

defenceupdate

Quarterly Magazine of the MDA National Group

Spring 2010



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From the President



Guilty Until Proven Innocent

The presumption of innocence is a fundamental human right. It is embodied under Article 14(2) of the International Covenant on Civil and Political Rights and serves as a formal caution to those parties concerned with the investigation and determination of guilt, whereby the prosecution is required to prove guilt rather than the defence having to prove innocence¹. It reflects the adversarial nature of our legal system and ensures that a fair balance is maintained between the State and those who are accused of an offence.

However, there is empirical research from the United Kingdom that shows that offences that deviate from the presumption of innocence are not exceptional². And it appears that it is neither the preserve of trivial summary offences nor serious crimes involving drugs or terrorism. In fact, the study concluded (on page 314) that: "Viscount Sankey's speech in Woolmington holds the key: what he said, in effect, is that courts should invariably place the burden of proof on the prosecution, but that parliament may do what it pleases".

While no comparable study of the presumption of innocence has been conducted of Australian Law, MDA National has some ongoing concerns regarding clauses in the new *Health Practitioner Regulation National Law Act*. We believe that these place an unreasonable burden on doctors, and their indemnity organisations, to prove innocence.

Indeed, the Act provides that a medical practitioner (including an employer) should report another practitioner when the first has formed a reasonable belief in the course of her or his profession that a second practitioner (including an employee) has behaved in a way that placed the public at risk of harm through a significant departure from accepted professional standards.

Unfortunately MDA National is concerned that a "significant departure from accepted professional standards" is a subjective measure and could be used to suspend and/or impose conditions upon practitioners where they are guilty of nothing more than unsatisfactory performance.

Furthermore, a subjective test intrinsic to the notion of a "reasonable belief", implies that the threshold for triggering a notification could be quite low. It follows that the mandatory notification process is potentially open to abuse by claims made in bad faith with the intention of adversely affecting the registration status and the subsequent employability of another health practitioner.

Therefore where the Medical Board chooses to take immediate action and suspend or impose conditions upon a doctor's registration, the doctor will be required to "show cause" why such conditions should not be imposed upon them pursuant to section 157 of the Act. This means that the burden of proof shifts to the practitioner and his or her legal representatives to establish the doctor's innocence of any reported claims before the Board acts.

Unfortunately, the introduction of mandatory notification was a political response to the public reaction to extreme incidents involving professional misconduct by health practitioners and very serious adverse incidents in our health care system. However, this process has the potential to have a very negative effect on the medical profession and particularly the retention/attraction of overseas trained practitioners.

It also implies that doctors are guilty until they are proven innocent.

A/Prof Julian Rait
MDA National President

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- 1 Bronitt S, McSherry B. *Principles of Criminal Law 2nd edition* (2005) p113
- 2 Blake A & M. *Presumption of innocence in criminal law* (1996) Crim Law 306, pp310-313.

Notice Board

Correction

The following excerpt was omitted in error from the *Bisphosphonates* article that appeared in *Defence Update Winter 2010*. *Defence Update* apologises for the error.

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 100,000.⁶

However the American FDA established and funded an independent study which has just been published. Lo et al found the risk of 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

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

If you would like to read the corrected article in full, visit <http://www.mdanational.com.au/media/91709/bisphosphonates.pdf>

References

- 6 Khosla S, Burr D, Cauley J, et al. *Bisphosphonate-associated osteonecrosis of the jaw: report of a task force of the American Society for Bone and Mineral Research [editorial]*. *J Bone Miner Res*. 2007;22(10):1479-1491
- 7 L et al. *Prevalence of Onj After Oral Bisphosphonate Exposure*. *J Oral Maxillofac Surg* 2010 243-253
- 8 Communication with Professor Goss Head of Oral & Maxillofacial Surgery University of Adelaide May 2010
- 11 The CTX test and Bisphosphonate-Associated ONJ Professor Alastair Goss ADA August 2008

National Registration and Accreditation Scheme for the Health Professions

Update for WA Members

Western Australia (WA) has recently passed the National Law and is expected to join the National Registration and Accreditation Scheme (the Scheme) in mid October 2010.

While WA joins the Scheme with all other Australian States and Territories, there have been some amendments to the National Law for WA health professionals.

Of particular note is the introduction of an exemption for health practitioners from the mandatory reporting requirements when treating or providing health services to other health practitioners.

Registration Renewal

The Board is now sending registration renewal notices to doctors in Victoria, Tasmania and South Australia. Registration renewal for most doctors in NSW is linked to the practitioner's birthdate and renewal notices will be sent to NSW doctors whose registration expired between July and September. Other renewal notices for NSW doctors will be sent out progressively as they are due. Most Queensland doctors renewed their registration with the Medical Board of Queensland by 30 June 2010 and are now registered until 30 June 2011. Medical practitioners registered in WA will renew their registration this year with the Medical Board of Western Australia and are expected to transition to the Scheme later in 2010.

For more information about the amendments to the National Law or renewal under the Scheme, visit www.medicalboard.gov.au

Farewell for Expert Legal Advisor

After serving as MDA National's Legal Advisor for 33 years, Mr Dominic Bourke of Clayton Utz has announced his retirement.

Mr Bourke first represented MDA National, known then as MDA WA, in 1978. He was also involved in Council meetings, since 1979, and participated in the Cases Committee for many years.

Mr Bourke contributed to the growth of MDA WA into a significant and respected national player in the medical indemnity industry.

It has been a privilege for everyone who has worked with Dominic over the years, to have observed the way in which he has applied his considerable skills in the service of MDA National and more particularly our Members.

While Mr Bourke retires from his current role, his expertise won't be lost as he will continue to work in a consultancy capacity with Clayton Utz.



Dominic Bourke

Queen's Birthday Honours

Professor Geoffrey Riley was appointed a Member of the Order of Australia (AM), for service to medical education, particularly to rural and clinical practice, as an academic and administrator, and to professional organisations.

