

defenceupdate

Quarterly Magazine of the MDA National Group

Winter 2010



 **MDA National**
Support Protect Promote

**Partnering Your
Professionalism**

**Mandatory Notification
of Colleagues:
Notifiable Conduct**

The High Court and Causation
A Return to First Principles

MDA National CaseBook

Risk Management
How We Aim to Protect You

From the President



In a recent copy of *The New York Times*, Dr Pauline Chen wrote of the surprise felt by colleagues when a practitioner of some 15 years announced that he really loved being a doctor¹.

This struck a chord as, while many of us can indeed recall older, usually retired, doctors speaking lovingly of their careers, hearing someone currently in practice speak with such fondness and satisfaction would probably leave most of us surprised, if not bewildered.

Certainly most doctors continue to have a sense of achievement and are reasonably content with their lives, but I have observed that many of our Members are working harder with less financial and personal rewards.

Expenses seem to be rising faster than our fees and an increasing number of patients appear less grateful and more demanding.

Indeed a recent survey showed that major stresses in medical practice included:

- Demands of the job – overload.
- Time pressure – balancing work and family.
- Finding coverage – especially for rural GPs and specialists.
- Patients who are difficult, negative, and unreasonably critical.
- Barriers to doing a good job – waiting times for imaging and specialist appointments, shortages of hospital beds and nurses and the ever-escalating paperwork.
- Lack of control over the direction of healthcare.
- Splits within the profession – specialists competing between themselves and with GPs for financial resources, leading to more rivalry, envy, and less camaraderie.

As well, each speciality reports its own concerns – Consultant Physicians are blamed for escalating drug costs, Surgeons crave more operating time, Anaesthetists must deal with over-worked and stressed Surgeons, while rural GPs cannot get specialist back-up or locums when needed. Time spent getting to know patients and/or to educate them is not valued and many doctors feel that they have become apologists for a poorly designed and under-funded health system – a sad phenomenon now occurring all over the developed world, and not just in Australia.

However, in return for our long and arduous training, the responsibility, the demands and the stressful nature of medical practice, doctors do receive many internal rewards – interesting work and a self-respect that comes from a concern for others and the feeling of making a difference in other people's lives. Showing concern, interest and kindness toward others and "going the second mile" for patients on a daily basis, is what makes our work positive, stimulating and uplifting.

“As the economy resets to ‘normal’, MDA National is committed to sharing the benefits of the recovering investment environment with Members.”

So while our relationships with patients will remain a continuing source of satisfaction for doctors, there is a need in such uncertain times for us to refocus on our professionalism. By having adequately defined values, boundaries, styles of interaction, and appropriate communication of likely outcomes and expectations, patients will continue to place significant value on our role and have trust and faith in our integrity to perform our jobs well and help them. At the heart of professionalism lies, in the inimitable words of Sir William Osler, the importance to “care more for the individual patient than for the special features of the disease”.

Equally, I believe that MDA National cares for its Members beyond what is just required as a provider of medical indemnity services. As an organisation we endeavour to “go the second mile” wherever we can to support, protect and defend you and the profession when medico-legal issues arise.

This commitment includes the management of your premium costs and MDA National is pleased to announce that this year there will be at least a 10% decrease in premium for most Members. This is due to a recovering global economy, our recent claims experience and the Group’s positive financial performance this past year. You will also discover that your indemnity cover is expanded for 2010/11 with product and policy improvements included in your MDA National Insurance Policy.

Members are reminded that if you have any concerns regarding meeting the cost of your premiums, the Federal Government’s Premium Support Scheme (PSS) is available to assist eligible doctors meet the costs of their medical indemnity insurance.

As the economy resets to ‘normal’, MDA National is committed to sharing the benefits of the recovering investment environment with Members. Further improvements in profitability will continue to deliver benefits to you, including through premium rates, extensions to your insurance policy or enhanced education, risk management and medico-legal services.

MDA National will continue to support Members throughout each stage of their career and despite continuing changes to our health system, our founding principles of mutuality and doctor ownership seem to be as relevant now as they were at our humble beginning, some 85 years ago.

A/Prof Julian Rait
MDA National President

References

- 1 Pauline Chen MD, *Fueling the Anger of Doctors*, NY Times 29 April 2010 <http://www.nytimes.com/2010/04/30/health/29chen.html?scp=2&sq=pauline%20chen%20md&st=cse>

Partnering Your Professionalism

YOUR CAREER

YOUR PRACTICE

YOUR SELF

YOUR LEARNING

YOUR COMMITMENT

Introducing Our Support and Education Program for You

MDA National’s newest and most innovative education and support program has been designed to benefit both the professional life and wellbeing of Australian doctors and medical students.

“A career in medicine, while rewarding, can be very challenging. We aim to alleviate these challenges by supporting, protecting and promoting doctors through the provision of the *Partnering Your Professionalism Program*.”
A/Prof Julian Rait, MDA National President.

The *Partnering Your Professionalism Program* explores the areas where your professional life, at all stages, can be impacted by external factors including the medico-legal environment.

How Will Our Program Benefit You?

Our program has been designed to assist you in negotiating the challenges arising from, and interacting with a career in medicine, with a comprehensive range of learning modules that sit under five main themes:

- Your Career
- Your Practice
- Your Self
- Your Learning
- Your Commitment

How Can You Take Advantage Of This Program?

The *Partnering Your Professionalism Program* is available for ongoing release, from July 2010, into hospital and university education programs nationally.

If you are interested in having a session in your hospital, please contact your State Liaison Manager on 1800 011 255 for more information.

Mandatory Notification of Colleagues: Notifiable Conduct

The National Registration and Accreditation Scheme for the Health Professions ("the Scheme") is scheduled to be introduced on 1 July 2010. It is essential that all medical practitioners ensure that their contact details held by their current State or Territory Board are accurate and up to date before 30 June 2010.

As part of the Scheme, all registered health practitioners will be legally required to report any other registered health practitioner who has behaved in a manner that constitutes 'notifiable conduct'. Making a mandatory notification is a serious step to prevent the public from being placed at risk of harm and should only be taken on sufficient grounds.

What is 'Notifiable Conduct'?

