

Defence Update

Quarterly Magazine of the MDA National Group

MDA National

**Failure to Diagnose
Breast Cancer**

**Clean IT Data
in General Practice**

**Professional Services
Review System**



1925-2005

80

YEARS OF SERVICE

December 2005

04

The Odd Lump...or Two

Matilda Marple (d.o.b. 1937) known as young Miss Marple so as not to be confused with her sister, Edwina (d.o.b. 1922), has come with her usual shopping list of veins, heartburn, take my BP, listen to my heart (listen to my heart sink, thought Dr Smiley)..... But, he and she survived the consult. He closes the computer screen, gathers up his college notes and turns with one hand on the door to usher her out when

"This is just a little bump I am worried about", pause "just here", pause, "see"

"He stops, looks, reassures and off she goes.

He is now 35 minutes behind and it is only 9.50 am.

8 months later (and 5 further agonising visits with the young Miss Marple), she says "remember the bump I showed you in October? Well, I don't like it".

He looks (and shivers inside)

He checks his notes (nothing there)

He gets out a light and a magnifier and desperately tries to recall his melanoma colleague's telephone number.

Histopathology says level 4 with nodular formation.

Soo-em & Sons Solicitors want notes and a report.

As does MDA National Insurance (MDANI).

But there are no relevant notes and between October and June was Christmas, New Year, a new baby at home and no relevant memory!

GP	Other		
Delayed or missed diagnosis	25	Missed follow-up GP - 2 Specialists - 2 Pathologists - 2	6
No claim (i.e. defensible)	6	Wrong pathology diagnosis	3

Discussion

This is very difficult, and not uncommon.

GPs get caught frequently by the door stop/exit request, 99% are innocuous, but 1% cause concern, and probably 0.1% cost significant money.

How to prevent this: It is easy. Keep good records - therefore, when young Miss Marple introduces her new problem with your hand on the door, re-open the computer file; sit down; write/type an addendum; measure and describe the lump. Request and note a repeat consult within 4 to 6 weeks, specifically to look at that problem or refer straight away if the lump is suspicious.

Recently, MDANI has had 2 cases involving dermatofibrosarcoma protuberans (incidence 0.8 per million). In one matter there was no description, whilst on the other there was. One will be expensive, time consuming and provoking very marked anxiety in a number of people. One won't.

Melanoma is more common, more serious, more fatal, more expensive and more often seen in young people.

The table above shows the number of claims dealt with by MDA National in relation to allegedly delayed diagnosis of melanomas. In 10 years (94-04) MDA National/MDANI has settled 9 claims (average 88k; range \$33 - 149k), of 40 cases of allegedly delayed diagnosis of melanoma. 18 matters remain open and not yet settled. Only in 6 of the cases was a fully defensible position evident from the records.

Therefore;

- **Look**
- **Think**
- **Measure**
- **Record**
- **Recall**

Therefore, as a consequence;

- **Protect your patient**
- **Worry less; about your patient, your practice, perhaps your premiums**

A very good reference is Dr David Watson's article, *Defence Update* June 2005 page 14.

Dr Reg Bullen

Medico-Legal Manager

2005 Nobel Prize for Medicine

The 2005 Nobel Prize for Medicine was awarded to an innovative pair of Western Australian based doctors.

Dr Barry Marshall and Dr Robin Warren received the award for their finding during the 1980s that the *Helicobacter Pylori* bacteria, not stress, is the main cause of painful stomach and intestine ulcers.

MDA National congratulates Dr Marshall and Dr Warren for their well deserved win.

Editorial



The MDA National Group Annual Report and Financial Statements for the year ended 30 June 2005 has been circulated to Members.

What does this mean for Members? Security and peace of mind that your medical indemnity provider is in excellent financial shape and has the foundations to be able to provide benefits going forward into the future.

To further confirm this, we commissioned our Consulting Actuaries, Finity Consulting, to undertake a review of the 5 doctor-owned medical indemnity providers as at 30 June 2005. Their analysis showed that:

- The MDA National Group remains number 2 in terms of net assets per member at 30 June 2005 and subscription/premium income for 2004/2005.
- MDA National Insurance (MDANI) has the highest capital adequacy multiple (MCR) of all 5 MIs as at 30 June 2005 at 232%. The MCR is based on the Australian Prudential Regulation Authority (APRA) requirements for the capital adequacy for licensed general insurers in Australia. The minimum MCR is 100%.

Another year of such solid growth continues to see MDA National operating soundly across Australia. We now have in excess of 60 staff managing the business and servicing the day to day requirements of Members. The staff are evenly spread throughout our offices in Perth, Sydney, Melbourne and Brisbane, ensuring that most Members can access our services at a local level.

I am always very willing to respond to concerns or issues of individual members and I invite any member to feel free to contact me at any time. Email contact is perhaps the best method as I am committed to working at different periods of time in our various state offices. My email address is pforbes@mdanational.com.au

Finally, in closing another successful year, I extend Seasons Greetings to all Members on behalf of the MDA National Council, the MDANI Board and all our staff and wish you a safe and enjoyable festive season.

