Defence Update

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MDA National
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From the President

State Advisory Committees

When MDA National was launched in mid-2000, one very important part of the strategy was a national structure that would build on the traditional strengths of the Association in WA. One of those had been Members access to Councillors. This had served us well during the difficult days (shared with MDAV) of 1986-'88 when we left the scheme of cooperation with the Medical Protection Society; Members felt that they could openly ask Councillors about the issues and how the Association would be affected. Later, it served us even more strongly as we moved from the old "occurrence" based indemnity cover to "claims made" in 1997.

State Advisory Committees (SAC) are an integral part of the MDA National structure and play a vital role in connecting the Association to Members.

MDA National now has offices in all mainland capital cities. The Melbourne office was opened in the third quarter of 2000. Sydney and Brisbane followed in early 2001 and Adelaide in 2006.

The NSW Advisory Committee was announced in December 2000. The Queensland Committee had its first meeting in September 2002 and the Victorian Committee in March 2004.

Until recently, the NSW Committee also functioned as a Cases Committee for Claims and other matters outside WA, SA and the Northern Territory.

In late 2006, two further decisions regarding SACs were made. The first was to separate the NSW Committee from its Cases function. The second was perhaps the more surprising in a sense - to set up a WA Advisory Committee. This has allowed Council to become more nationally strategic in function and avoid meeting agendas being over-burdened with WA specific matters. In NSW (on behalf of NSW, Queensland and Victoria and our few Tasmanian Members) separating the Cases Committee from the Advisory function has allowed greater expertise in case work.

We intend to establish an Advisory Committee in South Australia during 2007.

The SACs have amongst their purposes the provision of advice to our senior managers on business development, recruitment of new Members and Member support. They are also there to provide a link to other educational and representative bodies in the Profession at State level. Members of these Committees must be MDA National Members, be able to give time to the work of the Committee and the Association and be capable of effective communication with management and staff as well as their colleagues in the Profession.

For the information of Members, the members of each SAC and of Council are set out on the following page, along with a contact point.

Your Council is determined to see continued growth of MDA National in the next few years. The SACs are a very important pillar of that growth strategy. Please feel free to contact your "local members" with your feedback on your membership of MDA National.

A/Prof. David O. Watson
President

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Dr Rod Moore	General Practitioner/Sports Medicine
All members of the WA Advisory Committee can be contacted through the Perth office on 08 6461 3400 or Freecall 1800 011 255.	

Real Life Cases

These case histories have been prepared by Dr Sara Bird and are based on actual medical negligence claims or medico-legal referrals. However, certain facts have been omitted or changed by Dr Bird to ensure the anonymity of the parties involved.

Wrong lens

Case history

The 68 year old patient was booked for right cataract surgery on 13 January 2004. The procedure was performed under local anaesthesia. An incorrect intraocular lens (intended for another patient on the list) was inserted into the patient's eye. The error was recognised post operatively and, after discussion with the patient and his wife, a lens implant exchange took place. Visual acuity following surgery was 6/9. The visual acuity then rapidly deteriorated due to posterior capsular opacification and cystoid macular oedema. By 1 March 2004 the visual acuity had deteriorated to 6/36 and YAG laser capsulotomy was recommended and performed on the same day. Visual acuity improved to 6/9, however the patient continued to complain of blurring and ghosting of his vision. A second opinion was sought from another ophthalmologist regarding the patient's symptoms and lens decentration. Fluorescein angiography revealed no additional pathology. The second ophthalmologist proceeded to reposition the intraocular lens on 15 June 2004. Following this procedure, the visual acuity corrected to between 6/6 and 6/5. Despite the satisfactory visual acuity, the patient continued to complain of visual symptoms including discomfort and diminished vision in the right eye.

On 2 February 2006, the ophthalmologist who had performed the cataract surgery received a letter from solicitors requesting compensation for the patient's pain and suffering, anxiety and additional medical expenses. The solicitors' letter included an expert report by an ophthalmologist. The report noted that "all aspects of the misplaced intraocular lens were correctly handled by the ophthalmologist including good communication with the patient at all stages. Post operative cystoid macular oedema can happen after otherwise uncomplicated surgery but can be more likely to occur after complicated surgery as the patient had in the form of a second procedure the same day". The report concluded that the majority of the patient's problems were subjective and the patient appeared to have suffered some psychological reaction to the two surgeries performed on the same day followed by a period of blurred vision.

On receipt of the letter from the solicitors, the ophthalmologist sought MDA National's assistance. MDA National obtained an expert report from another ophthalmologist. He concluded that the patient had obtained a very successful visual result from his cataract surgery and intraocular lens implant. He stated that the surgeon was ultimately responsible for the correct intraocular lens being inserted into the patient's eye. While the theatre staff check the lens, it remained the surgeon's ultimate responsibility. The expert noted that the ophthalmologist had acted in an appropriate manner in replacing the incorrect intraocular lens once the error was noted. He concluded that the early occurrence of the cystoid macular oedema (four weeks post operatively) was possibly due to increased inflammation in the eye due to the need for a second procedure to replace the incorrect intraocular lens.