'Notifiable conduct' is defined in the *Health Practitioner Regulation National Law Act 2009* (the National Law) and means the practitioner has:

- (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
- (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
- (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
- (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

'Impairment' is defined in the National Law as a person who has 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practice the profession'. It should be noted that the practitioner's impairment must place the public at risk of substantial harm for the threshold for mandatory notification to be met.

Who is Required to Report 'Notifiable Conduct'?

The Scheme imposes a duty to report notifiable conduct on all registered health practitioners and employers. This means that there is a legal obligation to report a registered health practitioner who the notifier, in the course of practising their profession, has formed a 'reasonable belief' that the practitioner has behaved in a way that constitutes notifiable conduct.

The ten health professions covered by the Scheme are:

- Chiropractors.
- Dental care practitioners.
- Medical practitioners.
- Nurses and midwives.
- Optometrists.
- Osteopaths.
- Pharmacists.
- Physiotherapists.
- Podiatrists.
- Psychologists.

It should be noted that the obligation to make a mandatory notification applies to the conduct or impairment of all registered practitioners, and not just those in the same health profession as the practitioner who is making the notification.

Education providers also have an obligation to make a mandatory notification in relation to students, if the provider reasonably believes a student who is enrolled with the provider, or who is undertaking clinical training with the provider, has an impairment that in the course of the student undertaking clinical training, may place the public at substantial risk of harm.

What is 'Reasonable Belief'?

The threshold to be met to trigger the requirement to report notifiable conduct in relation to a practitioner is high, and the practitioner or employer must have first formed a 'reasonable belief' that the behaviour constitutes notifiable conduct. For practitioners reporting notifiable conduct, a reasonable belief must be formed in the course of practising the profession.

A reasonable belief requires a stronger level of knowledge than a mere suspicion. Generally it would involve direct knowledge or observation of the behaviour which gave rise to the notification. Mere speculation, rumours, gossip or innuendo are not enough to form a reasonable belief. However, conclusive proof is not needed. A report should be based on personal knowledge of facts or circumstances that are reasonably trustworthy and that would justify a person of average caution, acting in good faith, to believe that notifiable conduct has occurred or that a notifiable impairment exists.

How Do I Make a Notification?

The National Law provides for notifications to be made to the Australian Health Practitioner Regulation Agency (the National Agency), which receives notifications and refers them to the relevant board. The notification should be made as soon as practicable and include the basis and the reasons for the notification; that is, practitioners, employers and education providers must say what the notification is about. Practitioners should document the reasons for the notification including the date and time that they noticed the conduct or impairment.

Am I Protected if I Make a Notification?

The National Law protects practitioners, employers and education providers who make notifications in good faith (well-intentioned or without malice). Protection is provided from civil, criminal and administrative liability, including defamation, for practitioners making notifications in good faith. Making a notification is not a breach of professional etiquette or ethics, or a departure from accepted standards of professional conduct.

What Happens if I Fail to Make a Notification?

There are no penalties prescribed under the National Law for a practitioner who fails to make a mandatory notification; however, a practitioner who fails to make a mandatory notification when required to do so may be subject to action by their registration board.

There are consequences for an employer who fails to notify the National Agency of notifiable conduct. If the National Agency becomes aware of such a failure, the National Agency must give a written report about the failure to the responsible Minister for the participating jurisdiction in which the notifiable conduct occurred. The Minister must report the employer's failure to notify to a health complaints entity, the employer's licensing authority or another appropriate entity in that participating jurisdiction.

Conclusion

While MDA National did not support the introduction of mandatory reporting, we are committed to ensuring that our Members are aware of the legislation. Members are encouraged to seek advice from MDA National if they are unsure about their obligations in a particular situation, or uncertain about whether to make a notification.

MDA National argued that if mandatory reporting was introduced then exemptions should be provided to medical indemnity insurers, treating doctors, practitioner spouses, and other groups, such as doctors' health advisory services. Ultimately exemptions were provided to medical indemnity insurers and it should be noted that medical practitioners who are employed or engaged by MDA National are exempted from the obligation to make a mandatory notification. There is also an exception where the practitioner required to make the notification reasonably believes that someone else has already made the notification. Other exemptions apply to practitioners exercising functions as a member of a quality assurance committee, council or other body approved or authorised under an Act of a participating jurisdiction.

Further information about the Scheme is available on the Australian Health Practitioner Regulation Agency website at www.ahpra.gov.au

Detailed guidelines on mandatory notification are available on the Medical Board of Australia's website at www.medicalboard.gov.au

Dr Bird represented MDA National in the National Registration Stakeholder Meetings in relation to the proposed legislation.

Dr Sara Bird
Manager, Medico-Legal and Advisory Services



The High Court and Causation



A Return to First Principles

Amaca and Ors v Ellis [2010] HCA 5

Background

The 1990s was a period of “activism” by the High Court which may have contributed to the “liability crisis” and thus to the need for tort reform in the early 2000s.

An example of this “activism” was its dealing with the issue of causation.

The legal principle of causation was that the plaintiff must prove, on the balance of probabilities, that the conduct of the tortfeasor, whether by act or omission, caused the injury for which the plaintiff claims damages.

The High Court by certain judgments sought to modify the principle to deal with cases, such as failure to warn claims, where a risk of a procedure eventuated.

The best example is Chappell v Hart [1998] HCA 55 where by a 3 / 2 majority the High Court found a surgeon liable for a known small risk of a procedure eventuating, notwithstanding that it was agreed that there was no negligence in the technical performance of the procedure and that the plaintiff had to have the surgery at some time, albeit that it was not urgently required. The causal link was established by the High Court as the surgeon had not warned of the small risk and it eventuated. As the surgeon argued, if someone else had performed the procedure later would it not have been likely that the risk would have eventuated in any event?

In effect what the High Court held in Chappell v Hart, and other cases, was that where a breach of duty exists (in that case a failure to warn) and there exists an increase in risk from such breach, then if that risk eventuates causation is established absent some other explanation by the defendant. In effect there exists a reversal of onus of proof to the defendant to explain why the risk that eventuated is not related to the breach.

This modification to the law of causation was not uniformly accepted by State Courts of Appeal however it was by the WA Court of Appeal in cases dealing with the asbestos related diseases of mesothelioma and lung cancer.