Peter Forbes
CEO



IUCD - Change of Category

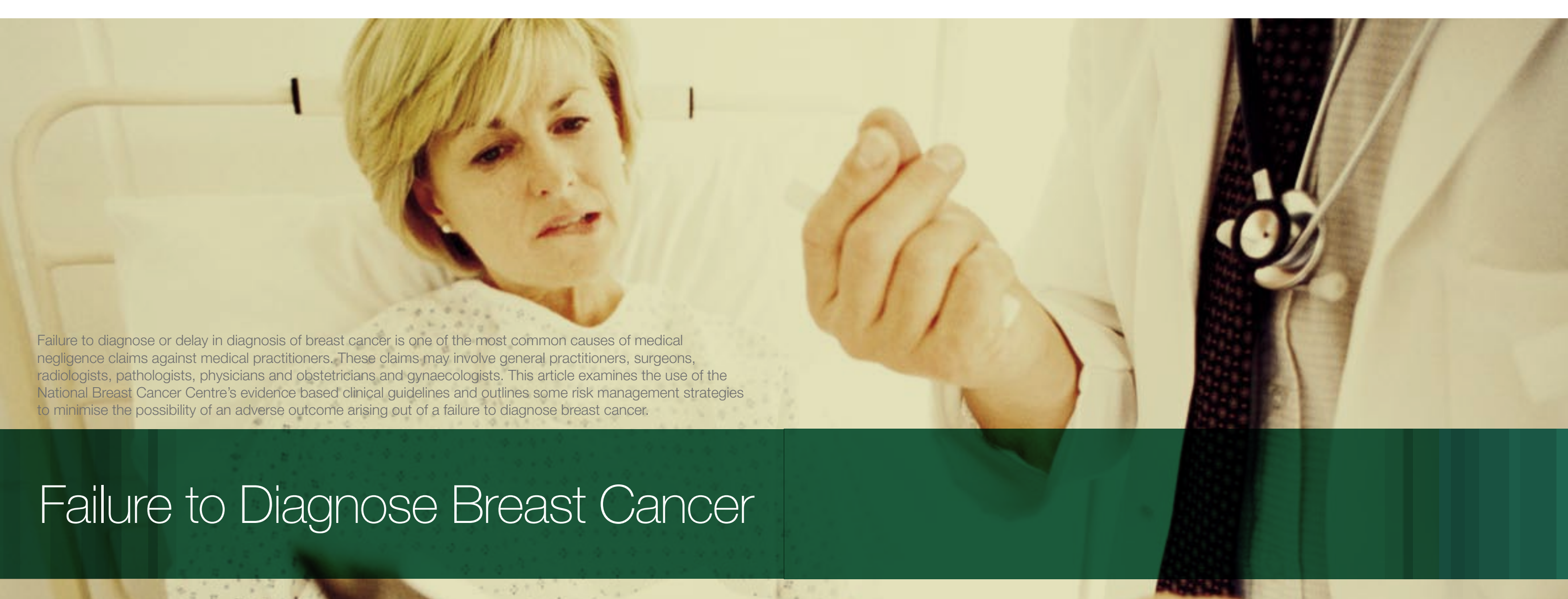
Over the past few years we have kept a watching brief on the classification of IUCD insertion. Previously, General Practitioner members could remove IUCDs at the non procedural rate, but insertion was considered to be procedural.

This classification has recently been reviewed and it has been decided that General Practitioners who insert IUCDs can now do so at Level 1, General Practice - Non Procedural.

This decision is effective from 8 October 2005 and is not retrospective. This means that anyone inserting IUCDs prior to this date would still need to have been covered at Level 3, General Practice - Procedural.

Please note we will continue to keep a watching brief on this new classification. If there is a substantial increase in claims and/or notifications due to this change, the decision will be reviewed.

If you are uncertain about your category and the procedures you are covered for, please don't hesitate to contact Client Services on 1800 034 466 (WA) or 1800 011 255 (all other states).



Failure to diagnose or delay in diagnosis of breast cancer is one of the most common causes of medical negligence claims against medical practitioners. These claims may involve general practitioners, surgeons, radiologists, pathologists, physicians and obstetricians and gynaecologists. This article examines the use of the National Breast Cancer Centre's evidence based clinical guidelines and outlines some risk management strategies to minimise the possibility of an adverse outcome arising out of a failure to diagnose breast cancer.

Failure to Diagnose Breast Cancer

Breast cancer in Australia

- **Breast cancer is the most common causes of cancer related death in women**
- **One in 11 women will be diagnosed with breast cancer before the age of 75**
- **The risk of breast cancer increases with age**
- **Of new breast cancer cases diagnosed in 2001:**
 - 24% were in women aged 20 - 49
 - 49% in women aged 50 - 69, and
 - 27% in women aged 70 and over ^[1].

Claims data

The 2002 Breast Cancer Study was undertaken by the Physician Insurers Association of America ^[2]. The study analysed 450 settled claims involving an allegation of delay in diagnosis of breast cancer. Pooled claims data from medical defence organisations in the United States, Australia, Great Britain and the Netherlands was analysed. Breast cancer was the most prevalent and second most expensive condition resulting in claims against medical practitioners. The average delay in diagnosis was 16.3 months. More than 69% of the women represented in the study were under 50 years of age. Radiologists were the most frequently claimed against specialty group in the study, accounting for more than one third of all paid claims. Of note, in 88% of the cases patients had at least one mammogram. In almost 80% of the cases in the study, the results of the first mammogram were reported as negative or equivocal.

