

Defence Update

Quarterly Magazine of the MDA National Group

Autumn 2009

MDA National

**Facebook: the Medico-legal Risks
A Discussion on Failure
Risk Management Workshops 2009
MDA National Casebook**

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Cognitive Institute Workshops Calendar: April – June 2009

	Date	Day	Start	Finish	Location	Workshop Topic
APRIL	04/04/2009	Sat	9:00	11:30	Adelaide	Mastering Your Risk
	04/04/2009	Sat	12.30	15.30	Adelaide	Mastering Shared Decision Making
	22/04/2009	Wed	18:00	21:00	Brisbane	Mastering Shared Decision Making
MAY	02/05/2009	Sat	9:00	12:00	Perth	Mastering Shared Decision Making
	02/05/2009	Sat	13:00	16:00	Perth	Mastering Adverse Outcomes
	16/05/2009	Sat	9:00	12:00	Brisbane	Mastering Shared Decision Making
	16/05/2009	Sat	9:00	12:00	Melbourne	Mastering Shared Decision Making
	20/05/2009	Wed	18:00	21:00	Melbourne	Mastering Adverse Outcomes
	27/05/2009	Wed	18:00	21:00	Sydney	Mastering Shared Decision Making
JUNE	27/06/2009	Sat	9:00	12:00	Canberra	Mastering Shared Decision Making
	27/06/2009	Sat	13:00	16:30	Canberra	Mastering Difficult Patient Interactions

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.

Registration is available online at www.mdanational.com.au or contact Risk Management at riskmanagement@mdanational.com.au

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From the President



Harvey Cushing, the American born pioneer of brain surgery is widely known as the greatest neurosurgeon of the twentieth century. He was a Professor of Surgery at Harvard from 1912 until 1932 and his school of neurosurgery was world famous. He wrote effusively on the diagnosis and treatment of brain tumors, while he trained many young men and women who later became the clinical leaders of their age.

Harvey Cushing was also one of the early champions of the open-disclosure of medical error. Cushing believed that publishing case reports of his and others surgical successes and failures, including unallowable mistakes and oversights, would improve the credibility of neurosurgery as a subspecialty and maintain high training standards. However for much of the remainder of the 20th century open disclosure of medical error became an ill-advised, if not reckless, practice because of the potential for an apology to be construed as an admission of legal liability.

The fear of legal action has not been the only barrier that has prevented doctors from disclosing harm-causing medical errors to patients and their families. Appreciating that an error has caused serious harm to a patient is one of the most psychologically distressing experiences that a health professional can endure. Most enter our profession with the highest ideals to relieve the suffering of others, but when this is not realised, or someone is unintentionally harmed, the impact can be devastating.

The emotional reaction to a medical error is usually one of intense anxiety and concern for the patient's welfare, then deep reflection on how the error occurred and how the outcome might be mitigated. This can be followed closely by the doctor's intense anxiety about his or her own welfare and the professional and legal consequences of the mistake. Consequently we can sometimes be tempted to rationalise away our role or minimise our responsibility for disclosing mistakes and failures. However, as the President of the Royal Australian and New Zealand College of Ophthalmologists remarks later in this issue of *Defence Update*, it is often through dealing with failure that we can appreciate our true measure as medical practitioners.

Indeed, for those practitioners with a healthy self-esteem and reasonably good psychological adjustment there is an over-riding need to apologise to their patients following an adverse event. This flows from an ethical and moral obligation but also from the knowledge that a sincere expression of regret is often therapeutic for all concerned. Furthermore, there is no doubt from the literature that a truthful and compassionate explanation of all errors that cause harm can actually reduce the risk of litigation. An apology is thus a powerful tool in facilitating the healing of the emotional scars of an injury, leading to a process of reconciliation and closure.

While 'open disclosure' is strongly supported by MDA National and appropriately encouraged by state health departments, there is no national consensus on the most appropriate methodology, the environment in which it occurs can differ between jurisdictions. Indeed, while all states have enacted legislation that attempts to protect defendants who apologise to plaintiffs, such protection is variable and inconsistent across Australia. Despite any admission of fault in the ACT or NSW, apologies there will be inadmissible in any future litigation.

However, in all other states any 'apology' (WA, VIC and TAS) or 'expression of regret' (NT, QLD and SA) that contains any admission of fault, will fall outside the protection of the relevant legislation. Therefore any admissions made after an adverse event could be used against you in these states (and NT) in any subsequent proceedings. So what to do?

Even in the NSW and the ACT, where an admission of fault is protected, Members should always seek our advice before participating in a formal open disclosure process and, if possible, before they speak to a patient or their family after an adverse event. Until Members have been able to seek advice and ascertain all the facts surrounding the event it is far better to say: "I am sorry that this has happened to you" rather than "I am sorry that I did that to you". Or "I can understand this has caused you great pain/anger/distress/anxiety" as opposed to: "I know that I have caused you great pain/anger/distress/anxiety".

One would have hoped that given the Federal funding of doctors and hospitals that there would have been more co-operation when formulating legislation designed to improve the safety, quality and transparency of health care. Obviously the varying state-based approaches will in time need to be replaced with a national and bi-partisan consensus if there is to be a more appropriate risk management culture to facilitate 'open disclosure' in all Australian jurisdictions.

Fortunately, despite the inconsistent approach to the disclosure of medical error in Australia, there does seem to be a continuing decline in medical indemnity claims. The annual report of the Australian Institute of Health and Welfare for 2006/07 showed a steady decline in the number of new claims over the past few years. One hopes that this trend can be continued and that improved clinical behaviours, including open disclosure will lead to less recrimination and blame and create a more positive climate for Australian health professionals and their patients in the year ahead.