From a legal perspective, the insertion of the incorrect lens was clearly negligent, although it was arguable that no long term damage had resulted from this error. The patient's solicitors sought a nominal amount in settlement which included legal costs. After some discussion, the matter was ultimately settled in May 2006 on the basis of a Deed of Release. This settlement included the patient's out of pocket costs following the initial cataract surgery and legal costs.

Discussion

A review of MDA National's claims data reveals that approximately one fifth of the claims against ophthalmologists involve an allegation of insertion of an incorrect lens. Not all of these cases actually involve the insertion of an incorrect lens, and many are the result of a 'refractive surprise'. The European Cataract Outcome Study reported a consistent post operative refraction error of 1.00 dioptre in 20% of patients over a four year period. Erroneous measurements, use of an incorrect 'A constant', incorrect lens selection and packaging errors may lead to refractive surprises. However, sometimes it is simply because the patient's eye does not fit the expected mathematical relationship for the post operative lens position and patient expectation is important in dealing with the limits of current implant power calculations.

In this case, an incorrect lens was actually inserted. The Royal Australasian College of Surgeons, in conjunction with the Australian Safety and Quality Council, has produced the "Ensuring Correct Patient, Correct Site, Correct Procedure" protocol which should assist in minimising these events.

Medication error: hydromorphone

Case history

The 35 year-old patient attended the regional hospital's Emergency Department (ED) complaining of a severe episode of renal colic. The patient had had a number of previous renal stones and had undergone ureteric stenting in the past. The patient informed the doctor that he was allergic to pethidine, morphine and various other analgesics. He specifically requested hydromorphone for the pain. The patient reported that this had been the most effective medication in the past. The ED doctor had not previously used hydromorphone but she was advised by the nursing staff that there were five vials of hydormorphone in the ward. While the doctor was seeing another patient in the ED, one of the nursing staff asked her to chart the hydromorphone so that the patient could be transferred to the day stay ward for observation. The doctor charted "hydromorphine 10mg" believing that it was the same as other morphine derivatives. Fortunately, the patient did not suffer any long term adverse sequelae from the excessive dose of hydromorphone.

Discussion

Hydromorphone (Dilaudid) is an opioid analgesic used for the management of moderate to severe pain. Over the years, a number of incidents have been reported involving the prescription of hydromorphone. While in many of the cases the patients suffered no residual complications related to the medication, in some cases the incidents have resulted in patient deaths. Most of the cases have involved either wrong dosage or over-prescribing of opioid analgesia. Hydromorphone is approximately eight times more potent than morphine. As always, if prescribing a medication with which you are unfamiliar, check the relevant prescribing information before charting the medication.

Beware retained throat pack

Case history

The 24 year old patient was scheduled to undergo prolonged oral surgery. At the request of the surgeon, the anaesthetist placed a throat pack at the start of the procedure. The surgery was uneventful. The patient was extubated without any complications and he was transferred to the recovery ward. The patient coughed up the throat pack some hours later on the ward. He was very distressed and later wrote to the anaesthetist complaining that he was suffering from nightmares as a result of the events surrounding the retained throat pack. The patient refused to pay the 'gap' fee for the anaesthetic. After discussion with MDA National, it was agreed that it would be reasonable for the anaesthetist not to pursue the 'gap' payment. MDA National assisted the member in preparing a response to the patient's letter, including the offer to waive the 'gap' payment.

Discussion

In this case, although the pharynx was sucked out under direct vision at the end of the procedure, the blood stained pack was not seen until the patient coughed it up several hours post operatively. Sporadic reports of this complication continue to occur, sometimes with disastrous consequences for the patient. A number of strategies have been proposed in the literature to prevent retention of throat packs, including:

- labelling the forehead of the patient;
- attaching a label at the end of the tracheal tube;
- fixing the pack onto the tracheal tube at a predetermined site; and
- recording the pack as part of the count sheet.

Alertness to the danger to the airway and a protocol for handling surgical packs, including throat packs, by theatre staff, the surgical team and the anaesthetist are critically important for prevention of similar mishaps.

A case of mistaken identity

Case history

The anaesthetist rang MDA National for advice after receiving a bizarre and troubling phone call. The anaesthetist reported that he had just received a call on his mobile phone from a female who said: "you had sex with me last night and you didn't pay me". The anaesthetist was absolutely aghast and said he had no idea what the caller was talking about. He asked the caller how she had got his mobile phone number. The female replied that he had given her his business card last night. The anaesthetist asked her where she was calling from and she replied that she was in Brisbane. The anaesthetist said that he did not live or work in Brisbane and he had certainly not been with her the night before. After some discussion about his physical appearance, the caller was satisfied that it was a case of mistaken identity and apologised to the anaesthetist for the error.