Underlying causes of these claims included:

- mammogram misread or report negative
- physical findings failed to impress medical practitioner
- failure to refer patient to specialist
- patient failed to keep follow up appointment
- communication failure between health professionals.

Pooled Australian breast cancer claims data is not currently available. However, anecdotal experience suggests that failure to diagnose breast cancer also represents a significant medico-legal problem in Australia.

Discussion

A delay in diagnosis of breast cancer, while seen as a failing by the patient and others, may sometimes occur despite good care and appropriate investigations ^[3]. The National Breast Cancer Centre (NBCC) has developed a comprehensive guide to maximise the effectiveness of investigation of women who present to their general practitioner (GP) seeking advice about a new breast symptom. The second edition of the NBCC's *The investigation of a new breast symptom* was released in October 2005 ^[4].

Triple Test

The triple test refers to the three diagnostic components:

- medical history and clinical breast examination
- imaging - mammography and/or ultrasound
- non-excision biopsy - fine needle aspiration cytology and/or core biopsy.

The sensitivity of the 'triple test' is greater than any of the individual components alone. The triple test is positive if any component is indeterminate, suspicious or malignant. The correct sequencing of tests is important to the overall interpretation of the results, as outlined in the NBCC's guide ^[4].

The managing clinician is responsible for the correlation of the cytological/histological results with the clinical and imaging findings.

Diagnostic Imaging

Ultrasound has a lower false positive rate and is more sensitive than mammography in the detection of cancer in young women.

The sensitivity of mammography increases with increasing age. Sensitivity is improved with the addition of ultrasound over all ages, though the size of this benefit is greater in women under the age of 50 years. Mammography should be performed in all age groups if the clinical or ultrasound findings are suspicious or malignant.

Given the limitations of both ultrasound and mammography, they are often used in a complementary capacity to give information in the evaluation of breast abnormalities. Referring practitioners may consult

with their radiologist about the most appropriate test for individual cases. The provision of a detailed history will assist the radiologist to perform appropriate targeted imaging. Further information is also available in the NBCC's booklet *Breast imaging: a guide for practice* (available at www.nbcc.org.au).

Non-excisional Biopsy

Both fine needle aspiration cytology (FNAC) and core biopsy have been shown to have high specificity and sensitivity when used for palpable and impalpable lesions. There are no absolute rules determining when FNAC or core biopsy is the more appropriate investigation. FNAC and core biopsy are complementary, although one may be more appropriate in achieving a definitive diagnosis. Core biopsy can often demonstrate invasive disease, whereas FNAC cannot differentiate between in situ and invasive cancer. Core biopsy can be used when FNAC fails to correlate with clinical findings or imaging studies. For further information, practitioners can refer to the NBCC's *Fine needle aspiration cytology and core biopsy: a guide for practice* (available at www.nbcc.org.au).

Surgical Referral

Surgical referral is recommended in any of the following situations:

- where any component of the triple test is positive (indeterminate, suspicious or malignant)
- where a cyst aspiration is incomplete, results in a bloody aspirate (not traumatic) or a lump remains post aspiration
- spontaneous, unilateral discharge from a single duct, especially in women 60 years and over.

Case Histories

The following cases are designed to illustrate some of the underlying causes of incidents involving an allegation of failure to diagnose breast cancer.

Case # 1

A 28 year old patient attended her GP complaining of a lump in her right breast. She had stopped breast feeding about six weeks previously. The GP could feel a discrete lump in the right breast, but thought it was some asymmetrical glandular prominence related to the recent breast feeding. The GP reassured the patient that the lump was 'just post breast feeding changes' and asked her to return if it enlarged. Sixteen months later, the patient presented with advanced, metastatic breast cancer.

The GP's management of the patient was not in accordance with the NBCC's guidelines. Even in very young women, where the likelihood of breast cancer is low, the finding of a breast lump warrants further investigation with diagnostic imaging and tissue sampling where appropriate.

Case # 2

The 32 year old patient was referred to a surgeon for review of a tender, mobile breast lump. The surgeon thought the lump was most likely a benign fibroadenoma and ordered a mammogram. This revealed no abnormality. The patient was reassured and advised to return to her GP for review if the lump changed.

In this case, the surgeon did not follow diagnostic breast imaging recommendations. For patients under 35 years of age, ultrasound is recommended as the first imaging modality.

Case # 3

A 55 year old patient presented with a hard, fixed lump in her left breast. The GP ordered a mammogram as part of the initial work up of the lump. He asked the patient to return to see him with the test results. At the radiology practice, the patient was given the mammogram films with the two copies of the report enclosed in the x-ray envelope.

On her return home, the patient opened the envelope and looked at the report which stated there was 'no abnormality detected'. The patient was greatly relieved and decided it was not necessary to return to see her GP.