MDA National congratulates Professor Geoffrey Riley on his recent achievement.

The South Australian Doctors in Training Ball

On Saturday, 9 October, MDA National will be hosting the annual South Australia Doctors in Training Ball which will be held at the Adelaide Convention Centre.

If you are a Doctor in Training and would like to attend, tickets are \$55 for MDA National Members and \$85 for non Members. For more information on the event or how to purchase tickets, contact the MDA National Adelaide office on (08) 7129 4500.

The 2010 MDA National Membership Satisfaction Survey

At MDA National, we are committed to providing Members with first-class service. In order to do so, it is critical that we maintain a good understanding of our Members' evolving needs and expectations and ensure that we are responsive to them.

One of the ways in which we gauge Members' views is through a comprehensive biennial survey, administered by an independent market and social research company, which explores Members' perceptions about our full range of products and services and the way in which we deliver them. Your contribution through this survey assists us to improve the services we provide to you.

The survey will be mailed to all Members in the next few months for written completion. However, the survey can also be completed online and a link to the site will be forwarded by email to all Members who have provided us with their email address.

If you would prefer to participate in the survey online, please ensure that you have provided MDA National with your email address by 15 October 2010.

Practice Self-Assessment Checklist and Handbook

The Practice Self-Assessment Checklist and the Practice Self-Assessment Handbook will assist Members identify and manage medico-legal risks in their practice.

Available in four speciality versions: Medical Practice, Surgical Practice, Anaesthetic Practice and Obstetric and Gynaecological Practice.

To access these new resources visit www.mdnational.com.au, email the Risk Management team at riskmanagement@mdanational.com.au or call **1800 011 255**.

The Criminality Of Treatment

Dr Patel & Beyond

After a 15 week trial a Queensland Supreme Court jury found Dr Jayant Patel guilty of 3 counts of manslaughter and one count of grievous bodily harm. While Dr Patel has appealed his convictions, one wonders how the apparently well intentioned treatment of a patient can go so wrong. What does it take for the death of a patient, arising from medical negligence, to give rise to medical manslaughter?

In this article we consider the concept of medical manslaughter and provide a short review of the law. A second article will follow the outcome of Dr Patel's appeal.

The term "medical manslaughter" is not a legal term. It is the colloquial term now so commonly understood to refer to the death of a patient through negligence where the act or acts of negligence are so gross as to raise the suspicion of criminality.

New South Wales, Victoria, South Australia and the Australia Capital Territory have a statutory offence of negligent manslaughter.¹ The Queensland Code enshrines a duty to preserve human life:

"...it is the duty of every person who...undertakes to administer surgical or medical treatment...to have reasonable skill and to use reasonable care ...and the person is held to have caused any consequences which result to the life...by reason of any omission to observe or perform that duty..."²

The generally accepted threshold for cases of negligent manslaughter (or murder without intent) is found in a 1977 Victorian case. *Nydam v R* [1977] VR 430 held that to establish manslaughter by negligence the acts must have "involved such a great falling short of the standard of care which a reasonable person would have exercised and which involved such a high risk that death or grievous bodily harm would follow that the doing of the act merited criminal punishment" (emphasis added).

The Dr Patel jury had to be convinced, beyond a reasonable doubt that not only was Dr Patel negligent (in the normal non-criminal sense) but that the degree and quality of the negligence, in the context of the risk, constituted "recklessness involving grave moral guilt"³ such that it deserved criminal sanction. This required the jury to take into account and analyse expert medical evidence and understand the civil concept of negligence. They had to make a value judgment on how far short of the standard expected of a reasonable director of surgery, which Dr Patel claimed to be, he fell.

The charges against Dr Patel involved four elderly and sick patients, three procedures resulting in death - two oesophagectomies and a sigmoid colectomy - and a proctocolectomy resulting in long term suffering.

There have been precious few convictions for medical manslaughter in Australia. In 1843 Dr William Valentine was found guilty of manslaughter for accidentally giving the patient the incorrect medication. In 2006, Dr Garry Gow, a NSW GP pleaded guilty to negligent manslaughter arising from the prescribing of 5 ampoules of morphine tartrate to his patient instead of the less potent morphine sulphate. He was given an 18 month suspended jail sentence.

On other occasions where doctors have been charged a conviction is not secured. In 2001 Dr Gerritt Reimers was found not guilty by a New South Wales District Court jury of the manslaughter of 74 year old Shirley Byrne. Mrs Byrne died of severe brain damage after Dr Reimers, the anaesthetist in her operation, failed to notice that she had stopped breathing. Dr Reimers was later suspended for 10 years by the NSW Medical Tribunal 'for taking patients' drugs and failing to properly monitor people under his care, contributing to at least one death'.

While Dr Patel performed the surgeries competently (at least not negligently), with no malicious intention and patient consent, it was held that he ought never to have recommended and performed them. The Court held that Dr Patel's judgment in:

- (a) recommending the procedures; and
- (b) his incorrect or inadequate diagnoses

were criminally negligent; they fell so far short of the standard of care expected of Dr Patel that it was recklessness involving grave moral guilt, grossly negligent and thoroughly reprehensible.

The small number of prosecutions for medical manslaughter is perhaps suggestive of a reluctance to prosecute doctors, except in extreme and, perhaps politically charged, environments. Perhaps even more so, the small number of prosecutions highlights the fairly significant legal obstacles to obtaining a conviction.

In our next article we will provide a more detailed analysis of the facts in Dr Patel's case and review the findings of the Queensland Court of Appeal.