Discussion

It was the anaesthetist's routine practice to provide patients with his business card post operatively in the event that a patient experienced any problems. The business card included his mobile phone number. The anaesthetist assumed that one of his patients had inappropriately used the business card. The anaesthetist wanted advice from MDA National about whether he should contact the Medical Board to inform them about the matter. He was concerned about his professional reputation being damaged by the 'imposter'. He had already discussed the phone call with the police. The police offered to investigate the matter and, in fact, subsequently interviewed the female caller and also the 'client/imposter'. It was decided that it would be appropriate for the anaesthetist to provide a brief notification to the Medical Board in the event that there were any further developments. Fortunately, the anaesthetist did not hear anything further about the matter.

Cognitive Institute Workshops 2007

The popular series of risk management workshops presented by the Cognitive Institute is being expanded this year. A total of 35 workshops will be provided by MDA National at no cost to Members.

The topics being offered during 2007 are:

- Managing Patient Expectations
- Mastering Your Risk
- Doctor Patient Communication
- Mastering Professional Interactions
- Mastering Adverse Outcomes

Managing Patient Expectations

Your patients have expectations, both realistic and unrealistic about the level of care they receive. The key to meeting these expectations is being able to identify them at the outset and diffusing those that are unrealistic. By being aware of, and valuing these expectations, you will be on the road to achieving a good doctor/patient relationship, high levels of patient satisfaction and a reduced risk of patient disappointment.

This 2 hour workshop provides the tools to reduce risk and prevent patient disappointment. It explores the theory around expectations and teaches communication skills and techniques to help identify, clarify and correct patient expectations before intervention or treatment.

Mastering Your Risk

The reasons patients sue are complicated and difficult to predict with accuracy. However, international research identifies good communication as one of the most effective risk management tools a medical practitioner can have. According to some research, when patients decide to sue, both predisposing and precipitating factors are generally present. Predisposing factors include; poor or miscommunication, unreasonable delays and perceived lack of interest/not caring. Precipitating factors include; an adverse outcome, unsatisfactory care, iatrogenic injury or system error. Research has shown that where no predisposing factors are present, it is unlikely that precipitating factors on their own will lead to a patient litigating.

This $2\frac{1}{2}$ hour workshop provides a good grounding in the issues surrounding risk management such as why patients sue, why certain "bedside" manners increase a doctor's exposure to risk and the link between communication and litigation. The workshop then moves on and introduces the preventative skills and techniques that doctors can implement immediately to reduce their exposure to litigation.

Doctor Patient Communication

According to Beckman[1] (1994), 71% of litigation is related to poor doctor-patient communication. Doctors who use good communication techniques generally experience very good doctor-patient relationships, achieve increased patient compliance and experience fewer complaints and claims. Complaints often arise when there is a breakdown in communication rather than when something goes wrong. A 1993 study by Lester and Smith[2] showed that the use of negative communication behaviours by doctors increased litigious intent even when there had been no adverse outcome. The same study concluded that doctors who improve their communication behaviours with patients may experience a reduced risk of being sued even when something has gone wrong.

This $4\frac{1}{2}$ hour workshop uses a combination of short lectures, reflective exercises and small group work. The workshop is designed to give doctors practical skills to apply effective communication techniques consistently in their practice. The use of videotaped case studies of realistic issues involving patients and live case situations provides the setting for participants to practice using communication strategies and receive feedback from their peers.

Mastering Professional Interactions

Much has been written on the consequences of poor doctor - patient communication. Increasingly however, poor doctor-doctor communication is being recognised as a source of risk, particularly referrals lacking sufficient information, handover and discharge summaries are emerging as significant medico-legal risks for doctors.

In this day and age, it is not unusual for an episode of care to involve more than one doctor. The consequences of poor exchange of information/communication between these doctors can be catastrophic for the patient. The 2004 JCI Report on Sentinel Events reported poor communication between medical professionals as the root cause of over 70% of reported sentinel events with death of the patient occurring in three quarters of these events.

This 2 hour workshop explores the two major areas where communication between doctors is a source of risk: handover and disagreement between colleagues on diagnosis and management of a patient. The workshop addresses these two areas of risk by exploring the nature of the risk; provides an opportunity for reflection on personal attitudes and behaviours in this area of risk and examines strategies to mitigate risk. Participants are given the opportunity to rehearse responses they may find effective when they find themselves in conflict with a colleague. They are also provided with Cognitive Institute handover and hand back checklists.

Mastering Adverse Outcomes

As movement towards full disclosure increases, pressure is mounting on doctors and hospitals to provide open and honest communication with their patients when treatment results in an adverse outcome. Studdert et al[3] (2007), suggests that disclosure reduces the risk of a patient suing because they are able to understand that their injury was not the result of a negligent act and they may feel less anger towards the doctor who provides an open and honest explanation. Honest and open communication is an essential component of restoring a patient's trust, the provision of ongoing care. It also influences how the patient and family will react.[4]

This 3 hour workshop addresses the difficult area of discussing adverse outcomes with patients. It highlights the importance of recognising patient expectations when an adverse outcome occurs and how failing to address them increases the risk of patient litigation. Participants are provided with a good grounding on the issues, legal obligations and implications of these discussions and examine how their own personal barriers to confronting patients can increase the risk of litigation. Doctor-patient video scenarios of various approaches to handling an adverse outcome are discussed in small groups and a model of handling adverse outcomes is introduced.

