

Implanon
Managing Risk to a Positive Outcome

Risk Management Update
EpiPen®

MDA National Insurance Pty Ltd:
Introducing the board

defence update

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10

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Implanon: Managing Risk to a Positive Outcome

OVERVIEW

In early 2003, the MDA National Council moved the insertion of Implanon from the GP Non-Procedural to the GP Procedural risk category. When we advised members of this, there was significant disappointment, but overall, understanding that it was an appropriate response to an unacceptable exposure of risk.

At the time we promised members that we would examine the underlying issues, evaluate the response of the manufacturer and the profession and, if indicated, reassess our decision.

I am delighted that last month both the Board and Council have agreed to return the insertion and removal of the contraceptive insert Implanon to the GP Non-Procedural category from 1 July 2004. This decision was taken based on recommendations following a detailed risk assessment .

BACKGROUND

The procedure was moved into the GP Procedural category following an unprecedented number of incident notifications in the brief period from the introduction of the product. The risk assessment undertaken at that time indicated that the change was required to manage the exposure. This was a difficult and unpopular decision that was made with the caveat that a further review would be completed prior to the next renewal period. We are aware that the restrictions during this year have been inconvenient for many Members and for patients. However we have been most heartened by the level of trust and loyalty demonstrated by our Members. Correspondence was received expressing extreme disappointment with the initial change although many acknowledged that this unfortunate step was required to ensure the ongoing financial stability that MDA National provides. Only a small number of Members chose not to renew and changed to another insurer. A handful elected to move to the higher category but most indicated that this was not a financially viable option.

RISK MANAGEMENT

The core principles of risk management are codified in the Australian and New Zealand Standard 4360/1999. This is the framework that was used to examine the problems presented by Implanon. It is a continuous process that:

- establishes the context;
- identifies; analyses; evaluates risk; and
- either accepts or treats the risk.

This cycle is undertaken within a framework of ongoing communication, consultation, monitoring and review. There are four ways to treat risk once it has been identified:

- risk reduction;
- retention;
- transfer; and
- treatment.

In an ideal world a full risk assessment would be conducted before any new device was released. In the case of Implanon the manufacturers embarked on a major education program. This was well intentioned but did not take into account all aspects of the implementation of a new technique.

Doctors welcomed this new form of contraception as it was inexpensive for patients, convenient and had a low failure rate if correctly inserted. There was widespread acceptance of the product with over 160,000 devices being sold within the first two years. By the end of the first year it was obvious that there were many problems beyond the usual side effects that are expected with a new treatment.

IDENTIFYING THE RISK

The incident database is regularly reviewed to detect any potential patterns of risk exposure. In June 2002, thirteen months after Implanon was released, the Risk Management Committee considered a report of the incident notifications relating to this treatment. The key concern was a number of unplanned pregnancies. The reasons for this outcome were not always clear but options included failure to insert the implant, incorrect timing of the insertion and implant failure.

One early claim was settled where the implant was too deep and required removal under a general anaesthetic and several other General Practitioners reported difficulty removing the implant.

ANALYSING THE RISK

All of the Members who notified incidents had attended a training session except for one who had watched the training video. It appears that the insertion requires a technique that like any dexterous task is easier for some people than for others.

There were numerous problems reported with the device. The counter intuitive action required when using the obturator was the source of much frustration for many doctors. Similarly there were problems with insertion as both the implant and the obturator were white. In the training session the implant was blue in colour, consequently it was visible that it had left the obturator.

From a claims management aspect documentation and the consent process remain important to the defence process even when there is a belief that there is no negligence in the insertion. In addition the three-year lifespan of the implant is drawing near and failure to replace the implant may see another wave of unplanned pregnancies.

EVALUATING THE RISK

The problems associated with Implanon were brought to the attention of Members in an effort to contain the spiralling number of incidents. However just raising awareness was not sufficient to reduce the problem.

At the time of the initial review the High Court decision in the *Melchior v Cattnach* case for wrongful birth had not been handed down. The finding that a claim for the cost of raising a healthy child could be successful meant that the potential cost of any unplanned pregnancy would be high. While NSW and Queensland have made legislative changes to block this decision this is not yet national policy. Any claims that have been lodged prior to these changes will be heard in the light of the High Court decision.

COMMUNICATION AND CONSULTATION

Regular articles were published on the identified problems and a mailout to all General Practitioner Members was distributed in September 2002. Over 160 written responses were received. Approximately 80 % were against moving the procedure to the higher Membership category. The key concerns were the social consequences, 'deskilling' of the profession, concerns over training offered and a strong feeling that the design of the device contributed to the number of adverse outcomes. The remaining responses strongly supported the move as they felt those who did not undertake the procedure should not carry the potential cost.

An Expert Panel was convened to examine the situation. The results of Members' replies, the claims and incidents data and a submission from the manufacturer provided background material for the Panel's deliberations. A raft of risk strategies were developed however the Panel elected to leave the decision on the appropriate category to the Council.

TREATING THE RISK

The treatment selected by Council was to reduce the risk by limiting the exposure to a smaller population of Procedural GPs. Members inserting the implant were also required to comply with a set of risk management strategies. This reduced the likelihood of further incidents simply by reducing the number of treatments. This solution was not satisfactory for the Members although it gave a window to further explore the problems with the procedure. The option of risk retention where MDA National retained responsibility for the financial burden, was not acceptable. As a mutual there is a responsibility to minimise financial costs.

MONITORING AND REVIEW

MDA National undertakes continual review of risk management. However, there was a pledge to provide you with an update on Implanon before the annual renewal. The analysis of the data was considered by the Underwriting Committee in November 2003. One problem identified was that incidents occur when the doctor is new to the technique or does not insert implants on a regular basis. Others included poor disclosure of risk, particularly scarring on removal, poor documentation and failure to palpate the implant following insertion. A strong case has been made that these problems can be risk managed and an expanded table of strategies will be developed.

