

# defenceupdate

Quarterly Magazine of the MDA National Group

Spring 2009



 **MDA National**  
Support Protect Promote

Seeking Expressions of  
Interest - President's  
Medical Liaison Council

Surgical Risk  
Management Update

Doctors Require Support  
Not Just Expediency

Rogue Cancer Unit

Medical Benefit Schedule  
(MBS) Compliance Audits

The Duty to Follow Up  
- A Recent Court Decision

Appointment Management  
- Are My Practice Systems  
Up To Scratch?

MDA National Casebook

# Seeking Expressions of Interest

## President's Medical Liaison Council

**The President's Medical Liaison Council seeks expressions of interest from Members who would like to join this newly formed Council. Some areas of involvement are, but not limited to:**

- Advising of early warning changes in medical practice and/or surgical procedures which will assist in providing service to Members
- Providing the claims, risk management and other departments with clinical knowledge to create resources for Members
- Contributing to workshops, presentations and publications arranged by MDA National
- Participating in national medical conferences
- Engaging with colleagues informally when the opportunity arises

**If you would like to contribute to the continued success of MDA National using your leadership attributes and your skills in verbal communication; presentation; networking and relationship building we would like to hear from you.**

The PMLC provides an opportunity to engage in medico legal issues and represent the local issues in your state. The local representatives will participate in 4 meetings annually to be held in the offices of MDA National, in Perth, Melbourne, Sydney, Brisbane and Adelaide. In addition there may be opportunities to attend and participate in national medical conferences;

MDA National organised promotional activities when possible; contribute to publications and other opportunities to engage on a personal level with your colleagues.

If you would like to register an expression of interest, or seek further information please contact:

**Robyn Ewart**  
Relationship Manager  
President's Medical Liaison Council:  
[pmlc@mdanational.com.au](mailto:pmlc@mdanational.com.au)

Please note applications close  
**Tuesday 20 October 2009**

# From the President



“The basic challenge is lifting our eyes toward the horizon and dispensing with short-term incentive structures and short-term ways of thinking in finance, in business, in politics and in culture and begin to take moral responsibility for the obligation we have to those who come after us”.

**Al Gore**

**Thanks to all those who renewed their membership and professional indemnity insurance with MDA National. I would also like to welcome all the new Members who have joined recently and are receiving their first copy of Defence Update.**

Given the impact of the global economic crisis, your Board and Council respectively, increased premiums and the membership subscription for this year. As reported recently in the press, the regulator, the Australian Prudential Regulatory Authority, has announced that Australia’s general insurance industry suffered a 61 percent fall in profit last financial year. The capital ratio, or how much capital insurers hold compared with their liabilities, has fallen from 1.91 to 1.85 for the industry. However, based on the draft 30th June 2009 end-of-year accounts, it would appear that MDA National Insurance has a much higher ratio than this.

But why does MDA National require more capital than the industry average? Unlike many forms of General Insurance, medical indemnity is termed a “long-tail” business. Given that claims can arise many years after an incident and there has been a recent global correction in asset values, the MDA National Group has remained focused on long term sustainability. You might agree that it is of paramount importance to our Members (and their patients), that MDA National Insurance’s financial position can cope with all contingencies.

These times require great caution in capital management. We understand that some of our competitors have undertaken unsolicited mail marketing campaigns offering what would appear, based on our experience, to be loss-leading premiums. This strategy to attract growth is always a dangerous sign in long-tail indemnity. In good economic times MDA National might respond by spending some of its reserves, because “short termism” can be appropriate in good times. When the economic and insurance cycles turn down together, our responsibility must shift from market share, to a focus on capital preservation and long term prudential management.

Indeed, the former US Vice-President Al Gore made some salient observations about “short-termism” while visiting Australia recently. In addition to indicating the serious threat that climate change posed to future investment returns, he also made some sobering comments concerning the current state of corporate governance and the management of financial risk:

“The basic challenge is lifting our eyes toward the horizon and dispensing with short-term incentive structures and short-term ways of thinking in finance, in business, in politics and in culture and begin to take moral responsibility for the obligation we have to those who come after us”.

He added that it was imperative for companies and investors to “break the spell” of short-termism before real progress could be achieved.

As a fiscally conservative, not-for-profit doctor’s mutual, MDA National does not have a history of embracing “short-termism”. We are particularly concerned that our younger Members, who will benefit from the strength of the Association in the years ahead, belong to a stable Association with an ethical investment structure and a sustainable asset allocation.

You can be assured that MDA National will continue to strive to provide affordable, secure and sustainable professional indemnity insurance and advisory services for our Members.

**A/Prof Julian L. Rait  
President  
MDA National**



# Surgical Risk Management Update

**“The surgeon has an obligation to review the operative field both manually and visually to ensure there are no retained sponges.”**

# “The SmartSponge System® from Clear Count Medical Solutions of Pittsburgh, USA, employs radio frequency identification (RFID) technology to both count and detect sponges during operations.”

## Surgical Safety Checklist

The last issue of Defence Update contained an article about the WHO Surgical Safety Checklist and how it may save lives and reduce postoperative complications. The checklist has now been endorsed by the Royal Australasian College of Surgeons as an important clinical Tool. A campaign to encourage its use nationally was launched in Canberra by the Federal Health Minister, the Hon Nicola Roxon MP, in August 2009.

## Retained Surgical Sponges

In spite of strict counting protocols, unintended retention of surgical sponges, swabs, instruments and other material are a rare but regularly recurrent cause of adverse clinical events, which are likely to result in severe patient injury, bad publicity and litigation.

The Australian Institute of Health and Welfare recorded that 27 such incidents in public hospitals alone were reported in 2004<sup>1</sup>; likely under-reporting means there were probably many more minor incidents or near-misses. Published estimates suggest an unintended retained foreign body occurs in 1 of every 1000 to 1500 operations<sup>1</sup>.

The most frequent setting for these events, according to MDA National data, is a throat pack used by anaesthetists in ENT or oral surgery or a vaginal pack in episiotomy. In many hospitals, counts are not done routinely in those procedures. Abdominal packs are most likely to be left behind in emergency operations, especially in obese patients. A sponge or pack is also more likely to be overlooked if there is an unplanned change of procedure or a shift handover of theatre staff during a long operation. A number of these events occur in spite of an apparently correct before and after sponge count; in most cases the exact source of the error is unclear. A new system that automates counting and checking is therefore of considerable interest.