It is arising out of one of those judgments that the High Court has recently reconsidered the issue and has, in effect, reversed the trend towards modification and returned to the original legal principle set out above.

The Case

The case involved a claim on behalf of the estate and dependants of a man who died from lung cancer who had been a reasonably heavy smoker, 15-20 per day, from age 17 until diagnosis when aged 43. He also had some exposure to asbestos during the course of various employments.

The case on causation against the asbestos defendants, being employers and a product supplier, was based on inference to be drawn from epidemiological evidence.



“This is a very significant judgment for medical negligence claims as causation is an issue in virtually every such case, whatever the alleged basis of the claim.”

No expert witness assigned a probability of greater than 23% to the chance that the lung cancer was caused by asbestos exposure, with or without smoking. One witness assigned a 1% probability to asbestos being a cause.

The Judgment

The High Court in a unanimous judgment of the court, a fact which is significant itself, found against the plaintiff on the issue of causation.

Underpinning the Judgment is the following sentiment:

“The Court’s response to uncertainty arising from the absence of knowledge must be different from that of a medical practitioner or scientist.”

The plaintiff’s case failed because it established no more than that exposure to asbestos may have been a cause of the deceased’s cancer. It did not establish that it was a probable cause.

It was argued on behalf of the plaintiff that such a result is paradoxical in that if the inference cannot be drawn then in virtually all lung cancers the plaintiff cannot succeed despite the epidemiology which suggests asbestos as a cause.

In Response the High Court Stated:

“Saying only that exposure to asbestos may have been a cause of the cancer is not a sufficient basis for attributing legal responsibility... The paradox, if there be one, arises from the limits of knowledge about what causes cancer.”

Thus the High Court has in an emphatic way returned the law of causation to the principle that a plaintiff must prove by evidence that on the balance of probabilities the conduct of the tortfeasor was a cause of the damage alleged to have been suffered.

The Significance

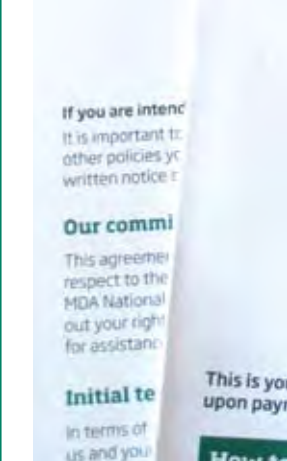
This is a very significant judgment for medical negligence claims as causation is an issue in virtually every such case, whatever the alleged basis of the claim.

It is probable that Chappell v Hart would be decided differently today based on this judgment.

It is binding authority on the State and Territory courts in which medical negligence cases are heard and determined.

Philip Rowell
Consultant, Monahan + Rowell

Your Renewal Made Easier



We have made some exciting and significant changes for your 2010/11 renewal, aimed at making it easier for you to renew your Professional Indemnity Insurance Policy and MDA National Membership.

By now you will have received your 2010/11 renewal documents in the mail and may have already noticed some of the changes made to your renewal this year. The following is a list of those changes and what they mean for you as a Member of MDA National.

The Renewal Notice

The first thing you might notice is that your renewal notice looks different. We have reviewed the look of this document to ensure that all the important information you need to renew, and full details of your indemnity cover, is contained within the same document.

A simple step by step of 'how to renew' is located on the front page, together with the total amount due. A breakdown of the subscription and premium and the policy schedule follow on pages 2 and 3. The important information section and a summary of the significant policy changes appear on page 4.

Most importantly, your renewal notice now becomes your tax invoice/receipt upon receipt of payment. We won't send you a separate receipt unless you specifically request one. You will notice there is space on the payment options slip on page 2 to record your receipt number and method of payment.

Proof of Indemnity

Proof of indemnity is often requested by hospitals and employers and is needed for you to renew your registration.

The great news is that your renewal notice contains your policy schedule and can also be used as proof of indemnity upon payment. This means that you will have immediate confirmation of your indemnity cover without delay.

This year upon receipt of payment, we will also automatically generate and send you a Certificate of Currency by mail. If you choose to renew online, you will be able to print a Certificate of Currency immediately after paying your premium.

If you choose to pay by direct debit, you will have your renewal notice as your policy schedule to use as your proof of indemnity. Additionally, you will receive your Certificate of Currency after we have debited your nominated bank account or credit card.

If you require a Certificate of Currency prior to your account being debited, please contact us.

Paying by Direct Debit?

It's now easier for you to pay your indemnity policy by direct debit.

There are a number of ways you can set up a direct debt arrangement and the quickest way without having to complete any forms is over the phone. You can also set up a direct debit arrangement online by visiting www.mdanational.com.au and clicking on the "Member Online Services". Alternatively, you can complete the direct debit authority form enclosed with your renewal notice and return to our office in the pre paid envelope provided.

The other good news is that if you have previously set up a direct debit arrangement there is no longer a need for you to complete another form.

The direct debit authority is enduring so if you signed an authority last year, you will not be asked to sign another form this year. We will debit your nominated bank account or credit card with the amount specified in your renewal notice on 1 July. If however, you no longer wish to continue with the direct debit arrangements you previously set up, please contact us and let us know immediately.

New Look Membership Card

Our Membership cards have also had a transformation, improving the look and feel and making them more prominent.

Upon renewing your policy with us, you will now receive a one off plastic Membership card, making it more durable and longer lasting, similar to a credit card. You can expect your new card between 3-4 weeks of renewing your policy.

This means you will no longer receive the peel off Membership card that was previously provided with your tax invoice/receipt at each renewal. Upon receipt of your new Membership card you may dispose of your previous peel off card.

During the time it takes for you to receive your new card you will continue enjoying the benefits and services provided under your MDA National Membership.

Risk Category Changes

It's always in your best interest to check the Risk Category Guide to make sure you are in the appropriate risk category. The Risk Category Guide is updated most years, usually with changes to only a small number of specialities or categories but even small changes can result in a change to your premium.

This year, a new higher billings band has been introduced for those whose billings are between \$900,000 and \$1,400,000. The highest billings band is "above \$1,400,000".

Additionally, we have simplified the Cardiology categories and have made some minor changes to the GP Non Procedural category. Please take a moment to check the



Risk Category Guide to make sure you are in the most appropriate category for the 2010/11 policy period. A Risk Category Guide was sent as part of your Pre Renewal Questionnaire or you can access a copy online at the 'Download Centre'.