LESSONS LEARNED FROM THE IMPLANON EXPERIENCE

Implanon is an example of an opportunity that was initially lost with the release of the contraceptive insert. If a full risk assessment of the introduction and implementation of this product had been conducted the number of adverse incidents may have been minimised. Furthermore the one-year moratorium imposed on Non Procedural GPs may have been avoided.

The risk management process that we have undertaken has given the Board sufficient confidence to return the procedure to the lower premium level. Non Procedural General Practitioners will be required to register as an Implanon provider at the 2004 renewal and comply with the risk management strategies to be covered. Ongoing monitoring will continue. It is anticipated that the risk strategies will effectively reduce the number of adverse outcomes.

The strong loyalty and trust shown by you through this process has been heartening. In these difficult and emotive times in the Medical Indemnity industry we have maintained our firm financial management. Hard decisions have been made and endured. The changes are based on a rigorous review process and were not influenced by political pressure or market considerations. We have resisted the commercial approach to risk management of discounts and rebates. This is risk management in action, we implement what will work for you in the long term.

Penny Johnston
National Risk Manager

Editorial

As usual the number of issues and meetings we have continues to grow. At the Federal level the industry is currently in negotiation with the Federal Government and the AMA to put in place arrangements for medical indemnity that will attempt to ensure sustainability, affordability and equity.

While there will be red tape involved it is likely that some sort of Premium Support Scheme will be available to those whose premium exceeds a threshold proportion of their income. Once the details are sorted out we will advise how the nuts and bolts will work. Keep an eye on the web site for latest details.

We remain committed to a competitive doctor owned insurer model, as opposed to a government or monopoly scheme, because we believe it best serves the interests of our owners, the profession, as well as the wider community. I was fortunate to visit our Queensland State Advisory Committee last month which further convinced me that local medical culture is different in each state and that a national Sydney or Canberra imposed model will not work in our federated country, because it will not serve the interests of the coal face doctors as well as the MDOs do. Or the state branches of the AMA for that matter. We acknowledge the valuable work of the AMA both at a Federal and State level to improve the medical indemnity landscape. We have the same aims to benefit all our members, who of course are one and the same.

Dialogue between the AMA and the Medical Defence Organisations has improved and will be central to warding off intrusive control of the profession by government, of either political persuasion. The alliance could also give us a powerful voice for tort reform, which will always be unfinished business. Any positive change encounters a backlash from plaintiff lawyers and as such we need to maintain and protect reforms over time. As the political landscape evolves in the lead up to the Federal election further advances will be even harder to gain.

Meanwhile, back at the offices around the country we have been working on complying with various other changes to the business brought on by the insurance reforms. These changes have and will continue to improve our efficiency and long term prospects. Dianne Browning outlines some of the intricacies of our Financial Services License in this issue. Holding this license means we have to tighten up the way we give financial product advice to members, in much the same way as you will have noticed that stock brokers and financial advisors have done. This means we will not always be able to give you exactly the answer you need immediately, as we are obliged to ensure the accuracy of all information. This should be easy for our members to understand, as we are faced with patients every day who want the answers right now, when life is not necessarily that simple. Routine matters will be dealt with in the same way as they always have been.

One of our tasks at this time of the year is to review our members who have a significantly adverse claims profile, which accounts for in total less than twenty or so members each year out of many thousands. You would have heard from us by now if this applies to you. We are refining this process continually to balance all the competing issues. We must be fair to the individual members and we provide them a chance to present their views on the reasons for the situation. We also recognise the stress involved and seek to minimise the negative impact of our investigation into their practise. At the same time we have a duty to all our members to attempt to identify ways to reduce claims and associated costs, and we will continue to be vigilant in that regard. The most common action that we take is simply to monitor the situation and provide support. A few members have deductibles (excess) imposed on their policies and some will also pay higher premiums than their craft group. Some have conditions such as the removal of certain procedures from their indemnity. In the vast majority of cases these terms are mutually agreed. Where they are not there is a process of dispute resolution which now includes an external appeals mechanism as part of our Financial Services License. Thus we are confident that the process is fair and thorough.

One thing that becomes obvious in this process is that some of us, perhaps many of us, are not good at looking after ourselves. Lack of holidays and other interests are common among doctors who are suffering professional and personal decline. In my specialty of Anaesthesia we have sadly had to focus on welfare of our Fellows and trainees more than some others because of our suicide and drug abuse rates. Penny Johnston addresses the issue as it applies to students, and all of us involved in teaching at whatever level can hopefully be more aware of demonstrating balance to the next generation of members. Maybe we should remind our own colleagues as well.

For those who kindly asked the boat has only required towing by the volunteer search and rescue people once this summer and it has not sunk at all, even a little bit!

Dr Andrew Miller
Vice President
Editor, Defence Update



MDA National since insurance contracts

Well before the 1 July 03 starting date for indemnity insurance for all Australian doctors, it was obvious to Council that to meet both the demands of the regulators and the wishes of Members would require major changes in the Association. This would involve staffing, bringing in new skills and changing the committees. These changes have been ongoing since that time.

In order to continue to provide indemnity to our members we have undertaken a major restructure of our internal operations. This has involved achieving APRA approval to conduct business as an insurer and meeting the complex requirement of obtaining an Australian Financial Services Licence from ASIC.

THE INSURANCE COMPANY BOARD

In late 2003, our wholly owned insurance company was renamed MDA National Insurance Pty Ltd. Following the retirement of Dr. Sol Levitt as Chairman in December 2003, the Board was restructured and is now chaired by Mr Graham Reynolds. Graham has been with us since 1994 and has an extensive background in insurance and broking.

As the legislative changes require that the indemnity component of our business is conducted through MDA National Insurance, the Directors of the Board carry significant responsibility.

Further information about the Board and profiles of the Directors appears on following pages of this issue of Defence Update.

To ensure congruity of thought between Board and Council, we have had several working days devoted to planning, strategy and risk planning. As well as attending each Board meeting I meet with the Chairman of the Board to examine the Agenda. Several joint Council/ Board meetings will be held throughout the year and Mr. Reynolds is an invitee to all Council meetings.

