

Defence Update

Quarterly Magazine of the MDA National Group

MDA National

**Not a Leg to Stand On:
Wrong Site/Wrong Procedures
are Preventable Errors**

**Stress and Distress
- The Ramifications**

**High Court
Decisively Dismisses
“Wrongful Life” Appeal**

Winter

06

Stress and Distress - The Ramifications

As discussed in the last edition of *Defence Update*, when a doctor becomes dissatisfied with his lot or experiences a sense of diminished control over his life, he risks slipping from 'stressed' to 'distressed'. The modern medical workplace poses significant challenges and doctors will, of course, respond differently to it. Some find it stimulating and enjoyable, whereas others, in the same or similar set of circumstances, will become stressed and burned out. 'Burnout' is a response to chronic emotional and interpersonal stressors on the job and typically manifests as: emotional exhaustion, cynicism and inefficacy¹. It is known as a problem born of good intentions because it happens to people who try to live up to unrealistic goals and expectations.

It is easy to blame a demanding workload as the obvious cause of such stress; however, there are alternate explanations. A longitudinal study following medical school students over a 12 year period, found that workload per se did not correlate with stress levels, but rather 'emotional exhaustion' – which was subjectively experienced². High perceived workload and poor support were determined as much by doctors themselves as by specific working conditions. Further, particular personality-traits of the young doctor were predictors of future reactions to work stress. Some of these traits were: higher neuroticism, being surface-disorganised (eg unsure what is needed to complete a task, finding it difficult to organise time); and greater introversion.

Depersonalisation – treating patients as objects, rather than people, is one manifestation of burnout. While bad for the patient, depersonalisation appears to be an adaptive behaviour which decreases the stress of the doctor – at least initially³. Other signs of burnout include:

- Anger at those making demands
- Self-criticism for putting up with the demands
- Cynicism, negativity, and irritability
- A sense of being besieged
- Exploding easily at inconsequential things
- Frequent headaches/gastrointestinal disturbances
- Sleeplessness/depression
- Suspiciousness
- Feelings of helplessness
- Increased risk taking

It is difficult to imagine how being in such a state could not in some way impact on those around you – family, friends, work colleagues, employees and patients. Breakdowns in communication and/or the doctor-patient relationship are at the core of most complaints about doctors, often regardless of how well the medicine was administered. Research into patient litigation and complaints also reveals that patients are highly sensitive to the doctor's manner, attitude and outward expressions of caring (or lack thereof).^{4,5}

Doctors suffering burnout are also significantly more likely to report engaging in 'suboptimal' patient care practices and attitudes⁶ and more likely to be involved in medical error⁷. Given the reported high rates of burnout – around 28% among Australian junior doctors⁸ and an incidence of 41% in Australian senior consultant doctors⁹, the potential for patient harm, be it physical or psychological, is significant. The situation is no better in general practice, with over half of GPs considering abandoning general practice because of stress and 13% having severe psychiatric symptoms¹⁰.

For doctors affected by burnout, it may be difficult to remember the moment when "they became like this" – when did the enjoyment of medicine end? In the previous edition of *Defence Update* we were introduced to Dr B - the sole General Surgeon in a rural setting who was feeling the strain of increasing demands and his growing inability to sustain his level of output. His compensatory responses were in full swing, but the negative impacts were beginning to outweigh the positive. In considering his options he may justify to himself that the community and patients he serves are better off with him (as he is) rather than with no doctor at all. However, the personal cost to himself, his family and his patients may be immense.

In the next article in this series we examine prevention, choices and solutions.

Heather Martin
Risk Manager

References

1. Maslach et al, Job burnout. *Annu Rev Psychol.* 2001; 52: 397-422
2. McManus I. et al, Stress, burnout and doctors' attitudes to work are determined by personality and learning style: A twelve year longitudinal study of UK medical graduates *BMC Medicine* 2004, 2:29
3. McManus I. et al, The causal links between stress and burnout in a longitudinal study of UK doctors, *Lancet*, Volume 359, Issue 9323:2089-2090
4. Beckman HB et al, The doctor-patient relationship and malpractice: lessons from plaintiff depositions, *Arc Int Med*; 154: 1365-1370
5. Vincent C et al, Why do people sue doctors? A study of patients and relatives taking legal action, *Lancet* 1994; 343: 1609-13
6. Shanafelt T et al, Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 2002; 136: 358-367
7. Houston DM and Alt SK, Psychological distress and error making among junior house officers *Br J Health Psychol* 1997; 2: 141-151
8. Willcock S et al, Burnout and psychiatric morbidity in new medical graduates, *Med J Aust* 2004; 181: 357-360
9. Bruce CT et al, Factors affecting female or male consultant stress in Australian teaching hospital *Med J Aust* 2003; 179: 174-175
10. Chew B and Williams A, Australian general practitioners: desperately seeking satisfaction *Med J Aust* 2001; 175: 85-86

From the President



To Report or Not To Report

You will have recently received documentation relating to the renewal of your MDA National membership and MDANI Professional Indemnity Insurance Policy for 2006-07. Although the process is more complicated than in the past, there are some perennial issues that will never go away.

First among these is incident reporting. For many years we have encouraged Members to report events in their practice that they might feel carry a risk of becoming a Claim in future. Traditionally June is the month of greatest incident reporting as Members reflect on the past year and have to sign a declaration to the effect that they have reported all incidents for that year. Some are still unsure what they should report and suggestions such as "well, I will just send in each operating list as a notification" reflect that uncertainty.

What then should be reported and when?