The SmartSponge System® from ClearCount Medical Solutions of Pittsburgh, USA, employs radio frequency identification (RFID)

technology to both count and detect sponges during operations. Each sponge is equipped with a small unique identification tag. The system can read each sponge's tag to identify the sponge, count it before and after surgery and detect a sponge within the patient (Figures 1–3). Counting is therefore continuous during a procedure, rather than episodic as in the traditional protocol and detection does not involve X-irradiation.

The cost of the SmartSponge System® is substantial, adding, it is estimated, \$US30 to each operation<sup>2</sup>. This has to be balanced against the large additional healthcare costs associated with the often severe injuries caused by a foreign body, as well as the adverse reputational risks for the hospital and its staff and the likely cost of litigation. Several US hospitals, including the prestigious Memorial Sloan-Kettering in New York, have started using the SmartSponge System®. Some estimate that the system will become routine in all major hospitals within five years<sup>3</sup>.

In the final analysis, regardless of automation technology, the responsibility for preventing unintentionally retained surgical foreign bodies is shared between the surgeon and the hospital and its staff. As noted in the NSW Health Policy Directive 2005–571, at the end of an operation “the surgeon has an obligation to review the operative field both manually and visually to ensure there are no retained sponges”.

**Thomas B Hugh MSc, FRCS, FRACS  
Chair, Eastern Cases Committee  
Councillor, MDA National  
Director, MDA National Insurance**

## References

- 1 Australian Institute of Health and Welfare & Australian Commission on Safety and Quality in Health Care 2007. Sentinel events in Australian public hospitals 2004–05. Cat. no. HSE. 51 Canberra: AIHW.
- 2 Gawande A et al. Risk factors for retained instruments and sponges after surgery. *NEJM*. 2003;348:229–35
- 3 [http://www.time.com/time/specials/packages/article/0,28804,1877020\\_1877030\\_1902491,00.html](http://www.time.com/time/specials/packages/article/0,28804,1877020_1877030_1902491,00.html)



**Figure 1.**  
The SmartSponge System® monitor

**Figure 2.**  
The SmartSponge System® wand, which can detect sponges retained inside the body

**Figure 3.**  
SmartSponge System® packs

# Doctors Require Support

## Not Just Expediency



**As our Western Australian Members are aware, the Medical Board of WA direct-mailed our Members recently to reply to our letter of June 11th entitled "Do Not Sign "Letter Of Consent" From WA Medical Board".**

The Board indicated that MDA National's circular to its Members implied that the 'Letter of Consent' was to be used as a "tool to entice practitioners into admissions" and that it was being used "to remove any of their rights". However, on any reading of our letter we find it hard to see how these implications can be drawn.

The Board has also suggested that it is unfortunate that MDA National "did not contact the Medical Board first to raise concerns about the Letter of Consent and discuss how those concerns could be resolved". However, for the information of Members, the Board did not consult with MDA National when the letter of consent was introduced in January 2007. Furthermore, we are aware that AMA (WA) has raised this issue with members of the Board (on our behalf) on at least two occasions.

We do agree with the Board that in the event that a practitioner does not challenge the facts or allegations in a complaint that it is a reasonable goal for the proceedings to be expedited. However, your Council has formed the view that in seeking to do so, some of our Members might admit to facts or allegations, without being fully cognisant of the possible consequences.

Furthermore, some practitioners can feel great shame and impaired self-esteem when a complaint is made and MDA National believes that all practitioners are entitled to support from their colleagues, not just expediency if a complaint occurs.

MDA National does share the goal of the WA Medical Board of creating a less adversarial culture and improving the quality of doctor-patient relationships in Western Australia. We are pleased that the Board has now agreed to alter the 'Letter of Consent' so that prior to signing, practitioners are encouraged to seek legal advice or contact their professional indemnity insurer.

We look forward to continuing our co-operative discourse with the Board and in representing your interests when complaints occur.

**A/Prof Julian L. Rait  
President  
MDA National**

# Rogue Cancer Unit

**A report from “The New York Times” suggest that individual and systemic problems lead to treatment errors in the use of Iodine131 seed brachytherapy for prostate cancer. A retrospective review of the Veteran Affairs (VA) hospitals in the United States experience was carried out after a dosimetry error was discovered and reported.**

The subsequent investigation was expanded when a number of geographical misses were found. It showed that: 57 of 116 targets were underdosed; 35 of 116 had excessive doses to bladder, rectum or perineum;

The procedure had been performed despite measuring equipment being unserviceable and there were unspecified computer interface problems for over 12 months.

Most of these were associated with one doctor – an outside contractor who visited and worked with the team provided by the hospital. It is alleged he rewrote surgical plans to redefine the target in two cases. The difference in expected outcome then isn't reported to the Radiation Safety Committee of the (accredited) VA hospital and avoids referral to the National Health Physics Program and from there the National Regulatory Commission which makes a public report to Congress annually.

The doctor stated that:

- he did not tell any of the patients;
- he did not know it was reportable;
- he must have the freedom to revise his surgical plan if circumstances are different;
- overall results were satisfactory;
- seeds outside the target area are a recognised risk of the procedure; and
- *The New York Times'* allegations were false.

One of the patients developed severe pain and incontinence and required a repair operation by a surgeon. This was the first time he discovered he had a radiation injury. He was notified by the treating institution of the cause 12 months later.

As reported this suggests a system failure by the hospital and an inability to take responsibility by the doctor. No one has been identified as being in charge of the whole process and the doctor's performance was not reviewed by a peer review process.

Iodine seed implantation is an appropriate treatment for low risk early prostate cancer in selected patients. The process in Australia is multidisciplinary with the Radiation Oncologist, Urologist and Radiotherapy Physicist attending a training course as a group to ensure their respective roles are understood.

The patient is counselled by both clinicians and attends for an ultrasound which determines if volume and geometrical constraints make them suitable for an implant.