Similarly, all committees managing the business of the MDA National Group now comprise members of both the Board and Council.

COUNCIL

Council has not changed. Shortly, we will be looking at changes to the Rules of the Association necessary to give effect to the changes legislation has required us to make in the way indemnity is provided. These will go to a General Meeting of Members in due course.

In line with the overall organisational restructure we are looking at the needs of members of Council and the Board (as well as our staff) for further education and development to make sure we are all able to do our work more effectively.

The challenge for all of us as Members is to consider how this principle might be brought in with respect to the future members of Council. How do we attract potential Councillors with skills that might fit into gaps identified by Council as lacking or needing strengthening? What constitutes suitability for Council service? How do we assess the work of Council as a group, and the Councillors individually?

These are profound questions, and ones that should challenge us all this next year. I look forward to comment and debate, particularly on Council selection, training and development.

Dr David O. Watson
President

The impact of our Australian Financial Services Licence

On 11 March 2004 MDA National Insurance commenced trading under the terms of its Australian Financial Services Licence.

This was both a beginning and an end.

The date is a milestone in the transition from discretionary medical indemnity provided by the Association to insurance cover issued by MDA National Insurance. The road was difficult and many changes needed to be made. With your patience and a lot of hard work by Council, Board and staff, that transition is complete.

But 11 March also marks the start of a new way in which we tell you about your indemnity cover.

You will notice with your renewal this year that two new documents will be sent to you. One is a Product Disclosure Statement. This gives you information about the insurance policy and you should read this carefully before you return your renewal application. The other document is a Financial Services Guide, which contains important information about MDA National Insurance. We hope you find these documents useful – apart from being documents which have been developed to meet regulatory standards we have tried to include information that will answer some of the questions we are regularly asked by members.

When you ring MDA National Insurance to ask a question you may find that some staff are not be able to answer all of your questions without referring you to a more senior member of staff. Similarly, members of Council and Committees may need to refer you to the staff to respond to specific queries. This is because when we give you “financial product advice” about your indemnity insurance, we must ensure that it is given by MDA National Insurance staff who have completed both external and internal training on our policy and the carriage of the AFS licence.

Financial product advice does not include answering your questions on what the policy says, what categories might apply to your practice, getting a quote, how a claim can be made or advice on a legal or risk issue. It mainly applies when you ask for our opinion or our recommendation when you need to make a choice on which of our products to acquire or retain.

When we do give you financial product advice, our staff will provide you with general advice based on circumstances applying generally to the query you have made. When they do so they are obliged by legislation to warn you that the advice they have given does not take into account your individual circumstances. This doesn't mean we provide you with any lesser service than we have in the past!

So, in a small number of circumstances a staff member who you have dealt with in the past may need to transfer you to someone else to answer your questions or you might feel that the personal nature of your discussion is disrupted by staff relaying information about their advice. Members should be aware that this is not MDA National adopting a more officious or bureaucratic approach. As the Federal Government has decided that Medical Professional Indemnity Insurance is uniquely categorised as “retail”, we have significantly more onerous disclosure conditions than other forms of Professional Indemnity. We will do our very best to ensure that you still receive the service you expect and which we expect of ourselves.

We look forward to your questions and feedback on any aspect of our service.

Dianne Browning
Compliance Officer

The importance of being on time!

Since we have been providing professional indemnity via insurance contracts, some members have commented that we are sending reminders for quarterly instalments prior to the expiry of their current period of cover. We do this by means of a Reminder Notice.

A small number of members have taken mild offence that we send a “Final Reminder” before the expiry date, and therefore the due date.

The reason we do this is to protect you, the insured member. If the payment is not made by the due date you will remain technically uncovered until we do receive payment. Although we behave with

fairness in mind where payments are received after that date, we can provide no guarantee that we will be able to cover you for a claim that arises while the premium is outstanding. We are aware that the tone of the Final Reminder is serious, however that is the point – practising without cover is potentially a very serious matter.

No one wants to find a technicality distracting us from assisting you in the event of a claim simply because a payment was received late. Least of all us!

MDA National Insurance Pty Ltd:

Introducing the Board

Following the retirement of Dr Sol Levitt in December 2003, the Board of MDA National Insurance Pty Ltd (MDA National Insurance) was restructured. In part, this restructure was part of the reforms to medical indemnity introduced on 30 June 2003 which required the appointment of several independent directors from non-medical backgrounds.

MDA National Insurance is now responsible for issuing professional indemnity insurance contracts to all indemnified members of MDA National. Therefore the responsibility for ensuring that the company runs smoothly, meets capital requirements, complies with legislation governing the provision of financial services and maintains the appropriate level of reinsurance, lies with the Directors of the Board.

The Directors themselves encompass a broad range of experience and come from both business and medical backgrounds. A brief summary of each Board member follows.



MR GRAHAM REYNOLDS - CHAIRMAN

Mr Reynolds has extensive (over 40 years) experience in the risk management and insurance broking industry. He is an Associate of the Australian Insurance Institute, a Fellow of the National Insurance Brokers Association of Australia, a Fellow of the Australian Institute of Company Directors, a Fellow of the Australian Institute of Management and a

Commissioner for Declarations. He is a Committee Member (and former Chairman) of the National Insurance Brokers Association (WA).