Feneil Shah, Lawyer
Kerrie Chambers, Partner
HWL Ebsworth

References

- 1 S.18 *Crimes Act 1900* (NSW).
- 2 S.288 *Criminal Code 1899* (Qld). See also s.265 *Criminal Code 1913* (WA), s.150 *Criminal Code 1983* (NT), s.149 *Criminal Code 1924* (Tas).
- 3 The standard of criminal negligence required by the Queensland Supreme Court precedent of *R. v Jackson & Hodgetts* [1990] 1 Qd R 456

Social Networking: Do You Really Want Them To Know?



Social networking services are nothing new; they can trace their roots to the mid 1980s where services such as CompuServe and America Online were launched and grew slowly in popularity. As the World Wide Web developed and matured the evolution of social networking grew along with it. Websites such as Friendster and MySpace gained popularity in the early 2000s and were ultimately superseded in popularity by sites such as Twitter and Facebook, who today boast user numbers of over 100 million and 500 million respectively.

Initially intended for college students, Facebook has grown to be widely used by people from a variety of social and professional circles. The use of social networking sites such as Facebook among people from the medical profession may expose them to particular risks which would have been uncommon for the site's original constituents. An article in the August 2009 *New England Journal of Medicine* describes some of the risks associated with medical professionals using social networking sites, including the story of a nurse who relates her experience with a difficult patient in an online blog but does not realise that one of the patient's family members is in her network of friends, raising a significant privacy breach. Another example involves a clinic patient who accesses the online profile of their treating medical officer, determining that they are single, and subsequently asking them on a date – an interaction which would most certainly damage their doctor/patient relationship. Having one's professionalism called into question is another risk associated with the use of social networking sites, illustrated by the example of a medical registrar whose patient sees pictures of them enjoying an excessive amount of alcoholic beverages on their Facebook page. These examples serve to demonstrate that the difficulty of doctors balancing their public and private lives as well as protecting patients' privacy concerns is as old as the profession itself and the advent of social networking sites only serves to refocus this well-worn concern.

It is not uncommon for medical professionals to discuss patient details among themselves in not-so-private confines of places such as hospital corridors within earshot of the public. The skill of not revealing private information in such an environment is one that many medical professionals have innately, but in the realm of social networks, some doctors may let their guard down and be more apt to discuss patient information without assessing possible risks and privacy concerns. The nature of the discussion of such information in a social

networking context, even when it is seemingly de-identified, is rife with danger. Firstly, the information is much more static and long-lasting than the instantly evaporating words spoken in a corridor. Conversations and ruminations posted on a website last much longer, and are subject to much greater scrutiny - oftentimes by individuals for whom the information was not intended for in the first place. The interconnections between the user of a social networking site and their online friends is often so entangled and intertwined that predicting a possible privacy violation regarding a seemingly innocuous comment regarding a patient would prove nearly impossible.

Another danger with social networking sites that is not restricted to the medical community is the relationship between the employee and employer and the interplay of social networking. Oft told is the story of the employee who calls in sick only to have their employer check up on them online, or the case of the job applicant who has their Facebook page scrutinised by a potential employer to try to gain insight into their character and habits. Certainly the veracity of these stories vary, but the theme remains – our private lives can possibly be made more public than we'd wish through use of social networking sites.

Social networking sites remain very popular and medical professionals should not feel the need to automatically shun them because of their potential risks. If a medical professional decides to use a site such as Facebook, they should do so while employing a certain degree of caution. Privacy settings should be reviewed with an awareness of how their page will appear when viewed by the general public, and precisely what information will be available to individuals who are not a part of their online network. Any and all information relating to any patient interaction, as innocuous as it may seem, should never be posted on a user's social networking page. There are differing viewpoints as to whether medical professionals should have online social contacts with their patients. At first thought, such a relationship may seem immediately inappropriate, but some clinicians do allow for such interactions due in part to the added ability to consult their patients and remain in contact with them. It goes without saying that relationships with patients in the setting of social networking sites should be approached with an appropriate amount of caution if not simply avoided altogether.

**Dr Christopher Baughman MBBS
MDA National PMLC Member (SA)**



What's The Common Denominator?

Certain facts in the following cases have been omitted or changed by the author to ensure the anonymity of the parties involved.

What do you think these cases have in common?

1. A patient is undergoing an outpatient abdominal procedure. A scalpel blade goes missing and it is thought by medical staff to have fallen to the floor. The attending nurse is not so sure, but doesn't say anything as she assumes that the doctors must be correct. Two days later the blade is found on X-ray in the abdominal wall. The patient suffered no ill effect.
2. An incorrect dose of a drug is ordered, and the doctor's writing is difficult to understand. The nurse is reluctant to ring the surgeon and interprets it incorrectly. The patient receives a toxic dose of the medication. The error is detected the next day. The patient suffered no harm.
3. A patient suffers a deterioration post surgery and the surgeon is contacted. He dismisses nursing concerns. The nurses manage the patient as well as possible overnight and the patient's medical specialist addresses the problems the next day.

In all three cases the thread is the same: that nursing concerns are dismissed or that the nurse is reluctant to speak out.

In the oft quoted Tenerife air disaster, 583 lives were lost when two planes collided on the ground. The engineer's concerns were dismissed initially, and then he didn't speak up later due to fear of rebuke. The Wikipedia account of the incident is enthralling. The discipline of Crew Resource Management (CRM) evolved from that disaster.

One of the primary tenets of CRM is awareness of human factors as a cause of error. For example, most pilots believe

that fatigue leads to error, but only 25% of surgeons concede that fatigue affects their operating efficiency.

CRM allows respectful questioning of authority, the primary goal being situational awareness. This should lead to a recognition that what should be happening is not what is actually happening.

In case 1 above, under CRM procedure, the nurse's conversation might go as follows:

Step one: Get the attention of those involved "excuse me Doctor"

Step two: State the concern directly "I can't see the scalpel blade"

Step three: State the problem as you see it "the blade might still be with the patient"

Step four: Offer a solution "if the blade is not in the drapes or found on the floor an X-ray should be performed immediately"

Step five: Reach agreement on the solution.