The implant is preplanned from the volume study or CT scan; that is the site of the seeds within the prostate, the spacing and the number and activity are all calculated. The seeds are then ordered either loose or in a fixed string such as Rapidstrand™. Their activity is checked and confirmed at despatch by the manufacturer and checked when received by the physicist.

They are implanted under ultrasound control using templates and introducer needles by the team. The implant is confirmed by orthogonal X-rays or a CAT scan and then the actual implant is planned and compared with the initial. The patient is told of the result and is followed up by both clinicians ensuring practitioners with expertise in the diagnosis and management of complications are available.

Databases are available for practitioners to enter their data and monitor outcomes and complications. Their use should be encouraged (funded) and they should be linked nationally.

Reporting of variations of more than 10% of the planned dose is mandatory in NSW. The Radiation Advisory Committee will then take action which may include referral to the HCCC or medical board.

There is an argument for a national dosimetry centre as there have been a number of systematic errors in Linac and HDR brachytherapy units over the past four years in NSW all of which entered the public domain as a policy of open disclosure was followed. The Royal Adelaide Hospital did not but planned to in the event of adverse outcomes being identified in the at risk group.

A policy of peer review and open disclosure would have enabled early intervention to decrease the number of incidents reported. Any new practitioners wishing to start an Iodine seed implantation program should attend one of the training programs offered with the other members of the team.

**Dr Richard Foster MBBS, FRANZCR**

**“57 of 116 targets were underdosed; 35 of 116 had excessive doses to bladder, rectum or perineum;”**

# Medical Benefit Schedule (MBS) Compliance Audits



**As part of its Responsible Economic Management package, in May 2008 the Federal Government announced the Increased MBS Compliance Audit Initiative. In addition to substantially increasing the number of compliance audits undertaken by Medicare Australia each year (from 500 to 2,500), a raft of legislative reforms to the Health Insurance Act 1973 Cwth will soon come into operation.**

These reforms will give Medicare Australia the power to require the production of documentation from doctors and third parties (such as practice service companies) and also to impose financial administrative penalties upon debts in excess of \$2,500.

According to Medicare Australia, the aim of an MBS compliance audit is twofold - first check that the patient and health care provider were eligible for Medicare benefits and secondly, to ascertain whether the service provided met the MBS item requirements (i.e. the item descriptor).

Since late 2008, Medicare Australia has conducted a number of compliance audits focusing upon the charging of MBS practice nurse item numbers 10996 and 10993 (for wound care and immunisations) in conjunction with a professional attendance by a doctor.

As part of this process, Medicare Australia may write to the doctor and 'invite' them to complete a self-audit of practice nurse items billed during a defined period. Alternatively, a Compliance Officer could either telephone the doctor or conduct a practice visit, to discuss the doctor's use of practice nurse items. In many instances, the doctor will then be asked to voluntarily complete a self-audit. This is in the form of a schedule which contains individual patient details, the date the service was provided and the MBS items that were billed.

When completing the self-audit, the doctor needs to answer "yes" or "no" as to whether the service has met all of the applicable MBS item descriptors. It is therefore necessary for each patient's clinical notes to be individually reviewed.

For example, MBS item numbers 36 and 10996 were charged when Joe Bloggs attended his local doctor on 1 January 2009.

When completing the self-audit, Joe's doctor would need to ensure that his or her entry in the clinical notes on 1 January 2009 was sufficient to support the billing of MBS item number 36 (i.e. length of the consultation in conjunction with the complexity of the patient's presentation) and that it also fulfilled the requirements of practice nurse item 10996 (treatment of a patient's wound by a practice nurse under the supervision of a doctor).

If a doctor believes that, in retrospect, one or some of the item numbers (either in relation to the practice nurse or the GP's professional attendance on the patient) have been billed incorrectly - albeit inadvertently - the doctor needs to explain each



# Election Notice

The Medical Defence Association  
of Western Australia (Incorporated)  
(MDA National)

## Election of Officers pursuant to 5F(eb)(1) of the Electoral Act 1907

Nominations are called from eligible candidates for the election of:  
**Councillor (3)**

Nominations will be accepted from Monday 21 September 2009

Nomination forms are to be completed in accordance with  
The MDA National Election Rules and must reach me no later  
than 12:00 noon on Tuesday 13 October 2009.

Should an election be necessary, voting will close at 10.00 am  
on Friday 6 November 2009.

### HOW TO LODGE NOMINATIONS

By Hand: Western Australian Electoral Commission  
Level 2, 111 St Georges Terrace  
PERTH WA 6000

By Post: GPO Box F316  
PERTH WA 6841

By Fax: (08) 9226 0577

Nomination forms are available either from any MDA National office,  
or by downloading them from the MDA National web site at  
**[www.mdanational.com.au](http://www.mdanational.com.au)** or from me at the Western Australian  
Electoral Commission. Originals of faxed nominations must be  
mailed or hand-delivered to the Returning Officer.

### ALL MEMBERS! Have you changed your address?

If so, please advise MDA National of your new address.

**Ian Botterill**  
**Returning Officer**

Phone: 13 63 06  
Email: [waec@waec.wa.gov.au](mailto:waec@waec.wa.gov.au)

discrepancy when returning the audit documents to Medicare Australia. For instance, upon review of the clinical notes, the doctor might consider that an item 36 should not have been charged. In these circumstances, the doctor should inform Medicare that an item 23 should have been billed instead. Medicare Australia is likely to then request a refund of the moneys that were incorrectly billed.

Although the number of such audits is increasing, it is still 'early days' in the audit process. The most important thing to remember is that you should discuss with MDA National any correspondence regarding compliance audits, to ensure that your response is appropriate.

**Yvonne Baldwin**  
**Claims Manager (Solicitor)**  
**Julie Brooke-Cowden**  
**Claims Manager (Solicitor)**

# The Duty to Follow Up

## A Recent Court Decision



**The Risk Management team is commonly asked questions such as “How far do we have to go to follow up?” and “What responsibility does the patient have when I have taken the time to explain why it is important to have certain tests?” Busy Members and their staff say it is impractical to keep track of all patients receiving advice and treatment, so they need an efficient system to minimise the time that practice staff spend on follow up. A recent judgment handed down in the Northern Territory Supreme Court, *Young v Central Australian Aboriginal Congress Inc [2008] NTSC 47*, identified a number of important contributing factors in what was ultimately found to be a breach of the duty of the practice to follow up a patient.**

The case involved the diagnosis and treatment of a 26 year old male patient provided by a multi-disciplinary medical practice. As well as general practice services, regular specialist clinics were provided by visiting physicians. Patients attended the practice and consulted any general practitioner who was available, hence there was no ‘usual GP’.