Past positions held have included:

- Director (Managing Director WA) Bland Payne Australia Limited
- Director, Sedgwick Pty Ltd
- Founding Managing Director, Fenchurch Insurance Brokers Pty Ltd
- Director, Fenchurch Group International Limited (London)
- Executive Vice Chairman, Marsh Ltd
- Managing Director, Marsh International

In addition to his work with the MDA National Group, Mr Reynolds has extensive company director experience, including:

- Insurance Commission of Western Australia - 1994 to 2002
- State Government Insurance Corporation - 1994 to 2002
- HBF Insurance - 1998 to 2000

Mr Reynolds also has significant directorial and leadership experience in the wider community, including:

- Past President, Rocky Bay Inc. (formerly WA Crippled Childrens Association)
- Past Chairman, WA & Federal Councillor, Australian Institute Company Directors
- Past Chairman, Botanic Gardens & Parks Authority
- Chairman, Corps of Commissionaires (WA) Limited
- Director, Local Government Self Insurance Schemes
- Perth Bone & Tissue Bank - 2000 to present

Mr Reynolds' past directorial and related work and experience within the MDA National Group includes:

- Director and Deputy Chairman of MDA National Insurance Pty Ltd 1993 - 2003
- Chairman Medical Indemnity Services Pty Ltd 2000 - 2003
- Attendee at MDA National Council 1993 onwards

Mr Reynolds has significant involvement in key re-insurance discussions and negotiations.



DR JOHN BLACKWELL - DEPUTY CHAIRMAN

Dr Blackwell holds an MBBS and a Diploma Clinical Pathology from Sydney University. He is a Fellow of the Royal College of Pathologists Australasia and Royal College of Pathologists (UK) and is presently a Clinical Professor with the Department of Orthopaedic Surgery at the University of WA.

Dr Blackwell was a co-director of St John of God Pathology from 1967 until 1994. For the last 12 years he has been Chair of the Perth Bone and Tissue Bank. Other directorships have included:

- Director Australian Society of Medical Research
- Councillor Royal College of Pathologists Australasia
- Chair Aged Persons Homes Board (Uniting Church)

Dr Blackwell has been a member of the MDA National Council since 1972, and was President from 1990-97. He has been a Director of MDA National Insurance Pty Ltd since 1992 and was a Director of MDA National subsidiary Medical Indemnity Services Pty Ltd.

Dr Blackwell is Chair of the Cases Committee (Western/Central).



MR JIM FREEMANTLE

Mr Freemantle holds Bachelor of Economics and Master of Administration degrees from Monash University. He is a Fellow of the Australian Institute of Company Directors and the Australian Institute of Banking & Finance.

Mr Freemantle was CEO of Home Building Society from 1995 – 2003. Prior to that he held positions in banking (NAB, Australian

Bank, Elders IXL) and corporate consulting. He currently holds the following positions:

- Member Board of Management John Wollaston College.
- Trustee – Anglican Diocese of Perth
- Member Western Australian Planning Commission Housing Advisory Committee
- Deputy Chairman of Racing & Wagering WA
- Chairman of Prostate Cancer Foundation WA Division

Mr Freemantle is Chair of the MDA National Group Capital Committee and a Member of the Nominations Committee.



DR DENNIS HAYWARD

Dr Hayward holds an MBBS from UWA, is a Fellow of the Australia and New Zealand College of Anaesthetists and a Member of the AICD. He has been a member of his professional practice, Western Anaesthesiology, since 1984.

Dr Hayward is presently studying for a Post Graduate Diploma in Insurance from Deakin University.

Board and Committee positions held by Dr Hayward have included:

- State Chairman Australian Society of Anaesthetists (ASA) and Member Federal Executive of ASA
- Director AMA Services
- Art Gallery Society of WA Council

Dr Hayward has been a member of the MDA National Insurance Board since 2002 and was a member of the MDA National Council 1994 – 97.

Dr Hayward is Chairman of the Nominations and Underwriting Committees, and is a member of the Reinsurance and Remuneration Committees.



MR JAMES LUTZ

Mr Lutz is a Fellow, Institute of Chartered Accountants, and an Associate, Certified Practising Accountants. He retired in 2003 as Chairman of Partners, KPMG Perth, after 40 years with that organisation. Some roles held within KPMG were:

- Partner in charge of marketing for over 20 years

- Staff Partner for Assurance division for 12 years
- Deputy Managing Partner for a number of years
- Partner in Charge of Assurance and Advisory Division 1998 – 2001
- Chairman of Partners 2000 – 2003
- KPMG National Foundation Board - Member
- Partner Remuneration and Nomination Committee - Chairman

Other positions Mr Lutz has held include:

- Red Cross WA - 7 years as Treasurer and member of State Council and National Finance Committee. Awarded the Distinguished Service Medal
- The Western Australian Institute of Sport - 7 years as member of the board – Government appointment
- The Western Australian Landcare Trust - 7 years as member of the board - Government appointment

Mr Lutz is also Chair of the MDA National Group Remuneration Committee, and a Member of the Audit, Risk and Compliance and Capital Committees. He attends the Nominations Committee in his role as Remuneration Chairman.



DR ROD MOORE - ALTERNATE DIRECTOR TO DR HUGH

Dr Moore holds an MBBS from UWA. After some 16 years experience in General Practice he established SportsMed Murdoch in 1994 and SportsMed Subiaco in 1999 (a multi-disciplinary Sports Medicine/ Physiotherapy centre). He continues as Medical Director and is a Principal of both practices whilst also filling the role of Team Doctor for the West Coast Eagles AFL Football team. He has been Team Doctor to several other football and hockey teams, both nationally and internationally.

He is currently a member of the AMA/Law Society (WA) Joint Medico-Legal Committee.

Dr Moore is a member of the MDA National Council and was appointed as an Alternate Director of the MDA National Insurance Board to Dr Tom Hugh in January 2004. He was previously a Director of subsidiary company Medical Indemnity Services Pty Ltd.

Dr Moore is member of the Capital, Cases (Western/Central), Remuneration and Underwriting Committees.



MS EVA SKIRA

Ms Skira holds First Class Honors in Economic History from the University of NSW, a Graduate Diploma in Applied Finance from the Securities Institute and an MBA (Distinction) from University of Geneva. She is a Fellow of the Australian Institute of Company Directors and the Securities Institute of Australia and is an experienced director and executive. She has held various technical and executive

positions at the Australian Government Publishing Service, the Commonwealth Bank and stockbrokers Barclays de Zoete Wedd Australia Ltd, and undertaken other individual business and corporate assignments.

