

At the conclusion of the inquest, the Coroner made the following recommendation:

'That the Royal Australian College of General Practitioners and the Royal College of Pathologists of Australasia review the process of notification by pathology services of clinical significant abnormal test results (sic) to GPs and the response to such notifications by GPs'.

Discussion and Risk Management Strategies

Criterion 1.1.4 of the Standards for general practices states:

'Our practice ensures reasonable arrangements for medical care for patients outside our normal operating hours'².

On 1 July 2007, the Royal Australian College of General Practitioners produced the following addendum to the explanation for this criterion:

'The successful follow up of abnormal life threatening results outside the normal opening hours of the general practice relies on general practices having robust and reliable systems for contact. Failures in these processes in pathology follow up have been the subject of criticism and recommendations for improvement in recent Coroner's inquests, where patients have been harmed through the lack of robust ways to convey urgent information.



General practices need to have after hours arrangements in place to allow abnormal and life threatening results identified by pathologists to be conveyed to a medical practitioner who will ensure that an informed appropriate medical decision is made and acted on promptly.

If the general practice uses another service (a cooperative, medical deputising service (MDS), hospital etc) then the general practice must have a defined, reliable means of access for the deputising practitioner to patient health information and to the practice in exceptional circumstances. This places an obligation on the general practice to establish this means of contact (e.g. a contact telephone number for one or more of the practice doctors). It also places an obligation on cooperatives and MDSs to contact the general practice in exceptional circumstances.

General practices need to clarify what is expected of the deputising doctors in cases of urgent and life threatening results being communicated to the deputising doctor in lieu of the GPs in the general practice and vice versa. Ideally, this will be outlined in a formal agreement between the general practice and the after hours care provider'.

Dr Sara Bird
Medico-legal Claims Manager

References

- ¹ *Inquest into the death of Sharon Brophy*. Westmead Coroner's Court, Sydney, 9 November 2005.
- ² *The Royal Australian College of General Practitioners. Standards for general practices*. 3rd edn. Melbourne: The RACGP, 2005.



Back to Basics - Missed Osteomyelitis

Case History

On the 6th of March 2006, a 16 year old female patient presented to her General Practitioner, complaining of pain in her left upper leg. According to the patient, she had injured her left leg playing netball three days earlier. The GP arranged for x-rays of the patient's leg to be performed and recommended that she take Panadol.

The patient returned to her GP on the 7th and 8th March 2006, complaining of swelling and pain in her left upper leg. The patient's leg was bandaged, she was advised to rest her leg and to return for review if her symptoms did not improve.

On the 15th of March 2006, the patient again presented to her General Practitioner. She was limping and complaining of increased pain in her leg. The patient was afebrile and a provisional diagnosis of ligamentous injury was made. She was referred for an urgent CT scan and arrangements were made for her to be seen by an Orthopaedic Surgeon.

On the 25th of March 2006, the patient presented to the Orthopaedic Surgeon, for review. She was mobilising with crutches, as she claimed to be unable to bear any weight on her left leg. On visual examination the Orthopaedic Surgeon noted there was no evidence of any effusion, nor was there any redness of the left upper leg. However, it was not possible for a detailed examination to be performed, because of the patient's significant distress, due to her pain. As the patient's CT scan and x-rays showed no evidence of abnormality, a referral was provided by the Orthopaedic Surgeon for an MRI scan of the patient's left leg.

Later that day, the patient's father went to the GP's practice, and requested that the patient be provided with analgesia. The patient remained in her father's car, as she was too sick to walk into the practice. She was therefore not examined by the GP, but a script for pain relief was provided.

On the 31st of March 2006, the patient was again seen by her General Practitioner. She had a tender and swollen left upper leg, and had lost weight. The patient complained of fever and rigors. The GP advised the patient to attend the Emergency Department (ED) of the local Hospital, for assessment and treatment.

Later that afternoon, the patient presented to the local Hospital's ED. She was significantly distressed, her left upper leg was swollen, and hot to touch, and her temperature was 38.0°C. A provisional diagnosis of osteomyelitis was made. The patient was subsequently taken to theatre, and half a litre of pus was drained from her left upper leg. Cultures taken intraoperatively revealed the presence of MRSA. After a stormy postoperative course, the patient remained in hospital for three weeks.

In March 2007, the patient commenced legal proceedings against her General Practitioner. She alleged that her General Practitioner's management was negligent, on the grounds that her GP had:

- Failed to appropriately examine her during her consultation on the 15th of March 2006:
- Failed to perform investigations such as CRP, ESR, WCC, and blood cultures, following her complaints of chills and fever made during the consultation on the 15th of March 2006;
- Failed to consider an alternative diagnosis (other than a ligamentous injury) at the consultation on the 15th of March 2006.