A/Prof Julian Rait
President

Facebook: The Medico-legal Risks



In an age where technology has become an increasingly ubiquitous fact of life and where the internet has become more than just an 'information superhighway', a discussion of the potential risks posed by the internet to our personal privacy and professional lives is important. In recent years, the popularity of social networking sites has increased exponentially. While there are over 200 existing social networking sites including MySpace, Nexopia, Bebo, Orkut and Hi5, this article will focus on the phenomenon of the social networking site known as Facebook which currently boasts over 120 million users and is one of the most used websites in the world.

Facebook is an online social network space where users can create a personal profile and connect that profile to others to create a personal network. It enables people to communicate by posting messages or notes on their "wall." Users can join networks organised by city, workplace, school and region to connect and interact with other people. Users can also add friends and send them messages and change their personal profiles with status updates to notify friends about themselves and the activities in their everyday life.

The exchange of personal information on social network sites creates an unprecedented capacity for transparent insight into the private lives of users. Never before has so much personal information been available through a public medium. This has inevitably increased the chances of a user's professional and private personas becoming intertwined and impacting upon each other. The effect of this increasing transparency becomes particularly pertinent in the medical context, in which medical practitioners are expected to maintain the highest standards of ethical and professional behaviour.

Potential Medico-legal Risks

The main medico-legal risk which medical practitioners should be made aware of is the risk of breach of confidentiality from using a social networking site such as Facebook.

In particular, medical practitioners have duties to ensure the confidentiality of information about their patients. These duties are found in codes of ethics as well as in the law.

The Australian Medical Association's Code of Ethics states:

"Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests."

At law, a medical practitioner's duty of confidentiality falls within the comprehensive general duty of care to a patient. Given the general duty under the law of negligence not to cause foreseeable harm to another in circumstances where the relationship between the parties is sufficiently proximate, unauthorised disclosure of confidential information about a patient may found an action in negligence if the disclosure causes damage to the patient.

In the context of social networking sites such as Facebook, a breach of the duty of confidentiality may arise where a medical practitioner records on his or her personal profile any confidential information revealed by a patient or discovered by the medical practitioner in connection with the treatment of a patient without proper authorisation from the patient. It should be noted that a breach may well occur notwithstanding that the patient's information is presented on a de-identified basis (e.g. not being named, or the date or location of a procedure not being recorded).

If a patient becomes aware that his or her private medical information has been disclosed, an action for breach of confidence can be brought and, if successful, a medical practitioner may be liable for damages. Alternatively, a patient could receive compensation for breach of privacy in respect of the disclosure of his or her health information under the *Privacy Act 1988* (Cth).

In addition, a medical practitioner who breaches their duty of confidentiality by disclosing patient information on their personal profile or in communications with other Facebook users without proper authorisation from the patient, may find himself or herself the subject of disciplinary action by the Medical Board. Penalties in some states include a fine, suspension or the cancellation of their registration or removal from the Register of Medical Practitioners.

A range of risk management strategies can be employed to minimise the medico-legal risks associated with using sites such as Facebook.

They include:

(1) Encouraging prudent practice and the exercise of reasonable judgment

The employment of responsible practices when using social networking sites is imperative. Medical practitioners who have profiles on sites such Facebook should understand that if they are going to put something on the Internet, they need to exercise caution. Medical practitioners should be careful to ensure that they do not have content on their profiles that would amount to a breach of patient confidentiality or that would otherwise be deemed inappropriate. The guide provided by Facebook states that "unless you're prepared to attach something in your profile to a resume or scholarship – don't post it."

(2) Education as to the risks and potential consequences arising from the use of Facebook

Medical practitioners should be educated about the risks and consequences associated with the use of social networking sites such as Facebook. Steps should be taken to raise awareness of potential legal liability and penalties that may be incurred (as outlined above).

(3) Discourage the membership of virtual Facebook "groups" formed to discuss workplace issues

Medical practitioners who choose to maintain a Facebook profile should be made aware of the risks of joining "groups" relating to their place of work or patients. The discussion that takes place in these "groups" is often informal, candid and therefore high-risk by nature.

(4) Discourage medical practitioners adding patients to their network of "friends" by requesting or accepting virtual friend requests

Medical practitioners who make their patients "friends" on Facebook introduce them to the details of their personal lives beyond what is required to be maintained in a doctor-patient relationship. Allowing a patient to have this access may potentially blur, compromise and undermine the professional relationship a medical practitioner must have with their patient.

Enore Panetta
Formerly Senior Associate
Clayton Utz

When a Scalpel Comes Flying Across the Room: Putting Staff and Patients at Risk

We have heard a lot recently about safety in hospitals and how errors can be the result of systems deficiencies and failures or of negligence, mistakes and oversights. Efforts to reduce patient injury have focussed on systems redesign, workplace reforms, introducing new and revised protocols and in some jurisdictions, legislative changes designed to encourage reporting of sub-standard care.

We also know that competence is more than technical skill and up-to-date knowledge. Effective communication, teamwork and coordination of care play a key role in keeping patients safe and reducing the likelihood of errors and injury. Members of the health care team who communicate well with each other at handover and at patient discharge; check correct sites, sides, patients and procedure before surgery; notice a mistake about to happen; check medicines and prescriptions and are thorough record-keepers, all contribute to providing continuity and safety of care.

But what if team members are too afraid to speak up, to question or clarify instructions, or to telephone a senior late at night when floundering over how to care for a critically ill patient? This is when errors can happen, as well as loss of personal confidence and even, in some cases, to anxiety, stress or distress.

