

Defence Update

Quarterly Magazine of the MDA National Group

MDA National

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1925-2005

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YEARS OF SERVICE

June 2005

Competitive Neutrality Review

In December 2004, the Federal Government established a review, under the chairmanship of Mr Graham Rogers, to examine the source and extent of any competitive advantages in the medical indemnity industry. Some medical indemnity providers were concerned that advantages for some parts of the industry may have arisen from measures undertaken by the Federal Government to specifically assist the medical indemnity insurers since April 2002.

Mr Rogers reported the findings to the Government in March 2005.

The key findings of the Rogers Review were:

- The assistance given by the Federal Government which extends across the industry, can have different impacts on different insurers from time to time but they do not have any systemic competitive bias. Further, the measures have been extremely valuable in stabilising the industry
- However, the specific assistance provided to UMP in taking over UMP's past IBNR liabilities has created a competitive advantage. As at June 2004, this was assessed at \$253m

Therefore the source of any competitive advantage has been the assumption by the Federal Government of UMP's IBNR liability of \$253m.

In order to seek a partial redress of this advantage, the Federal Government will be legislating to recoup part of this amount over a 10 year period.

The effectiveness of this recoup arrangement is still to be determined but will be based on a formula to be enacted in amending legislation to be introduced by the Federal Government.

It should be noted there will be no financial issues for the MDA National Group as a consequence of the Rogers Review.

A complete copy of the Rogers Review can be obtained on the following website www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicalindemnity-competitiveneutrality

Peter Forbes
CEO

From the President



The AMA Annual Conference in Darwin a few weeks ago was a chance to reflect on the progress and changes in medical indemnity over the last few years.

As well as a chance to hold a baby crocodile, which was deceptively strong and required special training to hold as it turned out! We have now had a period of relative stability in which to focus again on the fundamentals of our business. Happily the changes mean that all our base premiums are unchanged or reduced this year, on top of reductions for many categories last year. This is a success for us as an industry in that the systems we have had to implement have had the desired result for the profession.

Dr Bill Glasson has had a remarkably successful Presidency of the Federal AMA. His deputy, Dr Mukesh Haikerwal, has succeeded to the position unopposed, which is an endorsement of the team. As an organisation we hold in common many of the basic principles that Dr Glasson and his team have promulgated. An independent, patient focused medical profession that resists third party interference in the doctor patient relationship is the best model for our society.

Dr Glasson has been a critic of bureaucracy and decision making distant from the coal face of medicine. We also translate these values into the way we run the MDA National Group so that we can strike the same chord with the profession. If you are unhappy with an aspect of the structure of medical practice then getting involved in the AMA would be a good start to getting your complaints heard.

The Bundaberg Hospital Commission of Inquiry will probably have some important lessons for all of us. There are complex issues relating to workforce shortage, the use of overseas trained doctors in areas of need and resourcing of the public hospital system at play, as well as detecting and dealing with under performance. We should note that OTDs make an important contribution to Australian health care. Many of us have worked in other countries where we were OTDs ourselves. From the insurer perspective it is important that OTDs are fairly and properly assessed to make sure that there are not unreasonable expectations placed on them and that we provide the appropriate support and risk management tools. The inquiry can be followed at www.bhci.qld.gov.au

On the topic of risk management, the National Risk Management Working Party has recently seen the agreement of a minimum framework for Risk Management education. This working party is a collaboration of the AMA, the Committee of College Presidents and our industry and this agreement is an important step in reducing duplicated or irrelevant educational requirements on doctors. Because all sorts of authorities from hospitals to medical boards are starting to demand evidence of "risk management" activities it was important for the profession to lead the way in defining these requirements to prevent bureaucratic interference. The insurers have also agreed to a common data set to allow prospective and some retrospective compilation of national claims data. This is an exciting, unprecedented step forward that will provide important feedback to the profession as a whole. The latest claims report will be released soon on the industry website at www.miaa.com.au

And did I mention that the base premiums in all categories are the same as last year or reduced for the first time since 1997?

Dr Andrew Miller
President



Adverse Events in the Operating Room

Medical adverse events are unintended outcomes of treatment, resulting in prolonged hospital stay, patient injury or death. The best available data suggest that they occur in 10-20% of hospital admissions and almost half occur in or around the operating room.

Surgeons are obviously central to many of these bad outcomes. When asked to self-report adverse events they felt they had caused, surgeons can be surprisingly frank. In one recent study 38 surgeons in three American teaching hospitals provided reports on 146 incidents, 13% of which caused death¹. The most important underlying system factors were inexperience/lack of competence in a surgical task, communication errors and fatigue.