These steps can be difficult for individuals and require cultural change, as well as individual assertiveness. Cultural change might be encouraged by greater interaction on a higher level between nursing and medical staff (for example allowing nursing staff to attend and participate in clinical meetings), constant feedback to individuals particularly nursing staff about outcomes of incident reviews, and not allowing bullying of any kind particularly between nursing and medical staff.

Although there always needs to be a general hierarchy, encouraging a flat hierarchy in a clinical situation can only aid patient safety.

**Dr Patrick Lockie MBBS, FRACO
MDA National PMLC Member (VIC)**



Lessons From America

Physician Insurers Association of America Conference

I had the good fortune this year to attend the Physician Insurers Association of America annual conference in Chicago. There are over 200 medical indemnity insurers in the United States and they sent about 600 delegates to the meeting. There were a number of presentations that stood out as useful in thinking about the Australian indemnity scene.

1. Health Care reform always complicates physician insurance.

As in Australia, the Washington health care reformers are implementing new and more complex systems for service delivery through task substitution, delegation and collaboration. Wherever the responsibility for clinical decision making is shared, so is the liability. This increases the likelihood of complaints or negligence actions being shared among practitioners. Firstly boundary issues arise, which may lead to practitioners blaming one another and ultimately an argument over what the legal system calls 'contribution'. Secondly the culture of tort lawyers and tribunals has not assimilated the new team and system based thinking and will still tend to pursue the physician as the responsible individual.

2. The changing claims risks in the US are probably not surprising.

Consolidated paid claims data from the US insurers showed the changing areas in medical litigation to be:

- both pharmacological and surgical treatment of obesity claims show an enormous increase, with the surgical claims more often resulting in significant damages
- operative biliary tract claims continue reducing slowly from a peak in 1990-1994
- colonoscopy claims continue a moderate rise that began in 2000
- moderate and severe mammography claims are increasing
- newly rising claims areas under watch are:
 - › renal failure following CT scans with contrast
 - › severe adverse outcomes and resulting from injection of thrombolytic agents

In the decade from 1998 to 2008 (about 80,000 closed claims)

- claims expenses increased from a mean of \$20,000 to \$140,000 per claim (adjusted for inflation)
- 68% of claims were dropped, dismissed or withdrawn
- 25% were settled
- 1% were arbitrated or mediated
- of the remaining 6% (approx 4,800) that went to court, the verdict favoured the defendant in 4.5% about 3,600.

(Source PIAA Data Sharing Project)

3. Disruptive doctor behaviour can be improved long term with graded intervention.

We know some doctors are inappropriate in their interactions with patients and staff at times and this can lead to adverse outcomes, both medically and legally. The challenge is what to do about it when it is a recurring pattern.

Data was presented to back up the hypothesis 'that with appropriate training doctors and institutions can improve the habitual disruptive behaviour of their colleagues'. This ties in neatly with work we as an industry have sponsored in Australia on non-clinical competence for surgeons. The programs are detailed, sophisticated and backed by results, which show that around eighty percent of individuals exhibit less disruptive behaviours over time. Prof Gerry Hickson, who has been running the program from Vanderbilt University since the 1980s will be speaking at the Melbourne PIAA Conference on 6-8 Oct 2011. Professor Gerry Hickson has been running this program from Vanderbilt University since the 1980s. He will be speaking in Melbourne at the PIAA Conference on 6-8 Oct 2011. His keynote presentation will be complemented by a range of very interesting high profile local and international speakers. For more information and registration please see www.piaa2011.com.

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

Taking Up New Technologies In The Post Fellowship Setting

Much has been written on the training of surgical skill to registrars, including models and methods of training and outcomes, but much less has been written about the acquisition of new surgical skills in the post-fellowship setting. Acquiring skills in this setting is different to the pre-fellowship training in a number of important respects.

It is voluntary, often more commercially driven (by patients and “the trade”), and has, until recently, no specific competency assessment. Furthermore, traditionally there has been less focus on skill acquisition post fellowship, with a consequent lesser allocation of resources by colleges and governments alike.

Differentiation between truly new (revolutionary) procedures and evolutionary procedures needs to be made. Evolutionary procedures usually involve either:

- A. A small deviation from a standard technique
- B. An application of a known technique to perform a procedure in a different situation e.g. small joint arthroscopy

Revolutionary procedures involve the development of new skills and/or technologies.

Examples of such historically have included endoscopic surgery, robotic surgery, stereotactic neurosurgery, tele-surgery and soft tissue “manufacture” and transfer.

It is important to emphasise that while the level of technological assessment and re-skilling required for evolutionary procedures is considerably less than for revolutionary procedures, some professional scrutiny nonetheless is required whenever the clinician considers a new technology.

Requiring a new skill necessitates the completion of three phases:

- A. Perception of the essential steps of the procedure
- B. Integration of the framework of the procedure i.e. putting it into practice
- C. Automatization of the techniques involved¹

Many of the so called new techniques involve a modification of existing skills, so are evolutionary procedures which generally only involve integration and automatization of the technique and should have a faster learning curve and lower risk profile. Truly new techniques, such as occurred with the introduction of laparoscopic techniques, involve all three phases of the learning process, with an attendant increase in the learning curve and risk.

When considering the option of taking up a new technique or adopting a new technology, there are three steps essentially which need to be undertaken.

1. Evaluation of the general worth of the procedure

The procedure needs to be shown to possess one or more advantages over existing techniques. It must be:

- a. Safer.
- b. More effective.
- c. Quicker to perform.
- d. Associated with a shorter hospital stay and time off work.
- e. Less expensive.
- f. More cosmetic.²

Under the current system where there may not be definitive evidence to prove these benefits there should at least be a scientific basis of presumption that at least the first two criteria are likely to be fulfilled. An assessment of the safety and efficacy of a new procedure or technology should be undertaken after full research of available independent resources. Sites such as ASERNIP-S hosted by the Royal Australasian College of Surgeons; the ANZ horizon scanning network (www.horizonscanning.gov.au/) and the Cochrane Library (www.thecochranelibrary.org/) are the most well known avenues to explore, but a search through a specific medical search engine is also recommended.