For further information on these workshops, please contact Risk Management Services on 1800 011 255 or via riskmanagement@mdanational.com.au

1 Beckman, H.B., Markakis, K.M. et al., 1994, *The Doctor-Patient Relationship and Malpractice: lessons from plaintiff depositions*. Arch Intern Med; vol. 154, pp. 1365 -1370.

2 Lester, G.W., Smith, S.G., *Listening and Talking to Patients: A Remedy for Malpractice Suits?* West Journal Med; 1993 vol. 15, pp. 268 - 272.

3 Studdert, D.M., Mello, M.M. et al., 2007. *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*. Health Affairs, vol 1, no. 26 pp 215-226.

4 *When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals*. Burlington, Massachussetts: Massachusetts Coalition of the Prevention of Medical Errors; March 2006.

Providing Patient Reports to Insurance Companies - What are Your Obligations?

MDA National has recently noticed correspondence in the medical literature from some of our Members which raises concerns about the provision of medical reports to insurance companies regarding their patients. This presents a timely opportunity to address the issues surrounding the provision of medical reports to insurance companies on behalf of your patients.

Treating doctor reports

It is important at the outset to make it clear that this article relates solely to reports that are requested by a third party in relation to an existing patient. This article does not intend to examine the issues of a medico-legal examination or opinion in relation to a person who has never been your patient and has been referred to you solely for the purpose of a medico-legal assessment. This scenario raises a further set of issues in relation to reviewing a person for whom you are not a treating doctor[1].

Concerns in providing treating doctor reports

Some of our Members' concerns in relation to the provision of reports to insurance companies are as follows:

- The time it will take them to complete the report in terms of the detail required and the complexity of the information being sought.
- The remuneration to be received for preparing the report.
- The timeframe in which the report is required by the insurance company.
- Concerns in relation to their assessment or failure to provide a report adversely impacting on their patient's application for insurance or claim and the subsequent effect that will have on the treating relationship.
- The potential medico-legal ramifications for providing incomplete or incorrect information.
- The potential to be called to give evidence in court if the report is provided for the purpose of evidence in legal proceedings.

In addition to these concerns it is also our experience that the request for a medical report for an insurer may result in a complaint being made to the Medical Board or the Health Complaints body in the relevant jurisdiction. In these circumstances the complaint often originates from the patient who is dissatisfied with the content of the report.

Obligation to provide a treating doctor's report?

Given the above concerns you may ask yourself why you should provide reports for patients to insurance companies. As a general rule you cannot be compelled to author a medical report regarding a patient but can be required under the Federal Privacy Act (1988) to release a copy of your notes upon receipt of the appropriate patient authority. There are, however, some legislative schemes which compel you to provide information and also some insurance claims made by your patients will not be considered until a medical certificate is completed[2].

Notwithstanding this, some of the Medical Boards within Australia have made it clear that the provision of factual reports comprises part of the obligation of a registered medical practitioner to their patients. For example, the Medical Practitioners Board of Victoria states that "the provision, for a reasonable fee, of a factual report of the history, findings, treatment and progress of a patient's condition (is considered) to be part of a doctor's professional responsibilities...... Failure to provide a report within a reasonable timeframe, without adequate reason, may be deemed by the Board to represent unprofessional conduct"[3].

It is clear from this statement that where a reasonable fee has been provided for a factual report regarding a patient, and you refuse to provide the requested report in a timely fashion and without an adequate explanation, you may be deemed to have breached the Medical Practice Act in your State or Territory. This of course would require a complaint to be made with the Board in the first instance which would then lead to an examination of the circumstances surrounding the provision of the requested report. The complaint does not necessarily need to be made by the patient and may be made by the person requesting the report. In the latter scenario it would of course be necessary to ensure that the patient is aware of the complaint and has provided an appropriate authority to the Board prior to you responding to any request for information by the Medical Board. On this basis it may be arguable that you have a legislative duty to provide such factual reports, as in certain circumstances a refusal to provide the report may result in a breach of your relevant Medical Practice Act under the provisions that relate to unprofessional conduct[4].

The State and Federal AMA have also, through various publications, stated that treating doctors have an obligation to provide factual information, upon a patient's request, and hence consent, to a nominated third party where a reasonable fee is paid. The AMA does, however, make it clear that the obligation only extends to factual reports and not reports which request an opinion in relation to the condition or injury[5].

Issues to consider when providing factual reports

Should you decide that you will provide an insurance report you will need to consider the issues in relation to the provision of such a report. For example, the timeframe it will take to complete the report, the content of the report and the cost of preparing the report. Most complaints in relation to the provision of these reports can be attributed to a breakdown in communication. As a result, where you put a system in place to deal with these requests which ensures good channels of communication between your office and the requesting party the majority of complaints should be prevented.

