defenceupdate

Quarterly Magazine of The MDA National Group

Autumn 2010

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From the President

Medical Innovation and its Mixed Blessings

In February 2002, Donald Rumsfeld was confronted by reporters citing a lack of evidence linking the government of Iraq with Terrorism. He replied:

"Reports that say that something hasn't happened are always interesting to me because as we know, there are known knowns; there are things we know we know. We also know that there are known unknowns; that is to say we know there are some things that we do not know. But there are also unknown unknowns; the one's we don't know we don't know. And if one looks throughout the history of our country and other free countries it is the latter that tend to be the difficult ones" (Rumsfeld 2002).

Many dismissed this comment as amusing, but Rumsfeld's reply carried a lot of truth. Unfortunately, decisions in various domains occur in circumstances of risk and uncertainty, and modern medical innovations are no exception.

When new medical devices are designed, trialled and implemented, all the future consequences cannot be foreseen. Advances in the use of growth factors, gene therapy, implantable prostheses and tissue engineering will all pose particular challenges in judging the likely efficacy and safety of these interventions.

The evolution of implantable prostheses is a perfect example of the difficulties with this process. For example, many early knee replacements proved to be dismal failures, although subsequent and more successful knee replacements would not have been developed without them. Likewise the earliest intraocular lenses were too heavy and prone to dislocation after cataract surgery, but few would argue as to the efficacy of modern cataract surgery and the rarity of lens dislocation due to the light-weight and flexible materials that are now used.

However, some medical advances have recently been implicated in some serious side-effects for patients. Chondrolysis is a relatively rare ailment in which joint cartilage dies, leaving bone to grind on bone. In the most severe cases, this condition has required joint replacements and some sufferers face a lifetime of pain and disability.

Although it is still unknown why chondrolysis develops, several medical studies have recently suggested that a possible culprit is a pain pump, a postsurgical medical device that has been used to infuse local anesthetics into joints after surgery.

Whether the pumps caused chondrolysis – and whether manufacturers should have done more to warn surgeons about the potential risks – is now the subject of more than 150 lawsuits working their way through the US courts. And last January, one jury awarded nearly US$5.5 million to a chondrolysis patient, and at least a dozen cases are expected to go to trial in the US this year.

Of course, some lawyers argue that the manufacturers disregarded safety in their quest to expand into the orthopaedic market. But the manufacturers and many surgeons argue that more research is needed to determine whether these infusion pumps are actually to blame.

Likewise it has recently been suggested that radiation oncologists have become too trusting of new software and computer systems that regulate the amount of radiotherapy applied to patients. While errors can arise during the calibration and commissioning of such software, it has also been widely assumed that such proprietary systems have been tested over time, when in fact they have not and the consequences are uncertain.

So regulators and researchers can only guess how often radiotherapy accidents occur. Such accidents might be underreported, even where there is a clear legal obligation to do so, and separating radiation injuries from the normal complications of radiation can be difficult especially as there can be a long lead-time before complications are discovered.

Indeed, our Spring editorial referred to reports that a Philadelphia hospital gave the wrong radiation dose to more than 90 patients with prostate cancer – and then kept quiet about it.

And as a result radiation mishaps seldom result in litigation, but this does not suggest that there are not potential problems within this specialty and that these new technologies are not without risk.

In this context the proposal of a national dosimetry centre to support departments should be applauded although as usual the detail (audit: supportive or punitive, the source of funding and the status of the data: privileged or not) will be a significant issue for specialists.

So with new solutions and opportunities, technology invariably brings its share of new ethical, political, social and economic challenges. And it seems that the risk of unforeseen complications associated with new medical products cannot be clearly discerned in advance, and it is sometimes difficult for doctors and patients to weigh an innovative product's risk potential against its possible benefit.

Therefore in forthcoming issues of Defence Update during 2010, MDA National will be exploring some of these emerging risks. And as doctors, we may have to become less enthusiastic about new technologies and more prepared to admit to patients that we don't have all the answers and cannot foresee all the risks.

And medical professionalism will increasingly require greater caution about innovation and a higher priority for the quality and safety that our patients deserve. We just don't have the answers to all the questions that new technologies pose, and we will need to be more prepared to acknowledge modern medicine's "unknown unknowns".

A/Prof Julian Rait
MDA National President

MDA National Collaborates with Leading Indemnity Provider in UK

MDA National is pleased to announce an exciting opportunity to collaborate with The Medical Protection Society (MPS).

Based in the United Kingdom, MPS is the leading international provider of comprehensive professional indemnity advice and support to more than 260,000 doctors, dentists and health professionals around the world.

The arrangement between our organisation and MPS is based on a spirit of co-operation in looking for ways to best serve our respective Memberships in areas where we are not in competition. It means that in Australia we can look to each other first in matters of mutual interest to our Members.

MDA National and MPS have many significant areas of common interest; in particular, we share a common philosophy of being "doctor-for-doctor" mutuals whose prime objective is to protect the interests of our respective Members.

Collaboration with MPS presents a valuable opportunity to share knowledge and experience that will ultimately benefit you - our Membership. With the shared objective of enhancing services and outcomes for our respective Members, future areas of collaboration could include the development of education materials and the analysis of claims and advisory experiences.

This relationship with MPS represents an exciting move for MDA National and we are looking forward to exploring future opportunities.

Announcements: Council/Board Retirement and Appointment

It is with regret that we announce the retirement of Dr Thomas Hugh from his position as MDA National Board Member and MDA National Insurance Council Director; positions he has held since 2002.

Dr Hugh also held a number of committee appointments including Chair for the Cases (Eastern) Committee and Member of the Underwriting Committee.

We are pleased however to announce that orthopaedic surgeon, Dr David Gilpin, will fill this vacancy.

Dr Gilpin currently serves as Chair of the Queensland Presidents Medical Liaison Council as well as a Member of the Underwriting Committee.

Under the Rules of the Association, Dr Gilpin will be eligible to be elected by the Members at this year's AGM.

On behalf of The MDA National Group, we acknowledge Dr Hugh's contribution to the association. We also welcome Dr Gilpin.

Surgeon Skipper Claims Overall Victory in the Sydney to Hobart

South Australian sailor and orthopaedic surgeon Dr Andrew Saies has claimed overall victory with his boat Two True in the 2009 Rolex Sydney Hobart Yacht Race.

Dr Saies skippered Two True, in a time of 04 days 07hr 57min 43sec, to overall winner of the major handicap prize, the Tattersall's Cup.

One of three South Australian boats to compete in the gruelling race, the 42-footer, on debut, became just the fourth South Australian yacht to win this iconic race in its 65 year history.

On behalf of Board, Council, management and staff, we would like to congratulate Dr Saies and his nine-man crew on their victory of the seas.