Case # 4

A 48 year old patient presented with a 1.5cm lump in the upper outer quadrant of her left breast. She was referred for mammography and ultrasound. The mammogram was reported as normal. The ultrasound showed multiple cysts in both breasts, including a simple cyst in the upper outer quadrant of the left breast. On aspiration of the cyst, a small amount of straw coloured fluid was removed. The patient was reassured that the lump was 'just a cyst'. However, review of the ultrasound report revealed that the aspirated cyst was in the 9 o'clock position, while the patient's lump was in the 11 o'clock position.

In this case, there was inadequate correlation between the imaging and clinical findings and failure to appropriately ensure that no lump remained on clinical breast examination post aspiration.

Case # 5

A 31 year old patient presented to her GP with a palpable breast lump. Ultrasound revealed a benign appearing solid mass, possibly a fibroadenoma. The GP referred the patient for FNAC. The report

revealed a predominantly benign and non-specific aspirate with atypia. The GP mistakenly reassured the patient that no further investigation or referral was required.

The NBCC's guide states that the triple test is positive if any component is indeterminate, suspicious or malignant. In this case, the GP incorrectly interpreted the test results and failed to refer the patient for surgical review.

Case # 6

The patient was referred to a radiologist for FNAC of a small hypoechoic breast lesion. The FNAC was performed without complication. The pathology referral form recorded the radiologist as the referring doctor and the GP as the 'copy' doctor. Unfortunately, data entry at the pathology laboratory was unable to identify the (locum) GP's contact details and therefore omitted the name of the GP from the report. The radiologist received the report which revealed lobular carcinoma. The radiologist took no further action, assuming the patient would return to the referring doctor and that the referring GP would receive a copy of the result as requested by the radiologist. The patient was lost to follow up for several months until she returned to her usual GP who reviewed the previous medical records and noticed that a biopsy had been performed for which she had no result.

Risk Management Strategies

The importance of inter-professional communication and patient education regarding the need for tests and follow up cannot be overemphasised. The system for investigating breast symptoms often becomes a frustrating maze for the people it is intended to serve. The conduct of a breast examination in one setting, a mammogram or ultrasound in another and FNAC somewhere else is not ideal and can result in a failure to communicate significant results to patients.

Strategies for practitioners to minimise the possibility of an adverse outcome arising out of a failure to diagnose breast cancer include:

- follow up patients with breast symptoms and/or signs to a definitive diagnosis or resolution of the symptoms and signs;
- adopt and follow the NBCC's recently updated guidelines for the investigation of a new breast symptom;
- ensure the patient understands the need for investigations and follow up, including obtaining the results of any tests;
- do not discount the possibility of breast cancer because of a patient's young age - low risk does not mean no risk; and
- keep comprehensive medical records. Areas of inadequate documentation include:
 - failure to record details of the patient's presenting symptoms, family history, clinical breast examination and recommended follow up advice (including telephone calls);
 - failure to review test results and previous entries in the medical records; and
 - altered medical records.

Dr Sara Bird
Medico-legal Manager

[1] National Breast Cancer Centre. *Statistics and Research*. Accessed at <http://www.nbcc.org.au/bestpractice/statistics>

[2] Physician Insurers Association of America. *Breast Cancer Study*. Spring 2002; Rockville, MD.

[3] Houssami N, Buglar L, Ung O. *Delay in diagnosing breast cancer in clinical practice: why it happens*. *Medicine Today*. September 2002, Volume 3, Number 9: pages 96 - 99.

[4] National Breast Cancer Centre. *The investigation of a new breast symptom: a guide for General Practitioners*. October 2005. Accessed at <http://www.nbcc.org.au>



Doctors Treating Doctors and Confidentiality

At times, medical practitioners find it very difficult not to treat themselves. In reality, over 50% of all doctors do not have a doctor who treats them and less than 30% have a regular doctor who has a standard doctor/patient relationship with them. As a result of this, the doctors' health suffers and this can then be reflected in drug abuse, alcohol abuse, depression, suicide, untreated physical illnesses etc.

Frequently, self treating doctors are actually prescribing themselves the wrong medication, investigating the wrong symptoms and basically treating themselves badly.

One of the causes of self treatment is that, as a medical practitioner, there is a reluctance to enter into a doctor/patient relationship. This reluctance can come about because of confidentiality issues about potential bad health outcomes. Therefore, it is incumbent upon all practitioners to realise that the doctor/patient relationship includes the relationship one has with one's colleagues as "doctor-patients" and that the confidentiality due to all patients includes the medical records of colleagues.

With this in mind, it has become the practice of some doctors, including myself, to arrange that the files of any "doctor-patient" are kept separately, but otherwise handled in the same way as every other patient. In my case, I keep the records of "doctor-patient" in a separate filing cabinet. This type of system allows the "doctor-patient" to feel confident that his records are not being accessed by other people.

I have also observed that in a social context, doctors meeting together will discuss the health of colleagues, usually as a result of real concern about an individual. This social intercourse is normal,

but should not be undertaken by a doctor for any colleague with whom he has a treating relationship. If any conversation in which you are involved heads this way, you are obliged to remain silent, steer it into other areas or, preferably, to walk away from the conversation altogether.

An extension of this social intercourse is that medical information should not be sought, accessed nor given in social arenas for persons who could be "doctor-patients" of another colleague. It is inappropriate both to seek that information as the "doctor-patient" and it is equally inappropriate to give that information as the treating doctor.