Data from incident reporting systems (in NSW), defence organisation cases committees and Complaints Units reveal a pattern of regularly repeated errors which are outlined in this article.

Wrong Site Procedure

The most common wrong site error is operating on the wrong side. A frequent scenario is for the incorrect operative site to be prepared and draped prior to the arrival of the surgeon in the operating room, resulting in, for example, wrong knee arthroscopy or wrong side hernia repair.

Sometimes the wrong side is chosen in paired organs such as the kidneys or lungs because of a mistake in viewing X-Rays. Side-markers may have been wrongly placed on the films by the radiographer, or may not be visible because the X-Ray beam has been coned to improve definition, leaving the side marker out of the field. In the case of kidney operations careful observation of other reference points to true laterality, such as the gastric gas bubble and checking with a second observer may help to avoid such errors. Although the correct lung is usually easily identifiable on chest X-Rays, mediastinal or cardiac pathology may distort the appearances sufficiently to allow an error.

Consensus is now emerging on reliable methods of preoperative marking of the correct site.

For NSW 5-step correct site policy go to: www.health.nsw.gov.au

The "time out" technique, in which a pause is called by the operating team leader immediately before commencing an operation in order that all OR staff have an opportunity to hear announced the planned procedure and site, is also strongly recommended.

Wrong digit procedures may be avoided by the use of unambiguous identifiers – in the case of fingers, the best description is thumb, index, long, ring, little fingers. Wrong level laminectomy may be avoided by the use of intra-operative image-intensification X-Ray.

Retained Instruments, Parts of Surgical Equipment, Unintended Retained Surgical Material.

Despite meticulous instrument-counting procedures, retained surgical instruments such as scissors or retractors, sometimes of extraordinary size, continue to make newspaper headlines. In NSW, this has been the stimulus for a revision of the technical standard for theatre counts (NSW Health Standard TS10), but problem areas remain. Detachable blades from self-retaining retractors are occasionally left inside patients – should they be counted as well as the instrument itself?

New instrumentation and new techniques turn up novel problems. There have been four instances of retained "Murray Cod" plastic retractors, used as an aid to abdominal wall closure in obese patients, in NSW hospitals in the past two years.

Lost portions of endoscopic instruments, such as staplers, may lead to the need for conversion to an open operation if they are recognized.

The most significant risk factors for a retained instrument are patient obesity, an unplanned change in the operation and an emergency procedure².

Positioning Injury

The responsibility for safe positioning of the anaesthetised patient to avoid injury is shared between anaesthetist, surgeon and nursing staff. The increasing complexity of surgery has led to the use of elaborate and sometimes contorted positioning with consequently increased risk of injury. The excellent monograph *"Positioning the Surgical Patient"* (Anderton et al, Butterworths, London 1988) contains detailed descriptions of how to avoid positioning injury and should be read by all OR staff.

Burns

Although burns from electrocautery apparatus are now less frequent due to more sophisticated equipment with built-in sensors and better education in their use, they still occasionally occur. As simple a step as twisting the active diathermy lead around a towel clip may lead to induced current in the clip if the diathermy output is very high, resulting in a skin burn. Instrumental insulation failure is particularly likely to cause visceral injury in the moist conductive environment of laparoscopy.

All operating suites should have a documented policy for regular inspection and testing of electrocautery equipment in a recognised biomedical engineering facility. It is worth asking your hospital for a copy of such a policy.

Burns due to fire may occur with the use of electrocautery around the head and neck, where there is usually an oxygen-rich environment during general anaesthesia. The ignited material may be equipment such as the endotracheal tube.

Burns due to diathermy ignition of spirit-based skin preparations are insidious because the flame is usually invisible under bright theatre lights. They are now rare but may return with the recent renewed interest in spirituous hand disinfection for operating staff.

Fibreoptic light leads connected to high-powered light sources conduct heat and may rapidly cause burns if the free end is left lying on the operative drapes.

Falls

Falls by an anaesthetised patient off the operating table or a trolley are more likely to occur with unusual positioning and if surveillance by theatre staff is not continuous. Serious injuries such as fracture of the shaft of the femur may occur in a relaxed patient as result of a fall by an unsupported limb (usually resting unsecured on a stirrup).

It should be the rule that no unconscious patient is left unattended on an operating table or on a trolley without raised sides. The aviation analogy is the cockpit arrangement: no matter what the emergency, a specific person must at all times be assigned the task of "flying the aeroplane".