The Premium Support Scheme

The Premium Support Scheme (PSS) is a Federal Government program which aims to subsidise the cost of medical indemnity insurance for eligible doctors. Medical indemnity insurers have agreed to administer the program in respect of their members on behalf of the Government.

The PSS imposes various obligations on recipients of a PSS support payment. These include the requirement to complete risk management activities MDA National deems appropriate to assist Members to identify risk and implement appropriate risk management strategies.

In essence, the risk management requirement is based on the premise that doctors receiving publicly-funded subsidies should reasonably be expected to have some accountability for that public spend. As the PSS was introduced to reduce the cost of premiums for eligible doctors and the cause of higher premiums is the cost of claims, it follows that doctors receiving the subsidy should be required to take steps to reduce their risk. Much of the focus of medical practice is on reducing error and harm so doctors (irrespective of PSS eligibility) are already actively involved in reducing risks to patients; but the voluntary nature of requesting PSS assistance places a positive obligation on these doctors to participate in and complete an approved risk management activity. The PSS allows a Member to receive an advance payment in anticipation of the Member satisfying the eligibility criteria during the relevant policy period. In circumstances where the eligibility criteria is not subsequently met by the Member, the Member will not be eligible for the PSS support payment, and accordingly will have to repay that advance PSS support payment.

Risk Management Participation

The 2009/10 period is the second year where a positive obligation to participate in risk management has applied to all eligible PSS Members. Some of the outcomes from the 2008/09 period are detailed below.

Full details of the PSS risk management requirements were provided to all Members in the pre-renewal period and a further three letters were sent during 2008/09 to all Members who had applied for a PSS subsidy to remind them of their PSS risk management obligations. The Member Services and Risk Management Teams received many hundreds of phone calls and emails from our Members asking questions of their PSS risk management obligations during this time. This was certainly a 'learning' period for both our Members and MDA National.

To date, approximately 90% of the 2008/09 PSS eligible Members have provided evidence to MDA National of their completion of an appropriate risk management activity for that period, of which:

- 42% completed the online Practice Self-Assessment Tool (SAT);
- 29% provided evidence of participation in a MDA National approved 'external' risk management activity;
- 24% participated in a Cognitive Institute Risk Management Workshop;
- 4% completed the gplearning risk management module; and
- 1% participated in a 'Support in Practice' visit (Chart 1).

Chart 1: 2008/09 PSS Risk Management Activities

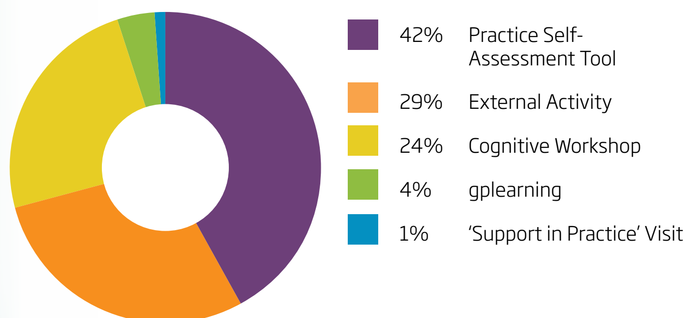
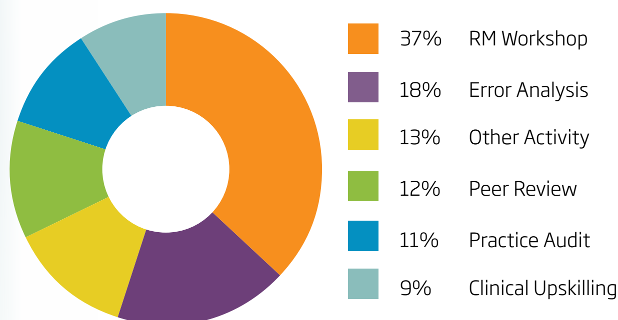


Chart 2: 2008/09 External Risk Management Activity Type



Am I Eligible for PSS?

There are a several different eligibility criteria but the most common path is the basic PSS calculation (below). Generally, you can be eligible for a PSS support payment if:

- Your gross indemnity costs for a premium period exceed 7.5% of your estimated or actual income
- You agree to the terms and conditions of the scheme including;
  - undertaking certain risk management activities
  - making a statutory declaration with regard to your billings within the agreed timeframe

Example:	
Gross Annual Billings	$100,000
Premium (gross indemnity costs ex tax)	$10,000
PSS Standard Calculation:	
7.5% of Gross Annual Billings ($100,000)	$7,500
Difference	$2,500
PSS Subsidy = 80% of difference	$2,000

For further information about PSS eligibility, visit **http://www.mdanational.com.au/insurance/premium-support-scheme.aspx** and download the PSS Information Booklet or contact Member Services on 1300 011 244.

Of those Members who provided evidence of completion of a MDA National approved 'external' risk management activity:

- 37% participated in a risk management workshop;
- 18% had undertaken an error analysis;
- 13% undertook an 'other' activity (e.g. practice improvement);
- 12% participated in peer review;
- 11% undertook a practice audit; and
- 9% participated in relevant clinical upskilling (Chart 2).

All Members who applied for a PSS support payment in 2008/09 would have received a letter from us in early 2010 asking them to complete a statutory declaration of their actual billings and gross indemnity costs and that they have completed a required risk management activity during this policy period. If Members are subsequently deemed ineligible for the PSS support payment for any reason or if there has been an overpayment, a PSS debt will arise and MDA National will seek to recover this payment from the Member.

What are your PSS Risk Management Requirements in 2009/10?

Members who are eligible for a PSS support payment under the 2009/10 PSS have similar options for meeting their risk management obligations as the previous year. We retain the view that the majority of our Members already incorporate risk management in their professional lives and that individual Members are in the best position to determine what their risk management requirements are – hence the option of providing evidence of their participation in an 'external' risk management activity.

MDA National remains committed to providing a range of risk management resources and tools that may assist Members in identifying and practice mitigating risks in their practice. We will be expanding our range in 2009/10 to include 3 new specialty-specific Practice Self-Assessment Tools (Surgical, Obstetrics and Gynaecology, Anaesthesia).

We will continue to monitor the participation and success of the various risk management activities and will make changes or refinements as necessary. As always, we invite feedback from our Members on the choice of activities, how these were communicated to them, the ease of understanding the requirements and their suggestions for future activities.

Of course, we want to assist all of our Members who have received a PSS support payment to meet their risk management obligations, as failure to do so will result in the Member being deemed ineligible and any PSS support payment will need to be repaid.

The details of the PSS obligations and risk management requirements can be found at www.mdanational.com.au, which also provides the contact details of MDA National staff who can assist you in both understanding your obligations and meeting them.