Ms Skira is presently a member of the following Boards and bodies:

- St John of God Healthcare Group (and Chair of Audit Committee)
- Securities Institute of Australia (Member, National Council; Chair, WA Division; and Chair, Postgraduate Academic Advisory Committee)
- Settlement Agents' Supervisory Board

She has held a number of other Board positions including:

- Director, Water Corporation of Western Australia (and Chairman, Audit and Compliance Committee)
- Director, Dnister Credit Union (Melbourne)
- Director, Transperth (and Chairman, Audit Committee)
- Deputy Chairman, Metrobus

Ms Skira joined the MDA National Insurance Board in December 2002 and is Chair of the Audit, Risk and Compliance Committee (ARC), as well as an attendee at the Capital Committee in her role as Chair of ARC.



DR THOMAS HUGH

Dr Hugh holds an MBBS from Sydney University, and is a Fellow of the Royal College of Surgeons of England and the Royal Australasian College of Surgeons. He was a Visiting Medical Officer at St Vincent's Hospital, Sydney and St Vincent's Private Hospital, 1967 - 2002, with a special interest in gastrointestinal surgery. Dr Hugh was appointed Emeritus Consultant Surgeon, St Vincent's Hospital Sydney Ltd in 2002.

He is the author of approximately 80 scientific papers in peer-reviewed journals. He is a member of the Editorial Advisory Board of the Australian and New Zealand Journal of Surgery and a member of the Honorary Editorial Board of Medicine Today and was a Clinical lecturer in Surgery at the University of New South Wales.

He was a Director, Board of Management, St Vincent's Hospital, Sydney from 1986-1989.

Dr Hugh's other Board positions have included:

- Chairman, Australasian Cases Committee, The MDU, 1995-99
- Director, Medical Defence Union Australasia Insurance Limited (MDUAIL), 1997 - 1999 and Member, Audit Committee, MDUAIL, 1998 - 1999
- Director, United Medical Protection, June 2000- February 2001

Dr Hugh is also a member of the MDA National Council, Chairman of the Cases Committee (Eastern), Chairman of the NSW Advisory Committee, and a Member of the Underwriting Committee.



MR PETER FORBES - CEO/ DIRECTOR

Mr Forbes is a Fellow of the Institute of Chartered Accountants in Australia (FCA). Having commenced his own chartered accountancy firm in 1975, he developed this business through both organic growth and merger. Its successor today is HLB Mann Judd. Mr Forbes retired as a partner on 31 October 2003.

In 1995 Mr Forbes stepped aside from full time practice to take on the role of Chief Executive of The MDU, Australasia, with responsibility for Australia, New Zealand, Singapore and Malaysia. During this period and continuing thereafter, he also maintained his role with the MDA National Group.

A founding Director of MDA National Insurance Pty Ltd in 1992 Mr Forbes was responsible for the formation of MDUAIL in 1997, a wholly owned captive insurer for The MDU in Australia. He was also a foundation Director of MDUAIL.

He is currently CEO of the MDA National Group, comprising MDA National and MDA National Insurance Pty Ltd, and has responsibility for all group operations. Apart from his general management experience, Mr Forbes' relevant technical experience includes:

- Extensive reinsurance negotiations, both locally and internationally
- Working with APRA and other regulators on the continued development of the Medical Indemnity Industry in Australia
- A deep understanding on actuarial and capital matters associated with the Medical Indemnity Industry

Mr Forbes is also a Director of Law Cover Insurance Pty Ltd. Law Cover Insurance Pty Ltd is owned by Law Cover which is a statutory mutual administered under the auspices of the Law Society (NSW). It is responsible for the compulsory indemnity scheme for all licensed solicitors in NSW.



DR ANDREW MILLER - ALTERNATE DIRECTOR TO DR BLACKWELL

Dr Miller is a Specialist Anaesthetist in private practice in Perth, WA. He holds MBBS and LLB (Hons) degrees, is a Fellow of the Australia and New Zealand College of Anaesthetists and a Member of the Australian College of Legal Medicine.

He is Deputy President of the MDA National Council and was appointed as an Alternate Director of the MDA National Insurance Board to Dr John Blackwell in January 2004. Previously, Dr Miller was a Director of subsidiary company Medical Indemnity Services Pty Ltd.

Dr Miller is Chairman of the Publications Committee (and thus Editor of Defence Update) and the At Risk Members Committee, and a member of the Cases (Western/Central) and Nominations Committees.

Risk Management Update: EpiPen®

EpiPen® is a single use auto-injector unit for allergic emergencies (anaphylaxis). From 1 November 2003 EpiPen® is part of the new listings on the Pharmaceutical Benefits Scheme (PBS). PBS anticipates that 90,000 patients may benefit from this subsidy. EpiPen® is regarded as a low-risk device that is currently available over the counter. Inappropriate use would result in an unpleasant and painful reaction however it is unlikely that there would be any long-term sequelae. EpiPen® costs approximately \$100 per unit. Obtaining the unit through the PBS will represent a significant saving with the cost to the patient being \$23 and less for concession cardholders. However to obtain this benefit, certain restrictions have been imposed.

To obtain EpiPen® at the reduced cost the treating Immunologist/Allergist must contact the HIC for an authority prescription. On 1 February 2004 access to this authority was extended to include Paediatricians and Respiratory Physicians. If the prescribing doctor is a General Practitioner and not one of the four Specialist specified he/she is required to provide the name of the Specialist with whom they have consulted. It appears the new restrictions are designed to contain costs rather than for safety reasons.