My rule of thumb is that if any Member asks whether a particular incident should be reported, then the answer is always "YES". In addition, if there has been a significant complication of treatment, it should be reported. "Significant" is not just the unscheduled return to the operating theatre for repair of a perforated caecum after a laparoscopic hysterectomy. It is any complication we perceive the patient to consider significant such as a drug rash, missing test results, dispute over an account or rudeness in a staff member. These "significant" problems are often defined by a request from a patient or patient's family for a meeting or advice or criticism over the telephone. Information may also come from nursing staff on a hospital ward, in the operating theatre or elsewhere. Our secretaries are also good monitors of patient satisfaction, and should be an early warning alert for potential difficulties, even when they are using their skills to sort out a complaint. Similarly, in our day-to-day practice, if we hear a colleague criticised by a patient, I believe we should alert that colleague to that criticism so he or she is able to take corrective action.

Reporting incidents should not wait until the end of the financial year when each of us is filling out the paper work for renewal. It should be an on-going process.

Another common concern with reporting is the extent to which doing that might put an individual Member "off-side" with MDA National. Most Members are aware that we have a process of examination of potential or actual adverse risk Members and there is a concern that zealous reporting of incidents might put an individual in the path of this process. This type of examination is related to the number of claims a Member has in a given period of time. Incidents are regarded as just that - incidents. They may provide an alert that a Member needs to apply appropriate risk management strategies to their practice as a means of avoiding similar incidents from occurring. However, it remains of greater importance to recognise potential issues early both in terms of managing the particular matter reported and introducing risk mitigation strategies if applicable.

Finally, there is another very important issue with reporting.

In the event that you receive a Solicitor's letter or a Writ, DO NOT SIT ON IT! While there is a tendency to enter a denial period, attending to this correspondence is urgent. It should be seen as a matter that needs action about as rapidly as someone with a BSL of 20 mmol/L. That is, action within two days. The action is to contact MDA National and provide copies of the correspondence, clinical notes, test results and other relevant material to our staff. In the event that the communication is from a Medical Registration Board or Health Complaints body, a draft response that you plan to send should also be prepared for our staff to consider and provide advice on. You should not respond without advice, any more than you should not respond at all. To do so is to potentially compromise your position and make our task of looking after your interests more difficult and you could also breach your policy conditions.

The process is really simple and the staff are there to support you. When in doubt, contact us.

Dr David O. Watson
President - MDA National

High Court Decisively Dismisses

Harriton v Stephens [2006] HCA 15; *Waller v James [2006] HCA 16*

On 9 May 2006 the High Court of Australia, by a 6:1 majority, dismissed what are commonly known as the “wrongful life” appeals, finding no cause of action. The New South Wales Supreme Court (Studdert J) and Court of Appeal (Spigelman CJ and Ipp JA, Mason P dissenting) had earlier dismissed the claims on the same basis.

Background

Alexia Harriton, now aged 25 and suffering from severe physical and cognitive disabilities, by her father and litigation tutor, alleged negligent failures by a general practitioner to diagnose prenatal rubella, advise her parents of risks to the foetus associated with rubella and to offer termination.

Keeden Waller, now aged 5½ years and suffering from profound disabilities, by his mother and litigation tutor, alleged Master Waller’s claim involved negligent failures by both an infertility specialist and IVF clinic to inform his parents of genetic risks associated with the father’s blood clotting disorder. He also pressed a claim against the antenatal obstetrician, for failing to diagnose the clotting disorder and offer a termination.

Both plaintiffs asked the court to determine whether a doctor who is negligent has a duty to advise the child’s parents of circumstances which would have allowed them to either lawfully terminate the pregnancy or take steps to prevent conception. So the issues before the court were confined to a consideration of two preliminary issues, namely whether a cause of action existed and, if so, what damages were recoverable. Each hearing proceeded upon a set of agreed facts.

The High Court Decision

The leading majority judgment in both cases was delivered by Crennan J (with whom Gleeson CJ, Gummow and Heydon JJ agreed). Shorter concurring opinions were delivered by Hayne and Callinan JJ. These justices focused upon the difficulty in finding a duty of care to prevent conception and the inability, in assessing damages, to compare the plaintiffs’ current position with that they would have been in but for the negligence, namely non-existence (being the traditional measure of damages in tort).

In dissent, Kirby J characterised the claims as being about “wrongful suffering” rather than “wrongful life”. He was unwilling to allow a result which would effectively give an immunity to health care providers in certain negligence claims. In any event, he thought that one could properly assess damages for a life, even where the alternative was non-existence.

Although the issue of damages appears to have been the most important consideration in the minds of the court, extensive consideration was also given to public policy considerations.

Finding a Duty of Care

The plaintiffs submitted that the defendants owed a duty of care to advise their parents of prenatal diagnosis, identify possible implications and offer termination.

Justice Crennan queried whether a foetus could have an interest in being terminated, as opposed to avoiding injury by other means. She thought that a duty to offer termination in the interests of a foetus may be inconsistent with the duty owed to the mother and may support a duty against the mother to terminate if there was a prospect of disability (also raised by Callinan J). She found difficulties in identifying the class of unborn to which the duty was owed, whether it was to all those who may be “disabled” or only those whose life was seen to be “not worth living”. The majority struggled with this concept and ultimately found no such duty existed. The litmus test for the majority was their view that if a duty of care existed to avoid conception or assist termination this would introduce “... conflict, even incoherence, into the body of relevant legal principle...”

Justice Hayne declined to make any findings on the existence of a duty of care.

Justice Kirby saw the claims as falling within the recognized duty on health care providers to take reasonable care to avoid causing reasonably foreseeable prenatal injury before birth, particularly because of the vulnerability of the unborn, the foreseeability of potential harm and any necessary management being within the normal clinical context. The mere potential for conflicting duties was insufficient to prevent any duty, particularly as the law dealt with such conflicts in determining whether to withhold treatment from a foetus in the mother’s interests. He did not perceive that any duty would lend support to a duty on the parents to terminate if there was a prospect of disability.

Was There a Causal Link Between Negligence and Injury?

Although the issue of causation did not receive the same degree of analysis as for duty of care and damages, Hayne J noted that finding a causal link between negligence and harm meant accepting that liability depended upon a parent’s subjective views on termination, which would only indirectly promote careful medical practice. The majority were mindful to distinguish the cause of the damage alleged, that being a life with disabilities as opposed to causing actual harm. By contrast, Kirby J thought that even if the defendant had not caused the harm itself, causation could be found in the failure to offer termination.