Risk Management Team

Cessation of Medical Practice

If you are planning to cease medical practice in Australia either temporarily or permanently, it is important to remember that your Professional Indemnity Insurance (PII) Policy is a claims made contract of insurance. This means that even if you have ceased practice in Australia, you still need to maintain a current policy in order to be able to continue reporting matters arising from healthcare services you provided while you were practising. The way in which you can maintain cover and ensure you remain protected will depend on the nature of your break from practice.

If you are ceasing practice in Australia for more than 3 months but less than 12 months.

If you are planning to take a continuous break of more than 3 months but less than 12 months during the insurance year, you have the option to downgrade your category to non-practising. This will reduce your premium for the time you are not practicing while allowing you to continue reporting matters arising from your practice prior to your break. It is important to remember to contact us at the time you return to practice so that we can adjust your category accordingly.

Please note that if you are ceasing practice for between 3 and 12 months due to maternity, you may be eligible for the Federal Government's Run-Off Cover Scheme – please see below for more information.

If you are ceasing practice in Australia for a period greater than 12 months.

If you are ceasing practice in Australia for a period greater than 12 months, you may be eligible for the Federal Government's Run-Off Cover Scheme (ROCS).

Run Off Cover Scheme (ROCS)

From 1 July 2004, the Australian Government introduced ROCS in order to provide free run off cover to eligible medical practitioners who have ceased private medical practice in Australia at no cost. You will be eligible for ROCS if you:

(a) are aged 65 years or over and have retired permanently from remunerated private medical practice;

(b) have not engaged in remunerated private medical practice at any time during the preceding period of 3 years;

(c) have not engaged in any (including public sector) remunerated medical practice in the preceding 3 years;

(d) have ceased all remunerated (temporarily or permanently) medical practice because of maternity;

(e) have ceased all remunerated medical practice because of a permanent disability; or

(f) have left Australia permanently having practised in Australia on a Visa sub-class 422 or 457.

A medical practitioner's estate will also be eligible for ROCS after the medical practitioner's death.

More information on this scheme is available from the Department of Health website www.health.gov.au or by contacting Member Services on 1800 011 255.

If you are not immediately eligible for ROCS at the time you cease practice, to ensure you remain covered you may need to purchase run off cover until you qualify for the Scheme.

Run Off Cover

As referred to above, if you do not qualify for ROCS at the time you cease practice in Australia, you can purchase run off cover from us in order to remain indemnified for matters that arise from your prior practice until such time as you meet the ROCS eligibility criteria.

The premium is at a reduced rate and is currently calculated as a percentage of the 3 year average of your PII policy premium (unless you have been indemnified by us for less than 3 years, in which case the averaging factor is adjusted accordingly). It is important to remember to contact us if you return to practice so that we can adjust your coverage accordingly.

If you would like further information about your indemnity options when ceasing practice in Australia, please contact Member Services on 1800 011 255.

Erin Ahern
Underwriter

The Medico-Legal Minefield Forums

National Registration: Mandatory Reporting of Colleagues and Dealing with Adverse Events

The National Registration and Accreditation Scheme for the Health Professions will be introduced on 1 July 2010. Mandatory reporting involving all health professions is one of the more controversial aspects of the Scheme. To discuss the realities of how mandatory reporting of colleagues may affect you and your practice, and to consider some of the difficulties you may face after an adverse event, MDA National invites you to attend an interactive forum.

Drinks and a light meal will be provided. Parking will also be provided by MDA National.

For full details including how to register, visit www.mdanational.com.au or contact Member Services on 1800 011 255.

Adelaide

Time	Date	Venue
6.30pm - 8.30pm	11 May 2010	The Majestic Roof Garden Hotel 55 Frome Road, Adelaide

Melbourne

Time	Date	Venue
6.30pm - 8.30pm	13 May 2010	Rydges on Swanston 701 Swanston Street, Melbourne

Perth

Time	Date	Venue
6.00pm - 8.00pm	17 May 2010	The University Club Hackett Drive, Crawley
6.00pm - 8.00pm	19 May 2010	The University Club Hackett Drive, Crawley

Sydney

Time	Date	Venue
6.30pm - 8.30pm	24 May 2010	Waterview Convention Centre Bicentennial Park, Entrance off Australia Avenue, Sydney Olympic Park
6.30pm - 8.30pm	27 May 2010	Royal Randwick Racecourse Alison Road, Randwick

Brisbane

Time	Date	Venue
6.30pm - 8.30pm	2 June 2010	Victoria Park Golf Complex Herston Road, Herston

A New Code of Conduct for Doctors in Australia

Background

In July 2009, the Australian Medical Council (AMC) released Good Medical Practice: A Code of Conduct for Doctors in Australia ("the Code")[1]. The final version of the Code was the outcome of a 12 month consultation process conducted by a working party of the AMC on behalf of the individual state and territory Medical Boards. It is likely that the Code will be adopted by the Medical Board of Australia, commencing on 1 July 2010, to provide guidance to medical practitioners on matters of professional practice. The Code will replace the existing individual state and territory codes of professional practice.

The stated aim of the Code is to set out the principles that characterise good medical practice, and make explicit the standards of ethical and professional conduct expected of doctors by their peers and the community.

How will the Code be used?

- To support individual doctors in the challenging task of providing good medical care and fulfilling their professional roles, and to provide a framework to guide professional judgment;
- To assist Medical Boards in their role of protecting the public, by setting and maintaining standards of medical practice. If a doctor's conduct varies significantly from this standard, the doctor is likely to be required to explain and justify their decisions and actions to the Board. Serious or repeated failure to meet the standards may have consequences for the doctor's medical registration; and
- As an additional resource for a range of uses that contribute to enhancing the culture of medical professionalism in the Australian health system; for example, in medical education; supervision of junior doctors and international medical graduates; and by administrators and policy makers in hospitals, health services and other institutions.

The Code explicitly states that it is not a substitute for the provisions of legislation and case law. Nor does it address in detail the standards of practice within particular medical disciplines.

What is included in the Code?

Topics that are canvassed in the Code include:

- Providing good care:
  - Access to medical care;
  - Shared decision making;
  - Treatment in emergencies;
  - Working with patients;
  - Communication, confidentiality, consent;
  - Adverse events and complaints;
  - End-of-life care;
  - Ending a professional relationship;
  - Personal relationships; and
  - Closing your practice.
- Working with other health care professionals:
  - Delegation, referral, handover; and
  - Coordinating care with other doctors.
- Working within the health care system:
  - Wise use of health care resources; and
  - Health advocacy.
- Minimising risk:
  - Risk management; and
  - Doctors' performance.
- Maintaining professional performance:
  - Continuing professional development.