In the situation where there is no available information concerning the technology the question needs to be asked about whether the technology is “experimental”. In this situation its use could be appropriate if it is part of a trial with a scientific protocol and full ethics committee approval.

After evaluation of any new technique in a general sense the clinician must then decide whether the technique is one for use in their practice. This ultimately is a subjective decision but will be influenced by such factors as the clinician’s motivation to take up the procedure, as well as the cognitive and technical skills required for the procedure. How far the technique varies from the clinician’s usual practice can act as a barrier to its uptake.³

2. Training and skill acquisition

The model for fellowship training involving a structured programme of cognitive and technical learning supervised by a senior colleague is impractical in the post-fellowship arena. The usual method of skill acquisition is often a company sponsored short course or master class using models, simulations or cadavers. However, some have questioned how well skills learned in such a course are transferred to the clinical setting, particularly if skill learning is incomplete and not subsequently reinforced.³



The place for verification of knowledge and skills, post course precepting and outcome assessment has been advocated for the safe introduction of new procedures.⁴

As the minimum it seems there is a requirement for some competency based certification after training with the new technology.⁵

3. Bringing the skill into clinical practice

Successful implementation of a new technology in the surgical setting involves consultation with theatre staff, hospital administrators, medical indemnity insurers and the patients themselves.

Most, if not all hospitals now require notification of intention to use a new technology as part of the credentialing process. Most requirements of the hospital administration will be fulfilled by the clinician's attention to the previous two criteria and serve often as a useful "final check". As part of the surgical team the operating theatre staff need to be considered and advised with respect to any technology and if justified should participate in training for the procedure. The role of the medical indemnity insurer is to advise of any risk management considerations and to provide the appropriate level of indemnity for the clinician, but not to determine the "value" of such a procedure.

Finally the use of informed consent in the context of new technology can prove problematic to the clinician where the justifiable desire to embrace new technology can

sometimes preclude a full discussion of the issue. Selecting the right patient profile and indications for the treatment are a prerequisite and the discussion of all treatment options should be undertaken. The basis for the use of the new technology along with potential disadvantages needs discussion, along with a discussion of the clinician's level of experience with the technique and opt out options.⁶

Finally the new technique/technology should be introduced into a theatre list where there are no pressures of time and where the resources of the surgeon, surgical team and company involved with the new technology are all fully prepared and ready to proceed.

**Dr David Gilpin MBBS (Hons), FRACS
MDA National Councillor and PMLC Member (QLD)**

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Diagnostic Radiation: Balancing The Risks From Rays

Modern medical imaging is not only exposing patients to increasing amounts of radiation, but may also be exposing doctors to a new source of medicolegal issues.

Lawsuits involving radiology have traditionally focused on cases of misdiagnosis or under-investigation. However doctors should also be mindful of the possible implications associated with rising radiation doses from inappropriate, unnecessary and excessive medical imaging.

There is no doubt that modern radiology has revolutionised diagnosis and increased management options. The convenience, accuracy and broad choice of contemporary radiological options have greatly improved patient care. But the emergence of better scanners, new applications, interventional techniques and commercial medicine has also resulted in a dramatic increase in the radiation doses across the population. Concerningly, but perhaps not surprisingly, recent studies have identified links between the proliferation of diagnostic and interventional radiation emitting scans, and a potential increased risk of cancer and other effects.

Radiation is an unseen part of everyday life and is absorbed from cosmic, terrestrial and other environmental sources. However, ionising radiation is also produced by x-ray, fluoroscopy, CT, nuclear medicine and radiotherapy machines. In large enough doses, such radiation has the potential to cause cell death or induce cancer-causing mutations.

In 2007, an estimated 3.6 billion ionizing scans were performed globally and over the last 15 years, the per capita effective dose from medical sources has doubled. In the United States, the number of ionizing scans has jumped 10-fold, and the per capita dose has risen a staggering 600%. CT scans in particular, which impart significantly higher levels of radiation, have risen 20-fold, and continue to increase 10% per year.¹ A North Carolina study of 78,932 paediatric patients found that between 2004 and 2006 presentation rates increased 2%, but CT rates increased 23% for heads, 366% for cervical spines, 435% for chests and 49% for abdomens.²

A CT scan of an abdomen is equivalent to 500 chest x-rays, and carries a relative risk of developing a fatal cancer of 1 in 2000.³ A CTPA is equivalent to 4 years of normal background radiation, and is associated with a 1 in 2500 risk of developing a fatal cancer.^{4,5} Risk is further increased in children, owing to their greater sensitivity to radiation and longer life expectancy.⁶ In 1996, approximately 0.4% of all cancers in the US were attributable to CT radiation. In 2009, that figure was estimated to be 1.5%-2.0%.⁷ This seems small when compared to the 15%-25% natural lifetime risk of developing a fatal cancer. But when extrapolated across large populations, the potential for significant numbers of cancer cases to develop from radiological procedures, and the emergence of associated medico-legal issues, is concerning.



Of particular concern are the high numbers of doctors who are unaware of the risks associated with radiation emitting scans. A survey of 83 registrars and consultants in the US found that 75% underestimate the radiation risks from CT, with more than half incorrect by a factor of 10. Only 7% of patients reported being informed of potential risks from a CT scan.⁸

Although the benefits from most CT-scans would almost always outweigh the risks, it is still important for doctors to be informed of the radiation doses and potential risks associated with the imaging they request. This is particularly when considering younger patients, as well as requests for inappropriate, inconsequential, or medically unjustifiable scanning. Without an appropriate awareness, doctors could be accused of not properly making risk vs. benefit assessments. If doctors do not fully comprehend the risks involved, no matter how small they may think they are, how can patients be fully informed?

