

# Defence Update

Quarterly Magazine of the MDA National Group

**MDA National**

**The Practice Policy  
- Do I Need it?**

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What to Report**

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1925-2005

**80**

YEARS OF SERVICE

**March 2005**



# Retroactive Cover: What you Need to Know

It will come as no surprise that since 1997, medical indemnity in Australia has changed dramatically. One of the most important changes has been the change from claims-incurred cover to claims-made cover. MDA National made this change on 1 July 1997 but other insurers made the move relatively recently.

Understanding this change is critical for those doctors who have recently moved from another Medical Indemnity Insurer.

A fundamental aspect of claims-made cover is retroactive cover. The retroactive date of your policy dictates how far back your policy reaches.

Over the past few months, we have become aware that some insured members have insufficient cover because they have not purchased (enough) retroactive cover. Unfortunately, this has only come to light after they have received notice of a claim or investigation.

Unfortunately, we are not able to determine the extent to which you may have exposures because everyone's circumstances are unique. We advise all members to double check their retroactive date on their policy and ensure that it provides the cover you need. Throughout your career, it is very likely you will have a combination of the following forms of cover:

- indemnity by your employer or through a State Government scheme;
- claims-incurred cover by your previous MDO;
- retroactive cover through your current claims-made policy; and/or
- run-off cover provided through a separate policy or other arrangement.

Retroactive cover can provide cover for identified gaps that have occurred during periods of claims-made cover or where you have intentionally or unintentionally been without any form of cover.

In some cases, doctors knowingly do not purchase sufficient retroactive cover because they believe the risk is minimal or the premium too high. Obviously, this risk is like most others in that it is a personal decision as to how, or whether, you decide to protect against it. We do endeavour to make sure that any such decision is made with full knowledge of the risks. What we would say in these circumstances is:

- it costs you nothing to ask us for a quote; and
- the largest claim ever in Australia was through a missed diagnosis.

The following questions and pointers will assist you in determining whether you have adequate retroactive cover.

## 1. WHAT IS THE DATE YOU LAST HELD CLAIMS-INCURRED COVER?

This date will be specific to each doctor. MDOs began offering claims-made cover at different times so you will need to know the date you moved from claims-incurred to claims-made cover.

## 2. DO YOU CONTINUE TO HAVE ACCESS TO CLAIMS-INCURRED COVER FOR ALL PRIOR ACTS?

If you held claims-incurred membership of an MDO and were required to pay a 'call' but left without doing so, you may have no cover at all for the medical services you provided while you held membership of that organisation.

If you do not have the right to seek indemnity from your previous MDO because you did not pay their 'call' or for some other reason, you should in the first instance contact your prior MDO to rectify the situation. In the event that you are not able to reinstate your prior membership benefits, you should contact us for a quote.

Please note, the cost of paying a 'call' cannot be directly compared to the cost of purchasing additional retroactive cover. In paying a 'call', you will have secured your previous claims-incurred rights for your period of membership, which means the cover is enduring. Retroactive cover provides cover only while you remain insured.

If you continue to have the right to seek indemnity from your prior MDO and do not have any gaps in coverage, your retroactive date should be the day after your final day of claims-incurred membership/cover.

## 3. DID YOU HAVE ANY GAPS IN COVER?

Have you ever intentionally or unintentionally been without cover? If so, you will be personally liable to pay any claims or fund the defence of any investigations arising from this period.

If you suspect you need additional retroactive cover and would like to discuss it further, please contact Client Services on 1800 034 466 (WA) or 1800 011255 (all other states).

**Luke Thomson**  
Insurance Manager

# From the President



As I write I am preparing for our annual get together of Council, Board and Senior Managers to discuss strategy for the next twelve months to five years. In doing so we examine a lot of data about the workings of MDA National. It still catches me by surprise how much we have grown:

- 55 staff in our offices in Perth, Melbourne, Sydney and Brisbane.
- Second largest medical insurer in Australia in terms of turnover and capital held to meet claims.
- Half our members and income from the Eastern States.
- Councillor doctors from Victoria, Queensland, New South Wales and Western Australia.

At this workshop we will re-examine our reason for being and our goals. One area I would like to examine is how we deal with issues that affect our public hospital systems around the country. In the majority of instances the medical negligence claims that might arise from this employment will be indemnified by the State. There are, however, other medico-legal problems that arise. More and more often we are being approached about lack of resources and how doctors should proceed if they are placed in a position of compromising their patient care by a system that is budget cutting or simply badly set up. We must have sympathy for those who hold the purse strings as we all know that Health Care is a bottomless pit for money and each participant could think of a way to spend a bigger budget. But what to do when the resources are so stretched that there is a clear gap between that which you can provide and that which an expert witness may say you should have provided? How do you deal personally, professionally and legally with an adverse outcome that you know you could or should have prevented with more resources? Something that would not have happened in your private practice? These are not new questions. What is new to a lot of us is the risk that doctors may be blamed for this type of system problem and held to account before a tribunal.

The King Edward Memorial Hospital Inquiry in Western Australia and the Walker Inquiry in New South Wales are examples of situations where doctors who worked in busy public hospitals ended up before a Medical Board inquiry responding to allegations about misconduct. They did not receive praise for holding the fort in the face of short staffed rosters or for working extra shifts to provide a service as best they could. Dr Tom Hugh's article in this edition (previously published in the BMJ) outlines the process that resulted in disciplinary action for individuals in the face of system wide problems.