A five year study of 4,500 physicians, nurses and senior executives in USA by Rosenstein et al¹ surveyed how such behaviours affected staff and their perception of how it impacted on errors and patient safety. The researchers found a direct link between such behaviours and levels of stress (95%), concentration (95%) and frustration (85%). Impacting on patient safety, they found there was impairment of team collaboration (92%), compromise of information transfer (89%) and reduction in levels of communication (95%). Behaviours included anger, berating in front of patients or peers or in private, abusive language and insults, condescension, raising the voice or yelling and disrespect. While 75% considered this was linked to staff dissatisfaction, 71% felt such conduct contributed to medical errors, 66% to adverse events and 25% to patient mortality.

A common experience reported was reluctance to call senior doctors to clarify or question instructions or orders for fear of a hostile response. Ducking a scalpel thrown across theatre and being yelled at in front of patients were some of the stories told in the study.

While we may think that such conduct is rare, 56% of the physicians in the study had witnessed disruptive behaviour in other physicians.

Professionalism in medicine has been described as embodying the following values²:

- Integrity
- Compassion
- Altruism
- Continuous improvement
- Excellence
- Working in partnerships with members of the wider healthcare team.

We see such values reflected in codes of professional conduct, curricula and competency frameworks of the Australian medical colleges and medical boards.

It is worthwhile reflecting on how disruptive behaviour may affect not only fellow practitioners but also the wellbeing and safety of patients. Maintaining constructive, cooperative relationships with staff and colleagues will make for a happier workplace and safer patients. *"Respect for everyone involved in the health care environment helps nourish the appropriate moral goals of medicine."*³

Elizabeth van Ekert
Risk Manager

References:

1. Rosenstein, A and O'Daniel, M. Invited Article: Managing disruptive physician behaviour: Impact on staff relationships and patient care, in *Neurology* Vol 70 (17), 22 April 2008, pp 1564-1570
2. Doctors in Society: Medical professionalism in a changing world. Royal College of Physicians, UK, 2005
3. Kushner, T and Thomasma, D (eds) *Ward ethics: Dilemmas for medical students and doctors in training*. Cambridge University Press, UK, 2001

Family's 11 Year Battle Against WA Hospital Fails

Michael Do was born with severe brain damage and cerebral palsy on 17 January 1991. In 1997 Michael's mother, Mrs Hoang, commenced an action on his behalf against the King Edward Memorial Hospital for Women (the Hospital) in Perth alleging that its failure to adequately monitor Michael's heartbeat during labour prolonged the intra-partum hypoxic event he suffered, thereby causing or contributing to his injuries.

The case was heard by Justice Sleight in the Western Australia District Court late last year. Justice Sleight found that there was no negligence on the Hospital's part and dismissed the proceedings. The case subsequently gained media attention when a state MP brought a grievance motion in Parliament on the family's behalf seeking that the Department of Health waive its legal costs in defending the case or negotiate an acceptable amount for costs with the family.

Background

On the evening of 16 January 1991, Mrs Hoang, who was 37 weeks pregnant at the time, attended the Hospital with abdominal pain. There was considerable dispute between the parties as to the time that Mrs Hoang arrived at the Hospital and the times at which examinations were conducted. By and large, the judge accepted the Hospital notes and evidence as 'usual practise' over the evidence of the parents and made the following findings:

Mrs Hoang arrived shortly before 22.56 and was examined by a midwife at 23.10. The foetal heartbeat was recorded as 144 beats per minute (bpm) at 23.10 and 130 bpm at 23.30.

At 23.40 she was examined by a senior obstetric registrar. The registrar confirmed Mrs Hoang was 4cm dilated; that the foetus was in a breech position; that the foetal heartbeat was within normal limits (120 to 160bpm); and ordered continuous electronic monitoring of the foetal heartbeat using a cardiotocograph (CTG).

At 00.00 the midwife conducted a further heartbeat check by auscultation and recorded it was 140bpm. On vaginal examination Mrs Hoang was 8cm dilated.

She was immediately transferred to the delivery room and on arrival at 00.15 a senior anaesthetic registrar was present to perform an epidural and caudal block. This procedure was completed at 00.30 and a CTG was then applied.

The CTG recorded an initial heartbeat of 144bpm, but by 00.35 showed a persistent bradycardia of 60-65bpm.

The midwives immediately commenced intra-uterine resuscitation and a senior obstetric registrar was paged. On attendance at 00.40 the registrar ruptured Mrs Hoang's membranes and Michael was delivered at 00.47.

Decision

The plaintiff's primary argument was that the Hospital's failure to use a CTG to monitor Michael's heartbeat prior to 00.30 meant that irregularities went undetected, thereby prolonging the period of hypoxia.

As part of their argument, the plaintiff relied on evidence that the Hospital's protocol and guidelines required electronic foetal heart rate (CTG) monitoring during labour for patients with a breech presentation and where epidural anaesthesia was administered.

As a general proposition, Justice Sleight found that the Hospital protocols were a guide as to the normally expected standard of care and that as a general rule a CTG monitor should be applied, subject to the clinical circumstances.

However, in this case, because of the rapid progression of Mrs Hoang's labour, the pain she was experiencing and the immediacy of delivery, the judge found that it was reasonable for the Hospital staff to depart from the protocols and postpone applying a CTG monitor until after the epidural. He also found that the Hospital's actions, once the bradycardia was detected at 00.35, were appropriate.