The increasing use of regional and local anaesthesia has seen the emergence of reports of fall-related lower limb fractures in patients who were allowed to attempt ambulation while affected by unrecognised motor blockade in the lower limbs. After inguinal hernia repair under local anaesthesia, for example, patients should not be permitted to ambulate until it is ascertained that no femoral nerve blockade is present.

Falling equipment may also be a hazard to patients. The transverse bar of a Goliher sternal retractor may fall resulting in a fractured nose or a fractured larynx. Drip stands may fall vertically in their holders and the crossbar may cause serious injuries.

Medication Errors

Medication errors in the operating room are most likely to involve anaesthesia administration. Particular care needs to be taken when anaesthetists or surgeons are called on to administer unfamiliar medications such as uncommon antibiotics or oncology drugs. For example, fatal misadministration of vincristine via the intrathecal route by anaesthetists has been reported from every continent.

Surgical medication errors in the past most commonly involved the use of adrenaline, either in an inappropriate concentration, or at an inappropriate site in vascular-critical areas such as a digit or the nose. The use of prepackaged vials of medication, rather than decanted colourless liquids in gallipots, has reduced these errors, but mistakes continue to be made when drug-checking routines are disregarded by impatient surgeons.

Omission of indicated medication, such as thromboembolism prophylaxis, or antibiotics in patients with an implanted prosthesis, may on occasions be judged negligent.

Structure Misidentification and the Deadly Tent

This error is of a type common to a number of surgical specialities. An example is misidentification of the common bile duct for the cystic duct during cholecystectomy, resulting in transection or resection of the bile duct. This still occurs with an unacceptable frequency of 0.3% . Other examples of misidentification leading to patient injury are mistaking the median nerve at the wrist for a tendon, mistaking the testicular artery for the vas, the internal for the external carotid artery, the axillary artery for one of its branches, or the femoral vein for the long saphenous vein. "Tenting" of the key structure is often a central element in this type of error.

The unrecognised induction of "tenting" of a critical tubular structure by lateral traction is a well-documented error. In vascular structures such as the axillary artery or the femoral vein this may occur when a

branch or tributary is retracted strongly. Traction on the gall bladder and cystic duct may tent the common bile duct. Adherence of the ureter to an inflammatory process such as diverticulitis may lead to tenting of the ureter when the mobilised sigmoid colon is retracted. Failure to recognize tenting often leads to resection of a significant length of the vital structure.

Laparoscopy

In the decade since it became widely popular laparoscopy has accumulated an impressive record of operator-based errors and litigation, often related to visceral or vascular injuries during induction of a pneumoperitoneum or during electrocautery use. Laparoscopic bile duct injuries due to duct misidentification are currently the most common cause of litigation against abdominal surgeons. Techniques for minimising these errors are well-documented but are beyond the scope of this article.

Laparoscopic visceral perforations are characteristically subject to delay in diagnosis, sometimes for appallingly long periods, a feature also seen in 75% of bile duct injuries. A good rule is that any patient whose clinical course after laparoscopy deviates at all from normal should be considered to have a perforated viscus or, in the case of cholecystectomy, biliary leakage, until proven otherwise. Post-laparoscopy diagnoses such as "constipation", "ileus" or "bowel obstruction" should be viewed with extreme scepticism.

The Dangers of Changing the Operating List Order

The simple variation in routine caused by changing the published operating list order may provide the setting for serious errors such as mismatched blood transfusion or wrong site surgery. The list order should only be changed for valid reasons and the potential dangers should be recognised by red-flagging the change and ensuring that all relevant people have been notified.

The Speed Hog

It is curious that operating rapidly should still be regarded in some circles as a particularly admirable surgical trait. While speed may have been essential in the pre-anaesthetic era it is of secondary importance today. While surgical tortoises are admittedly harmful and irritating, surgeons who pride themselves on speed of operating expose themselves and their patients to an increased possibility of error. The advice of Lord Moynihan is apt: "Surgical speed should be an accomplishment, not an aim".

Pressure to complete a procedure rapidly creates a dangerous environment conducive to error. Anaesthetists or OR managers who harass surgeons to produce rapid turnover of cases must be regarded as a menace and should be met with robust surgical resistance.

Summary

A regularly repeated pattern of operating room errors is identifiable. Knowledge of these patterns and the application of some simple preventative strategies may make a dramatic difference to the error rate. Complacency about error ("it can't happen to me") is the greatest danger. A sound basic philosophy is "every person and every piece of equipment in this operating room has the potential to harm my patient".