This particular patient presented to Dr B on one occasion, reporting retrosternal discomfort, some intermittent shortness of breath with pain and family pressures causing stress. Following examination, Dr B recommended a fasting cholesterol test, discussed the risk factors for ischaemic heart disease with the patient and at the patient’s request, organised a referral to the specialist clinic for a further opinion.

The patient did not attend for the cholesterol test and never attended the specialist clinic and the practice did not follow up with the patient. He subsequently returned to the practice with non-related complaints and also attended the local hospital on a number of occasions complaining of intermittent chest pain. Approximately 10 months after seeing Dr B, the patient re-presented to the practice requesting a repeat script for anti-inflammatory medication. Following the consultation he collapsed on his way home and subsequently died at the hospital. The cause of death was confirmed as coronary thrombosis. There was evidence of longstanding coronary artery disease.

There were two allegations against Dr B in an action for negligence: firstly, failing to properly diagnose or treat and secondly, failing to follow up on his diagnosis, investigations and treatment of the patient. The court found there was no breach in the standard of care concerning his diagnosis and treatment at the time of the consultation.

Because of the specific way in which the practice operated, the court found that the duty to follow up did not lie with Dr B, but with the practice. The practice, as the co-defendant, was found negligent and a number of issues were identified:

- There was no means of identifying that the patient did not attend for the cholesterol test
- There were incomplete details recorded on the appointment listing of the specialist clinic
- The file of a different patient with the same name was sent to the specialist clinic
- Inconsistent use of an internal referral form/process
- GPs did not refer to the outstanding referrals in the patient record during later patient consultations

However, due to the patient failing to act on the advice of Dr B and failing to fully inform various treating practitioners of his non-attendance amid ongoing intermittent symptoms, the court reduced the damages payable by 50% on the basis of the patient’s contributory negligence.



## “How far do we have to go to follow up?”

### What are Relevant Considerations Regarding the Obligation to Follow Up?

1. The treating medical practitioner is in the best position to reasonably decide who needs to be followed up and what lengths are required. Relevant factors include the patient's condition, the patient's insight and understanding, the purpose of any recommended tests or referrals made and the risk to the patient if they are not undertaken.

Although in this case it was the practice that was found to have the duty, we suggest that Members assume that follow up of patients with potentially serious conditions is their own personal responsibility when they refer for a specialist opinion or investigation and they satisfy themselves that a suitable system of follow up exists within the practice.

2. If follow-up is deemed to be necessary, the RACGP Standards for General Practices recommend that the number and types of attempts should take into account all of the circumstances. Depending on the likely harm to the patient, you should attempt to contact the patient on three separate occasions at different times of the day, followed by a letter to the last known address (Standard 1.5 Criterion 1.5.4). Members are encouraged to seek advice from MDA National's medico-legal advisers in specific circumstances. All attempts to follow up should be documented in the patient's health records.

In our experience, most Members and their staff have a reasonable system to track patients once information such as a specialist report or investigation results are received by the practice. However, as the case demonstrates, there may be a patient who has a potentially serious condition where tests or referrals are more urgent. Hence you need to track these patients from the time the referral or request is made.

3. The case demonstrates that there should be a consistent agreed approach to practice systems and process irrespective of which treating doctor is involved and practice staff should be encouraged to speak up when the agreed process has not been followed.
4. Members are advised to routinely review previous entries in the medical records, particularly if the patient is not well known to them or may have multiple conditions being treated by different doctors in the same practice.

### The Patient's Responsibility

It can be frustrating for Members who have taken the time to explain the importance of referral or investigations, only to have the patient not take that advice, unbeknown to the doctor until they next attend. This can sometimes have serious consequences for both the doctor and patient when the patient re-presents several months later with worsening symptoms and no diagnosis/treatment.

While patients have autonomy in making decisions about their treatment, the courts have not accepted that doctors can solely rely on the patient when it comes to follow up. That said, the courts have indicated that there will be circumstances where there is contributory negligence on the patient's behalf. Although this may result in a reduction in any damages payable, the emotional impact on all parties remains.

A majority of patients will listen to their treating doctor and will undergo recommended investigations, phone for results or make another appointment as advised. We encourage Members to continue to take the time to communicate the importance of having recommended tests and attending specialist consultations to ensure timely diagnosis and treatment. However, having a reliable system in place to pick up the exceptions will minimise the risk of a delay in the diagnosis and/or treatment of one of your patients.

### Risk Management Team

# Appointment Management

## Are my Practice Systems Up to Scratch?

In a previous edition of *Defence Update* we outlined the benefits of using MDA National's new on-line Practice Self Assessment Tool. The tool highlights some of the areas within your rooms that pose a potential threat to patient safety and/or satisfaction with your care.

All responses to the questions posed in the tool are de-identified and the data is stored in an application held and controlled by MDA National. This article is the first in a series that will report back to Members how you have responded to these questions.

The first topic in the tool is **appointment management**. While on the surface this seems like a 'benign' area of risk management, it is integral to the effective and smooth running of any practice. Problems in the appointment management area can have follow-on effects for many other areas of practice and impact significantly on a patient's 'experience' of your practice.

Members are asked 5 questions related to appointment management and respond by selecting: always, usually, sometimes, never, or not applicable.

1. Patients are provided with information regarding appointment availability, after-hours arrangements and emergency contacts.
2. Patients are notified and kept informed of any scheduling changes including delays and are provided with alternatives when appropriate.
3. Patients wait less than 30 minutes in the reception area.
4. Patients who cancel or did not attend (DNA) have a permanent record of this on their file or in the appointment system.
5. I review cancellations and "did not attend" listings and initiate follow up as appropriate.