Upon receipt of a request for an insurance report you as the treating doctor should review the request and determine whether you are prepared to provide the report. In the first instance you must establish that you have been provided with an appropriate patient authority to provide the information that is being sought. If this has not been provided then you should inform the requesting party that until an appropriate authority is received you are unable to consider their request any further. It is not your job to obtain the patient authority on behalf of the requesting party. If however, you are provided with an authority and you are concerned about whether it reflects your patient's current wishes it is always prudent to contact the patient directly, inform them of the specific information that is being sought and confirm that they consent to this release of information. This should all be documented in the patient file.

The decision of whether to provide a report or not will obviously be governed by the nature of the report which is being requested. In circumstances where you are being asked to comment on matters which you feel are outside your expertise you should decline the request, stating the reason.

Following review of the request you should make an assessment in relation to the likely cost of preparing the report and the timeframe which you will require to complete the report. This information should then be communicated to the requesting party. At this time you should also decide whether you will require pre-payment for the report. In the event that you require pre-payment you should inform the requesting party that you will not take any steps to commence the requested report until this payment has been received and that the anticipated timeframe to complete the report will commence only once payment has been received. In the event that any of these conditions are not satisfactory to the requesting party you should inform them that you are unable to provide the report. Once agreement has been reached in relation to payment and the timeframe any anticipated departure on your part from this agreement must be immediately communicated to the requesting party. Ideally, all dealings with the requesting party should be put in writing and placed on the patient file for future reference in the event of a complaint being made.

Completing the report

In terms of completing the report it is often ideal to ask the patient to attend your rooms. This is particularly the case where you are required to answer a pro-forma series of questions. This approach allows you to directly ask the patient for further information regarding their medical history in the event that your records do not contain the specific information being sought by the requesting party. For example, you may have a documented family history of breast cancer for your patient on file, however, insurers will commonly ask at what age breast cancer occurred in the patient's family member. Having access to the patient at the time of completing the report allows you to elicit this information from them directly. This also puts part of the obligation in relation to the timeframe for completing the report on the patient as you can make it clear to the requesting party that the report will be completed when the patient makes an appointment to see you. It also

ensures that the patient is fully aware of the information being sought and disputes relating to a lack of consent should then be overcome. Further, it allows you to complete the report during your clinical time and you do not have to do the report outside of clinical hours.

The information to be contained within the report must be accurate, complete and not aimed to mislead the requesting party. You have a duty to be impartial and should not set out to "support" the patient's claim or application for insurance[6]. If necessary provide qualifying comments where a closed response has been sought. If you are asked to comment on something that you do not feel you have the expertise or the ability to provide an answer then you should decline to answer the question and set out the basis for this. It is important to be aware that in some circumstances you may be held liable for information or a lack of information that is provided in a negligent manner. For example, if you knowingly fail to provide information which was within your knowledge and was sought by the report and this adversely impacts on the insurer then you may be held liable for the monetary difference incurred by the insurer as a result of this negligent omission.

Providing the report within a "reasonable" timeframe

Further, civil liability may arise when a report is not provided in a timely manner. Such cases usually relate to reports being sought in respect of an application for income disability insurance or life insurance. Where a patient has suffered illness, injury or death and the report has not been completed by the doctor resulting in non-progression of the insurance application, then the doctor may be held liable for amounts which the patient would have been entitled to under the policy. Depending upon the policy that was being sought then the doctor may also be liable for other amounts. For example, economic loss, general damages or other expenses incurred by the patient as a result of the damage caused by the negligent delay in providing the report.

Liability would only occur where it could be established that the patient would have been granted the insurance for which they applied and that the length of time taken to complete the report was negligent. The test for this differs throughout the jurisdictions of Australia, however, it is generally measured by what the doctor's peers would believe to be competent medical practice. Further, the type of report requested and other specific factual circumstances unique to the scenario would be considered when making a determination regarding whether the timeframe was negligent or not. The two cases considered by the Medical Practitioners Board of Victoria dealt with delays of two and a half years[7] and periods between 12 months and 26 months[8]. These delays were in the circumstances considered by the Board to constitute unprofessional conduct of a serious nature.

In these matters the Board made it a condition that the doctors involved acknowledge receipt of a request for a report within 14 days and provide the report within 60 days, or as agreed as being mutually acceptable with the requesting party. Interestingly, the AMA in its Medico-Legal Restatement suggests that a medico-legal report should be supplied "within a reasonable time, normally within 14 days"[9].

Conclusion

In summary, some Medical Boards in Australia and the AMA explicitly state that it is part of a medical practitioner's obligation to their patients to provide factual reports within a reasonable timeframe and when a reasonable fee has been provided. A failure in these circumstances to provide such a report may be deemed as unprofessional conduct. Silence on the part of the other Medical Boards within Australia does not necessarily imply that they would not take a similar stance. Careful consideration should therefore be given if you are contemplating declining a request to provide a factual report. Where a report is to be given care needs to be taken to ensure that communication as to cost and timeframe occur with the requesting party and terms satisfactory to both parties are agreed upon. Information contained within reports must be accurate, complete and not designed to mislead the requesting party. These reports must be provided in a timely fashion and in accordance with the terms agreed prior to accepting the request to complete the report. Any concerns regarding the provision of such reports are best answered by contacting MDA National for specific medico-legal advice which is tailored to your particular situation.