Our medico-legal advice line has been contacted by an Immunologist seeking clarification of his role in the 'consultation' to obtain an authority prescription. In these circumstances the specialist will not, at least in the first instance be reviewing the patient. In spite of this the Specialist is required to determine whether the patient warrants the provision of an EpiPen®. Our Immunologist Member was concerned regarding his (and other Specialists) duty of care to an 'unknown' patient. The matter was referred to the Risk Management Committee for consideration. The following conclusions were reached:

- Expressing an opinion that the patient does or does not warrant an authority for EpiPen® establishes a duty of care;
- In routine situations a Specialist would want to assess a patient before recommending any prescription. The PBS restrictions allow the specified Specialists to 'approve' or 'endorse' the request for the authority with a telephone consultation without seeing the patient. This is not a loophole and was incorporated into the restrictions to provide ready access without long delays waiting for Specialist appointments.
- It appears that the Pharmaceutical Benefits Scheme is using the specified Specialists as "gatekeepers" for EpiPen®.
- PBS listing allows only one prescription per adult patient and two for children. Many patients elect to purchase more than one EpiPen® to ensure that one is available at various locations at all times.

- It is unlikely that there would be an adverse event due to inappropriate prescribing.

The Risk Management Committee recommended that Members of the specified Specialist groups be advised that if they choose to assist General Practitioners in endorsing the authority for EpiPen®, certain steps should be routinely followed. We recommend the guidelines established by the Australasian Society of Clinical Immunology and Allergy (ASCIA). These can be downloaded from www.allergy.org.au/anaphylaxis.index.htm The following key points should be considered:

- Use a brief check-list to ask the General Practitioner to satisfy yourself that within broad parameters the patient is suitable to prescribe EpiPen®. There is a template on the ASCIA website. If completed this checklist would serve as adequate record of the telephone consultation. An EpiPen® file for these forms would be sufficient rather than individual patient files
- PBS restrictions require that EpiPen® is prescribed in the context of a comprehensive management and prevention plan. Indicate to the General Practitioner that the telephone consultation is confirming the prescription only and does not constitute treatment. Appropriate education regarding anaphylaxis prevention, recognition and management is imperative. If this is to be the first prescription a referral to a Specialist should be encouraged.

There is no obligation for you to agree to provide an 'approval' for an authority. You are entitled to decline or request a consultation with the patient before providing an endorsement. There is no Medicare benefit available for providing telephone consultations.

MDA National believes that the risks associated with providing an authority for EpiPen® following the guidelines above will be minimal. In the unlikely event of an adverse outcome and it was claimed that the specialist was negligent, the policy would respond, subject to its terms and conditions. It appears the process has been set up to enable limited access to EpiPen® at a reasonable cost for patients who are likely to suffer anaphylactic reaction. It has been argued that many patients live in remote and isolated areas where access to Specialists is limited. It is possible that this has been the reasoning behind the Government's restrictions as well as overall cost containment.

Penny Johnston
National Risk Manager

Footnote: Where EpiPen® is mentioned it refers to EpiPen® or EpiPen Jr®.



News from Risk Management

ANTI-COAGULANT THERAPY

On 4 March 2004 a medico-legal seminar on Anti-Coagulant Therapy was held at St John of God Conference Centre in Subiaco, WA. Guest speakers included:

Dr Ross Baker – Haematologist;

Dr Mark Donaldson – Geriatrician;

Mr David McKnight – Pharmacist;

Dr Michael Stacey – Vascular Surgeon; and

Dr Shiong Tan – General Practitioner.

The seminar addressed the risks associated with prescribing Anticoagulant drugs. An interactive Panel Session was facilitated by Dr Rod Moore. The seminar was a success with over 70 attendees.

The next topic in the Seminar Series will be Shared Care. The session will be held in June at St John of God Hospital, Subiaco.

COGNITIVE INSTITUTE SEMINARS

MDA National is once again hosting Dr Mark O'Brien from the Cognitive Institute and his popular series of workshops on Communication and Informed Consent. These sessions will be held in Perth in late May and early June. These seminars are provided at no cost to members but places are limited so register now to avoid disappointment.

Saturday 29th May 2004

2.00pm – 5.00pm

Mastering Your Risk

St John of God Hospital, Conference Centre, Subiaco WA

Sunday 30th May 2004

10.00am – 1.00pm

Mastering Your Risk

TradeWinds Hotel, Fremantle WA

Sunday 30th May 2004

2.30pm – 5.00pm

Mastering Consent

TradeWinds Hotel, Fremantle WA

Tuesday 1st June 2004

6.30pm – 9.00pm

Mastering Consent

St John of God Hospital, Conference Centre, Subiaco WA

RACS RISK MANAGEMENT PROGRAMME – SUBSIDY FOR MDA NATIONAL MEMBERS

With increasing membership in the Eastern States MDA National will extend its Risk Management Education Sessions and Seminars into NSW, Victoria and Queensland. One initiative that the Risk Management Department has undertaken is a joint venture with the Royal Australasian College of Surgeons (RACS).

In 2004, RACS is offering a series of Risk Management Workshops that include sessions run by Dr Mark O'Brien from the Cognitive Institute. The program is available to RACS and RANZCO Fellows. As the RACS sessions match what we run in WA, the Association has agreed with the College to contribute to the cost of the equivalent sessions in the Eastern States.

Members who attend the College Risk Management Workshops will qualify for a \$250 subsidy on completion of the session. Members are required to pay the full registration to the College and upon receipt of a copy of your attendance certificate; MDA National will provide a \$250 reimbursement.

OTHER RISK MANAGEMENT TOOLS

For those members unable to attend a seminar, don't forget our distance-based learning programmes including the Interactive Internet based Education Session available through the website at www.mdanational.com.au. The program covers the basic principles of medical record keeping, informed consent, test result tracking and management of adverse outcomes. This program attracts 10 CPD points from the RACGP.

Please contact the Risk Management Department on 1800 011 255 for further information on any of the seminars or distance learning packages.



Doctor heal thyself?

When medical students are surveyed to find out what motivated them to do medicine the three perennial responses are the intellectual challenge, altruistic reasons and opportunity insofar as having achieved the required marks. The first two suggest a very strong wish to ensure that we have a healthy population through a combination of good clinical skills and the desire to help people. It is always a paradox that while doctors expend knowledge, time and energy in looking after others, it is apparent that they can be negligent when it comes to looking after their own health.