Damages: “Wrongful Life” or “Wrongful Suffering”?

Ms Harriton’s representatives, acknowledging the comparison with non-existence in assessing damages, submitted that the court had to consider how the absence of negligence would have prevented pain and suffering. By contrast, Master Waller’s representatives submitted that the alternative should be a hypothetical person without disabilities as opposed to a nonexistent life.

“Wrongful Life” Appeal

Justice Crennan did not see any analogy to applications to withdraw treatment from the terminally ill, as these involved accelerating death and balancing exercises, not preventing life and assessing damages. Existence could not be compared with non-existence (a view also held by Hayne and Callinan J) and no life without suffering was possible. Justice Hayne also pointed out that to allege disability as a harm meant a comparison with a person without injury, which was not the method of assessing damages.

Justice Kirby thought assessing damages as “a practical exercise in approximation”, never completing restoring a plaintiff to a pre-harm position. As to special damages (being those of a pecuniary value such as out-of-pocket expenses), as a plaintiff would not have any monetary needs absent of negligence, the needs are directly caused by the negligence. As to general damages (being those of an intangible monetary value, such as pain and suffering), courts already had to measure existence against non-existence in the context of applications to withdraw treatment from terminally-ill patients. He did not see difficulties in determining the severity of “disability” to be recoverable to prevent recovery itself.

Public Policy Considerations

Justice Crennan saw it as “odious and repugnant to devalue the life of a disabled person by suggesting that such a person would have been better off not to have been born into a life with disabilities”, seeing “disabilities” as merely one aspect of existence. She did not consider that corrective justice, namely the ends justifying the means, as supporting recovery. Justice Callinan thought allowing recovery may lead to defensive medicine, in a greater willingness to counsel termination. As the claims are so philosophically and theologically controversial, he thought allowing recovery was a matter for the legislature.

Justice Kirby saw the claim as not one where the plaintiff asserts that their life should be terminated, but rather that a defendant’s negligence has caused them suffering. He did not perceive that allowing recovery would suggest the plaintiff’s life itself was “wrongful” or demean them in the eyes of society. Instead, he thought that recovery would empower them by allowing a better standard of living. He also found insufficient indication that the legislature intended to prevent such claims.

Implications

The High Court’s decisions are not surprising. In common law jurisdictions, “wrongful life” actions have only succeeded in some jurisdictions in the United States, albeit claims have been successful in some other, non-common law, countries. However, there would seem to be an overwhelming judicial view that tort law cannot and should not entertain “wrongful life” claims.

The controversial nature of “wrongful life” claims are reflected in their legal formulation, namely that the unborn have an interest in termination and that their mere existence can be a harm.

Obviously, this provides a forum for vast moral, philosophical and ethical dispute. Such opportunity for controversy does not bode well for finding the existence of such claims, either by the legislature or the judiciary.

The judgments raise important questions about how tort law responds to novel issues. Can a duty of care exist without conflicting with other duties already owed? It would seem much consideration would need to be given to various hypothetical scenarios. Should we maintain adherence to the traditional measure of tort damages, namely putting the plaintiff in the position they were beforehand, or can we contemplate assessment based upon measuring a plaintiff’s loss and needs against a societal standard? There are no easy responses.

It would seem that attempts to recover damages following the birth of a “disabled” child will now focus upon “wrongful birth” claims, which have been allowed by the High Court in *Cattnach v Melchior* (2003) 215 CLR 1. The disallowance of “wrongful life” claims arguably does not affect the viability of “wrongful birth” claims. However, as the damages recoverable in such claims are in some respects very different to those which one would seek to recover for “wrongful life”, a question arises as to whether there should be, or is, adequate compensation for those born with “disabilities”.

In light of the controversial nature of “wrongful life” claims, it would seem that the only real chance for finding a cause of action would lay in legislative intervention. At present, there would seem to be little impetus for such legislative change.

Accordingly, it seems likely that “wrongful life” claims will not exist in Australia for the foreseeable future.

Timothy Bowen, Lawyer
Kerrie Chambers, Partner
Ebsworth & Ebsworth Lawyers, Sydney

Reproduced with permission from the Ebsworth & Ebsworth *Health Law Alert*, 10 May 2006.

“Not a leg to stand on” was the headline to a 1995 story in *The Wall Street Journal* about a diabetic patient who had the wrong leg amputated in Tampa, Florida. It might also describe the figurative predicament of a doctor responsible for a wrong procedure, an incorrect implant, a mismatched blood transfusion, or an operation done at an incorrect site on a patient. These errors, which are uncommon but regularly recurring causes of claims against members, are generally indefensible, extremely humiliating, and very damaging to both the doctor and the institution in which they occur. Major examples are likely to attract adverse media attention. Fortunately, they are amenable to a systems-based approach to prevention and should therefore be avoidable. This article describes the common types of wrong site/wrong procedure errors, sets out the predisposing conditions and outlines a systems approach to prevention.

Not a Leg to Stand On:

Incidence

Data from New York State hospitals indicates that a wrong site procedure occurred in 1 in 15,500 operations and in US Veterans Hospitals a rate of 1 in 25,000 operations is cited (approximately 1/month)¹. In Australia it is estimated that wrong-site procedures comprise 25% of sentinel (serious) adverse events. The Victorian Department of Human Services was notified of 16 wrong-site procedures in 2003, NSW Health recorded 13 in 1.5 million hospital admissions in 2004, and 11 were noted in the WA 2005 sentinel event report. These low figures consist almost entirely of serious cases and are therefore poor indicators of the overall magnitude of the problem.