What should MDA National's role be in all this? We may not be able to change the resource allocation, but we can provide our members with tools to make sure their legal position before any future Inquiry is improved. If they are accused of bad practice when in fact they have been hampered by system wide problems, we would like there to be an audit trail in place to show that the problems have been brought to the attention of the appropriate authorities in a timely and professional fashion. It is unfortunate that doctors could be impugned when they have been trying hard to do their job but we will be proactive in protecting them. Please email me with any thoughts on these issues or examples of resource or other system problems you encounter: [amiller@mdanational.com.au](mailto:amiller@mdanational.com.au)

We now have regular meetings with the AMA at a Federal and State level. Tort reform is a state issue and I would like to acknowledge the efforts of AMA branches around the country on all of our behalf. We undertake to work more closely with the AMA to augment these efforts. In NSW the legal division of United Medical Protection deserves recognition for the tort law reforms that have been brokered in that state. However, as Deputy Treasurer Mal Brough has pointed out recently, the battle with plaintiff lawyers on this front is not over and hard won gains must be protected for the good of the medical profession and patients.

This month sees some changes to the members of the MDA National Council. Sadly I note the resignation of Dr Phil Melling from Council. He has been recruited by the Western Australian State Administrative Tribunal, a prestigious and well deserved appointment which will take up his spare time. We sincerely thank Dr Melling for his 18 years of solid service on Council. We will miss his experience and jocular, good natured contributions.

Under the Rules of the Association, Council can appoint a replacement to complete Dr Melling's term. Council resolved unanimously that he will be replaced by Dr Robyn Napier who, as many of you will know, is an impressive advocate for General Practitioners in New South Wales. She has served on our New South Wales Advisory Committee since its establishment in 2000. We welcome her to Council and look forward to her contribution and the special skills she brings.

**Dr Andrew Miller**  
President

# Protecting Your Association

MDA National values its reputation for honesty, integrity and transparency.

In many ways, our reputation is our most important asset.

To reflect and protect this, a Code of Conduct was introduced across the organisation in September 2004. It is intended to provide clear guidance to Councillors, Board and staff as to agreed standards of behaviour.

The Code addresses issues such as:

- how we deal with personal conflicts of interest;
- our requirement that as an organisation and as individuals we respect the spirit as well as the letter of the law;
- our rejection of corrupt, fraudulent or unethical business practices; and
- our support of non-discriminatory and safe employment practices.

Breaches of the Code will be treated seriously.

In addition to introducing the Code, as part of our wider risk management endeavour, we have conducted a series of staff workshops to discuss our exposure to fraud. Whilst we don't think the risks are high, we are aware that fraud is something experienced by most organisations at some time and that understanding a risk is the first step towards controlling it. We will continue to use our best endeavours to detect and address fraud risk to protect the assets of your Association.

The aspirational values set out in the MDA National Code of Conduct reflect our constitution and guide the Association in its day to day activities.

"MDA National is owned by doctors and exists solely for the benefit of its members. We aspire to:

- Support and protect the interests of medical practitioners and medical students.
- Promote honourable and contemporary practice by medical practitioners and to discourage irregular practice by medical practitioners.
- Develop and supply to our members quality medical indemnity products and services.

In discharging these objectives it is vital that we uphold the highest standards of ethical behaviour in order to safeguard our reputation with all stakeholders."

The Code and related activities is a further step to ensure that we continue to meet your expectations that you will be represented and served by an Association which endeavours to meet the highest ethical standards of our profession.

**Dianne Browning**  
Company Secretary

# Review of Commercial Neutrality in the Medical Indemnity Insurance Market

In December 2004, the Federal Government announced that an independent review would be undertaken into the commercial neutrality in the Australian medical indemnity insurance market. This was as a consequence of some medical indemnity providers having expressed concern about the commercial neutrality in the market, as a consequence of Government assistance to the industry in recent years.

The Government appointed Mr Graham Rogers to carry out the review. Until recently, Mr Rogers was President of the Institute of Actuaries of Australia. He is also an independent Company Director with a background in business leadership in the financial service industry. Mr Rogers will be reporting to the Government on 15 March 2005.

The scope of the Inquiry will examine the source and extent of any competitive advantages in the medical indemnity industry arising from measures undertaken by the Australian Government, specifically to assist medical indemnity providers since 29 April 2002.

*The terms of the Inquiry state that it will analyse:*

- *each form of Government assistance and their interactions, in assessing implications for competitive neutrality in the medical indemnity market; and*
- *any resulting competitive advantages, including but not limited to such possible advantages as savings on reinsurance or capital-saving costs.*

*(The analysis should consider each medical indemnity insurer individually, its parent or related medical defence organisation and also each medical indemnity group as a whole.)*

*Should any competitive advantage to one or more medical indemnity providers be determined, the Inquiry shall identify and evaluate options to restore competitive neutrality. The evaluation of such options shall have regard to the Government's general policy aim of ensuring a viable, affordable, fair and competitive medical indemnity market, recognising the interests of all stakeholders - insurers, doctors, patients and taxpayers.*

I will keep Members informed in relation to the outcome of this Inquiry in future publications of *Defence Update*.