Dr Tom Hugh FRCS FRACS

Member – MDA National Council & MDA National Insurance Board
Chair – NSW Advisory Committee

1. Gawande AA et al. *Analysis of errors reported by surgeons at three teaching hospitals.* Surgery 2003; 133:622-3.
2. Gawande AA et al. *Risk factors for retained instruments and sponges after surgery.* N Engl J Med 2003; 348:229-35.

Student News: Planning Your Elective?

The Medical Elective Essay Competition for 2005 and the Student Elective and Scholarship Placements Policy



Every year many students pack their bags and head off for their elective term overseas or within Australia. An elective provides a unique opportunity, a wonderful experience, as well as the chance to apply some of the medical knowledge you have learnt over the past years during your study.

MDA National offers student members support for their elective terms. If you are planning an elective this year, please check out our services.

The 2005 Elective Essay Competition

The Elective Essay Competition is held annually and has been running for many years with an increasing number of entries every year. By entering, MDA National student members have the opportunity to win funding towards the cost of their elective. This year the winning entry will win \$2000 with runner up prizes of \$1000 and \$500.

The MDA National Elective Essay Competition is open for 2005. An application form is available in this edition of *Defence Update* and on the website. This year students are presented with the statement:

"The medical elective term is a central part of the medical degree in Australia".

Then, in no more than 500 words, discuss the question:

"How does the medical elective add value?"

Entries are judged by members of MDA National Council and winners will be notified in person in August. The winning entries will be published on our website and in the September edition of *Defence Update*.

The competition closes on Friday 12 August 2005 so get your entries in for your chance to win a scholarship towards your elective.

The Student Elective and Scholarships Placement Policy

Even if you don't win the Student Elective Essay competition MDA National can still help you with your elective term by providing members with access to medical indemnity insurance for your elective. The MDA National Insurance Student Elective and Scholarships Placement Policy is a comprehensive medical indemnity policy designed specifically for student electives and scholarship placements.

The policy schedule can be used to provide evidence of your indemnity.

The Student Elective and Scholarship Placements Policy will also cover scholarship schemes not indemnified through your studies such as the John Flynn Scholarship Scheme. Once again, a copy of the schedule provides the administrators with confidence that indemnity requirements have been met.

Cover is provided for all countries except Canada and the USA. If you require information about indemnity in these countries please contact Client Services and they can provide you with details of relevant insurance companies in those countries.

The Policy costs \$15.00 (excluding taxes) and insures you for:

1. \$1,000,000 policy limit;
2. \$500,000 towards legal costs

For further information on the services we provide for students going on their elective please contact Client Services on 1800 034 466 (WA) or 1800 011 255 (all other states) or your Liaison Officer.



Elective Essay Competition Entry Form

Complete and return with Essay

Name:

Address:

Postcode:

MDA National Membership Number:

Contact phone number:

University:

Expected date of qualification:

Dates of elective period:

Country of elective period:

I have read and accept the conditions of entry (signature):

Forward your entry to: Elective Essay Competition, MDA National, Level 5, AMA House, 69 Christie St, St Leonards NSW 2065 OR hand it in at your local MDA National office.

Conditions of Entry

1. The competition is open to all medical students who are members of MDA National and are taking their elective within the next 12 months.
2. The essay must be typed and no longer than 500 words.
3. The bursary must be used to help finance an elective period of study approved by the Dean of the Faculty.
4. All applicants must be student members of MDA National.
5. The respective winners will be notified personally in August 2005 and their names will be published in a September 2005 edition of *Defence Update*.
6. Each entrant may submit only one essay to the competition.
7. Students who have previously won an MDA National bursary are ineligible to enter.
8. The judges' decision shall be final and no correspondence about the results will be entered into.
9. Recipients of the bursary will be asked to submit a short report on the elective period upon return.
10. The title of your essay is "The value of the medical elective"
11. Your essay must have this entry form attached to it.
12. The essay must be received no later than 5.00pm on Friday 12 August 2005.
13. MDA National reserves the right to publish any of the submitted essays in *Defence Update*.



MDA
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A Young Person's Refusal of Medical Treatment - a Question of Competence?

Joseph was a 16 year old Jehovah's Witness with lymphoblastic leukaemia. He had refused a life saving blood transfusion, on religious grounds. Can his refusal be challenged and if so when and by whom? Although the law normally recognises a refusal of treatment by a competent adult, it is less clear when a young person is involved.