Reliable incidence data is sparse because in the past there has been significant under-reporting of these embarrassing adverse events. Anecdotal data suggests that voluntary incident reporting systems do not solve the under-reporting problem. Medico-legal claims data are of limited value because they represent only a small proportion of wrong site incidents, many of which do not lead to a claim. Wrong side knee arthroscopy, for example, usually leaves no injury other than a scar and is seldom followed by litigation. It is hoped that more complete information may soon emerge from Medical Defence Organisations, given the increased recognition by doctors of the need for prompt reporting of all adverse incidents. MDA National notifications already point to a much higher frequency in the real world, especially if “near misses” without serious consequences are included.

Body Site Locations of Wrong Site/Wrong Procedure

US Veterans Hospitals data¹ indicates the following body site distribution of reported wrong site/wrong procedure incidents:

Eye
Groin or Genitals
Chest
Leg
Hand, Wrist, or Finger
Abdomen
Back
Head, Neck, Mouth, Anus, Colon, Buttock

*Font size represents approximate relative frequency –
with acknowledgement to Dr James Bagian, NCPS Director¹*



Wrong Site/Wrong Procedures are Preventable Errors

The relatively high frequency of wrong site/wrong procedure in eye operations is probably due, in part, to the high proportion of older patients, many with cognitive impairment, to the usual absence of externally visible ocular pathology and to the potential for insertion of an incorrect lens implant in cataract operations.

“Groin or Genitals” includes right-left mix-ups in hernia, testicular or ovarian operations and in operations for Peyronie’s disease (lateral penile curvature). It also includes hernia repair at a non-defective site (e.g. inguinal canal), when the patient actually has a different type of hernia (e.g. femoral or Spigelian). In the leg, prepping and draping of the knee before the surgeon’s arrival is often the setting for wrong-side arthroscopy. “Anus” wrong procedures consist of, for example, sphincterotomy instead of haemorrhoidectomy. “Colon” wrong procedures include resection of the wrong colon segment for a colonoscopically identified malignant polyp.

Types of Wrong Site/Wrong Procedure

Data from US Veterans Hospitals in 2002¹ indicated the following distribution:

- 44% were left-right mix-ups on the correct patient – 56% were something else
- 36% were the wrong patient
- 14% were the wrong implant or procedure on the correct patient
- 7% were the wrong site (but not left-right) on the correct patient

System Factors Predisposing to Wrong-Site Procedures

Although a common element in wrong-site procedures may be the failure of an individual doctor or nurse to follow accepted protocols such as site marking and checking, in most cases latent system errors (described by James Reason as “resident pathogens” in the system?) combine to produce the adverse event. More than one of the following system elements are usually present:

- Complacency. “Happens to the hospital down the road, not to us”
- Operating room (OR) time pressures
- High-volume OR lists; stressed or fatigued staff
- Emergency operation
- Change of OR list order
- Cognitively impaired patient (dementia, severe illness, sedation etc)
- No externally visible or palpable pathology in the patient
- Bilateral pathology e.g. ocular disease, diabetic lower limbs
- Complete clinical notes unavailable at the procedural location
- Delegated preoperative site marking by inadequately briefed or junior doctor
- Same name patients on procedural list
- Patient anaesthetised or sedated before surgeon arrival
- Patient prepped and draped before surgeon arrival
- Different operating surgeon from admitting surgeon
- Imaging studies unavailable in OR or films show poorly visible or incorrect side-markers, leading to left-right mix-ups in horizontally flipped films
- R and L abbreviations used on consent or procedural request form (Fig 1)

Figure 1: Operation consent form, with “R” (Right) abbreviation. The patient had discharge from the right nipple and was moderately demented. There was no palpable breast lump but mammography and needle biopsy showed carcinoma. The mammogram films and report were not sent to the OR. A left mastectomy was done. At least four system elements contributed to this error.

The Systems Approach to Prevention

Rare adverse events such as wrong site procedure may be the most difficult to prevent because dangerous complacency sets in when the things that can go wrong usually go right. The answer to this problem lies in disciplined adherence to an agreed protocol. Most Australian States and Territories health authorities have adopted, or are in the process of adopting, some modification of the 5-steps protocol mandated by the US Veterans Health Administration⁹. The 5 steps are:

1. A consent form stating the patient's full name, the procedure, the body site, including laterality if appropriate (written in full, not as R or L) and the reason for the procedure, is signed by the patient. The information should be in easily understandable lay terminology if possible. "Reason for the procedure" (e.g. hip joint replacement for osteoarthritis) is included so that patients may speak up if they believe the wrong procedure is on the form.
2. The operative site is marked, preferably no later than one hour preoperatively, by a doctor member of the operating team. The patient should be involved in the marking procedure whenever possible. All sites are marked with a non-toxic indelible marker as close as possible to the site of the incision because a significant proportion of wrong site procedures are on sites close to the intended site e.g. on the wrong digit or the wrong side of the knee. Non-lateral sites such as midline incisions should also be marked – more than half wrong site procedures are not laterality mistakes, but something else, such as wrong patient or wrong operation. If the site is difficult or impossible to mark, such as the oral cavity or perineum, if a decision about the site is to be made in the OR, or if there are multiple related sites (e.g. laparoscopic operations), a special-purpose wristband naming the procedure and site may be substituted for marking.

The mark may consist of an "X", the surgeon's initials, or the word "YES". It is desirable that there should be uniform agreement about the method chosen in any given institution. Multiple methods of marking may lead to confusion and disagreements between surgeons and nursing personnel. Marking of non-operative sites, such as the contralateral limb (a method previously used in some hospitals), should NOT be done.

Special techniques for identifying the exact operative site may sometimes be required. These include on-table X Rays to determine the vertebral level in spinal operations, on-table colonoscopy to locate the site of malignant polyps and hookwire localisation for breast pathology. The temptation to omit these procedures because of time pressures should be resisted.