Furthermore, his Honour accepted the evidence of the plaintiff's neonatal physician that it would have taken a minimum 15 minutes of total occlusion of oxygen until the CTG showed non-reassuring signs of foetal heartbeat. However, as there was no evidence of when Michael's hypoxic event occurred or the extent to which oxygen was occluded, his Honour determined that it was pure speculation as to when a CTG monitor would have showed irregularities.

Significance

Ultimately, his Honour's finding that Hospital staff acted in accordance with the required standard of care in delaying the application of a CTG monitor, was based largely upon the evidence contained in the Hospital records. The case serves to demonstrate how vital detailed contemporaneous treatment records are in defending negligence claims, particularly in circumstances where the events giving rise to the claim happened well before the time of hearing.

The case also highlights the importance for practitioners of being aware of any relevant Hospital protocols and guidelines when treating a patient and ensuring that any departure from those protocols is clinically justified.

Ashleigh Lester
Lawyer – Health
HWL Ebsworth

A Discussion on Failure

The following article is a transcript of the Presidential Address by Dr Iain Dunlop at the opening and graduation ceremony of the 2008 Annual Scientific Congress of The Royal Australian and New Zealand College of Ophthalmologists (RANZCO). It has been reproduced with the kind permission of Dr Dunlop and RANZCO.

"Tonight is a night to celebrate your success. A night to welcome you as fellows to the college, to acknowledge the efforts that you have made in reaching this night, to acknowledge the support of your families and loved ones in delivering you and to acknowledge the generosity of the many Fellows and teachers who have trained you first in medicine and particularly in ophthalmology. This is your night and tonight, you should be proud of and enjoy your success.

That you are here proves that you are successful and you probably have been successful for the greater part of your lives. This is why I have chosen to discuss Failure, as the major theme of this address.

For successful people, failure is a much more instructive and useful consideration than success. Indeed, your notion of failure may well be another's notion of success. Failure and success are relative. How you deal with your own failings and the failings of others will define the type of person you will become.

There are many aphorisms about this dichotomy. The most famous would be:

"Success has many relatives but failure is an orphan"

Clearly the presence of your relatives here tonight indicates your success.

The one that I would like to examine is the one that says,

"Success builds character, failure reveals it"

You have just begun to function as independent specialist medical practitioners, with all the responsibilities and expectations that go with that.

How will you know if you are, in the broadest sense metaphorically, personally and ethically, successful?

How busy your appointment book is? You will be busy. We are all busy. This will not discriminate for you.

How swiftly you can complete good cataract surgery? You have been well trained. Speed is irrelevant. The vast majority of your results will be excellent. This will not help.

The size of your referral base of GPs and optometrists? This is multifactorial, relatively impersonal and unhelpful as you will be busy.

The level of patient gratitude and even adulation? You are in the immensely fortunate position to be able to use your skills to profoundly improve patients' quality of life. Done carefully and graciously, great approbation will follow.

You see the paradox is that the standard measures of success will not be useful to measure your real success or worth. It is in your treatment of failure that you will really find that measure.

You must approach your failures humbly, honestly, openly and courageously. They are the events from which we grow. And the more specialized our work practices, the more easily they might be explained away. You have the capacity to know why a misadventure occurred. It is for you to take responsibility for the recognition and the remediation of the situation. The end result may be good or bad. The process is equally as important as the result. It may be that only you and your closest colleagues appreciate what has occurred but when you reflect on how you dealt with it, you will get a measure of the character of the practitioner that you are.

Open disclosure is the public concept of the mechanism of openly dealing with unforeseen medical irregularities. What's important is timely disclosure of the problem to the patient and relatives, active communication of the options for addressing it, involvement of colleagues and sincerity in expressing regret from individual to individual that the situation has occurred. Regret and apology without blame or buck passing. These situations are rare in an ophthalmologist's work but it is upon reflection on these situations that you will privately and truly find your measure of success as a practitioner.

A successful result need not always mean a clinically successful outcome.

I said at the outset that success and failure are relative. This brings us to dealing with the failures of others. What you might regard as a personal failure, in deed or knowledge, may be regarded as a success by another, less gifted or talented than you. Failure of another to function at your level is not necessarily a focus for criticism and you must be empathetic and considerate in your treatment of those perceived failings. You will carry colleagues and staff with you if you maintain perspective and lead with clarity of purpose.

Again it is your management of failure in others, rather than their success, that provides the better personal opportunity to measure your own success.

So, in celebrating your success in becoming Fellows, I have chosen to discuss failure. How much more valuable is our consideration of failure than of success.

I will remember this address tonight because of the honour I feel in the opportunity to deliver it. In years to come, it is most likely that you will forget everything that has been said tonight. But you will not forget that you were here tonight and, I hope, the emotions of the evening – the feelings of achievement after all the hard work, the pride of your families and loved ones and the welcome of your fellow Fellows.

Congratulations."

Dr Iain Dunlop
President, RANZCO

International Emerging Risks

In October 2008 I had the honour of being an invited speaker to the Physician Insurers Association of America (PIAA) International Section Conference in Paris.

The theme was "International Perspectives on Emerging Risks". Six speakers were allotted fifteen minutes in the Opening Session "Emerging Risks in Worldwide Healthcare: Becoming Equipped for the Future".

The other nominated presenters were from Argentina, UK, France and USA.

My presentation was the flipside of the coin to actuarial data. To prepare for the topic, as well as researching current literature (not much available for crystal ball gazing), I interviewed many Colleagues, so my presentation was an anecdotal compilation of emerging risks and a reflection of concerns amongst the profession in Australia. It was fascinating to speak to so many Doctors across the whole spectrum of Medicine - each with their own perspective on emerging risks and all happy to share information.