Changes to the Policy

There have also been a number of amendments and enhancements made to the Professional Indemnity Insurance Policy ('the Policy') for 2010/11 to further broaden the cover. The following information is a summary of some of the changes to the Policy effective from 1 July 2010.

The Policy will cover:

- Civil liability claims instead of only professional negligence claims. This includes coverage of certain claims arising from alleged breaches of trade practices legislation.
- \$150,000 in the aggregate for defence costs arising out of alleged breaches of the *Trade Practices Act 1974 (Cth)* (or any equivalent State or Territory fair trading legislation); legal costs arising out of certain employment disputes; and legal costs incurred in seeking an Apprehended Violence Order (AVO).
- \$500,000 in the aggregate for defence costs and costs orders arising out of investigations and inquiries, and allegations of sexual misconduct and criminal matters.

In addition, the definition of health care services will include the supervision of medical practitioners who require supervision, training or direction as a condition of their registration.

The policy wording has also been altered to make it clear that if a Member is found guilty of a criminal offence, assistance will cease and we may seek to secure or recover costs previously incurred. Proceedings in criminal courts are now included in the definition of 'inquiries'.

Clarification has been provided in the Appeals section of the Policy that if a Member proceeds with an appeal without our consent and the appeal is successful we will indemnify them for the reasonable legal costs of their appeal.

For the precise terms of cover, please refer to the 2010/11 Product Disclosure Statement and Policy wording booklet.

We believe these changes demonstrate our commitment to continually improving our business to meet the needs of our Members.

If you would like more information or have any questions about renewal, please contact us on 1800 011 255.

Tonya Timpano
Manager, Member Services

Competition Awareness

MDA National has recently observed an interest by the Australian Competition and Consumer Commission (ACCC) in the medical profession. A number of Members have contacted us over the last 12 months seeking assistance with ACCC investigations.

In response to this, from 1 July 2010, MDA National's Policy will include cover for claims arising from the breaches of the Trade Practices Act subject to the terms and conditions of the Policy. The cover has also been expanded to provide assistance and where necessary a legal defence (up to a specified sub limit) where the ACCC or another body investigates a possible breach of the Trade Practices Act (1974) and state fair trading legislation.

It is timely to reflect on situations which can arise that involve much stress and possibly also penalties for medical practitioners who run afoul of the competition laws. In particular, Members should be aware that the law often considers doctors who practise as Associates or Partners to be competitors under the law and communications and actions must be carefully framed to avoid anticompetitive behaviour. This seems to have been particularly relevant in recent investigations into rostering allocations of contractors and contract negotiations for the provision of services to hospitals by private practitioners.

In March 2010 the ACCC reported the results of its investigation into the conduct of a group of general practitioner associates in relation to their provision of on call services to a local hospital. In essence the ACCC found that the doctors each made a threat to boycott the after hours service if their identical demands were not met. Although it may be lawful in some defined circumstances for Associates to collectively bargain, collective boycotts can be a "serious breach of competition law" (<http://www.accc.gov.au/content/index.phtml/itemId/917301>).

In this case the ACCC were satisfied with undertakings from the doctors stating that they would not in fact collectively boycott the hospital. However it is likely that legal expense, time involved in responding and the stress would have been significant for the practitioners.

Members in private practice who intend to collectively bargain along with other doctors are advised to seek advice and be satisfied that they are authorised by the ACCC to do so.

The ACCC has stated very clearly that it will investigate any appearance of anticompetitive behaviour including through unauthorised collective bargaining or boycotts by medical practitioners. If Members may be at risk of entering this minefield it would be prudent to seek advice.

Dr Andrew Miller
MBBS LLB(Hons) FANZCA FACLM
and MDA National Councillor



Transfusion Confusion

From time to time a competent patient will express a clear and documented wish to receive no transfusion of blood products, even as a last resort life saving measure. MDA National was asked to comment on just such a hypothetical scenario involving elective surgery where the Surgeon consequently informs the Anaesthetist that, irrespective of the patient's direction, if the Surgeon requires the Anaesthetist to transfuse the patient and the Anaesthetist refuses then the Surgeon or their subordinate will transfuse the patient.

The query related to whether:

- the Surgeon is considered to be in charge of the clinical care in this situation (i.e. a so called "Captain of the Ship" doctrine) and therefore entitled to give such instructions expecting them to be followed; and
- what steps are available to the Anaesthetist to ensure the patient's instructions are complied with.

The so called "Captain of the Ship"¹ doctrine has not at any time been incorporated into Australian (case) law. The history of the doctrine in the US seems to be centered in Pennsylvania however interestingly, as one might expect in this age of the multi-disciplinary team, it seems that even there the USA Courts are increasingly moving away from the doctrine².

In Australia, a medical practitioner who treats a patient without their consent (and in particular contrary to their express instructions) will likely commit a trespass of the person, namely the tort of "battery"³, and possibly common law "assault", being the apprehension of contact rather than the contact itself. In addition to common law assault and battery, the conduct may also constitute a criminal offence.

It would be of no assistance (and perhaps embarrassing), for an Anaesthetist to assert that they were simply acting on the Surgeon's or, indeed, anyone else's instructions.

Assuming that they played no part in facilitating a transfusion, the Anaesthetist would not be held responsible for a tort which was committed by the Surgeon (or the Surgical Registrar). That said, the Anaesthetist is likely to be under a duty to take reasonable steps to ensure that the patient's wishes are respected.

Options open to the Anaesthetist include:

- Refusing to anaesthetise the patient until the issue had been resolved.
- Perhaps if the circumstances allow prior to the commencement of the case, seeking a clear written direction from the relevant Head of Department, Hospital Director or Administrator to the Surgeon compelling them to comply with the patient's instructions.
- Ultimately if the issue is not able to be resolved, the patient would need to be informed, and an alternate Surgeon sought.

If the events were to occur currently, and the Surgeon acted against the patient's wishes and administered a transfusion, there would likely be at least an ethical obligation for the Anaesthetist to report the matter to the state Medical Board (mandatory reporting not being currently legislated in all states).