Karen Kumar
Solicitor/Claims Manager

1. For further information regarding medico-legal assessments of a person who has not previously been your patient please refer to the medico-legal assessment guidelines published by your Medical Board or contact MDA National for further advice.
2. For example, Section 239 Accident Compensation Act (Vic) 1985 amongst other things may require a doctor to provide information to the Victorian Workcover Authority as directed. Also, in QLD a person cannot have a CTP claim considered until the set pro-forma Medical Certificate is completed by a doctor (S37 Motor Accident Insurance Act 1994).
3. Page 29, *Guide for Medical Practitioners, Medical Practitioners Board of Victoria.* Accessible at http://www.medicalboardvic.org.au/pdf/MPBofV_Guide.pdf
4. Two examples of such matters is *Dr Nicholas Sevdalis* [2005] MPBV 8; *Dr Chander Hrstic* [2004] MPBV 9
5. *"Guidelines for Doctors Acting as Expert Medical Witnesses"* (1997) Federal AMA at page 1 and 2. "AMA Code of Ethics" (2004. Editorially revised 2006) AMA at para 1.1(m) and 4(e) refers to an ethical obligation to report treatment and findings to another doctor at the request of the patient and assist by giving expert evidence to courts and tribunals however, does not specifically refer to treating doctor reports for nominated third parties. Accessible at http://www.ama.com.au/web.nsf/doc/SHED-5FTUUW/$file/legal_pp_ps_glines%20docs%20act%20expert%20med%20witnesses.pdf and http://www.ama.com.au/web.nsf/doc/WEEN-6VQ2NX/$file/AMA_Code_of_Ethics_-_2004._Editorially_Revised_2006.pdf
6. See *"Medico-Legal Guidelines"* March 2006, Medical practitioners Board of Victoria at page 26 for further information on writing reports as a treating Medical Practitioner. Accessible at www.medicalboardvic.org.au/pdf/Medico_Legal_Guidelines.pdf
7. Dr *Nicholas Sevdalis* [2005] MPBV 8
8. Dr *Chander Hrstic* [2004] MPBV 9
9. October 2005 at para 4.10

What Chance a Better Outcome?

What happens when you are sued and the act of negligence has not caused all of the harm but has only resulted in the patient losing the chance of a better outcome? This is the very position that has been debated in a number of recent Court cases.

Where an act of negligence is proved the injured party is entitled to recover any damages that flows from the harm caused (such as for pain and suffering, treatment expenses, domestic assistance, loss of capacity to work and equipment needs).

The law would only permit recovery where it was demonstrated the doctor's negligence was a material cause (i.e. greater than 50%) of the harm suffered. A discount would then be made to reflect the possibility of the harm occurring absent of negligence. However, in recent years, Australian Courts have been willing to award damages based upon the "loss of a chance" of a better outcome, even where there was a less than 50% chance of a better outcome - this view is not necessarily mirrored in the UK courts.

A common area where issues relating to loss of a chance occur is delay in diagnosis of cancer. Usually, oncologists can provide opinions as to the percentage chance, in 5 and 10 year survival rates, lost by reason of a delay in diagnosis. This provides a useful means of determining the "loss of a chance". However, it does not necessarily mean that the Court will adopt the oncologist's analysis without question. Indeed, it will look at all the available medical evidence in a "robust and pragmatic way" to determine what the value of the lost chance actually is.[1]

Two recent cases provide an insight into how Courts assess "loss of a chance". Where a patient suffered a cardiac arrest and hypoxic brain injury, found to be partially due to a negligent delay in arranging an ECG, the Court held that as there was a 65% chance of detecting pathology that would have avoided a cardiac arrest, the patient was entitled to recover damages reflecting the whole of the harm caused by the cardiac arrest and hypoxic brain injury - that is 100% recovery.[2] By contrast, where there was found to be four separate causes of cognitive impairment and other injuries caused by a medulloblastoma, only one of which arose out of a practitioner's negligence, the Court found that the negligent cause made a 25% contribution to the patient's ultimate injuries, for which the negligence resulted in a "loss of a chance" of 40%. Accordingly, the patient recovered 40% of 25% of a damages award reflecting the full extent of their injuries.[3]

The law relating to "loss of a chance" remains somewhat uncertain. The High Court of Australia is yet to provide a definitive statement upon it. Lower Courts have applied "loss of a chance" differently, particularly where the chance lost is greater than 50%, but less than 100% - some considered that the patient can recover damages for all of their harm suffered, whereas others considered they could recover only for the percentage "loss of a chance". These cases highlight what appears to be a trend towards an expanding field of quantifiable claims. Applying the "loss of a chance" principles is brought into stark contrast where the damage claimed is, for example, a 1% loss of a chance of an improved outcome - an almost incalculable claim but claimable none the less on these principles.

It is likely that the High Court will provide a definitive statement on "loss of a chance" over the next couple of years or so, particularly in light of this issue arising in an increasing number of cases.