**Peter Forbes**  
CEO



# Hospital Records: Who Owns and Controls the Notes you Write?

We recently received a letter from a Member requesting advice regarding the ownership of private hospital notes and whether a doctor had any control over the notes that they write within the hospital record. One of the hospitals at which the Member is working, was refusing to allow him to have copies of the notes he made for his in-patients. The Member used these notes to prepare discharge summaries and for management of patients once they had been discharged from hospital. There was also some concern about the hospital releasing notes without the consent of the admitting doctor.

As a matter of courtesy, it is often standard practice for hospitals to advise treating medical practitioners of any requests for access to medical records. Some hospitals will seek the consent of the medical practitioner to release the records while others do not. The Courts would regard hospital medical records generated for in-patients as being owned, and hence able to be controlled, by the hospital.

When hospitals release notes which they have control of, they are responsible for any breaches of confidentiality. In the event that the hospital discloses records without the patient's consent you cannot be held liable for any breach of confidentiality even where you have written in the notes or where the patient has been admitted under your care. It is important to be aware that legislation now enables patients to access their medical records from hospitals and individual practitioners, barring a few limited exceptions. Clinical records are often subpoenaed or accessed via the Federal Privacy Act and therefore a medical practitioner's consent to their release is often largely irrelevant.

A case considered in NSW<sup>1</sup> examined the issue where there was a dispute between the company running a medical clinic and the doctors who worked at the clinic. Whilst this situation is not exactly the same as faced by doctors working within the private hospital system (the patients presented to the clinic for treatment rather than to an individual doctor) I do believe that it is analogous. In this case there was a dispute in relation to who had ownership and control

of the files. The Court found that the doctors had no property in the files including examination sheets and consent forms which they completed.

As a matter of practice however, it is obviously important in terms of patient management to have access to relevant information. Usually under the By-Laws and Accreditation process set in place by hospitals, doctors have an obligation to document their consultations with in-patients in the hospital notes. Certainly you have a common law duty as a medical practitioner to deliver a certain standard of care. A refusal to document your consultations with patients in the hospital notes would definitely breach the required standard of care and almost certainly contravene the By-Laws. Where the hospital refuses to provide you with access to information you require for patient care you may wish to reconsider the appropriateness of your appointment at the hospital. It is clear that in the situation where the hospital refuses to allow access to appropriate information and this adversely impacts on the patient, that the hospital would bear some, if not all, liability in any resulting claim.

In summary, while doctors obviously have a common law duty to clearly document their consultations with in-patients in the hospital records, any notes written by individual doctors are owned and controlled by the hospital. In this situation the doctor therefore has no control over whether the notes are released or the degree of access that they are entitled to. Where you are not provided with appropriate access to the notes and this is impeding your ability to manage a patient it is advisable to notify the hospital in writing of your concerns. In the event that the hospital continues to refuse appropriate access to the notes it may be necessary to consider admitting patients to a different facility.

**Karen Kumar**  
Solicitor/Claims Manager

1. *Health Services for Men Pty Ltd & Ors v D'Souza & Ors* [2000] NSWCA



# Back to Punishment in

New South Wales appears to be reverting to its origins as a penal colony, if the interim recommendations of the special commission of inquiry into Campbelltown and Camden Hospitals are any guide.

The hospitals, on the southwestern outskirts of Sydney, serve a population of 800,000 people. In November 2002 four nurses made 71 allegations to the then state health minister, Craig Knowles, about "unsafe" care of patients in the hospitals. The allegations were referred to the Health Care Complaints Commission and were investigated. The commission's report of December 2003 focused on the systemic problems underpinning many of the adverse events, particularly under-resourcing and under-staffing. The report's accounts of individual cases will be familiar to any doctor working in a modern hospital, describing clinical errors of judgment, fumbled handovers, delays in treatment and poor communication.

The government was incensed that blame had been laid at its feet. The complaints commissioner was sacked and a senior member of the New South Wales bar, Bret Walker SC, was appointed to head a special commission of inquiry. His approach, detailed in two interim reports, was to recommend reinvestigation with a view to disciplinary action against individual doctors and nurses, almost 30 of whom have been referred back to a revamped complaints commission. None of

these doctors or nurses has yet had an opportunity to present their version of events. Meanwhile, an investigative television programme raised serious questions about the backgrounds and motivations of the four whistleblowers.

The government's response and Mr Walker's approach have dismayed people engaged in efforts to improve the safety of patients. Paradoxically, it was Mr Knowles who initiated these efforts when he set up the Institute for Clinical Excellence in 2001, an independent statutory authority, charged with improving patient safety. It has trained more than 2,000 senior clinicians and health managers in root cause analysis (RCA) of adverse events. Many system vulnerabilities have been identified and corrected as a result of RCA.

These successes have now been jeopardised. The initial inquiry triggered sensational newspaper headlines and aroused widespread distrust of the state's public hospital system. Staff at the hospitals involved are severely demoralised and anger in the community has been so intense that nurses walking in uniform down Campbelltown's main street have been spat at. Patient safety managers throughout the state report reluctance on the part of clinicians to be involved in RCAs for fear that they may become embroiled in similar inquiries. Concern about possible criticism by relatives has led to a state-wide reluctance to discharge patients from hospital, partly because a number of the complaints concerned patients who died after leaving Campbelltown Hospital. This has aggravated the already serious problem of blocked access.