After 1 July 2010, and the introduction of the National Registration legislation, there would likely be a more formal legal obligation on the part of the Anaesthetist to report the matter to the Medical Board. However while the Surgeon's actions would likely represent "a significant departure from accepted professional standards", the question will arise as to whether the patient has suffered "harm", particularly where the transfusion has saved the patient's life⁴. In the event that the matter is deemed notifiable conduct, and the Anaesthetist fails to report the matter, then they themselves may also become the subject of disciplinary action.

If the Surgeon was the subject of a criminal conviction as a result of their conduct then they would be required to report this to the Medical Board, which in turn would likely result in disciplinary action.

There would probably also be disciplinary consequences from an employing Health Service for all parties, that is the party administering the transfusion and anyone who did not act within reason to prevent it or report it.

These situations are at times intensely challenging for medical practitioners, especially where the transfusion may be the only life saving measure available. However Australian law is very clear that the competent patient has every right to refuse treatment in these circumstances and to have this wish respected by their doctors.

Dr Andrew Miller
MBBS LLB(Hons) FANZCA FACLM
and MDA National Councillor

Chad Edwards-Smith
Risk Manager

References

- 1 *Rockwell v Kaplan*, 404 pg. 574, 173 A.2d 54 (1961) and *Rockwell v Stone*, 404 pg. 561, 173 A.2d 48 (1961)
- 2 *Lewis v Physicians Insurance Company of Wisconsin*, 627 N.W. 2d 484 (WIS., 2001)
- 3 *Campbell v Samuels* (1980) 23 SASR 389 at 393 (Zelling J)
- 4 5140(d) of the *Health Practitioner Regulation National Law Act 2009*

CORRECTION: The following article is a corrected version of the original article that appeared in *Defence Update Winter 2010*. This version now takes into account recently published data which was omitted from the original article in error. *Defence Update* apologises for the error.

Bisphosphonates

Bisphosphonates are a commonly prescribed drug in Australia. There have been more than 10 million prescriptions in Australia for Fosamax and generic versions of the drug since it was approved in 1995¹ However we are aware that osteonecrosis of the jaw (ONJ) has been increasingly suspected to be a potential complication of bisphosphonate therapy.

In 2003, the first reports describing ONJ in patients receiving bisphosphonates were published with about 95% of these cases linked to cancer patients receiving high-dose intravenous bisphosphonates.²

The same year, five patients presented to the Oral and Maxillofacial Surgery Unit at Royal Adelaide Hospital, South Australia, with painful exposed bone in the maxilla, or both the maxilla and mandible.³

In 2005, the Food & Drug Administration (FDA) ordered that the label for Fosamax and other bisphosphonates be updated to include warnings about ONJ.

Philip Sambrook, Ian Olver, Alastair Goss on behalf of the Australian and New Zealand Bone and Mineral Society, Osteoporosis Australia, Medical Oncology Group of Australia, and the Australian Dental Association in October 2006 advised that even though the data was lacking it would be prudent to recommend assessment of dental health before or soon after commencing treatment with bisphosphonates as long as this would not compromise the initiation of therapy for the patient.⁴

ADRAC Bulletins in February 2005 and August 2006⁵ drew attention to the association of bisphosphonates and ONJ. In December 2007 the TGA alerted prescribing doctors, dentists, pharmacists and consumers to the uncommon but important association of the use of bisphosphonate drugs with ONJ.

Patients became alarmed when Reporter Nick Grimm on *The 7.30pm Report* in 2007 said *"Thousands of Australians have been prescribed drugs called bisphosphonates to treat conditions such as osteoporosis. But in hundreds of cases, the drugs have been linked to a ghastly side effect where the jawbone actually rots away"*.

What is the responsibility of the medical practitioner? What information do we need to impart to a patient?

The American Society for Bone Mineral Research Task Force recommended we should encourage patients to inform their dentist that they are taking a bisphosphonate, practice good dental hygiene and have regular dental visits. Because the risk of developing bisphosphonate associated ONJ seems to be related to longer duration of bisphosphonate exposure and the risk is low it is not necessary to recommend a dental examination before beginning oral bisphosphonate therapy. The authors indicated in their opinion the risk of ONJ was uncommon with routine oral therapy for osteoporosis at 1 in 1,000 to 1 in 100,000.⁵

However the American FDA established and funded an independent study which has just been published. Lo et al found the risk on ONJ on oral Bisphosphonates was 1 in 500 to 1 in 1,500⁷ which is very similar to a retrospective investigation of all Australian states which showed the risk of ONJ following an extraction as 1 in 1,1000.⁸

If a patient has been taking oral bisphosphonates for over three years then appropriate informed consent is recommended and documented if a patient is to have dental implants.⁶

Cases of bisphosphonate-associated implant failure were identified when 16,000 patients were reviewed in South Australia.⁹

The American Association of Oral and Maxillofacial Surgeons released a Position Paper on Bisphosphonate-Related Osteonecrosis of the Jaws in 2009 recommending dividing patients into those who have taken bisphosphonates for less than three years and have no clinical risk factors and those who have taken bisphosphonates for less than three years and have also taken corticosteroids or who have taken an oral bisphosphonate for more than three years with or without steroid medication. The latter should be advised to consider discontinuation of the oral bisphosphonate for three months before surgery and not restarted until osseous healing has occurred.¹⁰

The CTX test is available in Australia and can identify if a patient is in the risk zone for ONJ (a value of less than 150 pg/mL to 200 pg/mL). It is recommended to monitor bone turnover in osteoporotic patients and can give an indication of effect within six weeks. If medically appropriate, the bisphosphonate can be ceased so that the CTX value increases to bring the patient out of the "risk zone."¹¹

The informed and judicious use of bisphosphonates confers a clear clinical benefit in most carefully selected patients that outweighs potential risks associated with bisphosphonate use.¹²

The first of hundreds of Fosamax jaw damage lawsuits went on trial in August 2009 in a Manhattan federal courtroom. In Australia Slater and Gordon are currently looking for patients who may have had an adverse event from bisphosphonates.¹³

Dr Beres Wenck
MBBS (Qld) FAMA
MDA National Vice President

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MDA National CaseBook

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

Good Samaritans

Abstract

Over the years, medical practitioners have expressed concern about the possibility of being sued as a result of good Samaritan acts. This is despite the fact that there is no decided Australian case in which a good Samaritan has been sued by a person claiming that the actions of the good Samaritan were negligent¹. This article discusses the nature of good Samaritan acts and examines the good Samaritan legislation that has been enacted in Australia.