In my presentation I covered three key themes for emerging risks - our patients, our workforce and medical and technology advances.

Our Patients

- **Better informed** – challenging the authority of health professionals; more sceptical and inquisitive.
- **Higher expectations** – news reports about medical errors and drug industry influence have decreased their trust.
- **Older** – average life expectancy 77 years for men and 83 years for women.
- **Heavier** – WHO estimates 75.7% of males and 66.5% of females in Australia will be overweight by 2010 and 28.4% of adult males and 29.1% of adult females will be obese.
- **More chronic disease** – social and economic conditions support longer life expectancy.
- **Delaying fertility** – a whole new medical industry has developed with females delaying having their babies – huge expectation that science will deliver a baby.

Our Workforce

- **Ageing health workforce** – Medical student numbers in Australia capped for over a decade.
- **Feminisation** – Female doctors comprise 55.8% of the workforce with an estimated working life approximating 60% that of male doctors because of rightly significant demands of family.
- **New graduates – Gen Y – different expectations** – Young Doctors on the whole want to avoid responsibilities of owning a practice.
- **Fragmentation of care** – in General Practice large groups of Doctors working part time - over 11% of GPs are in corporate practices.
- **Corporatisation** – rising corporate activity is across other segments. Pathology, radiology, ophthalmology, gastroenterology taking advantage of scale and a business model more focused on the bottom line.

References:

1. *Computed Tomography — An Increasing Source of Radiation Exposure*, NEJM 2007
2. Chief Justice Margaret Marshall in the Massachusetts Supreme Judicial Court, PIAA News Brief

- **Task substitution** – Nurse practitioners capable of diagnosis; pharmacists managing repeat scripts; physios referring directly to orthopaedic surgeons. Problem is that "people don't know what they don't know".
- **Models of care delivery** – General Practice moving to more collaborative team approach especially in management of chronic disease patients and multidisciplinary care teams making decisions in cancer treatment.

Medical and Technology Advances

- **Prosthetics** – orthopaedic prostheses being used with limited evidence accumulated of their effectiveness.
- **Old versus new procedures** – Some newer mobile devices, joint discs and non fusion devices have only follow up data for five years but there can be price pressures from manufacturers of new technology.
- **Price drivers of uptake – hospitals and doctors** – GPs and cosmetics; surgeons and lap-banding; surgical beds more profitable than geriatric beds.
- **Imaging/Radiation** – if it is true that about one third of all CT scans are not justified by medical need and it appears to be likely, perhaps 20 million adults and, crucially, more than 1 million children per year in the United States are being irradiated unnecessarily¹
- **Information Explosion** – e.g. Are GPs managing prevention and early detection of heart disease? How long before the networked information economy gives a patient the knowledge to sue the Doctor?...loss of opportunity. "Where a physician's negligence reduces or eliminates the patient's prospects for achieving a more favourable medical outcome, the physician has harmed the patient and is liable for damages."²

Through the presentations it became clear that internationally, the profession faces similar emerging risks. The topics covered by the panel included – telemedicine, medical and dental tourism, pharmacogenomics, genetic testing, fragmentation of knowledge and care, managing patient expectations, robotic surgery, radiation overdosage, missing acute coronary syndromes, loss of opportunity, fertility medicine and anti-aging industry.

The next PIAA International Section Conference will be held in Melbourne in October 2011 and MDA National will have further involvement in the program.

Dr Beres Wenck
Vice-President
Chair, Clinical Risk Management Committee

GP of the Year 2008

Dr Christine Boyce, a general practitioner in Tasmania and MDA National Member, was awarded The Royal Australian College of General Practitioners' (RACGP) General Practitioner of the Year Award for 2008.

The GP of the Year Award is an annual opportunity to recognise an individual GP's commitment to general practice, service to their community and their involvement in ongoing training and continuing professional development.

Dr Boyce has been described as a truly outstanding GP whose focus on quality patient care and enthusiastic advocacy of general practice is inspiring the next generation of GP's and her patients.

MDA National took the opportunity to spend time with the 2008 GP of the Year to discuss her prestigious award and all things 'general practice'.



Dr Christine Boyce, GP of the Year

What does this award mean to you?

An opportunity to show an individual and positive view of a great job and raise the profile of refugee health.

Where did you study medicine?

Trinity College Dublin.

Why did you want to become a GP?

I liked geriatrics but didn't fancy juggling hard exams and punishing hospital schedules with colic and controlled crying (I always tried to control my crying as much as I could).

What is the one thing you wish you'd known about general practice prior to becoming a GP?

That I would lose my ability to read anything longer than one sentence.

What do you think has been your greatest achievement in your role as a GP?

Replacing fear with laughter.

What initiative, in the area of medicine, are you most proud of?

Securing low cost Vitamin D supplies for refugees.

What is the biggest change you've seen in medicine since becoming a GP?

The impact of corporatisation, the change in attitude of doctors entering general practice.

If you could change one thing about general practice, what would it be?

Bring back the house call. Make it a standard part of care for housebound people and remunerate it adequately.

If there is one thing you would want people to know about general practice, what would you tell them?

I would like people to understand the meaning of the partnership that exists between them and us in the modern paradigm of care and the shedding of the old paternalistic model.

What is the best advice you've been given?

Listen to people, they generally tell you what the problem is.

What is the best advice you've given?

Do impromptu things, hang around with people who make you laugh, actively avoid negativity.

If you weren't a GP, what would you be doing instead?

Society hostess in Hobart.

In closing...