# New South Wales

Mr Walker reacted angrily to criticism of his first interim report and has rejected the notion that a successful systems approach is incompatible with widespread punishment. He has repeatedly emphasised the need for individual accountability of doctors and nurses. However, almost all the incidents complained of did not involve egregiously culpable behaviour, such as drunkenness or deliberately unsafe acts, but resulted from clinical errors in which three closely related elements - the doctor's actions, the patient's illness and the system - have yet to be unravelled before an assessment can be made about any individual culpability. If this is done it should be possible to apply a decision tree of the type described by James Reason in *Managing the Risks of Organisational Accidents* to determine culpability, if any. It is unfortunate that doctors and nurses have been subjected to punitive sanctions before this process was applied.

The need to separate the tangled elements of a clinical event means that complaints about a doctor or a nurse require different handling from complaints about other professionals. Mr Walker rejected this ([www.lawlink.nsw.gov.au/special\\_commission](http://www.lawlink.nsw.gov.au/special_commission)): "I really don't have any patience with this idea that a complaints system for doctors should be different from a complaints system for anybody else and that doctors mustn't suffer the equivalent of a court martial."

Mr Walker eventually acknowledged in his final report the value of a systems approach. However, it was made clear that the interim

reports are not provisional and that the disciplinary recommendations will not be reversed. They therefore remain as a lamentable case study of an inappropriately punitive response to adverse events. The operation of the state's hospital system has been impaired and there are ill omens for the future improvement of patient safety. As James Reason has pointed out, communities generally get the disasters they deserve.

#### Dr Tom Hugh

Councillor /Board Member  
MDA National /MDA National Insurance Pty Ltd

*This article first appeared in the British Medical Journal, November 2004 and is reproduced with their permission.*

# The Coroner: Why and What to Report

On 30 July 2004, Mr Bret Walker SC handed down the Final Report of the Special Commission of Inquiry into Camden and Campbelltown Hospitals. The Commission focussed on allegations made by several nurses from Camden and Campbelltown Hospitals about adverse events, including patient deaths, at these hospitals. One of the allegations made by the nurses was the failure of medical staff to report certain patient deaths to the Coroner. The corollary of this complaint was the allegation that the medical practitioners had wrongfully completed death certificates in circumstances in which patient deaths should have been reported to the Coroner. In his Final Report, Mr Walker recommended that "further and better training or information be given to hospital medical staff concerning the reporting of deaths to the Coroner".

From time to time, members will need to consider whether they are required to refer a patient death to the Coroner or whether death certification can be completed. Members may also be asked to prepare statements for the Coroner and, on occasion, be required to attend a Coronial Inquest as a witness.

The aim of this article is to outline the circumstances in which a patient death should be reported to the Coroner and to provide guidance on the preparation of reports for the Coroner.

Historically, the role of the Coroner was to take charge of investigations into sudden and violent deaths and to collect 'chance' revenues which fell to the Crown as a result of these deaths. Today, the Coroner is mainly concerned with investigating deaths which occur in a number of unexplained circumstances. In addition, the Coroner is involved in the investigation of the causes of fires (in some states) and disasters. The office of the Coroner has an educative role.

Coronial Inquests and recommendations generally receive widespread media publicity and so the office may be used as a means of preventing other similar deaths in the future. The primary role of the Coroner is to determine:

- the identity of the person who died;
- the date and place of death; and
- the manner and cause of death.

Each State and Territory has separate legislative provisions for the certification of deaths and the notification of deaths to the Coroner. Members should seek advice from MDA National if they are uncertain of their obligations in a certain situation.

## Reports for the Coroner

A recent case highlighted some important issues regarding requests from the Coroner for reports from treating doctors.

*Dr X, a psychiatrist, first started treating the patient in the early 1990s. She saw the patient regularly in her rooms and also cared for her during several psychiatric hospital admissions. The patient died on 2 February 2004. Dr X had last seen the patient on 16 January 2004. Following the patient's death, Dr X arranged a meeting with the patient's family. The patient's husband expressed his gratitude for the care provided by Dr X to his wife over a long period of time. On 25 February 2004, Dr X received a letter from the police assisting the Coroner requesting a report about the patient. Dr X duly provided the report in March 2004. Some months later, Dr X received a summons from the office of the Coroner requiring her attendance at an Inquest into the patient's death. At this time, Dr X sought advice from her medical defence organisation. It transpired that Dr X's report*

## Risk Management Workshops:

**MDA National's Risk Management Department has developed a series of interactive workshops to assist Members to develop or consolidate risk management strategies in their practice.**

Promoting Safety and Confidence in your Medical Practice. Promoting Safety and Confidence

contained a number of factual errors. In particular, Dr X had failed to include the name of an anti-depressant that she had prescribed a few weeks prior to the patient's death in the list of medications in her report. The report also incorrectly stated that the patient had had 12 previous hospital admissions, when in fact she had been hospitalised on seven occasions only. The patient's husband expressed his concerns to the Coroner about the inaccuracies in the report. He felt that the medication that Dr X had omitted to mention in her report may have contributed to his wife's death.