3. The patient is identified by a staff member immediately prior to the procedure by being asked to state their name, date of birth, and the site of the expected procedure. If the patient is unable to respond, if possible another person with knowledge of the patient, such as a family member, is asked to do so. The responses are checked against the consent form, the patient's wristband and the marked site.
4. A "time-out" briefing is conducted in the OR prior to starting the procedure. The time-out is led by a designated member of the operation team and should include the surgeon, scrub and circulating nurse and anaesthetist. The name of the patient, the procedure to be done, the site and the implant to be used (if applicable) are stated for all to agree verbally. The time-out is documented in the clinical notes.
5. Two members of the OR team review relevant radiological images before commencing the surgical procedure. The function of the second member, who need not be a doctor, is to verify that the appropriate images are available and correctly labelled with the patient's name and any necessary side markers.

The multiplicity of predisposing system factors in wrong site errors means that multiple preventive barriers must be placed. Single safeguards cannot be relied upon. That is why there are 5 steps in the protocol and why all the steps must be done for the steps to work.

Objections may be made to the time required to carry out the 5-steps protocol. Data from the VA National Center for Patient Safety (NCPS) shows that the average total time needed is less than 10 minutes. The Director of NCPS, Dr James Bagian, points out that 10 minutes is nothing compared with the time needed to explain to a patient why you tried to fix something that wasn't broken.



Figure 2: NSW Health correct site/correct procedure poster. A similar poster should be on display in every operating suite.

Some Australian health authorities have produced local instructional posters (Fig 2)

When Should the 5-Step Protocol be Used?

As a general rule, the protocol should be used for any procedure that requires signed patient consent. This includes, for example, not only surgical operations but also such things as invasive radiology or insertion of a chest tube (wrong-side chest tube insertions have been reported).

The full 5 steps are not necessary when the consent process and the procedure are done at one sitting by the same doctor.

Conclusion

Successful abolition of wrong site errors requires widespread education and a commitment by institutions and individuals to a disciplined preventive protocol. It also needs to be underpinned by a culture change in attitudes to this problem. This change should acknowledge the universal systemic vulnerability to these errors and needs to be accompanied by a heightened awareness of the system conditions which predispose to wrong-site/wrong procedure mistakes. The resident pathogens are waiting in the system; if they trip you up it is likely you won't have a leg to stand on.

Dr Thomas B Hugh
 Chair – MDA National NSW Advisory Committee
 Councillor – MDA National
 Board Member - MDA National Insurance

References

1. Bagian J. (2004). *Advances in patient safety in the US since 1999*. May be accessed at the Australasian Association for Quality in Health Care (AAQHC) website: www.aaqhc.org.au/pdf/resources/2004_bagian1.pdf
2. Reason J. *Human Error*. Ashgate Publishing. Aldershot.1990.
3. The details and rationale of this protocol, together with useful information such as frequently asked questions, may be accessed at: <http://www.patientsafety.gov/CorrectSurg.html>

The MDA National Group Structure

This year's renewal will see MDA National Insurance (MDANI) issue professional indemnity insurance to members of MDA National for the fourth time. Since the introduction of medical indemnity through an insurance policy in 2003, we have continued to receive many queries from members about the structure of their indemnity and how the security of protection for doctors is now provided.

Medical Defence Organisations (MDOs) have had an extraordinary history of longevity internationally, with the original one being established in London in 1885. MDA National was established as an MDO in Perth in 1925.

The central role and purpose of the MDA National Group has not changed since that date. It is contained within the Rules but it can be summarised as looking after the character and interests of the members. This includes all issues loosely tied up within the broad definition of medico-legal issues but most importantly, medical indemnity protection.

Up until June 2003, that protection was provided directly by MDA National under a broad discretionary type of benefit. However, the collapse of United Medical Protection (UMP) in April 2002 brought the MDO industry under the spotlight of the Federal Government who moved to implement a series of financial and regulatory reforms to ensure there would be prudential and regulatory monitoring going forward. Importantly, MIIIs have to be licensed by the Australian Prudential Regulation Authority (APRA) and accordingly, are prudentially supervised as general insurers operating in Australia.

The key piece of legislation was the *Medical Indemnity (Prudential Supervision and Product Standards) Act (2003)* which came into effect from 1 July 2003. It removed the role of an MDO in providing discretionary indemnity assistance and required a Medical Indemnity Insurer (MII) to issue policies of insurance from that date. Since the introduction of the Act, the business operations of the MDA National Group have been conducted primarily through MDA National's wholly owned MII, MDA National Insurance (MDANI).

While we remain true to our central role and purpose as noted earlier, we are now functioning within a very complex prudential environment and I thought it would be useful to remind Members with an overview.

MDA National

- The mutual owned by the members.
- It is the entry point for members to join.
- Members elect a Council (up to 12 doctors) to oversee MDA National.
- MDA National is the 100% owner of its wholly owned insurer, MDANI.
- It appoints and monitors the performance of the MDANI directors.
- It monitors the financial performance of MDANI and its investment in that entity .
- It approves the overall strategic objectives for the Group.
- It sets the philosophy and provides input on medical issues.

MDA National Insurance

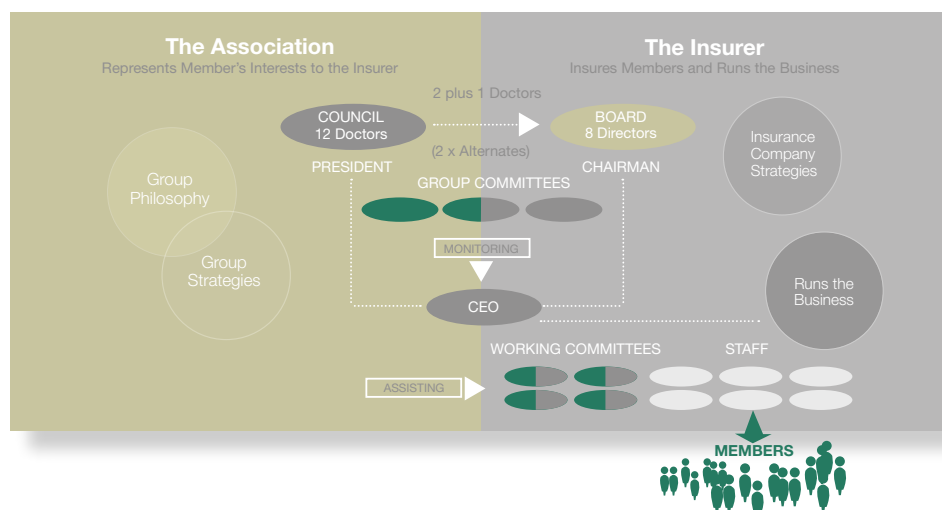
- Regulated insurer and wholly owned subsidiary of MDA National.
- It is responsible for compliance with all regulatory requirements.
- The Board is appointed by MDA National.
- The majority of the Board are independent and comply with APRA's "fit and proper" requirements for being a director of a licensed general insurer.