The Solicitors acting on behalf of the General Practitioner wrote to the Orthopaedic Surgeon in June 2007. They foreshadowed that the General Practitioner would be seeking a contribution from the Orthopaedic Surgeon (in relation to any damages awarded to the patient), on the basis that the Orthopaedic Surgeon had failed to properly examine the patient's left leg, to take her temperature, or to organise appropriate investigations, such as blood cultures, to be performed. The Orthopaedic Surgeon immediately sought assistance from MDA National.

An expert Orthopaedic Surgeon instructed on behalf of the GP was critical of the Orthopaedic Surgeon's management. According to the expert, further investigations in the form of a Full Blood Count, ESR and CRP should have been undertaken, a limited examination of the patient's left leg should have been performed, and the patient's temperature should also have been checked. Further, the expert believed that the level of the patient's symptoms should have caused the Orthopaedic Surgeon to consider a diagnosis other than a resolving ligamentous injury at the consultation on the 25th of March 2006.

The Orthopaedic expert qualified by MDA National agreed that the Orthopaedic Surgeon should have taken the patient's temperature, and ordered blood tests, to ascertain whether the patient was suffering from an infection. In the circumstances, a decision was made to attempt to resolve the claim for contribution, on the best possible terms. The GP's Solicitors had initially sought a contribution of 60% from the Orthopaedic Surgeon. The claim was resolved on the basis that MDA National (on behalf of the Orthopaedic Surgeon) would contribute 22.5% towards the total damages paid to the patient.

Discussion

The importance of undertaking basic observations on an acutely unwell patient is highlighted by this case. Although the Orthopaedic Surgeon's recollection was that the patient was afebrile and had not complained of fever or chills during her consultation, this had not been documented in the notes.

Julie Brooke-Cowden
Solicitor / Claims Manager

Medico-legal Correspondence - Where to Store it?

Case History

Mrs Brown consulted Dr A for the first time in November 2006. Mrs Brown was a 45 year old woman who was feeling very tired and run down and she wondered if it was 'her hormones' as her periods had been quite irregular recently.

Dr A took a history and found that she had not seen a doctor for some years. She had no significant past history and was not taking any medication. He performed a thorough examination, which was unremarkable and then ordered some pathology testing to further investigate her feeling of tiredness.

Four days later Mrs Brown returned to review her results with Dr A. Her TSH was quite elevated 18 mU/L (normal range .5-3.5mU/L).

Dr A explained to Mrs Brown that her thyroid was not working properly, that she would need to have some further blood tests, should start taking thyroxine and would probably need to take it for life. Mrs Brown was very unhappy at this news. She agreed to further blood tests, but said she would consult with her naturopath.

Further tests showed a raised antithyroid peroxidase 228IU/L (normal range <61). Mrs Brown returned to Dr A and told him that her naturopath was treating her with some natural tonics and supplements and she was feeling better already. Mrs Brown was adamant that no medication was necessary, but she agreed to return for follow up blood tests.

Over the next 6 months, Mrs Brown had blood tests on several occasions and her TSH was between 15-20 mU/L each time. Dr A repeated his advice but Mrs Brown remained unconvinced of the need for medication.

In October 2007, Mrs Brown presented stating she was feeling 'terrible', very sluggish and unable to cope with her children. In the interim months she had had some contact with the local mental health services and been diagnosed with depression. She was receiving counselling but was not taking any medication. Further testing showed her TSH was now 99 mU/L and her T4 <5 pmol/L (normal range 9-19). Dr A recommended again that she commence thyroxine and Mrs Brown reluctantly agreed to commence 50mcg daily.

A few days later Mr and Mrs Brown were in to see Dr A again. Mrs Brown was feeling worse than ever, in fact she stated that she felt so dreadful that she wanted to die. Because she had been feeling so bad, she had taken 5 tablets a day of the thyroxine, felt it had only made her worse and did not think she would continue with it. Dr A was not sure whether her current state was due to depression or hypothyroidism and he suggested that she present to the local hospital or be referred to an endocrinologist.

Dr A was very concerned with Mrs Brown's condition and refusal to take thyroxine. He phoned MDA National and discussed the situation at length with them. Dr A then typed in the patient's computerized progress notes 'spoke to MDO, they think this is a serious case and I should be sure to document all phone calls and consultations very carefully'.

Throughout the next few days there were numerous phone calls between Dr A and Mr and Mrs Brown, the mental health services and an endocrinologist. Mrs Brown eventually agreed to see the endocrinologist and an appointment made for 2 weeks time. In the meantime, Mrs Brown continued to refuse to take the thyroxine, despite Dr A's strong advice.

Dr A typed into the patient notes 'further conversation with MDO, they will open a file and please send a copy of patient's records to MDO'.

Unfortunately prior to her appointment with the endocrinologist, Mrs Brown became increasingly unwell, with more bizarre thoughts and she was unable to care for herself or her children. By the time Mr Brown took her to the emergency department she was psychotic and was transferred to a psychiatric facility with a diagnosis of myxedema madness¹. Her TSH was 130 on admission. She was treated with thyroxine and olanzepine and made a gradual recovery.