My personal crusade is to remove the word "patient" from the vocabulary by 2020. Early experiments with "person/people" have proved this a perfectly explanatory word that reinforces, rather than erodes, the modern partnership between us and the people who seek our advice.

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.

More Medicare – All Doctors Beware

Case History

In October and November 2008, a large number of ophthalmologists received letters from Medicare Australia regarding an audit on the prescribing of combination anti glaucoma medicines. The letter informed ophthalmologists that 'anomalies' had been detected in their prescribing profile and requested a 'written response stating any reasons for these anomalies within 28 days of receipt of this letter'. The ophthalmologists were provided with a list of patients who had been prescribed these medicines and asked to identify if the PBS restrictions had been met in each of the patients on the list. Some lists included more than 50 patients, requiring ophthalmologists to spend a considerable amount of time reviewing their patient records, in order to respond to the audit.

A number of concerns were raised by our Members about the manner in which the audit was conducted. In November 2008, a representative from MDA National met with representatives of Medicare Australia to discuss our Members' concerns.

Medico-legal Issues

Medicine that is eligible for subsidy under the PBS is listed in the Schedule of Pharmaceutical Benefits (the Schedule). The Schedule also details the medical conditions and other criteria that must be satisfied for a patient to qualify for a PBS subsidy. The Schedule is published online at www.pbs.gov.au¹.

Medicine is listed on the PBS based on the advice of the Pharmaceutical Benefits Advisory Committee (PBAC). A medicine listed on the Schedule will fall into one of three broad categories of pharmaceutical benefits:

- Unrestricted – medicine which can be prescribed through the PBS without restrictions on therapeutic use
- Restricted – medicine which can only be prescribed through the PBS if the prescriber is satisfied that the patient's clinical condition matches the approved therapeutic uses as determined by PBAC (this medicine will be identified in the Schedule as a restricted benefit)
- Authority – medicine that requires either prior approval from Medicare Australia or the DVA (noted in the Schedule as Authority required) or recording of a streamlined authority code (noted as Authority required (streamlined)).

Unlike Authority required medicine, a restricted medicine does not require an approval number or streamlined authority code to prescribe; however, there are important prescribing requirements with which prescribers must comply.

Only patients who satisfy the restrictions or subsidy criteria have access to PBS subsidised medicine. Where a patient is not eligible for PBS subsidy, the medicine can be prescribed as a non-PBS (or 'private') prescription. The onus is on the prescriber to ensure that a PBS medicine is prescribed in accordance with PBS requirements. Prescribing a PBS medicine to a patient who does not meet the restriction criteria is a breach of the legislation.

If a non-PBS prescription is written using a PBS prescription form:

- The PBS/RPBS boxes on the prescription should be crossed out; and
- 'Non-PBS' should be written on the prescription and duplicates should be torn up.

Discussion

Under the Increased MBS Compliance Audits program, the Government will increase the number of audits on MBS services to ensure that medical practitioners are fulfilling the requirements of relevant MBS item descriptors and PBS requirements. Audits on MBS claims will increase from less than 1% to over 4% of providers².

In 2009, the 'strategic risk' areas that will be targeted by Medicare Australia will include:

- Prescribing medicine outside PBS restrictions and authority requirements.
 - Audits of around 10 high risk/high cost groups of medicines will be undertaken, including Esomeprazole, Opioids, Lipid lowering drugs (C10A, C10B) androgens, Antipsychotics (Quetiapine Fumarate and Olanzapine) and drugs affecting bone structure and mineralisation.
- Specialist attendances, with a focus on:
 - time-based attendance items at risk of upcoding, including consultant physician and neurosurgery items; or
 - the billing of any specialist services without a valid referral or request.
- Routine billing of long GP consultations in association with other services.

- Detected non-compliance will lead to targeted information, with the potential for recovery action and possible referral to the Director of Professional Services Review.
- Incentive payments.
 - 10% of practices receiving payments through the Practice Incentive Program will be audited.
- Items at risk of upcoding where the provider will bill for a more complex and more expensive item than the service provided, specific attention will be paid to:
 - skin lesions, excisions, flap repairs;
 - time-based items including attendance items; and
 - deep and superficial wounds.
- GP consultations routinely claimed with practice nurse items.
- Care plans-management plans and health checks:
 - Focus on care plans being claimed when patients have had only one or no previous visits with a provider.
- The impact of corporate entities on providers and pharmacy behaviour.
- Unexplained growth in after hours items.
- The initiation and billing of diagnostic imaging and pathology services that are not clinically necessary.

Members are encouraged to immediately seek advice from our Medico-legal Advisory service if they are contacted by Medicare Australia.

Dr Sara Bird
Medico-legal Claims Manager

References

- [1] *The PBS and You Manual for Medical Practitioners*. Medicare Australia 2007. Accessed at <http://www.medicareaustralia.gov.au/provider/pbs/education/pbs-and-you/index.jsp>
- [2] *National Compliance Program 2008-09*, Medicare Australia 2008. Accessed at www.medicareaustralia.gov.au

Reception Staff - Risky Introductions

Case History

Susan the receptionist was early for work today and noticed there were loads of new faxes and two messages flashing on the answering machine.

She listened to the messages, recording them on a couple of post-it notes:

"James Brown, aged 2, grumpy and has a rash, seeks advice, 9320-0001" and

"John Baker, following up test results from last week, 0412 12 12 12"

Dr Smith walked through reception and Susan stuck the post-its on top of the first patient file for the day without saying anything else. The phone started ringing and ringing and Susan made appointments for the patients until there was only one emergency appointment left.