Timothy Bowen
Lawyer
Ebsworth & Ebsworth Lawyers

1. *Rufo v Hosking* (2004) 61 NSWLR 678
2. *Halvorsen v Dobler* [2006] NSWSC 1307
3. *Tabet v Mansour* [2007] NSWSC 36

New Online Services

You pay for your car insurance online, you do your banking online and soon you will be able to pay your MDA National Insurance premiums online too. At MDA National, we are continually looking at ways to improve our service to Members and therefore we are expanding the range of services that are offered online.

We will give you the flexibility and convenience of interacting with us 24 hours a day, 7 days a week. Some of the new web services will be available in late April, so visit www.mdanational.com.au closer to the time to find out more information.

One of our key considerations in launching the new online services is the security of your personal data and credit card details. Our online team is working with security experts to ensure that your personal details are protected through every step in the process. We are also committed to ensuring that we have the most up to date security protocols at all times. You can take comfort in knowing that the security of your personal details is the key consideration in all of our web developments.

The first step in interacting with us online will be registering for a new password. As we will be integrating our current system with new software to enable increased functionality, all Members who wish to interact with us online will need to apply for a new password. This will help to ensure that only you can access your personal data. More information about how to register for your password will be found online closer to the launch date.

Once you have registered for your new password, you will be able to take advantage of the exciting new web services that are listed below. These are the first in a series of improvements that will be offered in the next few years. As always, we welcome your suggestions on how we could serve you better through online services. Drop us a line at peaceofmind@mdanational.com.au or call us on 1800 011 255.

Phase 1: During the first phase of web improvements, Members will be able to update their personal details quickly and easily online. So if you have changed address details, changed your provider number or changed your email address, you will be able to log on at any time and update your details.

Phase 2: In the next phase of our web development, Members can accept and pay for their annual renewal online. This means that if you are happy with your hard copy renewal offer, you can logon to the website where you can pay for your renewal through a secure online credit card portal.

Our web services will be offered in a staged approach to ensure that our system is secure and stable at all times. Other improvements that MDA National is working on include an online incident notification process and online event registration.

As we expand our member service to you through web improvements, you will be able to interact with us when it suits you - whether it be at midday or midnight.

Practice Swap 2006

Between the Severn and Avon Rivers sits the medieval town of Tewkesbury. Site of the deciding battle of the "War of the Roses", it is a town of black and white, half-timbered houses.

In March this year my family and I, relocated to Tewkesbury. We exchanged practices, cars and houses for six, always interesting and sometimes challenging, months.

I have been asked to recount my impressions of the medical indemnity situation in the UK. I preface my remarks with the caveat that my impressions are just that. There is a paucity of readily available, comparative data. Having said that, the similarities with our system are more noticeable than the differences.

Regulation of UK doctors has been very much influenced in recent years by the Bristol paediatric cardiac surgery scandal and more recently by the Harold Shipman case. When negotiating the red tape necessary to work as a GP in Britain, the justification for almost all the regulations was that they were to prevent the next Shipman. Not everyone I spoke to was convinced of the effectiveness of much of this sometimes tiresome regulation but in the aftermath of such a well publicised medical disaster, the political power is with those who wish to regulate.

Hospital doctors are indemnified by the NHS but other doctors, including GPs, have to carry insurance as in Australia. Given that the scope of my practice in the UK was narrower than here and, in particular, I did not give anaesthetics or perform any procedures other than simple excisions and joint injections, I was surprised by the size of insurance premiums there. Converted to AUD they seemed very high (but so did most other things if the exchange was considered). Fortunately UK GPs have a new and much improved contract with the NHS and are more able to afford this than was previously the case.

My impression was that, despite a lower risk of being sued, the UK GP worried about litigation and complaints more than is the case here. This is in part explained by the number of regulatory bodies able to deal with concerns regarding one's practice. "Defensive medicine" was not common and risk management was not a topic of conversation over morning tea or in the medical broadsheets. Patients seemed less demanding and quite accepting of delays inherent in the system. The practice was in the process of fine tuning its own consent form for removal of lesions under local anaesthesia. Whilst this was much less detailed than the latest WA Health Department consent forms, it has not been my practice in WA to obtain written consent in the same circumstances.

Two significant differences in the UK were the practice of consulting patients over the telephone and the supervision of nurses practising with variable degrees of autonomy.

There were no problems with these practices in my six months, however, I remained uneasy diagnosing and prescribing over the telephone. In contrast, I became confident of our nurses' ability to share clinical load, whilst recognising when to involve the duty GP. This collaborative approach not only helped smooth peaks of demand but also added to the proportion of interesting cases one saw.

In summary, whilst there are differences in all aspects of practise in the UK, an exchange is a great opportunity to see somewhere different, meet new people and to revitalise one's interest in the art of medicine. I would like to take the opportunity to thank my partners here for their support, the doctors and staff in Tewkesbury for welcoming me, and not least, MDA National, for assisting me in obtaining indemnity cover for my adventure.

Dr Stephen Cohen

Membership Satisfaction Survey 2006

In 2002, MDA National implemented a Member Satisfaction Survey. Overall, the aim of the survey was to evaluate Members' satisfaction with the MDA National Group's core business areas and the importance they place on each of these areas in order to identify how MDA National can improve its service delivery. This survey was repeated in 2004 and 2006 marked the third wave of research.