In response to the spiralling radiation doses in the United States, the FDA has taken action to reduce unnecessary radiation exposures from medical imaging.⁹ There has also been intense media interest in a number of investigations into over-exposure of patients from inappropriately calibrated CT-scans, excessively high doses used to improve image quality, and an unnecessarily high number of scans performed on children. As a result, a number of class actions are underway, and some law firms are "aggressively investigating possible lawsuits".¹⁰ Ironically, it seems that "defensive medicine", which arose to protect doctors from negligence claims, may actually be creating new avenues for possible litigation.

Your Life As A Doctor

Modern radiology offers a suite of important and relevant diagnostic and management options. However, it is clear that the proliferation of radiological procedures is increasing radiation exposures across the population. The theoretical risks associated with increased utilisation of medical imaging, particularly for unnecessary or excessive scanning, should be familiar to all doctors. Armed with this knowledge, doctors not only provide better medical care for patients, but also protect themselves from emerging medico-legal exposure.

Study	Dose	Equivalent no. of CXRs	Equivalent exposure from normal background radiation
CXR	0.015 mSv	1	3 days
AXR	0.46 mSv	35	3 months
Pelvic XR	0.48 mSv	35	3 months
CT Head	2 mSv	150	1-1.5 yrs
CT Chest	10 mSv	750	5-6 yrs
CT Abdo/ Pelvis	15 mSv	1100	7.5 yrs
CT C-spine	5 mSv	400	2.5-3 yrs
Mammo	0.2 mSv	15	1 month
Ba meal	2 mSv	150	1-1.5 yrs
Bone scan	3-4 mSv	250	2 yrs

Data sourced from National Radiological Protection Board March 2002, and Queensland Health facilities 2007.

Dr Nick Brown BSc, MBBS, GCSpMed, MPhil
MDA National PMLC Member (QLD)

References

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- 2 Broder J et al. *Increasing utilisation of CT in the pediatric emergency department*. Emerg Radiology, 2007; 14 (4): 227-32.
- 3 Food and Drug Administration. *Whole body scanning using computed tomography (CT). What are the radiation risks from CT?* Available at www.fda.gov/cdrh/ct/risks.html.
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- 6 Donnelly LF. *Reducing radiation dose associated with pediatric CT by decreasing unnecessary examinations*. AJR, 2005. 184:655-657.
- 7 Brenner DJ and Hall EJ. *Computed Tomography - an increasing source of radiation exposure*. NEJM, 2007. 357;22: 2277-2284
- 8 Lee CI et al. *Diagnostic CT scans: Assessment of patient, physician and radiologist awareness of radiation dose and possible risks*. Radiology, 2004. 231:393-398.
- 9 FDA News Release, February 9, 2010.
- 10 Parker Waichman Allonso LLP Attorneys at law. Available at www.cat-scan-radiation-overexposure.com/

Work is a part of your life, a very important part. It defines who you are in the eyes of others, and largely defines your own sense of self. Balancing two aspects of the same thing doesn't make sense. Work and how else you fill your days and nights are on a temporal continuum.

Of course, what we mean when we speak of work/life balance is that one aspect of our lives i.e. what you do as a doctor, intrudes so much into the remainder of your life that it is you that gets off balance. The need for relaxation, taking it all in, spending time with friends and family, mowing the lawn, buying a shirt or a birthday present, getting a haircut and doing your tax can become stretched as work demands more of your time and energy. These things can get pushed aside all too easily. But as the months and years go by, you may find that the precious things in your life have passed you by, have given up on you. You forget how to play tennis, you neglect your friends' birthdays, you stop writing for pleasure, you no longer dream of learning French or taking the kids to the library, to the soccer or parent-teacher nights.

I doubt this is what you signed up for. Medicine is an all-encompassing, all-demanding profession and vocation. You live and breathe being a doctor. Your kids and partner may even reconcile to being secondary to your patients, to a point. But this can catch up with you, and tiredness, stress and the relentless pressure can leave you feeling drained, hollow and even cynical. Your life is not your own. Regaining a sense of control, happiness and fulfilment is an aim not impossible to achieve, but this may require some critical reflection about why doctors see themselves as they do, and how they often feel indispensable.

A new Cognitive Institute workshop offered by MDA National for Members explores these issues further. **Mastering Work-Life Balance** will enable participants to share experiences, discuss vignettes, reflect and evaluate strategies for addressing the self- and externally-imposed barriers, including the expectations of patients, self, managers and administrators. Regaining a sense of well-being and resilience in the face of the stresses and pressures of your working life will benefit you, your family and friends and your patients.

Please see the calendar on page 18 for details of this workshop and how to register.

Elizabeth van Ekert
Risk Manager

MDA National CaseBook



JMO Supervision: An Essential Safety Ingredient

A recent Coronial Inquest highlighted the need for appropriate staffing and supervision of JMOs in public hospitals.

Case History

On Sunday 22 January 2006, Ms Olga Krivitch, 81 years of age, presented to Royal Adelaide Hospital (RAH) with a several day history of a cold and painful right foot. A diagnosis of an ischaemic right leg was made. An angiogram and subsequent thrombolytic therapy was performed by a senior radiologist in the Department of Radiology on the afternoon of her presentation to hospital, but this was unsuccessful in improving the perfusion of her leg. The patient was then admitted to the Vascular Surgery Unit at RAH. There was no surgical option available to achieve re-vascularisation of the patient's right leg. In order to try to maintain the viability of her leg, the admitting vascular surgeon decided to commence the patient on an anti-coagulation regime, involving the RAH Heparin Protocol.

At the time of the patient's admission to the Vascular Surgery Unit in January 2006, there were no registrars working in the unit. Instead there were two "relieving" RMOs, working in conjunction with two interns in the unit.