Within these safeguards, confidentiality should be maintained and the likelihood of all of our colleagues getting into an acceptable and normal doctor/patient relationship would be greatly encouraged. This in turn will have good effects (hopefully) on the health of us all as medical practitioners.

Dr Reg Bullen
Medico-Legal Manager



Clean IT Data in General Practice

History

The majority (89%) of Australian general practices, particularly the larger practices, use computers. Virtually all (96%) practices with three or more doctors report computer use, as do 80% of two-doctor practices and 75% of solo practices. Computer use is greatest for general administrative work, less for patient-oriented administration, and least for clinical use. Of those of us who are computerized, some 70% use the computer in full or in part for clinical functionality.^[1]

Clinical Usage

Most of us have learnt the programs “on the run” and possibly attended a training night run by the local Division. I, like many of my colleagues, commenced with writing prescriptions. Downloading pathology, utilising recalls and reminder systems and writing referral letters on the computer gradually followed. Then came the realisation that having clinical notes in the paper chart and scripts and pathology living on the computer was a problem.

It took considerable time at our practice for all doctors to finally “bite the bullet” and put all clinical notes on the computer as we realised that it was extremely risky having “two systems”

In Australia we have some practices who consider themselves “paperless” but there are still a large number who are utilising a “hybrid system.”

Research Trial

For the past three years I have been the Medical Director of Team Care Health II, a 3 year research project aimed at improving the care of people with chronic disease by focussing on the collaboration of general practice with community nursing, hospitals and other service providers. GPs were asked to do a health assessment and a care plan for all of the patients that were enrolled in the intervention arm of the study. It wasn't until my involvement with this study that I realised how dirty my own data was especially in patients who had complex and chronic problems. It is impossible to do a quality care plan with “dirty data”.

In the Teamcare Study we did two things to assist GPs. We paid GPs from trial funds to review their chart file to ensure they were fully aware of all patients' chronic conditions and to record them on the computer. If during this review they found that the data needed significant cleaning we then suggested they call the patient in for a consultation to record all relevant information on the computer. We also produced a “training module” to assist GPs in entering clean data ^[2].

Usage of Data

Clinical data needs to be clean enough to allow accurate clinical notes; for quality care and medico-legal competence; to allow good continuity of care where there are a number of practitioners sharing access to the patient's records; for the purpose of writing accurate referral letters to specialists and hospitals and for our own practice's reflection and improvement.

Handy Hints

It is important when entering problems and diagnoses into software packages (and depending on whether your software package allows it) that they are stored as either “active” or “inactive”. As well, it is better to have “no date” recorded for problems than to have a referral letter written to a hospital in regards to the patient that shows that their osteoporosis, ischaemic heart disease, osteoarthritis and dementia all appeared to commence on the date that the data was entered.

For all patients it is helpful to say that you will be collecting some “housekeeping” information. This is an easy way of moving into questions on allergies, occupation, family and social history and smoking and alcohol history.

It may be valuable for GPs to think about dividing their new patients into “simple” and “complex”. For new patients that are potentially complex it can be useful to book a long appointment and your nursing staff may be able to enter some of this historical data in the record before you even see the patient.

Often we don't know the complexity till the first consultation so deal

with the “housekeeping” and presenting problem/s and then arrange for the patient to return for a long consultation purely to complete the past and current history and enter the data. This is good clinical management.

Whole of Practice Approach

Data is principally collected to support high quality individual patient care. A key component in getting clean data is having practice wide agreement on how data will be entered, retrieved and analysed. This seems to be one of the biggest barriers - getting consistency. This often has more to do with human factors than IM or IT systems.

The computer can be used to work towards preventive health rather than illness management. IT indicators can be set to prompt GP's to address these areas (e.g. this patient does not have a BP recorded, or this patient meets the requirements for Pneumovax). The GP can then involve the nursing staff to help address these issues (it does not necessarily mean more GP time). When the data is clean it also means that searches that are run on the demographic data can be relied upon. For example a search of patients taking asthma medication if the practice wants to do asthma education/prevention plans.

Meet with your practice colleagues and agree on a systematic approach to data collection. This needs to be a team effort to agree on the minimum data that must be accurately entered and kept clean.

- Allergies to medicines recorded and marked “no known allergies” if there are none. Allergies continually need to be checked before any medication is ever given
- Current medications particularly important - if not ongoing then delete from record because it can easily be prescribed in the future from “old scripts” but should not be left on the front page
- Relevant family history recorded or notated as “nil relevant.”
- Reason for consultation/Diagnosis - try and become obsessive about recording this and ensure that it does not get inadvertently stored in “past history” unless it is a significant diagnosis
- Problems/ diagnoses stored as either “active” or “inactive”
- Relevant clinical findings recorded.

Front desk staff need to be consistently checking patient's address on every visit. It is difficult to contact a patient to inform them of an abnormal result if the contact details are incorrect. As we print a pathology form we should be checking the patient's address as well as arranging how the patient will receive the results.