Case History

One hour into a 13 hour international flight, a 39 year old passenger developed left sided chest pain². A call was made by the cabin staff: 'If there is a doctor on board would they please make themselves known to the cabin staff'. An Orthopaedic Surgeon, Professor Wallace, responded to the call. Examination of the passenger confirmed tenderness of the lower left ribs with a probable fracture. The passenger gave a history of having fallen off a motorcycle on her way to the airport. Further examination revealed that the patient was in respiratory distress with mild tachypnoea. Chest examination could not be carried out effectively because of engine noise but the passenger's trachea was significantly deviated to the right. A diagnosis of a tension pneumothorax was made and an oxygen mask was immediately applied. Professor Wallace went to the flight deck and asked if medical advice could be obtained from the ground. It was not possible to receive immediate advice and Professor Wallace decided to proceed with the insertion of a chest drain.

The aircraft's medical kit contained a scalpel, sharp pointed scissors, and a 14 gauge urinary catheter. There was lignocaine for use as a local anaesthetic. The following equipment was prepared: heated hand towels for sterile drapes, a modified coat hanger as a trocar for the urinary catheter, a bottle of mineral water with two holes created in its cap for use as an underwater seal drain, and a length of oxygen tubing to attach the

catheter to the drain. Cellotape was used to anchor the catheter to the oxygen tubing and brandy was used as a disinfectant for the introducer. Professor Wallace advised the passenger that she had a serious condition and an operation was required. He then proceeded to insert the chest drain into the left second intercostal space in the mid-clavicular line under local anaesthetic. As soon as the drain was connected, air was released from the pleural cavity and within five minutes the passenger had almost fully recovered.

On arrival at the airport, the passenger was transferred to hospital. A chest x-ray revealed a 30% residual left sided pneumothorax. A full blood count and arterial blood gases were normal. The patient was given parenteral analgesia, intravenous antibiotics and tetanus prophylaxis. The urinary catheter was removed and a 28Fr chest drain was placed under local anaesthetic. A repeat chest x-ray showed complete lung expansion, and the passenger's subsequent recovery in hospital was uneventful.

Medico-Legal Issues

An in-flight medical incident will occur in about 1 per 11,000 passengers but 70% of these incidents are managed by cabin staff without a call for medical assistance³. If a call for medical assistance is made, the possibility of being sued may be of concern to the medical practitioner in this situation. The legal liability of a medical practitioner who responds to an on board medical emergency is confusing because the law varies from country to country and the determination of the jurisdiction of any action arising out of an in-flight emergency is complex. In any event, several major airlines have taken out insurance policies indemnifying doctors who come forward on request to assist in an emergency. The *US Aviation Medical Assistance Act 1998* also provides protection for airlines and doctors in good Samaritan situations. Additionally, medical practitioners should check with their medical indemnity insurer, as their insurer may provide worldwide cover for good Samaritan acts.



Discussion and Risk Management Strategies

A good Samaritan is generally defined as a person (including a medical practitioner) who in good faith and without expectation of payment or reward comes to the aid of an injured person, or person at risk of injury, with assistance or advice. There is an ethical and professional obligation on medical practitioners to act as good Samaritans. In NSW and the ACT there is also a legislative duty on medical practitioners to provide assistance on request. Outside of these circumstances, there is no legal duty to provide assistance on request, except in the NT where unique legislation requires any person to provide assistance to another irrespective of their training⁴.

With the exception of Tasmania, legislation exists in all Australian states and territories concerning the liability of good Samaritans (see Table 1). The purpose of this legislation is to encourage people, particularly health care professionals, to assist strangers in need without the fear of legal repercussions from an error in treatment.

Dr Sara Bird Manager, Medico-Legal and Advisory Services

References

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Table 1

	LEGISLATION	PROTECTION	EXCLUSION
ACT	<i>Civil Law (Wrongs) Act, 2002</i>	Honestly and without recklessness	Liability falls within ambit of a scheme of compulsory third party motor vehicle insurance Capacity to exercise appropriate care and skill was significantly impaired by alcohol or another recreational drug
NSW	<i>Civil Liability Act, 2002</i>	In good faith	If the Good Samaritan's intentional or negligent act or omission caused the injury or risk of injury Ability to exercise reasonable care and skill was significantly impaired by being under the influence of alcohol or a drug voluntarily consumed Failed to exercise reasonable care and skill.
NT	<i>Personal Injuries (Liabilities and Damages) Act, 2003</i>	In good faith and without recklessness	Intoxicated while giving the assistance or advice
QLD	<i>Law Reform Act, 1995</i>	In good faith and without gross negligence	
SA	<i>Civil Liability Act, 1936</i>	In good faith and without recklessness	Liability falls within ambit of a scheme of compulsory third party motor vehicle insurance Capacity to exercise due care and skill was significantly impaired by alcohol or another recreational drug
TAS	No legislation	N/A	N/A
VIC	<i>Wrongs Act, 1958</i>	In good faith even if emergency or accident was caused by an act or omission of the Good Samaritan	
WA	<i>Civil Liability Act, 2002</i>	In good faith and without recklessness	Ability to exercise reasonable care and skill was significantly impaired by being intoxicated by alcohol or a drug or other substance and intoxication was self induced

MDA National CaseBook

Checking Results

Mr Brown was a 61 year old man who consulted Dr Young with the problem of a lump in the anal area. Mr Brown had a past history of hypertension but was otherwise well.

Dr Young examined Mr Brown and found he had a largish skin tag at the 7 o'clock position, which Dr Young thought was probably an infected thrombosed external haemorrhoid. As Mr Brown was unhappy about the feel of this lump, Dr Young agreed to remove it and made arrangements to admit Mr Brown to the local hospital on 11 January 2007. Dr Young removed the lump and sent it to pathology in accordance with his usual practice.

Dr Young reviewed Mr Brown a couple of days after the surgery to check the wound, and he found that the wound looked clean and there was no bleeding.

The pathology results were received at the practice a few days later and showed: polypoid ulcerated, well and moderately differentiated squamous cell carcinoma, which extends to the margin of excision.