During her admission, the patient's APTT and haemoglobin were checked on 22, 23 and 24 January 2006. On 22 January 2006, her haemoglobin was 119. On 23 January 2006 it was 100 and on 24 January 2006 the haemoglobin was 98. On 24 January 2006, the patient was also diagnosed as suffering from a non-traumatic haematoma of her left shoulder. No haemoglobin was ordered or performed on 25 and 26 January 2006, although her APTT levels were checked on both of these days.

At 10:55am on Friday 27 January 2006, blood tests revealed a haemoglobin of 54 and an APTT of 109. Later that day, the RMO was contacted by the unit intern and informed of these results. The intern explained to the RMO that he had been unable to obtain any further blood for cross-matching. At about 3pm on 27 January 2006, the RMO examined the patient, but the source of bleeding was unable to be identified. The RMO obtained blood for cross-matching and ordered a CT abdomen and pelvis to try to identify if there was an intra-abdominal bleed. The

RMO attempted to contact the admitting and also the on-call vascular surgeons, without success. The RMO left a message for both of the vascular surgeons, outlining his concerns about the patient's deteriorating condition and his plan for a blood transfusion and CT scan. The heparin infusion was also ceased. The RMO went off duty at about 5:30pm and handed over the patient's care to the other unit RMO who was on-call from 5pm until 8am the following morning. The patient's blood transfusion did not commence until about 8:20pm on 27 January 2006. The CT scan revealed a massive haematoma of the right thigh. The admitting vascular surgeon was eventually contacted and the patient was taken to theatre in the early hours of the morning on Saturday 28 January 2006, where a bleeding point in the right femoral artery was oversewn. Post-operatively, the patient was admitted to the ICU. However, she had developed respiratory failure, renal failure, ischaemic hepatitis and an acute myocardial infarction. Her condition continued to deteriorate over the next 24 hours and eventually treatment was withdrawn. The patient died at 9:30am on 29 January 2006 and her death was reported to the Coroner.

Medico-legal Issues

A Coronial Inquest was held in June 2009 and the Coroner's findings were handed down on 4 February 2010. The Coroner found that the patient had died as a result of hypovolaemic shock following bleeding from the site of a femoral angiogram. Expert evidence was provided at the Inquest by an Intensive Care Specialist, Professor J Cade. The admitting vascular surgeon and the unit RMO also gave evidence at the Inquest.

Professor Cade had two main concerns about the patient's management: Firstly, that the patient's anti-coagulation regime was not stabilised in a timely manner, and she was over anti-coagulated for some period of time. Secondly, he was concerned that the significant bleeding from the site of Ms Krivitch's original thrombolytic therapy had not been identified in a timely manner with the result that the



patient experienced severe blood loss, hypovolaemia and significant coagulopathy from which she did not recover.

Professor Cade opined that a number of things urgently should have followed the discovery on 27 January 2006 that the patient's haemoglobin was 54. At the Inquest, he gave the following evidence:

"This is a red flag that needs immediate attention...Firstly it needs to be checked that it is correct, it may have been an erroneous sample....Then you need to urgently look at the patient, see if they are pale, see if they have got some bleeding and see what their general state is like. If it was believed on all those grounds that the reading is correct then two things have to happen from that: one is urgent repair of the haemoglobin with a blood transfusion; and secondly urgent investigation of the (bleeding) site.... Where is all the bleeding?"

He concluded that Ms Krivitch would have survived if appropriate interventions including an early identification of her haemoglobin levels and a blood transfusion on the morning of 27 January 2006 had been commenced. The Coroner stated that the fact that the patient's haemoglobin levels had not been checked on 25 or 26 January 2006 "was a significant oversight that was to have a direct bearing on Ms Krivitch's decline and death. The fact that no specific instruction was given to junior staff to monitor Ms Krivitch's haemoglobin levels on 25 and 26 January 2006 was to my mind a misjudgement given that there was already in existence evidence of spontaneous bleeding (into the shoulder) that was the product of over anti-coagulation". He went on to state that "I find that there was a significant and unacceptable delay in appropriate action being taken after Ms Krivitch's haemoglobin level was revealed to be 54. The haemoglobin test sampling was undertaken at 10:55am on 27 January 2006. There was no evidence as to when the result of that test would have been available for the first time, but it was not reported to... one of the two RMOs on the ward until shortly before 3pm that day. Even then there was considerable delay in administering the necessary blood transfusion...I conclude that the shortcomings in Ms Krivitch's treatment at the RAH were due to the inexperience of junior practitioners who were staffing the Vascular Surgery Unit at that time and the lack of supervision of those staff members.

It is hard to imagine experienced registrars, had they been employed within the unit at the time, not ensuring that appropriate monitoring was in place, particularly in relation to Ms Krivitch's haemoglobin levels. Similarly, in my view the delays experienced during the afternoon of 27 January 2006 could have been avoided if more experienced and senior medical staff had been on hand. If appropriate medical expertise had been available within the Vascular Surgery Unit at the relevant time, I find on the balance of probabilities that Ms Krivitch's outcome could have been avoided. Having regard to the inexperience of the medical staff who were employed at the Vascular Surgery Unit from 22 to 27 January 2006, there is no evidence to warrant the criticism of any individual junior medical practitioner. They should have been more closely supervised and, in particular, it should have been made clear to them that there was a fundamental need for Ms Krivitch's haemoglobin levels to be closely monitored and evaluated on 25 and 26 January 2006."

Risk Management Strategies

The Coroner's recommendations included the following:

- "That the Minister for Health draw to the attention of the Chief Executive Officers of all public hospitals the desirability of identifying in advance of the commencement of anti-coagulation therapy, the relevant blood grouping of the patient so as to facilitate the more timely delivery of a blood transfusion should the necessity for the same arise;
- That the Minister for Health draw my findings in respect of the necessity to monitor haemoglobin levels in circumstances such as those that pertained to Ms Krivitch to the attention of all the relevant persons at all medical schools in South Australia;
- That the Minister for Health take the necessary steps to ensure that wards in all public hospitals are at all times appropriately staffed."