- Professional behaviour:
  - Professional boundaries, reporting obligations;
  - Medical records and reports;
  - Advertising;
  - Insurance;
  - Conflicts of interest; and
  - Financial and commercial dealings.
- Ensuring doctors' health
- Teaching, supervising and assessing
- Undertaking research

Discussion

The development of the Code is part of a move towards re-defining and reinforcing professionalism in medicine. Medical professionalism has been defined as a "set of values, behaviours, and relationships that underpins the trust the public has in doctors".[2] The Royal College of Physicians has described the following values which form the basis for a moral contract between the medical profession and society:

- Integrity
- Compassion
- Altruism
- Continuous improvement
- Excellence
- Working in partnership with members of the wider health care team

Some commentators have expressed concerns about the Code. In particular, Komasaroff and Kerridge have commented that:

- Many of the provisions in the Code focus on values and aspirations of a very general nature and it will be impossible to enforce;
- The Code is based on a narrow and culturally specific view of medicine and ethics, and does not reflect the multicultural diversity of Australian society;
- The Code contributes to an insidious, creeping authoritarianism that threatens to erode the core values of a medical culture that has developed over many years; and
- Because of its limited, ideological view of medicine, the Code's implementation will impoverish medical practice and erode the ability to respond to circumstances and needs.[3]

Members are encouraged to review the Code and to consider its practical application. It will be interesting to observe over time how the Code is used in contemporary medical practice.

Dr Sara Bird

Manager, Medico-Legal and Advisory Services

References

1 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at http:/www.goodmedicalpractice.org.au

2 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world.* Report of a Working Party of the Royal College of Physicians of London. London; RCP, 2005.

3 Komesaroff PA, Kerridge IH. *The Australian Medical Council draft code of professional conduct: good practice or creeping authoritarianism.* MJA 2009; 190:204 – 205.

Your 2010 Renewal Will be Easier

We want to make it as easy as possible for you to maintain your medical indemnity coverage. That's why we're making changes to our renewal process in 2010.

This year, the renewal notice that you will receive in May will do more than just tell you how much to pay. Your policy schedule will be contained within your renewal notice so there is no need to send another out after you have renewed. Secondly, the renewal notice becomes your tax invoice / receipt upon payment so there is no need to send you a separate receipt. However to acknowledge that we have received your payment, we will automatically send you a Certificate of Currency which is often what employers or 3rd parties need for proof of indemnity.

So you won't need to sign and send back your renewal form and you won't need to request a Certificate of Currency.

Don't forget, you will also be able to renew your policy online and print your Certificate of Currency by following the links from our website.

These are just more ways that we are committed to improving our business to meet the needs of our Members.

Our Melbourne Office Has Moved

MDA National's Melbourne office has moved from its Albert Park location to new premises in South Melbourne.

Having outgrown its current location, the new office will provide a more amenable environment for our Members and accommodate future company growth.

The new Melbourne office details are:

Level 1, 80 Dorcas Street
South Melbourne, VIC 3205

Kevin George v Dr Hafizur Survery [2009] NSWSC 1348

Judgment of Hoeben J (9 December 2009)

Introduction

The value of damages awarded for future economic loss, attendant care and medical expenses are in part assessed by reference to the anticipated life expectancy of a plaintiff. Life expectancy is assessed by reference to Bureau of Statistics tables[1]. The often uncontentious issue of life expectancy (LE) was recently considered in detail during a decision of Justice Hoeben in the Supreme Court of New South Wales. Although this was a failure to diagnose a heart condition case, liability was admitted by the defendant general practitioner at the outset (for a failure to diagnose the plaintiff was suffering from either ischaemic heart disease or an acute coronary syndrome). The key issue was damages and in particular what value for LE should be used. Damages of $1,394,923.87 were awarded by the court.

Facts

At 57, the plaintiff consulted his general practitioner for advice in relation to chest pain. An ECG was reported as normal and following five further consultations, he was referred to a cardiologist on 15 July 2003. On 22 July 2003, the plaintiff presented to the Emergency Department at Mt Druitt Hospital where acute myocardial infarction with left ventricular failure was diagnosed.

Following further procedures at Westmead Hospital the plaintiff developed numerous associated conditions. The plaintiff was told that he needed a heart transplant in order to extend his LE, which was estimated at two years. The transplant on 8 April 2005 was successful however the change in his lifestyle had become significant.

Analysis of Life Expectancy

Damages for the past and certain expenses were agreed upon but those dependent on LE estimates were awaiting assessment by His Honour. The plaintiff submitted a figure of 12.5 years and the defendant submitted 8.5 years.

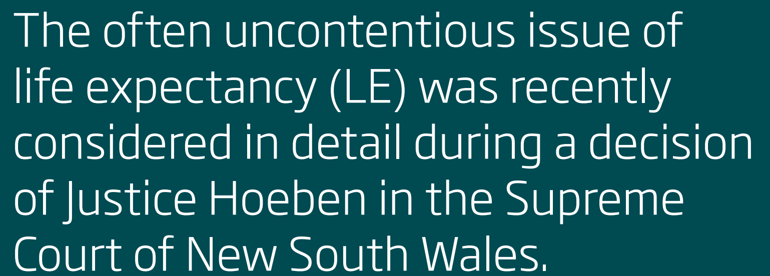
The plaintiff's cardiologist, Professor Anne Keogh, and the defendant's cardiologist, Professor Michael O'Rourke, gave oral evidence concurrently to assist His Honour. Both were highly distinguished practitioners however the defendant's expert conceded the plaintiff's expert had greater expertise in details of heart transplantation and management of such patients.

The plaintiff's expert used local data[2] which followed 2000 heart transplant patients from 1984 to 2008. It was data that was readily available, referred to in medical journals and readily presented at conferences. It was not peer reviewed. This data and her own observations of the patient (as her team provided follow up care and treatment) led to her view the plaintiff's LE was 12.5 years.

The defendant's expert used international data[3] that was produced in peer reviewed medical journals and it showed a lower LE for heart transplant patients of the patient's age. The expert arrived at his LE by beginning with normal LE, taking into account that:

(a) the plaintiff was 14 years older than the average transplant patient;

(b) the cause of the heart failure was probably one which would affect other arteries in the body; and



(c) the plaintiff's other co-morbidities adversely affecting LE such as renal insufficiency, diabetes, osteoporosis of the femoral neck, predisposition to skin cancer etc.

This produced the 60 percent discount[4] to 8.5 years.

Decision

His Honour preferred the discount and estimate of the plaintiff's expert for a number of reasons:

(a) Her data could not be peer reviewed readily but it was more accurate and reliable as it was local and not from international countries with varying standards of follow up care;

(b) The plaintiff's expert provided day-to-day treatment of the plaintiff and was fully aware of his actual state of health;

(c) Related to the above, the co-morbidities and assumptions the defendant's expert took into account were in fact not made out on closer analysis; and

(d) Related to this was the anomaly that the plaintiff's data showed heart transplant patients were highly selected for other diseases and so had longer life expectancies.