- The Chairman is independent.
- It is responsible for implementing and managing the MDA National Group's strategic goals and objectives.
- It issues policies of indemnity to members.
- It performs the operational requirements of MDA National under a Service Agreement.
- It employs all Management and Staff.

With this structure, in which the business operations are conducted through an insurance company operating within a tightly regulated environment, the MDA National Group has continued to go from strength to strength. It is significant to note that in a recent APRA report on the medical indemnity industry, it was reported that the MDA National Group is the number two MDO/MII in Australia on the basis of the number of insured members. MDA National has an Australia wide membership base; its business focus is therefore on medical indemnity issues across Australia.

I trust this overview is of interest to Members. If there are any queries I can be contacted via email pforbes@mndanational.com.au as I am happy to provide further detail and respond to Member queries about the structure and governance of the Group.

Peter Forbes
CEO



Editorial

I recently had the opportunity to attend the 2006 AMA National Conference. Some important medico-political issues got an airing. They all impact in some way on our medico-legal risk because they have the potential to affect how we work and who is responsible if and when things go wrong.

The first of these is role substitution and delegation in medical practice. That is, using nurses or others to do more of the doctors' traditional tasks. The discussion is being driven by the Productivity Commission report into the Health Workforce (<http://www.pc.gov.au/study/healthworkforce/index.html>). Where tasks are transferred from doctors to others, it is on a spectrum of supervision. From complete independence in the case of substitution, to greater or lesser degrees of supervision in the case of delegation. As we see new items introduced into the Medicare Benefits Schedule for nursing procedures, and other incentives or imperatives to delegate. Make sure your personal and/or practice indemnity covers whatever nurses and others may be doing in your name as any changes come in. Members should never feel that they have to practice medicine in a way that they are not comfortable with. Seek the support of your colleagues in the AMA and/or discuss the issue with MDA National if you are not sure where the boundaries lie.

In the context of improving productivity of the medical workforce, one obvious point was well made by the doctors present. That is, remove the barriers to productivity that already slow us down before trying to restructure the traditional roles. The examples given included cumbersome authority script approval processes and paperwork in general practice. The Productivity Commission is of the view that attempts to reduce red tape have foundered in the medical realm in Australia. It is to be hoped that the political and professional will to improve that situation returns soon. If you are interested in Regulation and reform of it, see the speech by the Chairman of the Productivity Commission, Gary Banks (<http://www.pc.gov.au/speeches/cs20060517/index>). He contends that "...even where regulatory action is clearly justified, options and design principles that could lessen compliance costs or side-effects appear to be given little consideration. Further, agencies responsible for administering and enforcing regulation have tended to adopt strict and often prescriptive or legalistic approaches, to lessen their own exposure to criticism if things go wrong. This, in turn, has contributed in some areas to excessively defensive and costly actions by business to ensure compliance". This does seem pertinent to the highly regulated medical insurance industry and we hope that as time goes and the stability remains in the industry that the regimen will be simplified.

There was also a presentation by the Hon Joe Hockey MP, Minister for Human Services, on the implementation of the new Access Card, which will replace the Medicare card and all other social security cards (see <http://www.joehockey.com/useruploads/File/Access%20card%20fact%20sheet.pdf> for further info). It has an electronic chip which stores the relevant details. As with all technological advances it has potential but the outcome will depend on the implementation more than the concept. The government currently has a limited agenda for the information included on the card but if in the future there is voluntary medical record information incorporated then

the profession will have to deal with the liability issues surrounding this. For example, what if the information is wrong, or incomplete, or not utilized in an emergency by a doctor? It is likely that medical practitioners would be involved in generating the relevant inputs. Although this is simply an extension of current medical record vulnerabilities, it will be emphasised when there are many millions of cards in circulation, if they eventually do contain health information.

This is an example of an "emerging" risk, which I have written about before. These are dynamic risks that have not been well known and/or handled by the profession in the past. They require vigilance and effective communication between doctors and their insurers as we delineate them and develop strategies for managing them. MDA National is always keen to hear of new ones.

The Abbott Review into Medical Indemnity continues in parallel with the Treasury review of the relevant legislation. The industry has been closely involved and I look forward to discussing the outcomes, hopefully in the next issue.

This issue again has excellent articles, in my opinion, and I thank the contributors. We always welcome member feedback.

Dr Andrew Miller
Councillor - MDA National
Editor - *Defence Update*



Difficult Patients

There are many reasons why patients are difficult, bearing in mind the breadth of the perception of a difficult patient. For example, some patients do not understand the medicine and that it cannot always fulfil their expectations.

Some patients provoke dislike or negative feelings because of personality characteristics and others invoke a loss of effective neutrality with the clinician. This can make it difficult to reach a shared understanding of the problems or for the patient and clinician to agree in the way forward in relation to their management.

Clinicians are aware patient complaints are often made by patients who are under the erroneous assumption that their health concerns have not been appropriately or adequately addressed. This complaint can take the form of a formal letter of complaint or a display of rude, aggressive or even violent behaviour. In a practical sense, how can these difficult situations be better managed and how do we effectively deal with these patients when difficult situations arise? Some tips are outlined on the following page.