### Your responses:

We can analyse these de-identified responses by an array of factors - e.g. Age, Specialty, Location, Billings band, Years in practice etc. We expect different responses to reflect different practice characteristics and the results confirm this.

Specialty analysis related to questions 1 and 2 reflect the obvious differences in how appointments are made - e.g. the 'doctors-in-rooms' groups had the highest 'always' and 'usually' responses (range 75-100%) to these

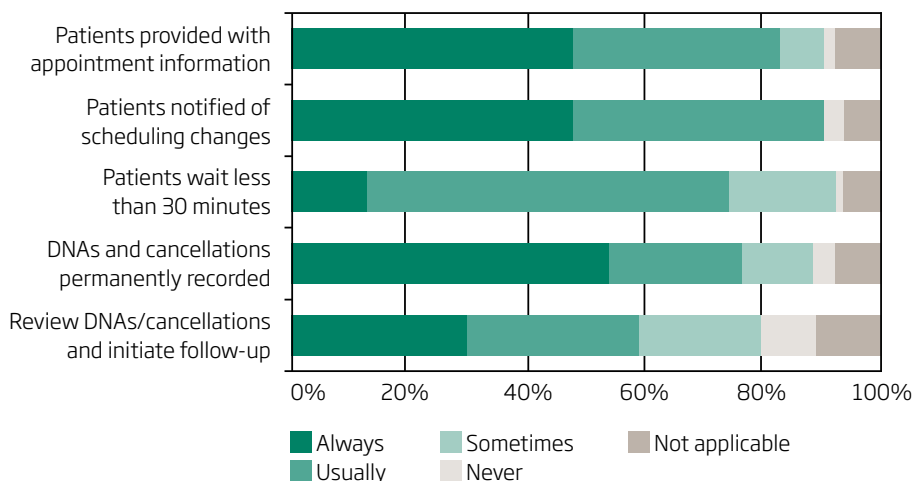
questions; anaesthetists, hospital-based and the 'other' group (eg radiology, pathology) were of-course more likely to respond 'not applicable'.

The responses to question 3 tend to suggest that the older the doctor the less likely a patient will need to wait for longer than 30 minutes. 'Always' and 'usually' responses to this question by Age are as follows: 30-39: 70%, 40-49: 75%, 50-59: 79%, 60-69: 98%. Those specialties with the highest responses of 'always' or 'usually' to this question were: Psychiatrists (100%), Obstetricians and Gynaecologists (89%), Surgeons (86%) and Physicians (83%). At the lower end, we have General Practitioners (range between 74-79%) and Ophthalmologists (50%).

The responses to questions 4 and 5 yielded some interesting findings. Overall specialists (range 84-91%) were more likely than General Practitioners (range 68-78%) to report 'usually' or 'always' to having systems in place to permanently record DNAs and cancellations. GP groups responded 'never' or 'sometimes' (19-33%) to permanently recording DNAs and cancellations. This result is somewhat surprising as one could generally expect greater utilisation of the software GPs have at their disposal given the higher level of computerisation in general practices.

Of note is that although there is an overall high level of 'always' or 'usually' responses to recording DNAs and cancellations (86%), a lower (58%) number of respondents report 'always' or 'usually' acting upon this information - ie reviewing and initiating follow-up where appropriate. This was particularly noticeable with Ophthalmologists - 91% recording but only 42% acting on this information; Surgeons - 84% recording and 69% acting on information and General Practitioners 68-78% recording but only 41-57% acting on information.

### Appointment Management - Responses



“A patient’s time is valuable and while they can be understanding of unavoidable delays, unexplained delays can be perceived as rude or dismissive.”

### Risk Management Tips

The appointment system goes beyond the basic organisation of the daily consultations by:

- Supporting patient care and safety.
- Contributing to time management.
- Enhancing patient satisfaction and compliance.
- Providing forensic evidence in the case of a factual dispute.

Orientating new patients to your practice’s appointment management processes can:

- Enable the exchange of important information between practice and patient.
- Notify the patient of the services/ access they should expect from your practice.
- Reduce the likelihood of any mismatch between a patient’s expectation of service/care and what you can provide.
- Reduce the likelihood of patient disappointment and complaints arising from these unmet expectations.
- Support patient safety by ensuring patients have information regarding alternatives in cases of emergency.

A patient’s time is valuable and while they can be understanding of unavoidable delays, unexplained delays can be perceived as rude or dismissive. It is of course not always possible to forewarn patients of unexpected delays, however on arrival it is good practice to provide your patients with:

- Information about any delay – an explanation and expected waiting time.
- An apology for the inconvenience caused.
- Options – i.e. wait, re-schedule etc.

Keep your patients informed if the original waiting time changes. Observing these common courtesies means patients are less likely to enter your consultation room annoyed or frustrated.

When patients routinely experience delayed appointments as opposed to the occasional unavoidable delay, this may be indicative of more entrenched problems in appointment scheduling procedures and/or practitioner time management skills. These issues should be addressed to minimise patient dissatisfaction.

Regularly running behind time can create a whole new set of problems, including rushed appointments, inadequate history taking, overlooking important issues or cues and inadequate documentation of the consultation.

Your appointment system is also a useful tool in assisting with patient follow-up and the monitoring of at-risk patients. It can be used to generate flags and recalls of particular patients. ‘Did not attends’ and cancellations should be noted and all no-shows should be communicated to the doctor as the patient may require further medical assessment or treatment. Where you believe follow-up is appropriate, document in the patient records and telephone log all attempts by your practice to contact the patient.

The appointment record also contains important information about patient compliance with your treatment recommendations and is often relied upon in cases of a factual dispute between doctor and patient.

If you would like further advice about how to manage your appointment system please contact the Risk Management Team at [riskmanagement@mdanational.com.au](mailto:riskmanagement@mdanational.com.au)

### Risk Management Team



**The Online Self Assessment Tool is available via the Risk Management pages of MDA National’s website [www.mdanational.com.au](http://www.mdanational.com.au). As this is a Members only resource, to access the tool you must log in via Members Online Services.**

**Did you know that by completing the self-assessment tool between 1 July 2009 and 30 June 2010 you will meet your risk management requirements under the Premium Support Scheme (PSS) for the 2009/10 policy year? Go to our website for further details.**

**Stay tuned for the release of specialty-specific self assessment tools:**

**Anaesthetics  
Obstetrics and Gynaecology  
Surgery**

The background of the page is a close-up, slightly blurred photograph of a filing cabinet. The cabinet is filled with numerous folders, each with a different colored tab (green, blue, purple, orange, yellow, red, black). Some of the tabs have white labels with black numbers, such as '06', '1', '9', '6', '2', and '1'. The lighting is bright, creating a professional and organized atmosphere.