In New South Wales, young persons aged 14 years and upwards may give consent to the administration of medical and dental treatment¹. On one view, consent may extend to refusal as well. By contrast, a treating practitioner can override a refusal of treatment by a young person up to the age of 17 years if the practitioner considers the treatment to be urgent and necessary to either save life or prevent serious harm.² In South Australia, young persons aged 16 years and upwards are given the same right as adults to validly make decisions about their own medical treatment³. Otherwise, what is known as the "*Gillick competency test*" allows young persons to consent to medical treatment if they have sufficient understanding and intelligence to enable them to understand fully what is proposed⁴. Whether a young person is competent will vary from case-to-case. Although Courts have intervened to permit treatment over a young person's refusal, on the basis that it is in the child's best interests, usually these have been in situations where there is questionable competence, such as a young person with a psychiatric disorder refusing treatment.

Joseph's case was brought before the New South Wales Supreme Court (*Royal Alexandra Hospital v Joseph*,⁵) for determination of the difficult decision asked of his treating practitioners. On the application the Court was told that Joseph would likely die without a blood transfusion in the subsequent 48 to 72 hours. Importantly, Joseph's parents gave evidence to the Court that neither they nor their religious community would condemn him and continue to love him if a transfusion was ordered. Justice Gzell considered that there was no doubt that it was in Joseph's best interests that the transfusion be ordered, as "[h]e will die otherwise. His life ought to be spared".

Two weeks later, the Hospital again sought an order permitting transfusion over Joseph's refusal. On this application evidence was given by Joseph's father that Joseph had been distressed when given the transfusion and by his mother that he had said he had felt "*violated, raped*". A treating practitioner gave evidence Joseph had

the "*intellectual age of a much younger teenager*". Justice Einstein decided that, even though his wishes as a 16 year old should be given serious consideration, it was in his best interests to allow a transfusion as he may die otherwise.

Unfortunately, with a legal system that does not give precise guidelines as to when it is permissible to override a refusal of treatment by a young person and is discretionary as to what constitutes a young person's best interests, those placed in the most difficult position are treating practitioners. It is an unhappy situation that requires, on occasions, these treatment decisions be brought before the courts for direction. Perhaps a better solution may lay in clearer legislative guidance as to situations in which a young person is competent to refuse life-saving treatment.

Timothy Bowen Solicitor

Kerrie Chambers Partner

Ebsworth & Ebsworth Lawyers

1. *Minors (Property and Contracts) Act 1970* (NSW), Section 49(2)
2. *Children & Young Persons (Care and Protection) Act 1998* (NSW), Section 174
3. *Consent to Medical Treatment and Palliative Care Act 1995* (SA), Section 6
4. *Gillick v West Norfolk AHA* [1986] AC 112 (UK House of Lords), recognised by the Australian High Court in *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218
5. [2005] NSW SC 422



Post Settlement Interviews

MDA National has unveiled its latest initiative to provide support to doctors who have gone through the "litigation experience". Post settlement interviews allow both the Claims Team and the Member to review the case together and provide feedback about the management of the claim. The interview is a two-way process during which the Member can discuss any issues that arose throughout the process as well as clarify any areas of contention. Similarly, the interview enables the Claims Manager to gain greater insight into the Member's understanding of the process and address any outstanding concerns. The process does not threaten the Member and all their comments will remain confidential.

When establishing the process, the purpose of the interview was to:

- monitor the Member's satisfaction with the case management;
- provide Members with an understanding of the operation of MDA National;
- identify any contributory factors that led to the claim;
- provide advice on risk prevention strategies;
- provide closure for the Member; and
- feedback any lessons to the Association and its Members.

Importantly, the program also has the potential to inform the development of risk management programs. Within the MDA National risk management program, the post settlement interviews will assist in clarifying areas of specific medico-legal risk. The risk management program has three arms:

1. *Clinical & medico-legal risk management* – for all members
 - risk management education;
 - early alert scheme; and
 - data analysis and feedback.
2. *Post settlement interviews* – offered to selected members who have had a settled claim
 - discussion of risk management strategies; and
 - feedback to claims management staff.
3. *Adverse Risk Member program* – members whose claims profile is significantly different than their peer group

A post-settlement interview pilot study was coordinated by Dr John Blackwell in 2004. In the twelve month period, eleven members were invited to participate in an interview and nine accepted. The experience of the pilot study has shown that it is a useful tool with the majority of participants finding it an extremely useful exercise.

Post settlement interviews are voluntary with Members invited to attend. In most cases the interview panel consists of two people, a doctor and the Claims Manager who handled the case. Interviews are mainly conducted face-to-face however for country or remote practitioners a telephone interview is offered.

The potential benefits of post settlement interviews include:-

- feedback for claims management;
- finalisation and information debrief for the member;
- to identify risks that require improvement, such as better records; and
- the opportunity for early intervention and risk management.