It is essential that a protocol or policy be put in place in order to provide some clear guidelines for all staff to implement when dealing with these types of patients.

It is advisable that every doctor's surgery have a simple and discreet alarm system, including nursing and reception areas, for use in the event of aggressive or violent behavior. This will ensure that all staff members are aware that there is an emergency situation and can assist or, alternatively, contact Police. It is also prudent immediately after a disturbance that all staff involved communicate with one another in order to talk out their immediate reactions. In order to deal effectively with difficult patients depending on the degree of their behaviour, it is advisable to discuss these patients at practice meetings with all members of staff, with emphasis on the "level" or "degree" of their difficult behaviour. Not only does this provide a debriefing for all the staff members concerned, it also provides a forum to enable your procedure to be reviewed and modified if necessary when dealing with challenging patients.

In the event you decide that the therapeutic relationship has broken down to the extent where you can no longer treat the patient, it is advisable to inform the patient. Depending on the patient, you can inform them in person or by letter that they need to find another clinician. It is preferable that this communication be in writing and the letter be sent by Registered Post to ensure that the patient receives your letter. Your legal duty then requires you to write a health summary and to arrange for photocopies of the patient's clinical records to be forwarded to the next clinician. If the patient has a serious condition you must ensure that the importance of being followed up by another clinician is emphasised in your correspondence. It is important that the patient's treatment not be compromised during the handover period.

Deborah Jackson
Solicitor/Claims Manager

References

- Breaking up is never easy*, Tim Stokes, Mary Dixon-Woods and Robert K McKinley, Family Practice, Vol. 20, No. 6 2003;
- Confrontation and Politeness Strategies in Physician and Patient Interactions*, SOC, SCI, MED. 1981: Vol. 27 (3);
- The Difficult Patient as Perceived by Family Physicians*, Dov Steinmetz and Hava Tabenkin, Family Practice 2001;
- Dealing with Difficult Patients What Goes Wrong*, Estfan Cembrowicz, The Practitioner, April 1989, Vol. 233;
- Royal Australian College of General Practitioners, *Difficult Patients Guidelines*.



Some tips for coping with difficult patients:

1. Understand that patients are usually only difficult when they are anxious, worried, frightened or they do not understand the information they have been given.
2. Treat patients with warmth, understanding, consideration and empathy.
3. Listen to patients in an active and interested manner. Ask open-ended questions in order to determine what is making the situation difficult.
4. Consider your body language. Studies indicate few people are physically aggressive without any non-verbal warning signs.
5. Be aware of your own feelings, values and behaviour making sure they do not cloud your response to the patient.
6. If it becomes evident that the patient is upset, give them time to talk, take care regarding the venue where this discussion takes place. Depending on the nature or degree of the patient's distress it may be advisable not to take the patient into a room. It may be advisable to communicate with the patient in an open area with another member of staff close by. You must ensure the patient's privacy if you speak to the patient in an open area.
7. Clinician and practice staff should be cognisant of their own responses, avoid any aggressive body language or signals and avoid any temptation to verbally or non-verbally provoke a situation which may increase the tension.
8. Remember, highly anxious and inarticulate people are most likely to express themselves in an angry and/or possibly violent manner.
9. At no time when dealing with difficult patients should you touch the patient.
10. Acknowledge and recognise that some people are anxious and may regress and become childlike, reacting in an angry manner. Staff must refrain from becoming angry themselves and not treating the patient as a child.
11. Validate the patient's feelings and acknowledge that they are angry and upset and that you will endeavour to do your best to fix the problem.
12. If need be, contact another member of staff to observe and be close by whenever you are dealing with difficult patients.
13. As a last resort, you can consider no longer treating the patient. You are legally and ethically bound only to treat a person in an emergency situation.



Can I Sue a Patient For Making a Claim or a Complaint Against Me?

From time to time, doctors upset about a patient complaint or claim have asked about the possibility of suing for defamation. It is an understandable reaction, especially when you genuinely feel that the complaint is malicious or unjustified.

In general terms, a person defames you if their words would tend to make people shun or avoid you, expose you to ridicule or damage your reputation. Recently, a number of Australian states introduced uniform defamation laws. Some of the important features of the new law are as follows:

- a one year limitation period (in most cases) within which to make a claim;
- a cap of \$250,000 on damages for non-economic loss, that is, the "pain and suffering" part of the damages award;
- if a trial by jury is allowed, a jury can only decide whether defamation has occurred. The judge must then determine the damages award;
- pre-litigation resolution through apologies or offers to make amends is encouraged. These may be used to mitigate any damages awarded if defamation is established; and
- corporations are excluded from suing for defamation unless they are not for profit or have less than 10 employees.

The new law has also codified a number of defences to defamation, which include statements that are:

- justified because they are substantially true;
- published in the proceedings of an Australian Court or Tribunal;
- fairly reported matters of public concern (which include court proceedings and disciplinary inquiries); and
- honestly held opinions about matters of public interest, which are based on proper material.

Importantly, the legislation contains a defence of absolute privilege for material published to or by the Medical Board, Medical Tribunal and related bodies for the purpose of the assessment or referral of a complaint or other matter or the holding of any inquiry, performance

review, investigation or appeal under the *Medical Practice Act 1992*. A similar defence operates for material published to or by the Health Care Complaints Commission in relation to a complaint. For this reason, even if a patient complaint is found to be unproven, you could not successfully sue for defamation simply because the complaint was made. If material was published outside of these contexts, for example, in a newspaper, absolute privilege would not apply, but another defence might be available.

Subject to any available defences, the new legislation would not prevent a doctor suing a patient where they have brought unsuccessful court proceedings and conduct of the patient was defamatory (the mere fact the proceedings were unsuccessful is not of itself proof of defamation). However, before launching into defamation proceedings consider carefully the financial costs, the chances of success and whether the result even if successful adequately 'cures' the harm that has occurred. Defamation proceedings also extend the stress of litigation and might attract further media interest. You might also need to pay your own legal costs. Even if successful, a court award of party/party costs will not cover all of your legal expenses and the patient may not be in a position to pay them in any event.