At the conclusion of the Inquest, the formal findings by the Coroner were that the patient's death was caused by an overdose of prescription medications. The Coroner noted that she was unsure of the patient's mental state at that stage. The Coroner outlined the deceased's long history of mental illness and treatment by Dr X. She noted the patient had a prior history of significant suicide attempts. The Coroner specifically stated there was no blame to be attached to Dr X in her treatment and she was satisfied as to the doctor's prescription of anti-depressant medications. However, the Coroner went on to indicate the Inquest 'might not have been necessary if Dr X had provided a full and accurate report to the Court and the patient's family at the outset. Dr X's report contained a number of factual errors which required clarification at the Inquest'.

Unfortunately Dr X had completed her report without access to the hospital records and without reference to her own medical records.

Reports for the Coroner should include the following information:

- Full name and qualifications of the medical practitioner.
- Full name and date of birth of the patient.
- For whom the report is produced and the date of the request.
- Detailed and chronological summary of past medical history, including relevant dates.

The report should always be prepared with reference to the medical records. It should be noted that a report for the Coroner is not the same as preparing a medical report for a colleague. As a general rule, Members should only include information about their first hand knowledge of the patient's medical history. If other practitioners were involved in the patient's care, these practitioners should be identified. The Coroner can then determine whether it is necessary to obtain statements from any of these practitioners. In this way, the Coroner can piece together the 'jigsaw' of reports which provide a complete picture of the patient's recent illness or the events leading to their death.

### Conclusion

Preparing a report for the Coroner and giving evidence at a Coronial Inquest are usually straightforward and MDA National deals with numerous requests each year from Members seeking advice or assistance in these circumstances. **Members are encouraged to always seek advice from MDA National prior to responding to a request for a report for the Coroner, no matter how routine the request may appear.** We are available to advise Members at each stage of the process, from the preparation of the report to legal representation at the Coronial Inquest itself, if that is necessary.

**Dr Sara Bird**

Medico-legal Claims Manager

Presented by Risk Managers Penny Johnston and Louise Kershaw, the series will assist you analyse the systems in place in your practice and to identify risks present in those systems. During the workshops you will explore the nature of communication and teamwork and the use of evidence based strategies for improving healthcare outcomes. You will be provided with practical and effective strategies for successfully implementing change in a clinical setting.

The first workshop will give you a thorough understanding of clinical and medico-legal risk and the relationship between them. The aetiology of claims and adverse events will be explored through case studies demonstrating the impact of communication and human factors on patient outcomes. During the session you will have the opportunity to develop a plan to implement some practical risk reduction strategies for your practice.

### Knowing your Risk: Hot tips for keeping out of trouble!

**When:** 11 May 2005, 6-9pm and 12 May 2005, 6-9pm

**Where:** Function Room  
Subiaco Clinic Conference Centre  
St John of God Hospital  
25 McCourt Street  
SUBIACO WA 6008

**If you are interested in attending please contact Stacey Mack on 1800 011 255 or email [riskmanagement@mdanational.com.au](mailto:riskmanagement@mdanational.com.au)**

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# Patient Safety in the Spotlight

The release of the first report on incident management in the NSW public health system 2003-2004 has created a flurry of attention on patient safety and adverse events in hospitals. The finding that 452 serious incidents occurred in NSW public hospitals in 2003/04 or the claim of 20-40 fold under-reporting of incidents will come as no surprise to those working in the system. Victoria first publicly reported its sentinel events program in May 2004 although their notification rate was significantly lower than that reported in NSW. These reports raise some important questions regarding the patient safety movement and what it means to the individual clinician.

The Victorian report showed that the most common factors contributing to the occurrence of sentinel adverse events was communication and the continuity of care. Most common communication problems were deemed to be between staff (88% of all communication problems) rather than between staff and patients/family<sup>1</sup>. This supports other studies on communication, multidisciplinary teamwork and their role in error prevention<sup>2</sup>.

The NSW Report echoes the Victorian experience with the most frequent contributing causes of adverse events being communication (26%) and availability of policies, procedures and guidelines (22%)<sup>3</sup>. A lack of or non-adherence to procedures and guidelines were cited as contributing to 41% of sentinel events in the Victorian Report.

Guidelines and clinical pathways have received a mixed response from different clinical groups. There are very few surgeons who would not manage their elective patients on some type of pathway. A recent European survey found that there has been an increase in the use of clinical pathways with an expected doubling in the percentage of case types covered by pathways over the next five years. However, major constraints affecting their use remain, including the belief that clinical guidelines, protocols or pathways prejudice medical autonomy and the lack of resources to support their development

and implementation<sup>4</sup>. Professor Dave Davis, a leading researcher in medical continuing education and family medicine at the University of Toronto, developed the following list of the top 10 reasons for not adopting clinical practice guidelines:

- My patients are different.
- I already do use the guidelines...100% of the time!
- My patients expect ME to make the decisions.
- There were no GPs (left-handed psychiatrists, etc) on the development panel.
- I don't trust this EBM stuff.
- They were developed in Brisbane (Broome, Ballarat) and so wouldn't apply here.
- Patients problems don't fit neatly into those little boxes.
- I'm too busy to adopt this new stuff.
- Guidelines, what guidelines?
- They change all the time.