Dr Young reviewed this result when it was received. However, when he next saw Mr Brown about a week later, he did not discuss the results.

Two weeks later Mr Brown returned as his wound had not healed, and Dr Young found that the wound had become infected. He offered to refer Mr Brown to a Surgeon for further treatment, but Mr Brown was concerned about the cost and so Dr Young agreed to continue to treat the wound. Over the next 3 months, Dr Young saw Mr Brown regularly every couple of weeks, and he dressed the wound, and prescribed several courses of antibiotics and the wound became a little smaller, but did not heal.

Mr Brown then decided to consult another GP, and in May of 2007 he saw Dr Ferrie. Mr Brown told Dr Ferrie that he had an anal lesion, which had been removed, and the histology was benign. Dr Ferrie found that Mr Brown had a large 3.5cm ulcerated area. Dr Ferrie suspected Crohn's disease and so referred him to a Gastroenterologist who performed a colonoscopy, which was reported as being normal in June 2007.

Dr Ferrie then referred him to a Surgeon for another opinion about the non-healing lesion and Mr Brown was seen by the Surgeon about 6 weeks later in July 2007. By this time the ulcer was about 5cm in diameter. The Surgeon took a biopsy, which showed moderately differentiated squamous cell carcinoma of the anus. Investigations showed no evidence of metastases. Mr Brown underwent chemoradiotherapy and the ulcer healed.

Medico-Legal Aspects

Sometime later Mr Brown commenced proceedings against Dr Young alleging that as a result of the delay in diagnosis he now suffered from faecal incontinence, and that he had a less favourable prognosis. The statement of claim was that Dr Young had failed to inform Mr Brown of the pathology report, failed to promptly consider the pathology report, or appreciate its significance and failed to refer Mr Brown to a Surgeon for treatment.

When Dr Young's notes were examined it was found that some of the entries in the early part of 2007 contained references to the pathology results. Questions were raised about the authenticity of these entries, and Dr Young admitted that he had added the references to the pathology to his old notes, and in fact he did not think he had ever discussed the pathology results with Mr Brown.

Standard of care was found to be inadequate. In the light of the retrospective amendments to the notes and the delay in communicating the results to the patient, the matter was deemed indefensible. It was decided that it would not be beneficial to take the matter to trial and the matter was settled for an undisclosed sum.

Managing Results

Managing investigation results is an important part of medical practice and practices need robust systems in place to ensure that investigation results are received, checked, communicated to patients and appropriately acted upon. A break down in any one of these steps can lead to an adverse outcome for the patient.

The RACGP Standards for General Practice¹ states that: all received test results, and clinical correspondence e.g. reports from other health care providers or WorkCover letters relating to a patient's clinical care are reviewed clinically significant tests and results are followed up.

In the recent TAPS study, it was found that errors in the process of providing health care were reported by general practitioners more than twice as often as deficiencies in a clinician's knowledge or skills. Approximately 20% of these process error events concerned investigations and the most potential for harm is related to the management of investigation reports².

Unfortunately, failing to inform patients of abnormal results is not a rare occurrence.

A recent study from the US³ examined the frequency of failure to inform patients of clinically significant test

“Managing investigation results is an important part of medical practice and practices need robust systems in place...”

results. The authors conducted a large retrospective study of 5434 randomly selected patients in 34 primary care practices. The rate of apparent failures to inform or to document informing the patient of an abnormal result was 7.1% with a range of 0% to 26.2%. Use of 'partial electronic medical record' (paper based progress notes and electronic test results or vice versa) was associated with higher failure rates compared with purely paper based notes or computer records.

Doctors must be constantly vigilant to ensure that results are followed up and communicated to their patients.

In this instance Dr Young was unable to fully explain his failure to act on the abnormal result. He did recall that at around the time the results were received, he was under considerable stress as his wife had just left him and he had some financial worries. In retrospect he considered that he was probably working longer hours than he should have.

Altering the Clinical Record

Dr Young was also advised that it is not acceptable to alter the notes retrospectively. An attempt to amend a contemporary clinical note, even with the best intentions, is liable to misinterpretation and criticism unless the date of amendment and the reason for it are both explicit. Clinical notes should never be altered, even if this is to correct an obvious error, but a correction can be added, with the date of the correction, and any relevant explanation.

Dr Jane Deacon Medico-Legal Adviser

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Risk Management

- How We Aim To Protect You

While the 'public face' of MDA National's Risk Management Program is plain to see - i.e workshops, resources, on-line learning etc, the 'meatier' side of our program is a bit of a mystery to most of our Members - unless of course you have used our services.

The Risk Management Program aims to act in the best interest of the membership, i.e. at an individual Member level and collectively. We recognise that we need to educate the general membership about some of the medico-legal risks they may face in their professional life and how to mitigate these risks. We also play a critical role in the early identification of Members who may be at an individual risk and in the delivery of support services to these Members.

There are two main categories of individual Member risk with which Risk Management is concerned - that which is addressed through early intervention, and that where a Member's risk falls outside a peer comparison - i.e. management of abnormal risk.

Early Intervention

Over the past few years in particular, MDA National has placed increasing emphasis on early risk management intervention. The aim is to assist a Member to address practice risk that may have been identified by:

- the Member and raised with Risk Management directly;
- one of our Claims and Advisory Managers; or
- Underwriting when assessing a Membership application.

The 'early intervention' that follows is designed to better understand the risk that is faced by the Member, work with the Member (and staff where applicable) to develop strategies to mitigate the risk/s and provide ongoing support to the Member as needed.

It makes sense to recognise problems early and address them to prevent further occurrences and ultimately protect the Member (and in some instances their patients) from further incidents. In some cases the incident that triggers early intervention may have resulted in no harm to any patient, but the issue is one which could potentially cause harm to either patients or to the Member in the future (e.g. lack of tracking system, breakdown in continuity of care, communication problem etc).

Increasingly, this early intervention takes the form of assisting members in satisfying medical registration boards requirements following a patient complaint. This assistance could include advice about record keeping, patient consultation skills, consent processes, or managing patient dissatisfaction.