The decision to offer an interview is based on a range of variables including, but not only:-

- the quantum of the claim;
- impact of the case on the individual member;
- evidence of inadequate risk management strategies;
- contentious commercial settlements;
- member dissatisfaction with the management of the claim; and
- the Member's co-operation and involvement in the management of the case.

In time it is expected that an interview will be offered to all Members for whom a settlement has been made. Reports of the post settlement interviews will be provided annually to the Cases Committees, the Underwriting Committee and any risk management trends to the Clinical Risk Management Committee.

Louise Kershaw
Risk Manager

There has been an increase in the use of complementary medicines amongst the general community over recent years. It is estimated that half of the Australian population uses complementary medicines and a quarter have consulted a complementary therapist providing such services as acupuncture, osteopathy, naturopathy or iridology¹. There have now been several high profile cases such as the deaths of baby Mitchell Little after treatment by a naturopath for his congenital heart defect and that of a 37 year-old chronic renal failure sufferer who underwent an alternate “de-toxification” program. While most medical practitioners will ask (quite rightly) what does this have to do with them, there is an increasing trend of incorporating “alternative” treatments into patient management by many medical practitioners.

Does Complementary Mean Risky?

Following the Pan Pharmaceutical recall in April 2003 complementary medicines came under increased scrutiny. The Australian Government established the Expert Committee on Complementary Medicines in the Health System to review their regulation and identify strategies that needed to be in place to ensure that their use was optimised to improve health outcomes for Australians.

The Government released its response to the review by the Expert Committee earlier this year. The response acknowledges that there is minimal regulation of complementary healthcare practitioners. Because regulation of healthcare practitioners is a State and Territory responsibility it is unlikely that there will be any significant changes in this area in the near future. While supporting self regulation of the complementary medicine professions they have not provided any clear direction in this. Other positive changes include:

- Enforceable standards of evidence to support claims for “Listed” complementary medicines. Increased monitoring of evidence held by sponsors with increased penalties for those not complying with a request for evidence by the TGA.
- Legally enforceable quality standards for the ingredients of complementary medicines.
- Encouraging adverse event reporting of complementary medicine through web-based programs.
- Modification of product identification numbering to improve identification of problematic ingredients in complementary medicine formulations.
- Regulation of homeopathic medicines and medicines containing herbal ingredients, to ensure they meet appropriate standards of safety, quality and efficacy.

Case Study

Dr A, a general practitioner, has established a practice specialising in the treatment of patients with nutritional disorders and assisting patients to manage “lifestyle” risk factors. She is most often consulted by patients seeking advice and complementary treatment of conditions that have not responded to conventional therapy. One treatment often used is serial IV Iron infusions. The pattern and frequency of consultations for this type and other therapy was noted by the HIC and Dr A underwent a Professional Services Review (PSR).

The PSR investigates whether health practitioners have engaged in inappropriate practice in providing Medicare services or when prescribing medication. The aim is to protect patients, the community and the Commonwealth from the risks and costs of health practitioners practicing inappropriately. ‘Inappropriate practice’ is deemed to be conduct in providing services that a committee of the practitioner’s peers would reasonably consider unacceptable to the general body of their profession.

Medical Practitioners practicing complementary therapies need to ensure that the medications and therapies they prescribe and carry out have robust scientific evidence supporting their efficacy and that the services they provide are considered appropriate by their peers².

In the words of Arnold S. Relman, editor-in-chief emeritus of The New England Journal of Medicine and professor emeritus of medicine and social medicine at Harvard Medical School, *“There are not two kinds of medicine, one conventional and the other unconventional, that can be practiced jointly in a new kind of “integrative medicine.” Nor..... are there two kinds of thinking, or two ways to find out which treatments work and which do not. In the best kind of medical practice, all proposed treatments must be tested objectively. In the end, there will only be treatments that pass that test and those that do not, those that are proven worthwhile and those that are not.”*³



Risk Management Tips

1. Always ask patients if they are taking any other herbal/complementary medicines.
2. When prescribing complementary medicines or therapies ensure you do this within a "conventional framework", using the same yardstick for safety and efficacy that you would use for conventional therapy.
3. If referring patients to alternative therapists ensure that they hold appropriate qualifications and retain membership with their respective professional bodies.
4. Report adverse side effects to the TGA's Adverse Drug Reaction reporting system.
5. Only offer alternative therapies for which you have been trained.
6. When billing for alternate therapy services ensure that you conform to regulations as set down by the HIC or other funder.