Standards

The new RACGP Standards for General Practice encourage us to improve our IT management - both in the recording of clinical data and security of patient health information. Criterion 1.7.1 states: *Our patient health records contain sufficient information to identify the patient and to document reason for visit, assessment, management, progress and outcomes*^[3].

Future

Researchers from The University of Sydney Discipline of General Practice and Harvard Medical School Department of Health Care Policy are conducting a study of how Australian general practitioners are using computers in practice. Three thousand GPs nationwide have been invited to participate in the study. Hopefully a good response from General Practitioners will give us contemporaneous data when their findings are published.

Dr Beres Wenck

Chair, Queensland Advisory Committee Council Member

[1]. Western M, Dwan K, Makkai T, del Mar C and Western J, 2001, *Measuring IT Use in Australian General Practice 2001*, Department of Health and Ageing, Canberra

[2]. Brisbane North Division of General Practice. www.bndgp.com.au “Chronic Disease Modules” 2004 (10 June 2005).

[3]. RACGP Standards for general practices 3rd edition pages 35-39

Collegiate Criticism

It is always disappointing during the investigation of medical negligence claims to come across unwarranted collegiate criticism. This is devastating when it is written criticism. In defending such claims, independent expert evidence, after reviewing all the facts in a dispassionate and scientific way, is often supportive of the initial treating doctor. Collegiate criticism generates a great deal of angst, expense and rear guard action in defending these claims.

Doctors have many reasons for being critical of a colleague's previous management of a patient.

It is always clearer in retrospect to make the correct diagnosis. What is obvious at this point in time may not have been clear previously and in reviewing previous decisions it is important to recall that certain information was not available to the initial treating doctor. Any assessment of another doctor's standard of care requires a full and independent review of the information including history, examination findings and investigations, available to that practitioner at the time.

Sometimes criticism is the result of different doctors preferring different management approaches. The practice of medicine allows a broad spectrum of management options tailored to the individual patient. While some treatments may not be considered mainstream or ideal they would still be classed as "reasonable". In medical negligence claims, the standard of care is based not on optimal care but on reasonable care. Clinicians can disagree on patient management but this does not infer there has been any lapse in the standard of care. It is important that we recognize and tolerate this diversity.

Self-aggrandisement is an almost universal human trait. It is very tempting to make ourselves out to be wiser and more astute than

the previous treating doctor. This is an easy trap to fall into, as the disgruntled patient may be eager to play along. They need the reassurance that their new doctor is better than the previous one to justify their decision to change doctors.

Sometimes anger at what is perceived as sub standard care can prompt a written criticism. It is always wise to delay and respond in a less emotional and more rational frame of mind, as retrospectivity and emotion may lead to a heated response that may be regretted later.

Practicing doctors unfortunately do not rise above the human throng and motives such as professional jealousy, business advantage and personal dislike fuel the fires of collegiate criticism.

In documenting the patient's past history and complaints it is important that you try to make a distinction between what the patient reports to you as fact and what you know to be independently verified as factual. This may require some vigilance on your part and a healthy dose of scepticism. It is useful to record the patient's history using terms such as "the patient reports or states..." rather than recording it as fact.

Avoid retrospectively reinterpreting previous test results in a critical fashion. If you do reinterpret a previous test recognize that you do so

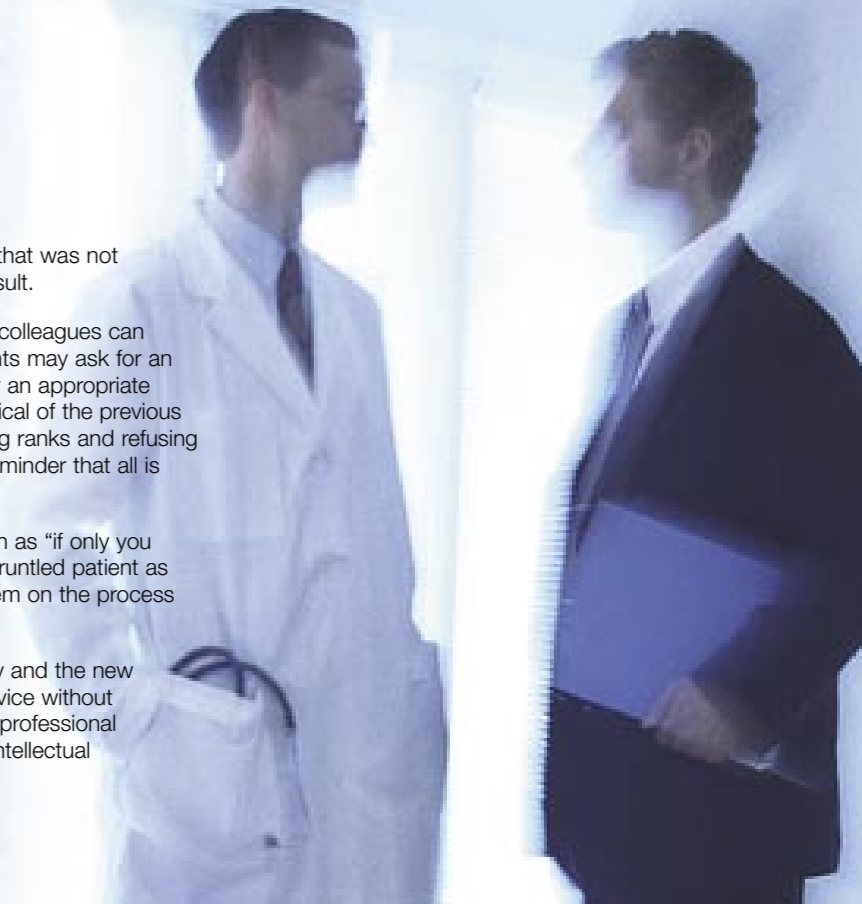
with the benefit of hindsight and state what additional information that was not available to the initial doctor has allowed you to amend the test result.