Many of the criticisms levelled at guidelines are undoubtedly valid however there is emerging evidence that innovative approaches to implementing clinical guidelines do work and can improve patient outcomes in areas other than surgery. A retrospective study of 290 obstetric delivery related medico-legal claims with 262 matched control cases showed that non-compliance with a clinical pathway was significantly more common among claims than controls (43.2% versus 11.7% p <0.001). In 79.4% of claims involving pathway non-compliance the claim was related directly to departure from the pathway<sup>5</sup>. Fifty hospitals participating in the NSW Children's Emergency Care Program have improved management and health outcomes of children presenting in Emergency Departments with gastroenteritis and asthma. Accurate recognition of severe asthma has increased from 60% to over 90% and more appropriate management of rehydration in gastroenteritis patients resulting in decreased admission and representation rates. Wollongong Hospital decreased their rate of aspiration pneumonia from 26% to 4% after implementation of a stroke pathway.



Guidelines are just one of many methods available to implement change in clinical practice. The sentinel event reports highlight the continued focus of the Australian patient safety movement on measurement and analysis rather than implementing changes to improve the infrastructure and processes in which clinicians must operate. In a recent interview on ABC National radio, Dr Ross Wilson said that the current Australian focus is on finding problems and that we are not giving adequate attention to solutions or putting in place the solutions we already know will work.

One example that supports this view is the statistics on the incidence of Surgical Site Infections. 2-5% of operated patients will develop a Surgical Site Infection (SSI). This translates to between 80,000 and 200,000 SSIs per year in Australia, contributing to 7,000 deaths annually<sup>6</sup>. The annual cost of surgical site infections is estimated at \$268 million with the cost of blood stream infections, of which 30-50% are attributable to health care procedures, in excess of \$600 million<sup>7</sup>.

A review of the MDA National's previous 7 years claims experience has shown that infection is the cause of complaint in a number of claims.

Specialty	% claims with infection injury code
General Practitioners	3.4%
General Surgery	3.0%
Orthopaedic Surgery	7.1%
Obstetrics & Gynaecology	4.7%
Ophthalmology	8.3%

It has been demonstrated that reduction in SSI is achievable with preventative measures that are well documented in the scientific literature however these measures are not being used consistently across the hospital system.

The increasing demands on doctors time makes it difficult to keep up to date with the vast amounts of evidence available. Involvement in quality improvement initiatives requires time and effort and it is recognised that there are significant impediments for the independent specialist practitioner. In acknowledgement of this and in the hope of assisting those members interested in improving prevention of avoidable Surgical Site Infections, MDA National is hosting a teleconference with experts in this field. The teleconference will provide a forum to discuss the latest advancements in this area and exchange ideas on effective measures and implementing changes. It will be held mid year and will be open to the profession. If you or your colleagues are interested in participating in this teleconference please contact Risk Management on 1800 011 255 or by email to [riskmanagement@mdanational.com.au](mailto:riskmanagement@mdanational.com.au)

**Louise Kershaw**  
Risk Manager

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# UWA Students are Now Teaching on the Run

I've only recently learnt that the word 'doctor', in Latin, means 'teacher'. Though the title 'doctor' was ascribed to medical practitioners as a courtesy title, the more one considers it, the more the 'teacher' definition seems appropriate. On observation, it is easy to see how even the modern day doctor might have been perceived to be just as much teacher as healer.

It is clear that the qualities of a good teacher also benefit the doctor. Both doctors and teachers need to be good communicators. Young doctors especially need the skills to explain complex terms clearly to both patients and their inevitable bevy of medical students. Also, the ability to garner an interest for a particular subject is a crucial objective for both doctors and teachers alike if their students are to become inspired and motivated to learn.

Unfortunately, despite obvious benefits, modern medical students have limited opportunities to develop effective teaching skills. Appreciating this, the Western Australian Medical Students' Society (WAMSS) launched a new program earlier this year aimed at giving clinical students valuable teaching experience while simultaneously providing some clinical relevance for our third year medical students.

Here enters, the Student Grand Rounds (SGRs). These are student led teaching tutorials and are much less like the traditional Grand Rounds one might see in hospitals, where consultants and junior doctors discuss interesting cases. With our student oriented Grand Rounds the teachers are clinical medical students and the participants are pre-clinical third years. Doctors have long been in a culture of peer-to-peer learning and although there are immediate benefits for the third year students, the main objective of the SGRs is to give clinical students teaching practice.

Hippocrates himself recognised many years ago this hierarchical nature of medical knowledge in his famous oath;

*"... and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else."*

*Excerpt from the Hippocratic Oath ~ 400BC*

However with SGRs, the focus is on providing teaching experience rather than supplementing the medical curriculum and our pre-clinical participants accept these limitations. None-the-less, participants greatly benefit from the teaching. In fact, there are many positives for both teacher and participant.

By becoming involved, our clinical students receive formal, professional teaching training and valuable practice in organising, co-ordinating and delivering small group tutorials within a clinical setting. The participants also receive much desired clinical relevance to the traditionally non-interactive, didactic teaching of third year. There is also the added benefit of inter-year bonding and the invaluable learning experience that only comes by actually being the teacher.