MDA National

# CaseBook

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

“He had never turned his mind to the possibility of Mrs Brown becoming pregnant and whether enalapril would be a suitable anti-hypertensive during pregnancy.”

## ACE Inhibitors and Pregnancy

Mrs Brown, aged 38 years, consulted her usual doctor, Dr A, after concerns were raised at her gym about her blood pressure. Dr A found that her blood pressure was raised and after a couple of reviews and investigations, he made a diagnosis of hypertension and commenced her on enalapril. This controlled her blood pressure very effectively.

Sometime later Dr A was shocked and surprised to receive a letter of complaint from Mrs Brown. In the letter Mrs Brown explained that she had recently had a miscarriage. When she had a D and C at the local maternity hospital, the doctor there advised her that enalapril should not be used during pregnancy. She was angry that Dr A had never informed her of this.

Dr A vaguely recalled that Mrs Brown had told him that she attended a female GP at a different general practice for her Pap smears. He had never enquired of her as to whether she was using any contraception, or whether she wanted to have children. He had never turned his mind to the possibility of Mrs Brown becoming pregnant and whether enalapril would be a suitable anti-hypertensive during pregnancy.

He consulted Therapeutic Guidelines and was surprised to find that enalapril and all angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) are category D in pregnancy<sup>1</sup>.

### What are the Risks Associated with use of ACE Inhibitors and ARBs in Pregnancy?

Research first emerged in the early 1990s of the association of ACE inhibitors in pregnancy and the development of severe fetal abnormalities. A significantly increased incidence of oligohydramnios, neonatal renal failure, pulmonary hypoplasia, calvarial hypoplasia and fetal death was reported<sup>2</sup>. The increased risk of fetal abnormalities was initially thought to be limited to women receiving ACE inhibitor therapy in the second and third trimesters of pregnancy. However, a more recent study suggested a significantly increased risk (>2.7) of major congenital malformations in women receiving ACE inhibitors therapy in the first trimester of pregnancy<sup>3</sup>. A higher incidence of fetal abnormalities in the offspring of women taking ARBs during pregnancy has also been noted.<sup>4</sup>

A recent study from the UK reviewed women aged 16–45 years who were referred to a tertiary Hypertension Clinic.<sup>5</sup> The authors found that 47% of women in this age group were taking an ACE inhibitor or an ARB or both and of these women, about 25% were using no contraception, or barrier methods. The authors of this study were concerned at the frequent usage of these drugs in this group of patients.

With the increased incidence of obesity and its associated co-morbidities of hypertension, it is likely that it is going to be increasingly common to see women of child bearing age who require antihypertensive treatment. There is some value in the old adage that ‘all women between the ages of 15 and 50 years should be assumed to be pregnant’.

Doctors who are prescribing ACE inhibitors or ARBs to women of childbearing age should ensure that the patient is informed of the serious risks to a developing baby if the woman should become pregnant. The doctor should ensure that the woman is using reliable contraception, or if she desires pregnancy, reconsider the drug choice.

Dr A consulted MDA National who assisted him to write a suitably apologetic letter to Mrs Brown and he heard no more from her.

**Dr Jane Deacon**  
Medico-legal Adviser

### References

1. Victorian Drug Usage Advisory Committee. *Therapeutic guidelines. Cardiovascular*. North Melbourne, Vic.: Therapeutic Guidelines; 1999. p. v.
2. Shotan A, Widerhorn J, Hurst A, Elkayam U. *Risks of angiotensin-converting enzyme inhibition during pregnancy: experimental and clinical evidence, potential mechanisms and recommendations for use*. *Am J Med*. 1994 May;96(5):451-6.
3. Cooper WO, Hernandez-Diaz S, Arbogast PG, Dudley JA, Dyer S, Gideon PS, et al. *Major congenital malformations after first-trimester exposure to ACE inhibitors*. *N Engl J Med*. 2006 Jun 8;354(23):2443-51.
4. Quan A. *Fetopathy associated with exposure to angiotensin converting enzyme inhibitors and angiotensin receptor antagonists*. *Early Hum Dev*. 2006 Jan;82(1):23-8.
5. Martin U, Foreman MA, Travis JC, Casson D, Coleman JJ. *Use of ACE inhibitors and ARBs in hypertensive women of childbearing age*. *J Clin Pharm Ther*. 2008 Oct;33(5):507-11.

# MDA National CaseBook

## Saved by the Notes

### Case History

Dr Young was a suburban GP who was consulted by a 42 year old man, Mr Black in 2002. This was the first occasion Dr Young had met Mr Black. Prior to calling Mr Black into his room, Dr Young noted that Mr Black had been seen by one of the other doctors at the surgery four days prior with the problem of headaches and a provisional diagnosis of tension or migrainous headaches.

Mr Black told Dr Young that he was still suffering with headaches. Mr Black said that he was not sure about the diagnosis of tension headaches, as he felt that there was not really any tension in his life. Mr Black said that he worked as a mobile mechanic and had no stress in his work and he was happily married with no stress at home. Dr Young then proceeded to take a history of the headaches. He established that the headaches began about a week ago. The headaches tended to come and go and were sometimes severe and sometimes mild. They did not tend to occur at any particular time of the day and there were no associated other symptoms. Mr Black said they had been quite bad for a couple of days since he saw the other doctor, but then had seemed to be a bit better over the next two days and at the time of the consult Mr Black did not have a headache at all.

Dr Young then proceeded to examine Mr Black. He found him to be a fit looking man and he checked his blood pressure and performed a neurological examination. All was normal on examination. Dr Young felt the most likely diagnosis was tension type headaches and he spent some time discussing the diagnosis with Mr Black. Dr Young provided Mr Black with some handouts on tension headaches and he also told him to seek further medical advice if his headaches were worse first thing in the morning, or associated with nausea or vomiting, double vision or any other neurological symptom. The consultation lasted about 30 minutes.