While we are dealing here with written criticism, verbal criticism of colleagues can be just as dangerous for the disaffected patient. Disgruntled patients may ask for an opinion on a previous doctor's treatment. It is never easy to deliver an appropriate impromptu response, which is honest and is not unnecessarily critical of the previous doctor. The patient deserves a frank answer rather than just closing ranks and refusing to comment. Recognizing diversity of treatment options and the reminder that all is clearer with the passage of time should temper your reply.

It is wise to be vigilant as sometimes even innocuous phrases such as "if only you had come to see me sooner ..." can be misinterpreted by the disgruntled patient as criticism of the previous treating doctor and be enough to start them on the process of litigation.

In any claim and complaint, there are always two sides to the story and the new treating doctor should be wary of forming a view and providing advice without considering both sides of a story/complaint. It is therefore not just professional courtesy to refrain from unnecessary criticism; it is also a form of intellectual honesty and prudence.

Dr Fiona Bettenay
Council Member



When You Don't Want to Tell:

In an environment where there is so much emphasis on patient autonomy and patient's right to access records what do you, or can you do, when as a medical practitioner you come into possession of sensitive health information, such as genetic information or risk of infection, and a decision has to be made what to do with it.



Disclosing Information That May Harm

Whilst we know Privacy legislation allows a medical practitioner to withhold patient access to their records, where there is a risk to their health or wellbeing, there is very little case law that guides the decision making process where a practitioner holds medical information about a patient which is unknown to the patient, or which may be of relevance to family members (eg. Genetic information or a transmittable infection). Privacy legislation offers no real guidance on the decision whether to disclose such information, and if so, to whom - the disclosure of this sensitive information is not a threat to the health or wellbeing of the patient.

Courts have recognised the concept of therapeutic privilege in particular with respect to validly withholding psychiatric records on therapeutic grounds so one might expect courts may well extend therapeutic privilege to a situation where disclosing information contained in records may be 'harmful' to a patient. However, when entertaining disclosing this information to others the law does not yet endorse breaching confidentiality just when there is a possible risk that someone else might be affected by the condition.

There certainly is very little law directly on point and so the various legal principles being developed in different contexts are not really tailored to deal with the particular dilemmas. At the moment the law does not impose a positive legal obligation to disclose all health

information to affected individuals in all circumstances. Guiding principles need to be clearly defined and, if so, a court is more likely to endorse a legal duty to disclose as being ethically valid in situations where;

- a serious medical condition is involved;
- there is a high risk that the individual is affected;
- the condition is treatable;
- there is some benefit from early detection, so that if the person can undergo testing there might be some benefit to them from knowing of the risk in advance;
- the disclosure could avert a risk to a third party; and
- the information might affect significant life decisions of the person concerned.

Clearly more work needs to be done and with some haste as access to sensitive information, such as genetic information, is becoming more common.

Kerrie Chambers
Partner, Ebsworth & Ebsworth

(I am grateful to my partner Julie Hamblin who first delivered this as a more detailed paper to the NSW Medico-Legal Society in June 2005)



The Professional Services Review System

A member received notification that the State Medical Board and Medicare Australia were to investigate her practice, with specific references to her use of pathology services.

Her first fear was whether she would be de-registered, and then a greater worry, would her appearance before the Medical Board be publicised, and by implication, her reputation damaged - would she be fined, branded incompetent by the Board (who at least technically were her peers) and made a laughing stock?

She didn't worry much about Medicare Australia, as she knew she had never accepted payments for pathology referrals. She always filled out the forms and signed them, and she wasn't a particularly high through-put doctor, so her overall numbers would never cause concern!

But.....

When after 8 months had elapsed, it wasn't the Medical Board which brought her undone. They (her peers), found that she had adequately pursued her professional duties and sent her a letter informing her that it could not sustain a complaint that her behaviour breached Section 13 (improper or infamous conduct), of the Act.

Medicare Australia was altogether something else!

Her computer printout (courtesy of the artificial neural network (ANN) of Medicare Australia), was analysed. She was subject to Medicare Australia counselling; was referred to the Director of the Professional Services Review (DPSR); and eventually negotiated with DPSR on the basis that her peers had strongly criticised her pathology ordering, on the grounds that her notes and request forms did not provide sufficient "clinically relevant detail" (in 38.5% of cases) for another practitioner to continue to manage her patients. The DPSR then offered her an agreed compromise, that she repays the 38.5% of all patients' pathology rebates for the 2 years under review. Such repayment was also to be accompanied by an admission by the doctor of "inappropriate practice". She negotiated a compromise offer which was then sent to the determining authority and ratified. It cost her \$63,600.00 to meet her agreed obligation. She was not disqualified from participation in the Medicare scheme (either in full or in part) and there was no publicity.