To create this program WAMSS sought the help of Associate Professor Fiona Lake and Dr Alistair Vickery who helped adapt their 'Teaching on the Run' program for junior doctors to fit the needs of medical students. WAMSS greatly appreciated financial support from MDA National and the Education Centre of the Faculty of Medicine and Dentistry. This support afforded us the resources to train over 20 clinical students in our first year.

So far this year we have run 16 tutorials to over 50 different third year students with flattering feedback and, encouragingly, demand for tutorials far exceeds our current capacity. Tutors usually run tutorials for about five third year students at a time. They usually run for an hour and tutors have permission to take third years into the hospitals that are usually held sacred until a student reaches fourth year. There are still some improvements to be made but the SGRs benefit from being directly self-evaluating. We will also benefit in years to come when our current participants have become the teachers, bringing valuable first-hand experience into the program.

I would be so bold as to say that SGRs could mark the beginning of a shift in medical education. Well, at least in Western Australia. As new medical schools are beginning<sup>1</sup> and as UWA continues to increase its own intake of medical students<sup>2</sup>, the burden of clinical teaching will become ever larger and more difficult to coordinate. Faculties will need to look at alternative teaching methods to cover learning objectives and it is here that the Student Grand Rounds initiative could prove its worth. Students from higher years could become more involved in teaching students in years below, themselves gaining from the experience. Also, our first trained, founding medical students will soon graduate with new practical teaching skills as well as an appreciation of what makes medical teaching more effective. It is 'self-directed' learning with a new spin. This time the 'self' is the medical student collective.

Student Grand Rounds are a positive way of ensuring an interesting and engaging undergraduate experience that truly benefits all involved. It has immediate benefits and puts the importance of a doctor's educator role in the medical student's psyche! I would hope, that as more students are trained and more tutorials are delivered, our students will continue to become more inspired and creative teachers and go on to become more inspired and creative doctors bringing benefits that will flow on to future medical students and patients alike.

I would like to take this opportunity to thank Sandy Dusting at MDA National and Assoc. Professor Fiona Lake and Dr Alistair Vickery at the Education Centre of the Faculty of Medicine and Dentistry for their continued support of this program. I look forward to bigger and better SGRs in 2005!

## Michael Winlo

Project Founder of the WAMSS Student Grand Rounds

1. Both the University of Western Australia and the Private University of Notre Dame University begin post-graduate medical schools in 2005.

2. University of Western Australia increased the intake of first year students from ~120 students in 2003 to over 200 students in 2004.



# When can Treatment be Withdrawn from a Patient?

The Solomonic question. When is it appropriate to withdraw treatment from a patient with seemingly no prospects of a meaningful recovery? The last thing any person, either medical practitioner or family member, wants is for the matter to have to go before a Court. Two judgments provide a clue as to how to appropriately apply the legal test of whether the withdrawal is in the “best interests of the health and welfare” of the patient.

## Northridge

In *Northridge v Central Sydney Area Health Service* [2000] NSWSC 1241, a 37 year old patient was admitted to Royal Prince Alfred Hospital in Sydney in an unconscious state, having suffered a cardiac arrest as a result of a heroin overdose. Four days later, the hospital decided to withdraw treatment without seeking the family’s consent (which arguably was against hospital policy). The patient was later transferred to a renal transplant ward, making the family suspicious of the hospital’s motives. The family also claimed that the hospital subjected them to psychological pressure to consent to a withdrawal. Although subsequent examinations over the following month did not suggest a positive prognosis, independent practitioners engaged by the family around a month and a half post-admission found real improvement over the previous two weeks and offered a relatively optimistic prognosis.

Upon an application by the family for an order that treatment continue, **Justice O’Keefe not surprisingly ordered that treatment should continue.** Observing the patient’s clinical course, he criticised the premature diagnosis, a lack of communication with the family and a failure to adhere to relevant hospital policies.

## Messiha

In *Messiha v South East Health* [2004] NSWSC 1061, a 75 year old patient was admitted to the St George Hospital in Sydney in a deep coma, having earlier suffered an asystolic cardiac arrest. He had a history of previous cardiac surgery, severe lung disease and a recent admission for a cardiac arrest. After two days of no demonstrable improvement, the hospital raised the possibility of withdrawing treatment with the patient’s family. Unfortunately, a passing reference was made to the resource requirements of the hospital. An independent neurologist who conducted an examination at the request of the patient’s family (being one of the practitioners

who offered a hopeful prognosis in Northridge’s case) agreed with the hospital’s practitioners that there was no realistic prospect of a meaningful recovery. However, the family maintained that they observed eye movements and that he responded to verbal cues.

Upon an application by the family that treatment continue, Justice Howie commented that **it would be an unusual case where unanimous medical opinion was ignored.** A submission that continued treatment would not be detrimental to the patient was rejected in circumstances where it would have required an invasive procedure and posed risks of infection. In the absence of unusual circumstances, the Court declined to order a continuance of treatment.