Medico-legal Issues

Some months later, Dr A received a request from Mrs Brown for a copy of her medical file, as she wanted to transfer to another doctor. When Dr A reviewed Mrs Brown's file, he realised that the comments about him consulting MDA National were included in the file. He felt very uncomfortable about that and he asked for further advice. Dr A had also made some less than complimentary comments about the husband including describing him as 'obstructive', 'ill-informed' and 'difficult'.

Under the Privacy Act, National Privacy Principle 6², a health service provider is obliged to give an individual access to their personal information. Access can be denied in certain circumstances, one of which is if access would pose a serious threat to the life or health of the individual and this threat must be judged to be significant. Dr A did not feel that access would pose a serious threat to the patient's health, so it could not be denied on this basis. However, access can be provided in a number of ways and a summary can be provided if that is acceptable to the patient.

In this case, the practice then wrote back to Mrs Brown, explaining that her notes were extensive and that it would be more helpful to her next doctor to have a summary of her records. Mrs Brown agreed to this.

Dr A was advised that in future, any records of conversations or letters from MDA National should be kept separate to the patient's medical records in a 'medico-legal file'. He was also reminded of the medical advice – never write anything in the patient's file, which you would be embarrassed to have read out in court (or read by the patient).

Dr Jane Deacon Medico-legal Advisor

References

- 1 Heinrich TW, Grahm G. *Hypothyroidism Presenting as Psychosis: Myxedema Madness Revisited*. Prim Care Companion J Clin Psychiatry. 2003 Dec; 5(6):260-266.
- 2 *Guidelines on Privacy in the Private Health Sector*. Office of the Federal Privacy Commissioner.

THE ANNUAL GENERAL MEETING 2008

The Annual General Meeting (AGM) of the Medical Defence Association of Western Australia (trading as MDA National) was held on 12 November 2008.

During the meeting the President announced that the following three members had been elected to Council for a further term:

Dr Beres Wenck
Dr Andrew Miller
Dr Rosanna Capolingua

Following the AGM, A/Prof David Watson announced he was retiring from the position of President although he would remain on Council. The Council of MDA National then met to elect a new executive.

Your New Executive



President:

Associate Professor Julian Rait

An Associate Professor of Ophthalmology at the University of Melbourne, A/Prof Rait is a fellow of RACS and RANZCO. He currently serves as the representative of the Medical Indemnity Industry Association of Australia on the Competence and Performance Working Party of the Royal Australasian College of Surgeons.

A/Prof Rait has been a member of the MDA National Council since 2004. He has served on a number of committees within the MDA National Group including Underwriting and Clinical Risk Management. He has also chaired the Victorian State Advisory Committee since 2003 and is an Alternate Director on the Board of MDA National Insurance.



Vice President:

Dr Beres Wenck

A General Practitioner from Brisbane, Dr Wenck is also a visiting GP to Royal Children's Hospital Brisbane and Principal Medical Director of Family Care Medical Services, the largest Medical Deputising Service in Australia.

She is currently the Chair of the National Standing Committee of the RACGP for GP Advocacy and Support and has two Ministerial nominations as a Board Member of Q-Comp and Health Promotion Council, Queensland.

A Past President of the AMAQ, Dr Wenck was awarded Fellowship of the AMA in 2000 and received the AMAQ President's Award in 2007.

Dr Wenck has been a member of the MDA National Council since 2004. She serves on a number of committees within the MDA National Group including Underwriting. She has chaired the Queensland State Advisory Committee since 2002 and the Clinical Risk Management Committee since 2006.



Chairman of Finance:

Dr Max Baumwol

Dr Baumwol is a General Surgeon from Perth. He is attached to the University of WA (UWA) Surgical Teaching Unit and an examiner for both UWA and the Royal Australasian College of Surgeons.

Dr Baumwol has been a member of the MDA National Council since 1993 and held the position of Chairman of Finance since 2002. Prior to that he held positions as Treasurer (1998-2001) and Secretary (1997). Dr Baumwol has served on a number of committees within the MDA National Group. He is currently on the Capital and Cases (Western/Central) Committees.

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.

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 _____

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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

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
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Please notify us now...

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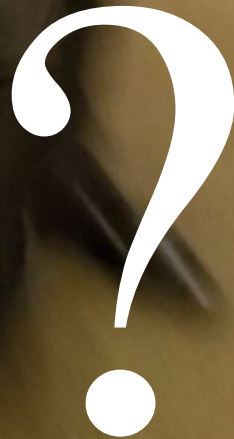
It is also a condition of your MDA National Insurance Professional Indemnity Insurance Policy that claims or circumstances are notified in writing as soon as practicable.

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.

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



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