In 2006 the questionnaire was mailed to all Members who held an insurance policy with MDA National Insurance at the time. There was a very high response rate of 17% and of these surveys, 1,000 were randomly selected for analysis.

The aims of the 2006 survey included:

- to determine any trends or shifts in attitudes since the previous survey; and
- to quantify MDA National's performance on key indicators.

MDA National

Member Survey 2006

Introduction

Section A

Instructions for sections B to H

Medico-legal advice and claims handling continue to be the most important areas for MDA National Members. The remaining core areas, listed by relative importance are: price of insurance premiums, financial stability, membership services, risk management information and having offices in your region.

Of the top two, medico-legal advice is the most important aspect of MDA National's service. While most scores have remained constant since 2004, satisfaction with the professionalism of staff has risen, as has satisfaction with the timely response to queries.

Case management by legal staff and professionalism of staff, continue to be the most important aspects of claims handling.

General perceptions regarding MDA National were examined with results indicating that MDA National members are extremely positive about the MDA National Group, as follows:

- I would recommend MDA National to others - 92% agree, 1% unsure, 7% disagree
- MDA National is closely aligned with the medical profession - 85% agree, 15% unsure
- MDA National understands my needs as a medical practitioner - 89% agree, 8% unsure, 3% disagree
- I am likely to stay with MDA National - 96% agree, 4% unsure

Members were also asked to indicate their general perceptions of the medical indemnity industry with the following results:

- Medical indemnity should be in the hands of the medical profession – 87% agree, 7% unsure, 7% disagree
- Increased Government involvement has improved medical indemnity – 57% agree, 24% unsure, 19% disagree
- Medical practitioners should have a choice of medical indemnity provider – 96% agree, 2% unsure, 2% disagree

The 2006 survey showed a high overall level of satisfaction with MDA National and the current medical indemnity system. As the medical indemnity crisis fades further into the background, the focus on delivery of Member services becomes even stronger. It is positive that the area of highest relative importance, medico-legal advice, has seen small increases in satisfaction on what were already high ratings.

We would like to thank all Members who responded to the 2006 survey. Many of the other sections covered in the survey are being used to inform our product and service delivery into the future. It is hoped that the 2008 survey will see a further increase in your satisfaction as we refine our level of services to Members in response to your feedback.

Claire Leonard
Communications Manager

MDA National

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. Please ensure your original records are preserved and kept separate from any correspondence with MDA National Insurance. If this matter develops into a claim, they will become critical to your defence.

Attach any correspondence relevant to the notification. Attach additional comments on separate pages if necessary.

Signature: ______________________________ Date:____________________

Policy holders based in WA, NT, SA and overseas

Please post or fax the completed form and related documents to:

Claims Division, MDA National Insurance
PO Box 1557, Subiaco WA 6872
Claims Fax: (08) 9415 1492

Policy holders based in all other states

Please post or fax the completed form and related documents to:

Claims Division, MDA National Insurance
Level 5, 69 Christie St, St Leonards NSW 2065
Fax: (02) 9460 8344

Perth
Level 3
516 Hay Street
Subiaco WA 6008
Ph: (08) 6461 3400
Client Services Fax: (08) 9415 1493
Claims Fax: (08) 9415 1492

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

Sydney
Level 5, 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 24, Santos House
91 King William Street
Adelaide SA 5000
Ph: (08) 8233 5842
Fax: (08) 8233 5858

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Privacy: The MDA National Group collects personal information to provide and market our services. 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 112.2

MDA NATIONAL INSURANCE PTY LTD

Early Warning System: New Technologies and Treatments in Medicine

New technologies and treatments are constantly being developed and introduced into all areas of medical practice. Whilst many of these may offer great benefits to patients and indeed to the medical practitioner, we should all be aware of potential pitfalls.

MDA National seeks to maintain an "Early Warning System" to assist in the early identification of exceptional risks related to new technologies or treatments, and, where necessary, refer to the appropriate body for further assessment.

The Early Warning System will also enable us to provide Members with timely information as risks are identified, allowing you to better manage those risks where they occur within your practice.

Members of MDA National are invited to assist in the process of identifying any clinical problems with new technology or treatments they may have experienced with a patient. All information submitted will be reviewed by a network of senior colleagues drawn from our Council and Committees. This network will assess the information and advise our staff on possible problems.

An Early Warning Notification Form is available on the MDA National website. It can be completed online and emailed to the Risk Management Department on riskmanagement@mdanational.com.au or faxed to 02 9460 8344. Please be assured that all advice provided by Members will remain confidential.

If you have any queries or would like more information about the Early Warning System, please contact the Risk Management Department on 1800 011 255.

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** 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.

Freecall: 1800 011 255 **mdanational.com.au**

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91 King William Street
Adelaide SA 5000
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Fax: (08) 8233 5858

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.

Any case histories used are based on actual medical negligence claims or medicolegal referrals; however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

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