A study conducted by the NSW Department of Health and the Doctors' Health Advisory Service in 1994 found that only 42% of doctors stated that they had their own general practitioner. A further 44% consulted specialists to whom they had referred themselves. While these figures were of concern the more disturbing result was the proportion of doctors who self medicated with prescription only drugs. These included antibiotics (75%), oral contraceptive (55%), non-narcotic analgesics (45%) and non-steroidal anti-inflammatory agents (35%). Approximately 10% of respondents indicated that they would treat themselves for serious illnesses such as a potentially serious lump or alcohol and other drug problems.

The study recommended that doctors and medical students be educated to consult a medical practitioner not only for illness but also for stress. Following this study there has been significant emphasis in discouraging doctors from treating themselves and their families. Medical students and junior doctors are encouraged to establish a relationship with a General Practitioner while they are young and healthy. Having regular check ups and developing a rapport will ensure an ongoing monitoring of the doctor's health status.

It is not clear if it was the prevailing medical culture that seemed to pressure doctors into feeling they should never be sick. An identified barrier was that many doctors were reluctant to hand over their own health care to another practitioner. As a result a number of 'doctors for doctors' programs have been established.

At the tenth anniversary of this benchmark study, its message has gathered momentum. More doctors are indicating that they recognise the benefits in having their own GP. It is no longer seen as acceptable to treat a colleague with a corridor conversation, a quick script or referral. This form of treatment is fraught with clinical and medico-legal risk. In these circumstances rarely is a proper history taken or physical examination conducted. The treatment is not generally recorded to allow for any continuity of care. Furthermore there have been cases of civil litigation following cursory treatment between 'friends'.

A recent study by the Norwegian Medical Association found similar results to the earlier Australian study. However this study examined gender specific responses and found that over twice as many female doctors had a regular General Practitioner than their male counterparts. Among the complications found in doctors who treated themselves was delayed diagnosis.

The legal profession has an old adage that states, "a Lawyer who handles his own case has a fool for Counsel". The medical profession does not want a similar analogy and is recognising the need to seek health care by having one's own General Practitioner. As students it is important that you follow best practice. Find a good General Practitioner and have regular medical checks. If you are ill seek help promptly and allow yourself the luxury of being a patient. It is not only the right of the community it is yours too.

Penny Johnston
National Risk Manager

References

Pullen D, Lonie CE, McLyle D, Cam DE, Doughty MV 1995, 'Medical Care of Doctors', Medical Journal of Australia, vol 62, pp 481-484.

Rosvald EO & Bjientness E 2002 'Illness Behaviour among Norwegian Physicians' Scandinavian Journal of Public Health', Vol 30.

Joel Carson “Joelius Carsoni”

Joel Carson was one of the prominent faces within the student cohort of Medicine at the University of Western Australia. Born on 16 February 1981, Joel spent his younger years in Darwin before moving on his own to Perth to commence his tertiary studies.

A flamboyant, some-what eccentric, humble and seemingly care-free person doesn't necessarily come across as someone who would command the attention and respect from his fellow peers, however this was the case with Joel. His warm nature and open attitude made it almost impossible to not befriend him.

Joel appeared to lead a balanced life as Student, Leader, Employee, Boyfriend, Friend and Colleague, and still managed to find time for himself. The fact that he was a cycling fanatic meant there were many occasions when the public was exposed to his taste for skin-tight lycra racing suits, as the staff at the AMA (WA) may easily recall. He also had a penchant for motorcycles, following up this lycra fashion with a wool-lined leather jacket to simulate the Steve McQueen look.

As a medical student, he proudly represented his peers as President of the WA Medical Student's Society during 2003, involved himself in almost every aspect of student life, and had successfully completed 5 years of study at UWA. From a first-year with pigtails to a dread-locked third-year, to the El-Suavo that he matured into being, his looks and manner were always admired. Joel was one of those once-in-a-lifetime people who touched everyone he met with his warmth and easy to get along with attitude. He approached his academic life with seriousness and dedication, working hard at Sizzler to support himself in his goal to become a doctor.

He interacted with people at a very human level, always mindful of others' feelings and comfort. He could relate to all kinds of people from all different walks of life, possessing an innate ability to find common ground with everyone. He was everything a person could hope for in a friend - always there if we needed him, sharing in all of our joys and disappointments. He could also be the life of a party – always great to have around and to be around.

His passing in tragic circumstances has been another sad event within the Faculty of Medicine and Dentistry in recent times, making it all the more pertinent that we should be more aware of the well being of those around us.

Joel will be remembered by his student larrikinism, his professional attitudes towards Medicine, his relaxed approach to being himself, his warmth and affection towards peers and colleagues, and his love for those who surrounded him. He will be honoured in death, as he was in life by those that knew him, as the kind, intelligent, fun, passionate, good-looking boy from Darwin that we were blessed to have with us, though for far too short a while.

A student, sportsman, leader, and character... he was so many things to so many people. Unforgettable.

Our mate, Joel.

May he find peace.

Philip and Jessie Singh

This obituary has previously appeared in Medicus, the magazine of AMA (WA).



Post-operative re-admissions: Closing the Information Loop

From time to time, MDA National receives a telephone call from a surgical member who has received a claim or complaint in respect of a post-operative complication or readmission, of which he or she had no prior knowledge.

Leaving aside the consideration of professional courtesy, there are obviously a number of compelling reasons why it is beneficial for the original surgeon to be kept informed of the post-operative complications, particularly those requiring readmission. To name only a few:

- It allows the surgeon to monitor trends in an early, informal way;
- It allows the surgeon to provide any information to the current treating practitioners that may be relevant in the ongoing management of the patient;
- The surgeon can then make a decision about whether it is necessary or appropriate to contact the patient in relation to the complication; and
- It reduces the likelihood that the patient will feel disenfranchised (if the surgeon is unaware of the readmission).