His Honour read all the material which relied upon the statistics and data by both experts and concluded that survival rates were higher in Australia and New Zealand and that data was more accurate for the plaintiff's LE. In fact, the plaintiff's expert's data, considering it was so subjective as to the plaintiff's health, obviated the need to consider vicissitudes[5] for LE.

Implications

The experts in this case gave evidence concurrently - that is they sat in the witness box together and were able to give their own evidence and comment on the evidence of others as that evidence was given. The Supreme Court of NSW instituted this initiative in an effort to get to 'the truth' in expert evidence and to enable the experts to 'debate' the evidence as that evidence is given. The court believed an unbiased expert view is more likely to be achieved. In this case it may well have resulted in the concession made by Prof O'Rourke as to Prof Keogh's preferred expertise

The relevance of this aspect of the decision relates to medical expert reports on both liability and on damages. The Court held that an assessment based on local data and on the actual state of health was more reliable than a statistical model which was internationally recognised and peer reviewed. This decision should remind litigants that the Court is more likely to approve of data and opinions which consider the plaintiff's medical circumstances rather than the condition in the abstract, despite its respect and acceptance in the medical community.

Feneil Shah
Kerrie Chambers
HWL Ebsworth

References

1 Australian Bureau of Statistics "Population Projections, 2006-2101"
2 From the Australia and New Zealand Cardiothoracic Organ Transplant Registry
3 From the International Society of Heart Lung Transplantation
4 The normal life expectancy for a 63 year old Australian male was about 22 years
5 Vicissitudes take into account events that could cause death or occur suddenly and without warning, such as accidents and disease.

The following cases have been prepared by the Claims and Advisory Services Team. They are based on actual medical negligence claims or medico-legal referrals. Certain facts have been omitted or changed and all names changed by the authors to ensure the anonymity of the parties involved.

More Changes to Medicare

Case History

The GP received a letter from Medicare Australia advising her that a recent Medicare claim for one of her health services had been selected for review. The letter listed the patient's name, date of birth and the date of service. The GP was asked to contact Medicare by phone within the next two weeks to confirm the claim details.

Medico-legal Issues

The GP contacted MDA National's medico-legal advisory service for advice.

The GP was informed that the letter was part of Medicare Australia's Payment Accuracy Review program which is designed to measure the accuracy of Medicare payments. As part of this process, Medicare contacts both the medical practitioner and the patient to verify details of a service for which MBS or PBS benefits have been paid. The GP was advised to contact Medicare on the phone number provided, at which time she would be asked a couple of standard questions, confirming provision of the service. The call would take a few minutes.

This program is being conducted in addition to the Increased Medicare Compliance Audits initiative which commenced in 2009 with the aim of increasing the number of Medicare audits from one to four per cent of medical practitioners. To facilitate this increased audit activity, amendments to the *Health Insurance Act 1973* are expected to be introduced in 2010.

The legislative amendments will include:

- a requirement for medical practitioners and other specified persons to produce documents, which may include medical records, to substantiate Medicare benefits paid, when audited by Medicare. The Chief Executive Officer (CEO) of Medicare Australia will have the authority to issue a Notice to Produce Documents. The CEO must take advice from a practitioner employed by Medicare on potential sensitivities associated with the type of documents a medical practitioner may need to provide to substantiate the service. The person who receives the Notice has the discretion to decide what documents are available to substantiate the MBS service, and does not have to produce documents containing clinical details to anyone who is not a practitioner employed by Medicare.
- a financial administrative penalty for medical practitioners who cannot substantiate a Medicare benefit paid in respect of a service. Under current arrangements, although benefits that are incorrectly paid can be recovered from the practitioner who caused the incorrect payment to be made, no additional penalty applies. It is proposed that a base penalty of 20% will be applied to debts in excess of $2,500. The base penalty amount may be reduced or increased according to individual circumstances, including whether or not a practitioner advises early on in an audit that incorrect amounts have been paid for MBS services.

Discussion

In the past 10 years, the Medicare Benefits Scheme has undergone significant growth and expansion. The increased number and range of items available through both the MBS and PBS has made it difficult for medical practitioners to ensure compliance. The increasingly complex MBS items and PBS listings may be open to more than one interpretation. Medicare Australia has introduced an email service for medical practitioners where they can obtain written advice with regard to the interpretation of items. This service can be accessed at: **medicare.prov@medicareaustralia.gov.au.**

The increased number and range of items available through both the MBS and PBS has made it difficult for medical practitioners to ensure compliance.

Risk Management Strategies

Medicare Australia has identified the following areas of risks in relation to GPs which they will focus on in 2010:

- Care Plans – especially where a medical practitioner has not met all the requirements of the MBS item and where patients have had only one or no previous visits with the practitioner.
- After Hours – in May 2010, changes will be introduced to the MBS after hours attendance items, including new commencement times for urgent after hours items (details of these changes and other changes to the schedule are available at *www.health.gov.au/mbsonline and at www.health.gov.au/mbsprimarycareitems*).
- Practice Nurse Items – in 2009, Medicare Australia conducted a preliminary audit which found that just under one in four practitioners who were audited had made non compliant claims. Audits of these items will continue in 2010. The compliance issues identified included:
  - The practice nurse was not appropriately qualified and trained.
  - The provider was rendering practice nurse items when the nurse was employed by a public or private hospital.
  - The provider was claiming a practice nurse item in addition to another service when there was no additional service.
  - The provider was claiming practice nurse wound management items during the ineligible after care period.
  - The provider was claiming practice nurse immunisation items for ineligible injections.
  - The provider was claiming cervical smear items on the same day as another cervical smear item for the same patient.
  - The provider was making routine claims for practice nurse items in addition to consultation items for the same patient.
  - The provider was routinely claiming multiple practice nurse items on the same day for the same patient.
- Up-coding – involving billing for a more complex and more expensive item than the service being provided, especially in relation to skin lesions, excisions, flap repairs and deep and superficial wounds.
- Initiation and billing of tests and investigations not clinically relevant – including diagnostic imaging, especially CT scans, and overuse of pathology especially in relation to iron studies, folate/B12 and TSH.
- Practice Incentives Program – a number of concerns have been identified including:
  - Practice nurse payments where nurses are not working the minimum number of hours required.
  - After hours tier one payments where the practice is not meeting the requirement that patients be able to access medical care 24 hours a day, seven days a week (especially when practices are closed during normal business hours).
  - After hours tier three payments where practices do not have mechanisms in place for patients to access practice doctors 24 hours a day, seven days a week.
- Mental Health Nurse Incentive Payments .
- Prescribing – particularly in relation to benzodiazepines, narcotics and antibiotics.
- Specific purpose clinics and niche areas – concerns about the provision of vascular and cardiovascular diagnostic services that may not be clinically relevant.