With respect to risks identified by Claims and Advisory Services, referrals to Risk Management for support are always made with the Member's knowledge. The focus is not on past claims/performance, but on how the Member can voluntarily engage with Risk Management to address identified risk in a practical and effective manner. It also provides the opportunity to reinforce what a Member and his/her staff are already achieving in practice or have already implemented as a result of an incident or near miss. In addition, Risk Managers often pick up very useful tips from Members and/or their practice staff that can benefit other Members.

The support provided to the Member may be a 'one off' or a more prolonged process of follow up, depending on the level of assistance the Member believes that he/she requires. Importantly for MDA National, the Member becomes aware that there is someone available on an ongoing basis for any future risk management queries, outside of a claims or complaints environment.

MDA National does not prescribe standards of clinical practice, and any risk management recommendations are made acknowledging there often needs to be a balance between what is ideal risk management, and what can be practically achieved with regard to time, costs, demographic or geographic realities.

From time to time, Underwriting may ask for risk management assistance in better understanding the risk posed by a new member application or an existing Member's request for a change of category. The advice we provide is based on research we conduct into the particular procedure/modality or the result of communication we have directly with the applicant/Member. The goal is for Underwriting to better understand the risk that both the individual Member and the organisation as a whole is 'taking on' and implementing necessary steps to mitigate any potential risk.

Member uptake of early intervention risk management services is steadily increasing, which we hope reflects both improved identification processes and a more positive Member's impression of risk management participation.

It is 'never too late' to avail yourself of the support we can provide you. The service is free to all our Members - we tailor our advice to suit your circumstances and confidentiality is of-course assured. To purchase this type of service privately would cost your practice many thousands of dollars. At MDA National - it is provided free to our Members as part of our commitment to supporting you in practice and protecting your interests.

Risk Management Resources to Suit Your Speciality, Your Practice and Your Experience!

Managing Abnormal Risk

In some instances, a Member's risk profile may be such that it continues to lie outside that of the Member's peer group, despite the Member having perhaps already participated in risk management activities via early intervention. This may or may not be reflective of the Member's individual skill or expertise, and may simply reflect the presence of protracted risks that are difficult to address.

In protecting the best interests of the Membership, Members who represent abnormal risk may require additional measures as a condition of ongoing medical indemnity cover. These measures may mean ongoing involvement in suitable risk management activities, non-standard policy conditions such as claims excesses or premium loading, or in very rare cases, restrictions on indemnity.

Risk Management works closely with Underwriting to identify, address and review abnormal risk in a fair, consistent and appropriate manner. This will usually occur in circumstances where a Member has already worked with Risk Management in an attempt to mitigate identified risk(s).

Getting the Right Balance

Does it work? We believe it does. Providing Members with the opportunity to discuss their concerns in a supportive and educative environment with one of our experienced Risk Managers is reported by our Members as a very useful and worthwhile exercise. The information and strategies we impart assist the Member in better understanding their risk and taking steps to mitigate these risks. While some Members may be apprehensive at first, by the end of most visits Members express a sense of relief that there are some things that can be done to change their situation and that someone has taken an interest in their circumstances.

If you would like to find out more about how we can best support you in your practice please feel free to contact the Risk Management Team.

To learn more about MDA National's Risk Management Program, please visit our website or email riskmanagement@mdanational.com.au

Heather Martin
Manager, Risk Management Services

MDA National's risk management resources are designed to promote your practice of medicine. This year, MDA National has been committed to Australian Doctors for 85 years and to demonstrate our ongoing commitment, we have introduced even more resources for our Members.

Many Members have already used our online Practice Self-Assessment Tool. Its aim is to help you identify and manage medico-legal risks in your practice.

To complement this resource, we have developed hard-copy paper versions of the online tool in the form of the Practice Self-Assessment Handbook and Practice Self-Assessment Checklist.

Practice Self-Assessment Checklist

The Practice Self-Assessment Checklist is a simple list of key issues you should consider when undertaking a risk assessment in your practice. The Checklists will be available to download from our website or take away with you from MDA National events or workshops.

Practice Self-Assessment Handbook

The Practice Self-Assessment Handbook introduces key topics that are known sources of medico-legal risk. Strategies for managing these risks are provided for each topic. A tear out Action Plan that you or your staff could complete is included in the Handbook. This resource will assist you in identifying opportunities for change that are relevant to your practice.

The Handbook and Checklist are available in four specialty versions:

Medical Practice

Surgical Practice

Anaesthetic Practice

Obstetric and Gynaecological Practice

These resources are the first to be released in our series, with more specialty-specific versions of the Handbook and Checklist available soon.

Visit our website www.mdanational.com.au for full details.

If you have any questions or you would like more information about risk management resources, please email your Risk Management team at riskmanagement@mdanational.com.au or call 1800 011 255.

MDA National Risk Management Workshops

Cognitive Institute Workshops Calendar

August 2010

Mastering Professional Interactions

Wednesday 4
6.30pm - 8.30pm
Perth

Mastering Professional Interactions

Wednesday 11
6.30pm - 8.30pm
Sydney

Mastering Professional Interactions

Wednesday 18
6.30pm - 8.30pm
Melbourne

Mastering Professional Interactions

Wednesday 25
6.30pm - 8.30pm
Brisbane

New for October 2010

Mastering Work/Life Balance

Juggling the need to attend to family, find appropriate time for leisure and keep enthusiasm for work high can be a challenge when demand for services is climbing, on-call rosters can place onerous burden on lifestyle, and shortages of medical workforce place enormous pressures to maintain services for patients in need. This workshop identifies the challenges and barriers that clinicians face in getting this balance right, and examines strategies to overcome those barriers.

October 2010

Mastering Work/Life Balance

Wednesday 6
6.00pm - 9.00pm
Brisbane

Mastering Work/Life Balance

Wednesday 13
6.00pm - 9.00pm
Melbourne

Mastering Work/Life Balance

Saturday 23
9.00pm - 12.00pm
Sydney

Mastering Difficult Patient Interactions

Saturday 23
1.00pm - 4.30pm
Sydney

Mastering Work/Life Balance

Saturday 30
9.00pm - 12.00pm
Perth

Mastering Difficult Patient Interactions

Saturday 30
1.00pm - 4.30pm
Perth

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.

Freecall: 1800 011 255

Risk Management Fax: 1300 011 240

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details changed?

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