It is difficult to imagine immediate legal consequences of failing to advise a surgeon of a post-operative complication or admission. However, if the surgeon is in possession of relevant information which would be of use in the management of the complication, which has not previously been relayed to the treating team, legal problems may arise. Secondly, the legal pitfalls are obvious, if the surgeon subsequently proceeds to further surgery in circumstances where he or she is not fully apprised of prior adverse events.

In light of all the compelling reasons why the information loop should not be closed on post-surgical complications and readmissions, the valid question arises whether there is, in fact, a significant incidence of this type of omission.

An interesting article published in the *Internal Medicine Journal*¹ tends to suggest that the anecdotal reports can be objectively substantiated.

Dr Swan and Professor Spigelman undertook an audit to assess whether surgeons were made aware of the outcome of patients who had been readmitted to John Hunter Hospital (JHH) with either deep venous thrombosis (DVT) or pulmonary embolus (PE), following a surgical procedure.

For the purposes of the audit, a readmission was recorded when the patient had an unplanned readmission in which DVT or PE formed part of the diagnosis, and the first admission included a surgical procedure.²

In the audit, 79.4% of patients reviewed were readmitted under the care of a different consultant. Of these patients, only 44.4% had documented evidence in their record that the previous surgeon was aware of the readmission during the hospital stay. In the remainder of the cases, there was no such evidence, and no discharge summary had been copied to the surgeon.³ Of the remaining 55.6% the readmission was either not communicated, or communicated in an informal, unrecorded way.

This outcome is perhaps even more alarming in light of the fact that, of the patients reviewed, 47% had had their first procedure performed at JHH, where the subsequent readmission occurred.

The result of this audit calls for a reflection of how this situation may arise. In one sense, it is easy to envisage how the consultant under whom the patient is readmitted could assume that the original surgeon will find out either through the provision of a copy discharge summary, or through the advice of some other person in the medical team, or from the patient themselves. Moreover, a consultant may intend to raise the issue of the readmission in an informal way, when the surgeon is next seen around the workplace. That opportunity may never subsequently arise.

Whilst it would never be suggested that a "corridor conversation" is not, at times, a courteous and convenient way to discuss a post-operative complication between colleagues, it should be borne in mind that the process should be taken one step further and followed up in writing. This is because of the inevitable risk that the information provided in the corridor will be discarded unwittingly. Moreover, it is a tired truism that a personal recollection that a conversation occurred is a very poor cousin to a written record that proves its occurrence.

This audit tends to highlight three of the perennial issues of risk management as seen by MDA National, namely an awareness of the importance of communication, the requirement for good record keeping, and the implementation of systems to facilitate these. It is noted that the authors of the John Hunter study propose to implement changes and reaudit the topic.⁴ The outcome of that study will be considered with interest.

Catherine Carroll
Legal Counsel

¹ J Swan and A D Spigelman *Audit Surgeon Awareness of readmission with Venous Thromboembolism*, *Internal Medicine Journal* 2003; 33:578-580

² *Supra* page 579

³ *Supra* page 579

⁴ *Supra* page 580

Notification of Incident Form

1. Member Details

Member Name: _____
Member Number: _____

2. Patient Details

Name: _____
Address: _____
Employment: _____
Date of Birth: _____ Gender Male Female
Treatment Given: _____
Outcome: _____
Patient type: Private Public

3. Other Practitioners Involved

Name: _____ Address: _____
Name: _____ Address: _____
Name: _____ Address: _____

4. Incident Details

Location of incident: _____
Date of incident: _____ Date you became aware of incident: _____
Your medical speciality at time of incident: _____

Brief summary of incident

Include details of patient presentation, diagnosis, treatment and outcome.
Do not send originals of medical records – send copies only if relevant to the notification preserved and kept separate from any correspondence with MDA National Insurance. If this becomes critical to your defence.
Attach any correspondence relevant to the notification. Attach additional comments on separate page.

Signature: _____ Date: _____

Policy holders based in WA, NT, SA and overseas
Please post or fax the completed form and related documents to:
Legal Practice Division, MDA National Insurance
PO Box 263, West Perth WA 6872
Fx: (08) 9481 2451

Policy holders based in VIC, QLD, NSW, ACT, TAS
Please post or fax the completed form and related documents to:
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Please notify us now...

Do not forget to let us know of any incidents that may give rise to a claim as quickly as possible. 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. It is a good rule of thumb that if you are worried about an outcome, you should report it.

In order to assist you with this process, MDA National Insurance has developed this Incident Notification form. A copy is also available on our website www.mdanational.com.au

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

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Damages for wrongful birth

NSW responds to the High Court's decision in *Cattanach v Melchior*.

Following Queensland's lead, the New South Wales Parliament passed legislation in December 2003 to reverse the effects of the High Court's decision in *Cattanach v Melchior* in July 2003, when it upheld the rights of parents to claim for the costs of bringing up a healthy child born as a result of medical negligence. This has been a much vexed proposed head of damage. The courts have traditionally denied such claims for public policy reasons. In their defence the courts have found difficulty allowing parents to claim damages for a healthy, but unwanted, child. Although divided the High Court ignored public policy in favour of extending the categories of permissible damages to this further head of damage. However the decision came at a time when all Australian parliaments were actively legislating to restrict the grounds upon which an action in negligence could be brought as well as reducing amounts that could be recovered in a claim. It is not, therefore, surprising that the NSW parliament reacted swiftly once the High Court delivered its decision.

The Civil Liability Amendment Act 2003 amends the Civil Liability Act 2002 to specifically prohibit compensation being awarded for:

- the costs associated with past or future maintenance of a child; and
- any loss of earnings incurred by the parents in bringing up a child.

The Act does not interfere with the rights of parents of disabled children to claim for the additional costs of maintenance over and above those that would normally be incurred.

The amendments brought by the Civil Liability Amendment Act 2003 are retrospective in their effect and will apply to claims for wrongful birth issued after 20 March 2002 – the date of enactment of the Civil Liability Act 2002.

Philip Hopley
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