Dr Young never saw Mr Black again, but received a discharge summary from hospital a few weeks later. Mr Black had presented to hospital three days after his consultation with Dr Young. He had experienced an increase in his headaches on that day, associated with nausea, vomiting and irritability. An urgent CT scan revealed gross hydrocephalus with cerebral oedema secondary to a colloid cyst of the third ventricle. An urgent ventricular drain was inserted, but Mr Black sustained significant brain damage and he never regained consciousness, succumbing a couple of weeks later to infection.

About two years later Mr Black's widow commenced legal proceedings against Dr Young.

Dr Young recorded the following notes:

Headaches persisting though less severe

BP 134/80

Onset last week in pm

Daily and worsening

No vomiting or nausea

No diplopia

No gait problems

No fever

O/E PERLA

Fundi normal

Neuro normal

FBC and ESR normal

Plan; rv next week or

sooner if worsening



**“The judge found that there was a difference in the history as obtained by the doctor and the history as outlined by the widow. However, the widow admitted that her late husband was not a particularly forthcoming man.”**

## Discussion

Colloid cysts are benign congenital tumors that almost always arise from the anterior third ventricle (immediately posterior to the foramen of Monro). These epithelium-lined cysts are problematic because of their location; they can cause serious morbidity and mortality due to acute obstructive hydrocephalus, increased intracranial pressure and, rarely, intracystic hemorrhage.

Although these tumors are considered congenital, their presentation in childhood is rare. The tumors are usually symptomatic in patients aged 20–50 years. Approximately 0.5–1% of all primary brain tumors and 15–20% of all intraventricular masses (most common) are colloid cysts.

Often, colloid cysts are found incidentally. If symptomatic, colloid cysts are associated with the classic symptoms of intermittent obstructive hydrocephalus and paroxysmal headache associated with changing head position. In reality, the presentation is typically less specific. Headache may be part of the presentation, as well as vertigo, decreased memory and behavioural changes. In addition, sudden weakness in the lower limbs associated with falls without loss of consciousness has been reported. Other symptoms are associated with signs of increased intracranial pressure (eg, papilledema, emesis). Additionally, symptoms similar to normal pressure hydrocephalus (eg, dementia, gait disturbance, urinary incontinence) have been associated with the presentation of colloid cysts.

## Medico-legal Aspects

A writ/statement of claim was issued by the widow claiming damages for nervous shock and on behalf of their two children. The writ/statement of claim alleged that Dr Young had failed to exercise care and skill, failed to take a proper history, failed to conduct a proper examination and failed to consider a more serious cause of the headaches and failed to order a CT scan.

Expert opinion from several doctors was obtained by the defendant's solicitors.

An expert neurologist considered the difficulties of management of headache in general practice, noting that at least 40% of the general population will have a severe episode of headache at some time in their life, necessitating time off work and presentation to a doctor. He felt that there was nothing in the history or examination that could, without knowing the subsequent history, predict the unfortunate course of events and one would have to say that there were no indications for urgent neuroimaging.

Two eminent GPs were consulted and they opined that 'a reasonably competent and careful GP, who was given the history and obtained the results of a neurological

examination which Dr Young obtained, would not have referred Mr Black for a cranial CT scan on that day' and that 'the diagnosis of a tension type headache in this circumstance is very reasonable'.

In view of the supportive opinions, it was felt that Dr Young had a strong case and this matter eventually went to trial.

The judge found that there was a difference in the history as obtained by the doctor and the history as outlined by the widow. However, the widow admitted that her late husband was not a particularly forthcoming man.

The judge found that Dr Young was an impressive witness who was consistent in his recounting of what was said. He stated that if there was conflict between Dr Young's evidence and that of the widow, then the judge preferred the doctor's evidence. One of the GP experts had stated that the record of the examination findings was thorough and the detail in the clinical notes was to be commended.

One of the plaintiff's GP experts was initially critical of Dr Young for not ordering a CT scan, as judged on the widow's presentation of Mr Black's symptoms. However, when Dr Young's account of the patient's history was presented to this expert, he changed his view and agreed that there was no indication for a CT scan, based on the history as obtained by Dr Young and as documented in the notes at the time.

The question as to whether the patient should have been referred for a CT scan was then addressed. The judge found that the GP experts, as well as a neurologist and neurosurgeon felt that given the history that Dr Young obtained of headaches coming and going, but not present at the time of the consultation and responding to simple analgesia coupled with a normal neurological examination, then referral for a CT scan was not indicated. He accepted that a 'wait and see' approach was reasonable with advice to the patient to take immediate steps to obtain assistance in the event that his symptoms worsened.

This case illustrates that doctors do not have to practice defensively. The court found that a thorough history and clinical examination which was well documented was what was expected of the GP and Dr Young was entitled to rely on his clinical findings. Although a CT may have revealed the diagnosis and may have changed the outcome, the court did not find that Dr Young was negligent in not ordering this test as it was not indicated on the history and examination.

The case was settled in favour of Dr Young and there were no grounds for appeal.

**Dr Jane Deacon  
Medico-legal Adviser**

# Risk Management Workshops

## Cognitive Institute Workshops Calendar

### Sept 09

Mastering Difficult Patient Interactions  
**Saturday 26th**  
9.00am - 12.30pm **FULL**  
**Sydney**

Mastering Adverse Outcomes  
**Saturday 26th**  
1.30pm - 4.30pm **FULL**  
**Sydney**

### Oct 09

Mastering Adverse Outcomes  
**Wednesday 7th**  
6.00pm - 9.00pm **FULL**  
**Perth**

Mastering Difficult Patient Interactions  
**Wednesday 21st**  
6.00pm - 9.30pm **FULL**  
**Perth**

### Nov 09

Mastering Difficult Patient Interactions  
**Saturday 14th**  
9.00am - 12.30pm  
**Perth**

Mastering Adverse Outcomes  
**Saturday 14th**  
1.30pm - 4.30pm  
**Perth**

### Feb 10

Mastering Shared Decision Making  
**Wednesday 24th**  
6.00pm - 9.00pm  
**Perth**