Medicare Australia has identified the following specialties which they will focus on in 2010:

- Anaesthetists – not fully meeting the requirement of the item descriptor and up-coding anaesthetic time units and pre-anaesthesia consultations.
- Gastroenterologists – performing and billing additional procedures that are not clinically relevant.
- Non- specialist surgeons – up-coding of procedure items, clinically irrelevant services and use of long consultations.
- Orthopaedic surgeons – duplicate billing of a service and billing for services integral to another service, e.g. osteotomy with a joint replacement.
- Plastic and reconstructive surgeons – billing cosmetic services that are not eligible for Medicare benefits.
- Psychiatrists – up-coding of time based consultations.

Members are encouraged to seek advice from MDA National's medico-legal advisory team, especially if you are contacted by one of Medicare's Medical Advisers, or you are asked to participate in an audit.

Dr Sara Bird
Manager, Medico-Legal and Advisory Services

Reference

Medicare Australia's National Compliance Program 2009-2010. Available at: www.medicareaustralia.gov.au

MDA National CaseBook

Good Records Will Set You Free …

Case History

On 21 November 2004, the 39 year old patient consulted a plastic surgeon and informed him that she wanted to undergo a bilateral breast reduction.

On 2 December 2004 the surgeon performed a bilateral breast reduction. Post-operatively, the surgeon ordered that the patient mobilise after several hours, wear a supportive bra, go home when ready and attend the rooms for review on 5 December 2004.

On 5 December 2004, the patient was seen by the surgeon's practice nurse, who took down the dressings, cleaned the wounds and re-dressed them with Op site spray and Micropore. The practice nurse recorded that there was good union of the breast wounds.

The practice nurse next saw the patient on 9 December 2004, at which time the sutures were removed and steri-strips were applied to the wounds.

The surgeon first saw the patient post-operatively on 12 December 2004 and wrote "great early result" in the medical records. The surgeon arranged to review the patient the following week. No other notations were made in the medical records. The patient did not return for review.

On 23 January 2005, the patient returned to see the surgeon, who recorded that revision surgery was required to elevate both nipples. The surgeon considered the patient had a good result from the initial surgery, and understood her request for further surgery arose from a desire to have "a bit more done" – not because she was in any way dissatisfied with the surgical result.

On 24 February 2005, the surgeon revised the bilateral breast reduction.

The surgeon reviewed the patient on 27 February 2005, but did not make an entry in the medical records. The surgeon's nurse or secretary subsequently recorded "post-op. All fine" in the medical records. The surgeon expected the patient would return to see him for further review in one week, although this was not recorded in the medical records.

In January 2007, the patient consulted another plastic surgeon (Dr Z), who told the patient she had a "terrible result" and that she should ask to get her money back.

On 9 April 2007, the patient again consulted the surgeon, but did not inform him she had obtained a second opinion from Dr Z. The surgeon recorded "breasts loose again" and noted the patient wanted fuller breasts. The surgeon considered progressive stretching from pregnancy, breast feeding and weight gain had caused breast distortion and more lipodystrophy, altering the patient's original surgical result.

The surgeon reviewed the patient on 27 February 2005, but did not make an entry in the medical records. The surgeon's nurse or secretary subsequently recorded "post-op. All fine" in the medical records.

On 14 November 2007, the surgeon again consulted with the patient and recorded that she needed scar revision of the right axilla.

On 28 November 2007 the surgeon performed a bilateral breast augmentation and right axillary scar revision. The post-operative orders included for the patient to rest in bed for 18 hours, take analgesia PRN, go home when ready and to return to the rooms for review on 4 December 2007.

Post-operatively, the patient consulted Dr Z instead of the surgeon, and said she was deeply distressed about her breasts. Dr Z sent a report to the patient's general practitioner that said the patient's nipples were displaced medially, that there was no evidence of an uplift having been performed and that there was a large unattractive infra-mammary fold in the medial side of the right breast.

On 31 December 2007, the surgeon's secretary telephoned the patient to make a post-operative appointment for her, some 28 days after the intended review date. The patient said she did not want to travel to the surgeon's rooms and would instead see her local doctor for follow-up.

The patient subsequently consulted with a third plastic surgeon, Dr A, who performed a reduction mammoplasty, nipple repositioning, replacement of bilateral breast prostheses and removal of fibrous capsules in June 2008.

In December 2008, the patient commenced legal proceedings against the original surgeon.

Medico-legal Issues

In the Statement of Claim, the patient alleged the surgeon negligently performed the surgery in that he failed to reduce scarring as much as possible. The patient also alleged that the surgeon had failed to warn her that she would have extensive heavy scarring, 'dog ears' and large areolae with suture 'hatch marks'. The patient alleged injury in the form of 'dog ears', 'hatch marks' and scarring on her breasts, misshapen and poorly positioned breasts, injury to each nipple areolar complex, excessive scarring, anxiety, depression and excessive weight gain.

In support of her claim, the patient served an expert report by a cosmetic surgeon, who interestingly had examined her some 4 months after she had undergone surgery at the hands of Dr A. The expert was critical that the nipple areolae complexes were too large and too high, and was also critical of pleats and 'dog ears' that had not been resolved or addressed by the defendant surgeon. The expert considered that a reasonably competent surgeon would only perform a breast reduction if the patient was fully informed and willing to accept the possibility of extensive heavy scarring and secondary procedures to correct 'dog ears' or unspecified complications from the first operation.

The expert also considered that if the surgeon had used reasonable care, he would have avoided creating larger nipple areolar complexes, would have reduced the scarring as much as possible, and would not have left the patient with 'dog ears'. The expert went so far as to suggest that the surgeon should have assessed the patient's psychological state to ascertain whether she was mentally capable of dealing with problems and complications that could arise from the proposed operative procedures.

Expert opinion was obtained on behalf of the defendant surgeon. The expert viewed pre and post-operative photographs of the patient and opined that the surgical results fell within the limits of acceptable results after breast reduction (with or without augmentation). The expert considered there was no indication for a reasonably prudent plastic surgeon to arrange for a patient to be psychiatrically assessed and opined that such a referral is rarely indicated in cosmetic surgery patients.

In terms of the failure to warn allegations, the expert noted that none of the surgeon's entries in the medical records referred to discussions that had been held with the patient in relation to advice, information or warnings. The records were silent in relation to any possible risks and complications that were discussed and furthermore, there was no notation to support the surgeon's contention that the patient had been shown pre and post-surgical photographs of good and average results. The expert considered the claim would be difficult – if not impossible – to defend because of the failure to warn aspect, given the paucity of the surgeon's medical records.

Discussion

This claim highlights the importance of keeping good medical records. It is important that medical records contain information relevant to diagnosis and treatment (including history and examination findings), clinical opinion, treatment plan, medication and dosage, information and advice given to the patient and full details of any medical/surgical treatment or procedure. In addition to supporting safe patient care, providing the doctor with an aide memoire and facilitating continuity of care in the doctor's absence, good medical records are essential when responding to complaints or defending a claim.