Louise Kershaw
Risk Manager

1. Aust Adv Drug Reactions Bull 24(1), Feb 2005
2. http://www.psr.gov.au/the_scheme.html
3. Arnold S. Reiman A Trip to Stonesville <http://www.crhp.net/article5.html>

Casebook - A Case of Preventable

Case History

The 42 year old patient presented to the Emergency Department (ED) complaining of a two week history of a dry cough and a one day history of fever, vomiting and headache. The patient informed the ED registrar that she had three young children who had all been unwell and she thought she may have caught an infection from her children. The patient had seen her general practitioner (GP) three days before her presentation to ED. The GP made a provisional diagnosis of bronchitis and gave her a prescription for antibiotics in case her condition did not improve. The patient had taken one dose of antibiotic on the day prior to her presentation in ED but she had then started vomiting. The patient was on no regular medications. Her past history included Hodgkin's lymphoma which had been diagnosed when she was 19 years of age. The patient was treated with chemotherapy and radiotherapy and she had been in remission since this time. She had undergone a splenectomy as part of the staging process for the lymphoma and there was no other surgical history. She was a heavy smoker and drinker. On examination, the patient looked unwell. Her temperature was 39.2, pulse 100/min, BP 100/70 and RR 20/min. There were bilateral chest crepitations. The registrar noted marked neck stiffness. A provisional diagnosis of septicaemia/pneumonia/meningitis was made. Intravenous therapy was commenced and blood was taken for culture. About 30 minutes after her initial presentation to ED, the patient's level of consciousness suddenly deteriorated and she suffered a cardiac arrest. The patient died despite intensive cardiopulmonary resuscitation. *Streptococcus pneumoniae* was subsequently isolated from the blood cultures.

Discussion

The annual incidence of invasive pneumococcal disease in Australia is estimated to be 8 – 15 per 100,000¹. The case-fatality rate for invasive pneumococcal disease is 12 – 14%, increasing to 23% in the elderly. The disease is significantly more common in Indigenous people. Certain groups are recognised as at increased risk of pneumococcal infection. Those particularly at risk include individuals with anatomical or functional asplenia, lymphoid malignancies, chronic cardiac disease or diabetes mellitus. Smoking is also a strong independent risk factor for pneumococcal disease among immunocompetent, non-elderly adults.

In this case, the patient died as a result of invasive pneumococcal disease. On review of the patient's medical history and records, it was apparent that she had not received pneumococcal polysaccharide vaccine following her splenectomy. Splenectomy is accompanied by a lifelong risk of acquiring potentially fatal infections, mainly caused by polysaccharide encapsulated bacteria, such as *Streptococcus pneumoniae*.

The incidence of post splenectomy septicaemia and/or meningitis in adults varies from 2.1 to 7.4% over a 30 year period depending on age at splenectomy, cause of splenectomy and host immunity. Two thirds of the fatalities in overwhelming post splenectomy infections occur in individuals less than 50 years of age. Retrospective reviews of patients who have undergone splenectomy suggest that current recommendations regarding vaccination are not being followed. It has been estimated that more than one quarter of patients who undergo splenectomy do not receive pneumococcal vaccine^{2,3}. It is probable, as in this case, that individuals who underwent splenectomies more than 10 – 20 years ago are more likely to have missed out on protective measures.

Pneumococcal Disease?

Greater attention to the practice of post-splenectomy pneumococcal prophylaxis is necessary. The critical role of patient education regarding the importance of early treatment of infection should also not be overlooked. The NHMRC Australian Immunisation Handbook states that all splenectomised individuals should receive the pneumococcal polysaccharide vaccine⁴. A further dose five years after the first dose is recommended. In elective splenectomy the vaccination should be given two weeks before the operation. In unplanned splenectomy vaccination should be given when the patient has recovered from surgery.

The current recommendations for pneumococcal polysaccharide vaccine include:

- all individuals aged 65 years and over;
- Aboriginal and Torres Strait Islander people aged 50 years and over;
- children aged over 5 years who have underlying chronic illnesses predisposing to invasive pneumococcal disease (including asplenia and immunocompromise);
- individuals aged over 5 years with asplenia, either functional (including sickle cell disease) or anatomical. Where possible, the vaccine should be given at least 14 days before splenectomy;
- immunocompromised persons aged over 5 years at increased risk of invasive pneumococcal disease (eg patients with HIV infection before the development of AIDS, acute nephrotic syndrome, multiple myeloma, lymphoma, Hodgkin's disease and organ transplantation);
- immunocompetent persons aged over 5 years at increased risk of complications from invasive pneumococcal disease because of chronic illness (eg chronic cardiac, renal or pulmonary disease, diabetes, alcohol-related problems);

- persons with CSF leaks (aged over 5 years);
- tobacco smokers.