### March 10

Mastering Shared Decision Making  
**Wednesday 3rd**  
6.00pm - 9.00pm  
**Sydney**

Mastering Adverse Outcomes  
**Wednesday 3rd**  
6.00pm - 9.00pm  
**Brisbane**

Mastering Adverse Outcomes  
**Wednesday 3rd**  
6.00pm - 9.00pm  
**Perth**

Mastering Adverse Outcomes  
**Wednesday 10th**  
6.00pm - 9.00pm  
**Melbourne**

Mastering Difficult Patient Interactions  
**Saturday 13th**  
9.00am - 12.30pm  
**Perth**

Mastering Shared Decision Making  
**Saturday 13th**  
1.30pm - 4.30pm  
**Perth**

Registration can be completed online through the Member Online Services section of the MDA National website or by contacting Risk Management at [riskmanagement@mdanational.com.au](mailto:riskmanagement@mdanational.com.au) or 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.

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 doctors who hold a current Professional Indemnity Insurance Policy. Please check the online calendar regularly as more workshops will be added throughout the year.

**Freecall:** 1800 011 255

**Risk Management Fax:** 1300 011 240

**Email:** [riskmanagement@mdanational.com.au](mailto:riskmanagement@mdanational.com.au)

**[www.mdanational.com.au](http://www.mdanational.com.au)**

# Please notify us now...

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

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

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

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

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

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

## 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. <b>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.</b></p> <p>Attach any correspondence relevant to the notification. Attach additional comments on separate pages if necessary.</p>

Please Sign and Date Here	
Signed	Date / /

<p><b>Policy holders based in WA, NT, SA and overseas</b> Please post or fax the completed form and related documents to: Claims Division, MDA National Insurance PO Box 1557, Subiaco WA 6904 <b>Fax: 1300 011 235</b></p>	<p><b>Policy holders based in all other states</b> Please post or fax the completed form and related documents to: Claims Division, MDA National Insurance Ground Floor, 69 Christie St, St Leonards NSW 2065 <b>Fax: 1300 011 235</b></p>
---	--

Freecall: 1800 011 255 Member Services Fax: 1300 011 244  
Email: [peaceofmind@mdanational.com.au](mailto:peaceofmind@mdanational.com.au) [www.mdanational.com.au](http://www.mdanational.com.au)

Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417 AFS Licence No. 238073. With limited exceptions, they are available only to Members of MDA National. MDA National Insurance is a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated), trading as MDA National, ARBN 055 801 771. Incorporated in Western Australia. The liability of Members is limited.

Privacy: The MDA National Group collects personal information to provide and market our services or to meet legal obligations. We may share personal information with other organisations that assist us in doing this. You may access personal information we hold about you, subject to the Federal Privacy Act. If you wish to change your contact details or be removed from our mailing lists, please contact us at 1800 011 255. For more information or to see our Privacy Policy contact us on 1800 011 255. 15.4.4 Sep 09

Have you moved?  
Have your practice  
details changed?

If so, please take a moment to notify us of your new information. To update your details, please call Member Services on 1800 011 255 or log on to the Member Online Services section of our website [www.mdanational.com.au](http://www.mdanational.com.au)

It is important that you notify us of your updated information to ensure you maintain continuous cover and to make sure that we can continue to contact you with important information about your medical indemnity.

Would You Like to  
Receive *Defence  
Update* via Email?

We offer all readers the opportunity to receive an electronic copy of *Defence Update* instead of a hard copy.

If you would prefer to receive your quarterly magazine by email, please let us know by sending an email to [defenceupdate@mdanational.com.au](mailto:defenceupdate@mdanational.com.au) putting the word 'Subscribe' in the subject line and including your name and Member number in the body of the email.

You will be able to change the way you receive *Defence Update* at any time, simply by sending an email to the address above.

It is also possible to change the way you receive publications from MDA National by logging into the Member Online Services and noting your preference on your Membership record. If you require assistance logging into the secure section of the website, please contact Member Services on 1800 011 255 during business hours.

**Freecall: 1800 011 255**  
**Member Services Fax: 1300 011 244**  
**Email: [peaceofmind@mdanational.com.au](mailto:peaceofmind@mdanational.com.au)**  
**Web: [www.mdanational.com.au](http://www.mdanational.com.au)**

**Perth**  
Level 3  
516 Hay Street  
Subiaco WA 6008  
Ph: (08) 6461 3400  
Claims Fax: 1300 011 235

**Melbourne**  
Level 1  
101 Dundas Place  
Albert Park VIC 3206  
Ph: (03) 9915 1700  
Fax: (03) 9690 6272

**Sydney**  
Ground Level  
AMA House, 69 Christie Street  
St Leonards NSW 2065  
Ph: (02) 9023 3300  
Fax: (02) 9460 8344

**Brisbane**  
Level 8  
87 Wickham Terrace  
Spring Hill QLD 4000  
Ph: (07) 3120 1800  
Fax: (07) 3839 7822

**Adelaide**  
Level 1  
63 Waymouth Street  
Adelaide SA 5000  
Ph: (08) 7129 4500  
Fax: (08) 7129 4520

#### Disclaimer

The information in *Defence Update* is intended as a guide only and should not be taken as legal or clinical advice. We recommend you always contact your indemnity provider when advice in relation to your liability for matters covered under your insurance policy is required.

The MDA National Group is made up of MDA National and MDA National Insurance Pty Ltd. Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073. With limited exceptions they are available only to Members of MDA National.

MDA National Insurance is a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated) ARBN 055 801 771, trading as MDA National incorporated in Western Australia. The liability of Members is limited.

Before you make any decision whether to buy or hold any products issued by MDA National Insurance please consider the relevant Product Disclosure Statement and Policy Wording. Contact us if you require a copy.

Privacy: The MDA National Group collects personal information to provide and market our services or to meet legal obligations. We may share personal information with other organisations that assist us in doing this. You may access personal information we hold about you, subject to the Federal Privacy Act. If you wish to change your contact details or be removed from our mailing lists, please contact us at 1800 011 255. For more information or to see our Privacy Policy contact us on 1800 011 255. Form number 301.2 Sep 09.