In this case, although the surgeon was certain he had held several consenting discussions with the patient prior to each of the surgeries and had given her information pamphlets, there were no notations and pamphlet stickers to this effect in the medical records and accordingly, no objective evidence to corroborate his assertions. In the absence of documentation of the consent process, it was felt that the claim would be difficult to defend in Court. Settlement was achieved at mediation.

Yvonne Baldwin
Claims Manager (Solicitor)

The Importance of Being Expert

Case History

The 68 year old patient was referred by his GP to the orthopaedic surgeon for management of his hip osteoarthritis. The patient was otherwise well, and on no regular medications. The surgeon saw the patient on 8 August 2005. On the basis of the patient's symptoms, clinical signs and x-ray findings, the surgeon made a diagnosis of advanced degenerative disease of the left hip. The surgeon discussed treatment options with the patient, these being limited to putting up with the pain or undergoing a hip arthroplasty. The surgeon discussed the nature of the surgery, and the benefits and risks of the procedure. He also provided the patient with a booklet about hip arthroplasty, which included information about the benefits and risks of the procedure. The patient was keen to undergo the hip surgery as soon as possible.

On 9 September 2005, the patient was admitted to hospital for the purpose of a left hip arthroplasty. The surgical procedure was uneventful. The orthopaedic surgeon's routine post-operative orders included Clexane 40mg nocte, the use of calf compression devices and intravenous antibiotics for 48 hours post-operatively.

On the first post-operative day, the patient complained of left thigh, calf and foot pain. He was reviewed by the registrar who noted there were no neurovascular changes in the lower limb. The orthopaedic surgeon reviewed the patient two days post-operatively, on 11 September 2005. On examination, he found the patient had a slightly swollen left foot and calf. There appeared to be decreased sensation in his toes, ball of the foot and left leg. The patient was booked for a Doppler ultrasound that afternoon. This did not reveal any evidence of a deep vein thrombosis (DVT), but the arterial Doppler studies showed widespread atheroma in the left common femoral and superficial femoral arteries. A vascular surgeon was consulted who did not recommend any specific treatment. The patient continued to complain of 'cramps' in his left lower leg. On 14 September 2005, the patient's left foot and ankle area were noted to be inflamed and swollen, and there was reduced power in the foot muscles. Peripheral pulses remained palpable. Over the next few days the patient's foot remained much the same. He had pain in his left foot but was able to get up and walk with the aid of a walking frame.

On 21 September 2005, the patient complained of chest pain. It was thought that the patient may have had a pulmonary embolus (PE) and a V/Q scan was arranged. The dose of Clexane was increased to 80mg bd. The V/Q scan was reported as showing an intermediate probability of a PE. A physician was consulted and the patient was commenced on Warfarin. Three weeks after the hip arthroplasty, the patient was transferred to a rehabilitation facility for ongoing management.

The patient ultimately developed significant weakness in the left ankle, and clawing of the toes of his foot. There was dysaesthesia and hyperaesthesia of the left lower leg, consistent with a complex regional pain syndrome. The patient was reviewed by a neurologist who performed electrophysiological studies. These revealed absent digital motor responses from both the peroneal and tibial nerves in the left leg. The neurologist thought this might have been secondary to traction or possibly a vascular injury to the nerves.

Medico-legal Issues

In August 2008, the orthopaedic surgeon received a Statement of Claim alleging negligence in his management of the patient. The Statement of Claim alleged that following the hip replacement, the patient (now a plaintiff) developed a DVT and sustained "injury, disability, loss and damage" as a result of the DVT. The particulars of negligence included:

a) Failing to advise the plaintiff to wear PEG or other compressive stockings post-surgery;
b) Failing to ensure that the plaintiff was given a calf compression pump post-surgery;
c) Failing to closely observe the plaintiff post-operatively which observation would have revealed that he was developing signs and symptoms consistent with a DVT;
d) Ignoring the plaintiff's complaints of severe pain in his left leg;
e) Failing to monitor the plaintiff's condition; and
f) Failing to administer adequate anticoagulant therapy post-surgery.

Attached to the Statement of Claim was an expert report written by a general physician. The physician was of the opinion that the patient had developed a DVT post-operatively and that this was the cause of his ongoing left leg problems. The expert was critical that no attempts were made pre-operatively to prevent the development of a DVT. He stated that "no use was made of compression stockings or of a calf compression apparatus and no anticoagulant was administered". The report went on to state that "it is well recognised that lower limb orthopaedic surgery carries a high risk of deep vein thrombosis and it is normal and routine best practice to try to prevent this from occurring

The Statement of Claim alleged that following the hip replacement, the patient (now a plaintiff) developed a DVT and sustained "injury, disability, loss and damage" as a result of the DVT.

because of the subsequent morbidity and mortality. Such practice includes the pre-operative use of compression stockings, of calf compression apparatus and pre-operative anticoagulation with Clexane. Many surgeons use all three measures". His report concluded with a statement that the orthopaedic surgeon "was seriously remiss in not ensuring that preventive measures were commenced pre-operatively and thus he was negligent in his duty of care towards the patient".

On receipt of the Statement of Claim, the orthopaedic surgeon immediately contacted MDA National for assistance. MDA National instructed solicitors to protect his interests in relation to the claim. Two weeks later, a meeting was arranged between the surgeon, the solicitors and the MDA National Claims Manager to obtain a detailed statement and to consider the allegations made against the surgeon. The orthopaedic surgeon confirmed that there was no evidence that the patient had, in fact, developed a DVT post-operatively and he was perplexed by a number of the statements made by the plaintiff's expert.

After obtaining a detailed statement from the surgeon, MDA National's solicitors sought an independent expert report from another orthopaedic surgeon. The expert report concluded that the "professional service provided by the orthopaedic surgeon to the patient would be widely accepted in Australia by his peers as constituting competent professional practice". The expert was also provided with a copy of the plaintiff's expert report to comment upon. The orthopaedic surgeon opined that there was no evidence that using pre-operative precautions for DVT, such as Clexane or stockings, has any effect on the incidence of post-operative DVT. Indeed, the surgeon commented that the use of Clexane pre-operatively increases the risk of haematoma in the joint, and the risk of spinal cord haematoma in the event of epidural or spinal anaesthesia. He reported that the physician's comments in this regard were "completely false". He further noted that the physician's comment that "calf pain post-operatively is considered to be a DVT until proven otherwise" was "a fair statement except when it is proven not to be a DVT. The patient had a Doppler examination as soon as he complained of calf pain and no DVT was found". The orthopaedic expert went on to comment that the physician was unlikely to have been involved in major joint replacement surgery. He also queried whether the physician had been acting in a clinical environment recently.