This case provides potent support for Dr Lehmann's statement:

"The worldwide burden of pneumococcal disease is enormous, yet use of pneumococcal polysaccharide vaccine in at-risk groups remains low... We need to increase awareness among health professionals of the seriousness of pneumococcal disease and the potential benefits of vaccination according to the guidelines of the NHMRC"⁵.

Dr Sara Bird
Medico-legal Claims Manager

- 1 Gilbert G. *Retreat of the pneumococcus?* Med J Aust 2000; 173 Suppl: S20-S21.
- 2 Kind EA, Craft C, Fowles JB, McCoy CE. *Pneumococcal vaccine administration associated with splenectomy: Missed opportunities.* Am J Infect Control 1998; 26:418-22.
- 3 Siddins M, Downie J, Wise K, O'Reilly M. *Prophylaxis against postsplenectomy pneumococcal infection.* Aust NZ J Surg 1990; 60:183-187.
- 4 *NHMRC Australian Immunisation Handbook.* 8th ed. Canberra: AGPS, 2003.
- 5 Lehmann D. *Efficacy and effectiveness of pneumococcal polysaccharide vaccines and their use in industrialised countries.* Med J Aust 2000; 173: S41-S44.



Patient Follow-up

Superficial Lesions: Are they Superficial?

MDA National has had the carriage of a small number of claims where Members have seen patients worried about cutaneous or sub-cutaneous lesions. In the relevant disputes, some controversy has centred on the advice given to the patients by Members concerning follow-up. Almost invariably that advice has been couched in terms of "If there is a change return to us for review". There has been very little information given to patients about what "change" means and the patient records have not been helpful in documenting the advice given to patients or, at times, even that the patients had, in fact, been advised to return.

There may well be a general lack of awareness amongst Members of a potential for this type of issue to lead to future disputes in the event of an adverse outcome. The problem is a common one in general practice. It reflects the lack of satisfactory documentation of consultations and the extent to which this can impact on MDA National's ability to defend Members should a claim arise against them. In this particular context I wish to highlight an issue of clinical risk reduction.

From that point of view, it appears that the most appropriate manner in which to manage such a patient is that, regardless of whether the patient initiates the consultation about a lesion or a lesion is discovered on an examination of the patient:

1. There should be a detailed history taken as well as an examination undertaken, all of which should be well documented in the notes;
2. The notes should contain full documentation as to the existence of the lesion, including its location, size and a description of its appearance;
3. A clinical diagnosis should be made. If that diagnosis is one of a benign condition, and there is no clinical doubt in the mind of the medical practitioner, then that most likely will be the end of the matter;
4. However, if there is any doubt as to the diagnosis, then a differential diagnosis of a non-benign lesion should be maintained until it can be excluded. To this end a documented management plan, setting out appropriate investigations and referrals, should be instituted, including a follow-up plan and this should be communicated to the patient. All referral letters should be included in the patient's file;
5. While the differential diagnosis remains that the lesion might not be benign, it would be prudent for the patient to be scheduled for a follow-up consultation within a reasonable time, to be determined by the clinical context, but probably between 4 - 6 weeks. This will ensure that the lesion will continue to be monitored.

Results

Members should also be aware of the need to track test results and to make sure that they have seen and assessed those results. Members should also be aware that they need to review imaging files INDEPENDENTLY of the reports and, in the event of a discrepancy, that they should seek clarification from the reporting imaging specialist.

It is clear from a number of the cases we have managed that some medical practices do not have appropriate systems in place to manage results.

The principles of good practice include:

- Good documentation of the need for the tests/investigations and the fact that the patient has been sent to have them.
- A system of managing results that ensures that the requesting doctor sees them within a reasonable time and takes appropriate action.
- With respect to sessional doctors - that a system is in place that ensures that results are seen and acted upon within a reasonable time (generally 1 - 2 days) either by the requesting practitioner or someone else in the practice.
- A system is in place which ensures that results actually come back and are rechecked and discussed with the patient.
- Full documentation of the actions taken and advice given to the patient upon receipt by the practitioner of the results.

A separate, but related, issue is the question of referral for an imaging study that is "not routine"; that is to say, that requires a booking. Members need to consider whether such investigations are sufficiently important to justify requiring their staff to make the appointment for the patient so that they can be sure that the follow-up is done. This should be recorded in the clinical notes and, if the patient does not keep the appointment, at the very least, this will be recorded.

Dr David O. Watson
Council Member, MDA National

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: _____

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