Ultimately, suing a patient for defamation will rarely be a satisfactory remedy for doctors.

Meghan Magnusson

Senior Associate – Health
Ebsworth & Ebsworth Lawyers

Notification of Incident Form

1. Member Details

Member Name: _____
 Member Number: _____

2. Patient Details

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

3. Other Practitioners Involved

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

4. Incident Details

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

Brief summary of incident

Include details of patient presentation, diagnosis, treatment and outcome.
Do not send originals of medical records – send copies only if relevant to the notification. Please ensure your original records are preserved and kept separate from any correspondence with MDA National Insurance. If this matter develops into a claim, they will become critical to your defence.

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

Signature: _____ Date: _____

Policy holders based in WA, NT, SA and overseas
 Please post or fax the completed form and related documents to:
Claims Division, MDA National Insurance
 PO Box 1557, Subiaco WA 6872
 Claims Fax: (08) 9415 1492

Policy holders based in all other states
 Please post or fax the completed form and related documents to:
Claims Division, MDA National Insurance
 Level 5, 69 Christie St, St Leonards NSW 2065
 Fax: (02) 9460 8344

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

Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417 AFS Licence No. 238073. With limited exceptions, they are available only to members of MDA National. MDA National Insurance is a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated), trading as MDA National, ARBN 055 801 771. Incorporated in Western Australia. The liability of members is limited.

Privacy: The MDA National Group collects personal information to provide and market our services. We may share personal information with other organisations that assist us in doing this. You may access personal information we hold about you, subject to the Federal Privacy Act. If you wish to change your contact details or be removed from our mailing lists, please contact us at 1800 011 255. For more information or to see our Privacy Policy contact us on 1800 011 255.



Please notify us now...

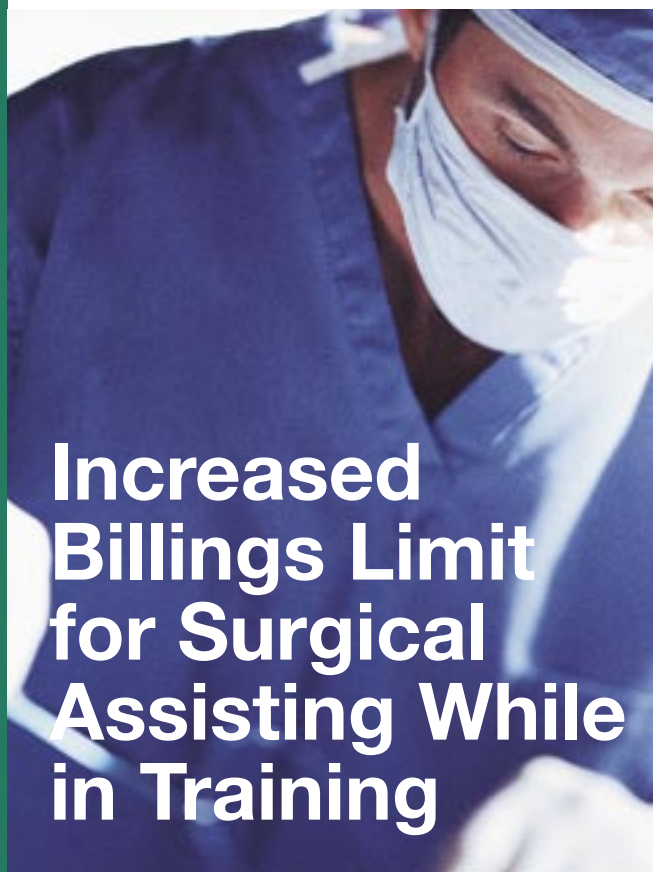
Do not forget to let us know, as quickly as possible, of any incidents that may give rise to a claim. In some cases a claim can be minimised or even avoided altogether where we have immediate notification.

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

Don't wait for a complaint or adverse outcome to become a claim before you notify us of the incident concerned. It is a good rule of thumb that if you are worried about an outcome, you should report it.

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

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



Increased Billings Limit for Surgical Assisting While in Training

From 1 July 2006, MDA National Insurance policyholders in the Post Graduate Years 1 to 4 and Doctors in Specialist Training categories will be able to generate up to \$50,000 of Gross Annual Billings from Surgical Assisting with no change required to their category and no additional premium payable.

This change applies to those Gross Annual Billings generated outside an accredited training programme. Registrars can continue to generate unlimited private billings within their training programme.

Where your Gross Annual Billings exceed the specified limit, you will need to select the appropriate category from the General Practice or Physician/Surgeon categories.

For more information, please refer to the MDA National Insurance Risk Category Guide 2006/07 or contact Client Services on 1800 034 466 (WA) or 1800 011 255 (all other states).



Would You Like to Receive Defence Update via Email?

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

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

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

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



**Freecall: 1800 034 466 (WA)
1800 011 255 (All other states)
mdanational.com.au**

The information in *Defence Update* is intended as a guide only and should not be taken as legal or clinical advice. We recommend you always contact your indemnity provider when legal advice in relation to your liability under your insurance policy is required. Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417 AFS Licence No. 238073. With limited exceptions they are available only to members of MDA National. MDA National Insurance is a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated) ARBN 055 801 771 trading as MDA National incorporated in Western Australia. The liability of members is limited. Before you make any decision whether to buy or hold any products issued by MDA National Insurance please consider the relevant Product Disclosure Statement and Policy Wording. Contact us if you require a copy. **Privacy:** The MDA National Group's privacy policy is available by calling us on 1800 011 255 or by visiting our website at www.mdanational.com.au. If you wish to change your contact details or to be removed from our mailing list please contact us on 1800 011 255.