Her records thereafter, were kept under a further ANN review and she was re-interviewed after 12 months..... and commended upon her records.

Explanation

Medicare Australia via the PSR mechanism is charged with ensuring proper and appropriate use of the patient rebates available from the Federal Government's system. It does that by an agreed legislative mechanism first introduced in Labour days, amended by Carmen Lawrence, reviewed and amended by Michael Wooldridge and confirmed and expanded under the current regime. It is designed to safeguard Commonwealth funds and it basically works.

Here's how

Medicare Australia runs the artificial neural network (ANN), to look at all the funds paid for patient's medical services where Medicare makes a rebate payment. It thereby profiles all participating professionals (doctors, dentists, chiropractors, nurses, optometrists and physiotherapists) and compares them with their specific peers.

If you look different, then Medicare Australia investigators want to know why. They initially write to you and send pages (20+) usually of statistics and comments about usage. They invite a response; a lack of response will not make them go away. Sometimes the response is accepted at this stage and nothing further happens. But sometimes they want more - either a better written explanation or an interview.

If they are still unsatisfied, Medicare Australia then refers the matter to DPSR - a statutory independent (of Medicare Australia) body. He then, using his own investigator enquires of you. At the end of this he can do three things:-

1. He can Act on Section 91 - there is no case to answer, or, the case to answer could not be fully proven;
2. A Section 92 - where he writes to you and says he cannot dismiss the matter and requests submissions on what action should be taken; or
3. A Section 93 - where he refers you to the PSR Committee.

Section 92 is what our doctor in the story was offered and accepted. Section 93 is the most significant step - although it can still result in a dismissal as no case is likely to be proven. This is an unusual outcome. Findings by Committee are usually subject to public notice.

Both options 2 and 3, can result in full or partial disqualification for up to 3 years to Medicare benefits for your patients, repayment of the excess amount paid and reprimand. Both also mean you are kept under future surveillance. Note also, that DPSR can also cross refer your behaviour to the relevant State Medical Board for the further action.

So, what now

Well, MDA National can help.

If Medicare Australia writes to you about their concerns, please treat it as you would a subpoena, solicitors letter, Medical Board complaint etc and contact our office.

We will meet with you, or review the letters and your records and/or negotiate with Medicare Australia on your behalf. We will engage solicitors (in-house or external), to protect your interests. We will meet the costs involved in your defence costs. We cannot make the repayment (in our contract Section 8(vii)) but our assistance will probably minimise that amount. Please, as with all such matters involve us early, before your initial response. This process can take months (and usually does) to run, can be subject to yearly review (and usually is) and will tax your patience and resources (almost always).

Use your membership benefits to help yourself in this arena.

How successful is PSR?

For the year 1997/98, the ANN identified 1,890 GPs of interest. That same year, 666 General Practitioners and 113 Specialist Practitioners were counselled. 48 of them were referred to PSR and of the matters referred, 15 were dismissed, 5 had a Section 92 arrangement and the remainder had a Section 93 referral to the Committee. For the GPs counselled (that is the 666), the savings that resulted from their future spending had been estimated as:-

1. PBS	\$8234.00
2. Medicare Australia Patient Rebates	\$34,930.00
3. Diagnostic Imaging Rebates	\$9159.00
4. Pathology Rebates	\$7251.00

This represents a saving of \$39,676,284.00 per annum to the Medicare Australia budget. It does not represent the recoveries ordered. This is merely the spending not drawn upon in subsequent years. No comparable figures for the specialists are available.

This is why the system exists (the Government rationale).

Definitions etc.....

Inappropriate practice, sampling/statistics, deeming provisions and the availability of generic findings have all been defined in the Act, so have the sanctions that should be determined at Committee level. Needless to say, the activities of all the people involved within the process are also defined, and most of these matters have now been to the High Court for challenge, ratification or amendment as a result of Court findings.

Dr Reg Bullen
Medico-Legal Manager

Upgrades to the MDA National Website

MDA National are excited to announce the launch of our new-look website. The website, which will continue to be improved over the coming months, is a comprehensive source of information for our doctors and their staff. Log on to www.mdanational.com.au, and you will notice easy to navigate sections, which will guide you through the useful content available exclusively to our members. We also have specific services and advice tailored for our junior doctors and students.

Visit the improved risk management section, where you can learn basic strategies to implement within your practice, as well as review illustrative case studies. Our Risk Updates page contains information on emerging risks and specific procedures and equipment identified through the MDA National Early Warning Scheme.

Other improved features include our online pricing indication and the ability to download application packs directly from the web. Heading into the New Year, we will be continuously updating and improving the website, so be sure to check back often to see what has changed. As always, we value your feedback, so if you have any suggestions, just go to the 'Contact Us' section, and fill in the form at the bottom of the page.



www.mdanational.com.au

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
 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

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 516 Hay Street
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 Ph: (08) 6461 3400
 Fax: (08) 9415 1492

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

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 Level 5, AMA House,
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Please notify us now...

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

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

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