In November 2008, MDA National's solicitors served the expert orthopaedic report on the plaintiff's solicitors with an offer to discontinue the claim on an own costs basis (each party to the proceedings to bear their own legal costs to date). The plaintiff's solicitors rejected this offer and served a supplementary report from their physician expert. This report reiterated the statement that when a patient complains of calf pain post-operatively it is considered to be a DVT until proven otherwise. The report concluded "it is overwhelmingly clear that the patient developed a DVT within 24 hours of his hip replacement. His symptoms of pain were not immediately communicated to the surgeon and correct treatment was not initiated immediately. This resulted in progression of the DVT to a pulmonary embolus. The contention that a negative Doppler proved that a DVT had not occurred is not only incorrect, but indefensible".

MDA National's solicitors sought additional expert opinion from a vascular surgeon. The vascular surgeon reported that the patient's post-operative symptoms were not typical of a DVT. He further noted that subsequent investigations by venous diagnostic ultrasound showed no evidence of a DVT. He stated that ultrasound diagnosis was about 95% accurate. The expert went on to state "for a DVT to cause swelling of the calf and foot with possible nerve compression, then the DVT would need to be extensive and would be readily diagnosed by a competent ultrasonographer". He also noted that it was unlikely that the patient had suffered a PE because the patient's scan was equivocal and, in the absence of a lower limb DVT, it was improbable that a PE occurred. The vascular surgeon thought that the patient's ongoing leg problems were more consistent with a nerve lesion. With regard to the expert opinion provided on behalf of the plaintiff, the vascular surgeon noted that the physician was not a vascular or ultrasound specialist, and that many of the comments he made in the report were "simply not correct".

In June 2009, this expert opinion was served on the plaintiff's solicitors with a formal Offer of Compromise for a verdict for our orthopaedic surgeon Member, with each party to bear its own costs. Under Court rules, the Offer of Compromise was open for a period of 28 days from the date of the offer. Two weeks later, the plaintiff's solicitors accepted the offer, bringing the claim to a conclusion. MDA National's legal defence costs were approximately $30,000.

Discussion

In this claim, it was apparent that the plaintiff had suffered left leg problems post-operatively, but the mechanism of injury remained somewhat unclear. However, what was clear was that the patient had not suffered a DVT post-operatively. Nevertheless, the plaintiff's expert was mistakenly of the view that the plaintiff had suffered a DVT and his solicitors had based their pleadings in the Statement of Claim on the fact that his injuries were the result of a DVT. On this basis alone, the claim was doomed to fail.

Ultimately, service of well reasoned expert reports by an orthopaedic surgeon and a vascular surgeon convinced the plaintiff and his solicitors that there was absolutely no merit to the claim.

Dr Sara Bird
Manager, Medico-Legal and Advisory Services

MDA National

Risk Management Workshops

Cognitive Institute Workshops Calendar

April 2010

Mastering Shared Decision Making
Wednesday 21
6.00pm - 9.00pm
Melbourne

Mastering Shared Decision Making
Wednesday 21
6.00pm - 9.00pm
Brisbane

May 2010

Mastering Shared Decision Making
Saturday 15
9.00pm - 12.00pm
Sydney*

Mastering Difficult Patient Interactions
Saturday 15
1.00pm - 4.30pm
Sydney*

Mastering Shared Decision Making
Saturday 22
9.00pm - 12.00pm
Perth

Mastering Adverse Outcomes
Saturday 22
1.00pm - 4.00pm
Perth

Mastering Difficult Patient Interactions
Saturday 26
6.00pm - 9.30pm
Perth

New for August 2010

Mastering Professional Interactions

It is recognised that the quality and the effectiveness of the relationships between doctors can impact on patient care and safety. Two challenging doctor-to-doctor interactions, the handover of patient care or referral of patients and disagreements about patient management, are examined in this workshop. Understanding how these professional interactions can be better managed is key to both reducing risks to your patients and to your professional relationships.

Wednesday 4
6.30 - 8.30 pm
Perth

Wednesday 11
6.30 - 8.30 pm
Sydney*

Wednesday 18
6.30 - 8.30 pm
Melbourne

Wednesday 25
6.30 - 8.30 pm
Brisbane

Registration can be completed online through the Member Online Services section of the MDA National website or by contacting Risk Management at riskmanagement@mdanational.com.au or 1800 011 255.

Full descriptions of the workshop topics can be found in the Risk Management section online.

All workshops attract CME/CPD points and are free of charge to doctors who hold a current Professional Indemnity Insurance Policy. Please check the online calendar regularly as more workshops will be added throughout the year.

Numbers are limited for these sessions so make sure that you register early to ensure your place.

There will be no workshops for June / July.

* We are trialling a new venue for Wednesday night workshops in Sydney. These workshops will be held at the Eastern Suburbs Leagues Club in Bondi Junction, which we hope will be more convenient for our Members. We welcome your feedback about the location and venue.

Freecall: 1800 011 255
Risk Management Fax: 1300 011 240
Email: riskmanagement@mdanational.com.au

www.mdanational.com.au

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.

Please use this form to notify us of any incidents. It is a good rule of thumb that if you are worried about an outcome, you should report it.

To quickly notify us of an incident you can also log-in to our secure Member Online Services at www.mdanational.com.au to complete and submit the form online. If you require assistance logging into the secure section of the website, please contact Member Services on 1800 011 255 during business hours.

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

Notification of Incident Form

MDA National
Support Protect Promote

Member Details

Full name

Membership number

Preferred contact number/email address

Patient Details

Name

Date of birth / /	☐ Male ☐ Female	Marital status	No. of dependents

Employment

Treatment given

Outcome

Patient type ☐ Private ☐ Public ☐ Public with private consultation ☐ Not yet known

Other Practitioners Involved

Name

Address	Postcode

Name

Address	Postcode

Incident Details

Location of incident	State of occurrence
Date of incident / /	Date you became aware of incident / /

Your medical specialty at time of incident

Brief Summary of Incident

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

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

Please Sign and Date Here

Signed **Date / /**

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Please post or fax the completed form and related documents to:
Claims Division, MDA National Insurance
PO Box 1557, Subiaco WA 6904
Fax: 1300 011 235

Policy holders based in all other states
Please post or fax the completed form and related documents to:
Claims Division, MDA National Insurance
Ground Floor, 69 Christie St, St Leonards NSW 2065
Fax: 1300 011 235

Freecall: 1800 011 255 Member Services Fax: 1300 011 244
Email: peaceofmind@mdanational.com.au www.mdanational.com.au

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MDA National
Support Protect Promote

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It is important that you notify us of your updated information to ensure you maintain continuous cover and to make sure that we can continue to contact you with important information about your medical indemnity.

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