Dr Smith came out and asked if there were any faxes for him. Susan handed over the bundle faxes to Dr Smith to look at, saying they hadn't been logged yet as she had been so busy. Dr Smith took John Baker's pathology results to his room to return the patient's call.

At around 9.30am Dr Smith was feeling pretty good as he had returned John Baker's call, asked him to come in for an appointment and given the pathology results back to Susan for scanning and filing in the patient's records and although very busy, was on-time for once.

Just as Dr Smith had taken in his next patient a woman with a pushchair rushes into the waiting room. She approached the desk and said:

"I am Jane Brown, James' mum, I left a message on your answering machine at around 7am this morning, I haven't had a call back and I don't know what to do?"

"Don't worry," says Susan, "I have passed your message through to the doctor; he mustn't think it is that urgent if he hasn't called back. Last week your sister came in with a UTI and she had to wait for 45 minutes!"

Medico-legal Issues

Reception and office staff in a busy general practice are often the first and last point of contact with patients. They are also in ongoing contact with patients, patients' family members or carers, other practitioners, laboratories and government agencies.

The medico-legal risks associated with practice staff are often easily recognisable but can be more difficult to manage in a busy practice. Careful supervision of practice staff in areas such as patient communication (written and via the telephone), the

development of a functional system in relation to tracking the in and out flow of pathology and radiology reports, the provision and encouragement of ongoing training in relation to the complex issues relating to patient privacy (such as access to records and third party access) all serve to minimise complaints and problems.

Common issues resulting in patient complaints include breaches of confidentiality in waiting rooms and reception areas. Others arise from a lack of standard messaging system to convey messages from patients and other parties. From time to time

letters or results in paperless offices are scanned onto computer systems and occasionally saved into an incorrect patient record. These problems are compounded unless there is an established uniform system in place. Important and potentially serious problems can arise where triaging fails and a patient is incorrectly given an appointment or advised to wait rather than proceed to an emergency department.

Delays experienced at the surgery can cause complaints and your staff's role in booking patients can be integral in minimising such complaints.

Risk Management Strategies

Practice staff must ensure they are always polite and professional in the way they perform their crucial roles. Clear lines of communication mean more efficient and less risky practice. Expectations should be clearly outlined from the manner in which the telephone is answered, to the manner in which messages are recorded. Staff should be encouraged to record standard information including name, contact number, information provided, any advice given and the patient's expectations in relation to any return call and the level of urgency. Although it might not feel like it, careful documentation may actually save time and effort in the long run.

Practice staff members who greet patients should receive training to enable them to identify emergencies and act appropriately to ensure the patient receives prompt medical attention. A check list of symptoms should be displayed at the reception for staff to review and to ensure the patient has access to the doctor as urgently as possible. Alternatively your practice may have an automatic referral to the practice nurse or a doctor when they are available immediately. This will also assist in the smooth operation of an appointment system with spaces being kept available for urgent cases.

When appointment bookings are being made, staff should be encouraged to investigate whether a longer consultation is required. If possible, patients should be contacted where delays are excessive and given the opportunity to re-book or attend at a later time as expected. Some practices are employing mobile phone text message to alert patients to delays. If the practice habitually takes emergency patients then the booking should be planned to accommodate such emergencies.

Discussion

Practitioners are vicariously liable for the actions of their employed practice staff, therefore it is incumbent on the practitioner to ensure regular reviews and feedback take place to confirm that the system is running smoothly and there is no room for improvement. Should a complaint be made by a patient, the policy should be to routinely alert the practice principal and practice manager in order that problems can be identified and addressed in a timely manner.

The RACGP have developed extensive resources for reception and practice staff and this is available online to support their professional development¹. We advocate a comprehensive practice manual which sets out the abovementioned emergency symptoms checklist, guidelines for scheduling appointments, logging of test results, billing queries, recall of patients and otherwise standardised message recording. It is imperative that all staff follow the established guidelines in the practice manual to ensure consistency in all areas where potential complaints arise.

Helen Baxter
Medico-legal Advisor

References:

1. <http://www.racgp.org.au/runningapractice/receptionist>

Missing The Big Picture

Abstract

This is an unusual case, in more ways than one, in that the GP's care was found to be below standard, not on any one presentation, but because over a period of two years he failed to consider the increased number of infections that the patient was experiencing. GP experts felt that each consultation on its own was managed appropriately, but the overall management was not.

Case History

Mr A was a 42 year old man, who worked as a labourer. He had been attending a solo general practice for some 10 years.

On May 16th 2004 he consulted his GP with the complaint of neck pain. He stated that he had been working with a jack hammer since the previous day and his neck had become sore. The GP's notes were brief, but he recorded that Mr A was very tender around the neck and movement was painful. The GP prescribed Tramal and gave Mr A a medical certificate for 4 days off work.

Two days later Mr A presented again, complaining that his neck was not getting any better and the GP recorded 'pain+++'. His GP prescribed Valium on this occasion and extended Mr A's time off work for another 3 days.

The following day June 19th, Mr A awoke and found that he was unable to move his arms or legs and he had no sensation below the nipple line. He called an ambulance and was taken to hospital.

At hospital, Mr A underwent an MRI scan which showed a cervical epidural abscess. He underwent a laminectomy and drainage of the abscess followed by intravenous antibiotics. He had a rather stormy course in hospital and was eventually discharged some 87 days later, a complete quadriplegic at the C5 level.

He required assistance with all activities of daily living, including assistance with all transfers and assistance with bowel and bladder function. He was unable to return to his previous employment or to any employment at all.

Medico-legal Issues

Two years later, Mr A commenced proceedings against his GP.