## A Way Forward?

Some guiding principles for medical practitioners can be drawn from these cases. Thankfully, disputes between the practitioner’s advice and the family’s wishes are rare. Although not directly relevant to a Court’s decision, communication with the patient’s family is paramount. It is advisable to involve the family at every stage of the decision-making process, to make every attempt to reach a decision by consensus and to be extremely careful about conveying any unhelpful perceptions, thereby minimising the chance the Courts will become involved.

Where a dispute might arise, it is advisable to take a relatively conservative approach as to diagnosis. Although clinical presentation may suggest no real prospect of a meaningful recovery within a relatively short time, it may be better to adopt a “wait-and-see” approach for a period, particularly where the possibility exists that respected practitioners would disagree with the diagnosis. In such cases, or where a family disagrees with the diagnosis, it would be advisable to arrange for an eminent independent practitioner to conduct an examination, so as to lend support to the diagnosis and show the family that every appropriate step is being taken to make the appropriate decision.

It should be noted that if questions as to withdrawing treatment arise in Victoria, the Medical Treatment Act applies, which provides different criteria for withdrawing treatment.

## Timothy Bowen

Solicitor  
Ebsworth & Ebsworth Lawyers



# The Practice Policy: Do I Need it?

Since we issued our first indemnity insurance policy in July 2003, Members have been asking an obvious question: 'What happens if my practice company is sued, will you cover it?'

For a long time, the benefits of membership had been personal - to the Member. And so, faced with converting our traditional membership benefits into an insurance policy it followed that policies would be issued to and indemnify the individual Member.

The policy style was written broadly, responding to the fact that doctors not only individually need cover, but they also instruct and supervise others. The individual policy caters to a large extent for a doctor's vicarious liabilities. However, plaintiff lawyers don't bring medical negligence claims in a uniform way. Sometimes they will name a single doctor, other times they will name all doctors involved or even name every possible person or entity associated (no matter how loosely) with the practice or the treatment received. This raises the questions:

- What happens if staff are named in a claim?
- What happens if my practice company or trust is named?
- Am I covered for the administrative duties of my receptionist or practice manager?

Our typical response is to persuade the plaintiff lawyers to reduce the number of defendants and, where possible and appropriate, to only include the doctor's name on the writ. If successful, the problem is resolved. The claim is then managed by us without the complication of other entities being involved. However, we cannot always guarantee that plaintiff lawyers will agree.

The Practice Policy was launched in January with these types of exposures in mind. It is designed to complement our Professional Indemnity Insurance Policy so there is no doubling up of cover. The Practice Policy insures a practice entity whether it is a sole trader, partnership, trust or Company. It can also provide cover to multiple entities where they are related to a single practice (subject to

underwriting approval). It provides cover for civil liabilities and defence costs incurred as a result of medical negligence claims made against the practice entity and/or an individual non doctor employee of the insured practice. The Practice Policy does not provide indemnity for claims made against employed medical practitioners as these claims are typically met by the doctor's own individual policy.

Not all doctors will need to take out a Practice Policy. The question of whether to take out the policy depends on your unique situation and the way you have structured your practice. If you are wondering about your need for a Practice Policy, you may wish to discuss the following issues with us:

- Does your practice have a separate legal entity?
- Does your practice entity employ staff including nurses and other allied health professionals?
- Are your employees covered in the event they are personally named in a claim?
- Does your practice entity have cover in the event it is named in a claim?
- Are the administrative duties of your receptionists and practice managers covered?

Some Members have asked about the likelihood of these claims being made. That's a fair question. All we can really say is that we believe the exposures of medical negligence are largely covered by your individual policy, however, the risks of a claim falling outside the scope of that policy are real. So it comes down to your personal decision as to how or whether to protect against these possibilities.

If you would like to discuss any of these issues further or would like more information about the Practice Policy, please contact our Client Services team on 1800 034 466 (WA) or 1800 011 255 (all other states).

**Luke Thomson**  
Insurance Manager

# 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  
 Fx: (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  
 Fx: (02) 9460 8344

**Perth**  
 Level 3  
 516 Hay Street  
 Subiaco WA 6008  
 Ph: (08) 6461 3400  
 Fax: (08) 9415 1492

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

**Sydney**  
 Level 5, AMA House,  
 69 Christie Street  
 St Leonards NSW 2065  
 Ph: (02) 9023 3300  
 Fax: (02) 9460 8344

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

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

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

## Defence Update via email



### Would you like to receive Defence Update by email?

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

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

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

## MDA National Insurance Board

Following the election of Dr Andrew Miller to the position of President of MDA National, the membership of the Board of MDA National Insurance has been revised.

As of 9 February 2005, Dr Fiona Bettenay was appointed as alternate director to Dr John Blackwell. An alternate takes over the role of director if their appointing director is unable to attend a Board meeting, however, they are invited to attend all Board meetings, even when the director they alternate with is in attendance.

Dr Miller will continue to attend all Board meetings in his capacity as President.

The MDA National Insurance Board members are:

- Mr Graham Reynolds, Chairman
- Dr John Blackwell, Deputy Chair
- Mr Peter Forbes
- Mr Jim Freemantle
- Dr Dennis Hayward
- Dr Tom Hugh
- Mr James Lutz
- Ms Eva Skira
- Dr Fiona Bettenay, Alternate to Dr Blackwell
- Dr Rod Moore, Alternate to Dr Hugh

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