Dr Sara Bird Manager, Medico-Legal and Advisory Services

Reference

Inquest into the death of Ms Olga Krivitch, Coroner's Court of South Australia, Inquest number 13/2009 (0154/2006).

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.

On Whose Authority?

Doctors often receive correspondence from insurance companies (or the insurer's solicitor) requesting a copy of the doctor's clinical notes. Such requests are usually made in circumstances where the patient has made a workers' compensation claim or motor accident claim. Other instances in which a doctor's records may be sought from an insurance company (or its solicitor) include when a claim is made on a travel insurance policy or pursuant to an income protection policy.

Although the request letter on its face might seem innocuous, before a doctor provides a copy of the patient's medical records, he or she needs to ensure that the patient has consented to the provision of their health information to a third party. The patient's consent to such a disclosure needs to be provided in the form of a written Authority, a copy of which should be sent with the letter requesting a copy of the medical records. If a doctor provides a copy of the medical records in the absence of the patient's written Authority, this constitutes a breach of the patient's confidentiality.

It is important for doctors to be aware that not all requests for medical records will comply with the terms of, or parameters set by, the patient's written Authority. Recently, MDA National has received calls from Members seeking advice in relation to requests from insurers' solicitors for a copy of their records.

Case 1

Dr A received a letter from a law firm which, after the introductory paragraph, stated:

"We request a copy of your clinical notes and enclose a copy of the Authority signed by Mr B in support of this request.

Please note that to properly comply with our request, you need to provide a copy of your entire file, including but not limited to consultation records, correspondence, referral letters, specialist letters, radiology results, pathology results, care plans, and any other document evidencing your treatment of Mr B for any condition at any time."

The Authority attached to the letter was a copy of the final page from a workers' compensation claim form and stated:

"I, Mr B, authorise my treating health care professionals to provide to MMM Insurance or its legal representatives, information concerning treatment provided to me in respect of the work place injury I suffered on 5 May 2008."

Dr A was aware of Mr B's workers' compensation claim and had seen him in relation to his knee injury, as well as for unrelated matters. Dr A was concerned that the request contained in the solicitor's letter was broader than the Authority contained within the workers' compensation claim form and sought advice about what documents should be provided and what documents should be withheld.

Case 2

Dr B consulted with a long-standing patient who had suffered a heart attack while travelling overseas. Shortly after the consultation, Dr B received a letter from a solicitor who stated that he acted for YYY Travel Insurance Pty Ltd and requested a copy of the patient's entire medical records. Attached to the letter were two Authorities signed by the patient that purportedly supported the request for the medical records.

Dr B sought advice from MDA National because the Authorities provided did not make sense to her in the context of the solicitor's request. The first Authority relied upon by the solicitor was in fact an Authority the patient had signed to enable the insurer (or its legal representatives) to obtain information from Medicare Australia in relation to benefits paid in respect of recent hospital treatment. The second Authority relied upon by the solicitor authorised Medicare Australia to provide the patient's PBS claims history to the travel insurer.

With the Member's consent, MDA National contacted the solicitor and indicated that the Authorities provided did not support the request for Dr B's records.

Discussion

Each case exemplifies the importance of ensuring that the Authority provided covers the records sought. If either doctor had not carefully reviewed (and questioned) the Authorities and had simply provided a copy of the patient's records, this would have constituted a breach of the patient's confidentiality and privacy, as health information would have been provided without the patient's consent.

Members are encouraged to seek advice from MDA National if they are asked to provide a copy of a patient's medical records and they are uncertain as to whether the Authority provided covers the request. Please feel free to telephone MDA National's 24-hour medico-legal advisory line on 1800 011 255 or e-mail advice@mdanational.com.au.

Yvonne Baldwin
Claims Manager (Solicitor)

The Medical Defence Association of Western Australia (Incorporated) (MDA National)

Election of Officers pursuant to 5F(1)(eb) of the Electoral Act 1907

ELECTION NOTICE

Nominations are called from eligible candidates for the election of:

Councillor (3)

Nominations will be accepted from Monday 20 September 2010.

Nomination forms are to be completed in accordance with the MDA National Election Rules and must reach me no later than 12.00 noon on Tuesday 12 October 2010. Should an election be necessary, voting will close at 10.00 am on Friday 5 November 2010.

HOW TO LODGE NOMINATIONS

By Hand: Western Australian Electoral Commission
Level 2, 111 St Georges Terrace
PERTH WA 6000

By Post: GPO Box F316
PERTH WA 6841

By Fax: (08) 9226 0577

Nomination forms are available from any MDA National office or by downloading them from the MDA National web site at www.mdanational.com.au

You can also request a nomination form from me at the Western Australian Electoral Commission. Originals of faxed nominations must be mailed or hand-delivered to the Returning Officer.

Ian Botterill
RETURNING OFFICER

Phone: 08 9214 0456
Email: waec@waec.wa.gov.au

Have you changed your address?

If you are a Member of MDA National and you have changed your address, please advise MDA National of your new address.



WESTERN AUSTRALIAN
Electoral Commission

MDA National Risk Management Workshops

Cognitive Institute Workshops Calendar

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
9.00am - 12.00pm
Sydney

Mastering Difficult
Patient Interactions
Saturday 23
1.00pm - 4.30pm
Sydney

Mastering
Work/Life Balance
Saturday 30
9.00am - 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

Email: riskmanagement@mdanational.com.au

www.mdanational.com.au

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Have your practice
details changed?

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The information in Defence Update is intended as a guide only. We recommend you always contact your indemnity provider when you require specific advice in relation to your insurance policy.

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