Initially it was thought that this case was defensible, when the two consultations in June 2004 were considered. Expert opinions were obtained from a number of general practitioners that the standard of care in these two consultations was appropriate and it was not unreasonable that the rare diagnosis of epidural abscess was not made. However it became apparent that there was a long lead up to these final presentations.

Mr A had been a patient of this GP for about 10 years. During this time, he had consulted his GP on about 100 occasions for a variety of ailments and injuries. During the early part of this ten year period, Mr A was prescribed antibiotics for infections at a rate of about once a year, which is consistent with common experience throughout Australia. Commencing about two years prior to the final presentation, Mr A began to experience far more frequent infections and consequently his attendances upon his GP for the prescriptions of antibiotics increased dramatically. During this two year period, the GP was consulted on about thirty occasions and twenty four of these were in relation to infections.

Most of these infections were skin infections. Some were boils and some were larger, more serious abscesses. Mr A required referral to a surgeon for formal drainage of large soft tissue abscesses on four occasions. Swabs were taken several times and on each occasion grew *Staph. aureus*.

Expert opinion was that a competent general practitioner should have been alerted by this highly significant change in the number and nature of the plaintiff's presentations to him. If the GP had considered this increase in infection he should have been aware of the more likely conditions that may give rise to an increased susceptibility to infections and should have arranged appropriate investigations or referrals. Swabs were taken on several occasions from the skin infections themselves and also from the patient's nose. *Staph. aureus* was found in heavy concentration in the wound swabs and also in Mr A's nose. The GP did not consider the possibility that Mr A was a chronic staphylococcus carrier and institute any further investigation, treatment or referral despite the frequent attendances with serious skin infections and the GP experts were critical of this.

The same surgeon was involved in the drainage of all of Mr A's abscesses. Expert opinions were also critical of the surgeon in that he did not highlight the unusual nature of this presentation to the GP and suggest further management strategies such as more thorough microbiological investigations or referral to a specialist microbiologist or initiate such measures himself while the patient was directly under his care.

Unfortunately it was the general opinion of the experts that if Mr A had been referred to a specialist regarding his recurrent skin infections and received appropriate antistaphylococcal treatment, then he may not have developed the epidural abscess.

It is not uncommon for patients to be infected with a strain of *S. aureus* and for that strain to cause chronic colonisation of the body with repeated skin infections and other more serious infections from time to time. Unless such patients are treated aggressively to try to eradicate not just skin carriage, but also pharyngeal and gut carriage, then recurrences are common. A decontamination regimen would include topical antiseptics and a prolonged course of systemic antibiotics^{1,2}.

The matter was eventually settled for a large sum with a significant proportion from the GP and a smaller proportion from the general surgeon.

Discussion and Risk Management Strategies

GPs are uniquely placed to care for patients over a period of time and develop a relationship with them. They are also in a unique position to detect changes in the patient's health, such as a marked increase in infection. GPs should consider both the presenting complaint and also the patient's history and background.

Epidural abscess is an uncommon condition, but MDA National has received incidents and notifications of this condition as the diagnosis is often elusive and can result in devastating neurological damage. The percentage of patients achieving full recovery is between 41% and 47% with mortality at 16%. The incidence appears to be increasing and comprises up to 2/10,000 hospital admissions³. Spinal epidural abscess is more common in men and can occur at any age, although it is more common in the over 30 age group, with a peak incidence in the sixth decade. Risk factors include intravenous drug use, concomitant infections which are the source of haematogenous spread or direct extension, diabetes, malignancy, chronic renal disease, AIDS and steroid use. Epidural anaesthesia is also a risk factor, accounting for approximately 5% of cases.

The triad of fever, back pain and progressive neurologic deficit is the classic presentation, but not all patients have fever. Staphylococcus is the most common causative organism with an incidence of 60-80%. MRI is the investigation of choice. Treatment is urgent surgical decompression and appropriate intravenous antibiotics for 4-6 weeks.

The prognosis is dependent on the neurological condition of the patient at presentation. A high index of suspicion is required, particularly in those patients with predisposing risk factors. Early diagnosis and prompt treatment are essential to prevent serious morbidity and mortality.

Dr Jane Deacon Medico-legal Advisor

References:

1. Raz R, Miron D, Colodner R, Staler Z, Samara Z, Keness Y. A 1-year trial of nasal mupirocin in the prevention of recurrent staphylococcal nasal colonization and skin infection. *Arch Intern Med.* 1996 May 27;156(10):1109-12.
2. Therapeutic Guidelines Limited. *Therapeutic guidelines : antibiotic.* North Melbourne, Vic.: Therapeutic Guidelines Limited; 1998. p. v.
3. Curry WT, Jr., Hoh BL, Amin-Hanjani S, Eskandar EN. *Spinal epidural abscess: clinical presentation, management and outcome.* *Surg Neurol.* 2005 Apr;63(4):364-71; discussion 71.

Notification of Incident Form

Member Details	
Full name	
Membership number	
Preferred contact number/email address	

Patient Details	
Name	
Date of birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status	No. of dependents
Employment	
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

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
<p>Include details of patient presentation, diagnosis, treatment and outcome.</p> <p>Please send a copy of the relevant patient's medical records. Do not send the originals. Please ensure your original records are preserved and kept separate from any correspondence with MDA National Insurance. If this matter develops into a claim, the medical records will become critical to your defence.</p> <p>Attach any correspondence relevant to the notification. Attach additional comments on separate pages if necessary.</p>

PLEASE SIGN AND DATE HERE	
Signature	Date / /

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