defenceupdate

Quarterly Magazine of the MDA National Group

Autumn 2011

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From the President

Professional Performance and the Dunning-Kruger Effect

The notion of cognitive bias was introduced by Ames Tversky and Daniel Kahneman in 1972.[1] They demonstrated that there were many reproducible ways in which human decision making could become irrational. Unfortunately rules which are reassuring in their simplicity, and easy for the brain to adopt and comprehend, can also produce systematic errors in decision making. Indeed, this school of thought led to the emergence of behavioural economics as a discipline and earned Kahneman the Nobel Prize in 2002.[2]

One obvious cognitive bias that is relevant to economics, is the "Gambler's fallacy": the tendency to think that future probability can be altered by past events when in reality, they are unchanged. For example: "I've flipped heads with this coin five times consecutively, so the chance of tails on the sixth toss is much greater than heads"!

Equally cognitive biases have been identified in Medicine and are discussed extensively in Jerome Groopman's excellent book "How Doctors Think."[3] He makes the salient point that while every doctor can make a mistake in diagnosis or treatment, the frequency and severity of these mistakes might be mitigated by an understanding of cognitive bias and how we might think more clearly about patients and their problems.

One cognitive bias seen in doctors is the Dunning-Kruger effect. This phenomenon was proposed in 1999 by Justin Kruger and David Dunning of Cornell University.[4] Kruger and Dunning noted earlier studies suggesting that ignorance of standards of practice seemed to lie behind a great deal of impaired performance. This pattern was seen in studies of skills as diverse as reading comprehension, operating a motor vehicle, and playing chess or tennis.

Kruger and Dunning proposed that, for a given skill, less competent people will:

1. tend to overestimate their own level of skill;
2. fail to recognize genuine skill in others;
3. fail to recognize the depth of their inadequacy;
4. acknowledge their own previous lack of skill, but only if they can be trained to substantially improve.

What this all means in ordinary terms, is that if we are less competent at something we are unfortunately more likely to overestimate our abilities.

Equally, we sometimes rationalise our failures under the pressure of high cognitive load, and we usually will assess our own skills more charitably than we assess those of others. But the Dunning-Kruger Effect powerfully suggests that those of us with the weakest skills, whether it be in medicine or in the kinds of critical thinking necessary to separate truth from nonsense, are also the least likely to be able to recognize deficiencies.

However, there is some good news. The study also looked at whether or not the least competent subjects could improve the accuracy of their self-assessment. Fortunately it appears that if you improve people's skills, they also become better able to accurately gauge their own performance against others and be more self-critical.

Thus there is a strong argument for teaching of critical thinking skills and encouraging a critical outlook about our performance. This is why MDA National is financially supporting the Competence and Performance projects of both the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians. It is also why we have committed our group to the "*Partnering Your Professionalism*" program, which encourages self-directed, critically aware individuals to imagine and realise alternative ways of thinking. Hopefully we can assist doctors and students to explore their own problems with decision making and find better solutions.

MDA National's efforts are potentiated by recognition and analysis of the complex adaptive system that is healthcare – particularly respecting the evidence that much of a doctor's working life involves them in a Vulnerable System Syndrome. Professor James Reason – a luminary of the modern age in understanding safety and error – notes, "In all complex, well-defended systems, a bad event requires some assistance from chance in order to create a path for accident opportunity... not withstanding this chance element... analysis of many disasters... suggest that there is a recurrent cluster of organisational pathologies that render some systems more vulnerable... blame, denial, and blinkered pursuit of the wrong kind of excellence."[5]

So while many incidents can be attributed to poorly designed systems, there's an increasing body of evidence that as doctors, we can improve the assessment of our own capabilities and can encourage higher professional performance amongst our peers. And despite the skepticism of some doctors about the intention of the specialist colleges to become more interested in these issues, ongoing self-awareness, and continuing professional development and training – coupled with a sophisticated understanding of the context of ourselves in work and life will continue to be one of the best strategies to reduce errors and improve clinical risk management.

A/Prof Julian Rait
MDA National President

References

1 Kahneman D, Tversky A. Subjective probability: A judgment of representativeness. Cognitive Psychology, 3, 430-454, 1972.
2 Nobelprize.org
3 Groopman JE. "How Doctors Think". Scribe Publications, 2007.
4 Kruger J, Dunning D. Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments. Journal of Personality and Social Psychology 77 (6): 1121-34, 1999.
5 Reason J. The Human Contribution: Unsafe acts, accidents and heroic recoveries. Ashgate, 2008.

Editor's Note

Welcome to the first issue of *Defence Update* for 2011

One of the roles of *Defence Update* is to update you on recent medico-legal developments which will impact on contemporary clinical practice. Raising awareness about emerging and perennial medico-legal risks is also a key aim.

With this in mind, this issue provides an outline of current e-Health initiatives, discusses the complex area of professional performance and examines the role of AHPRA and other bodies in investigating individual medical practitioners. Also included are practical strategies and tips on ending the doctor-patient relationship and our regular CaseBook which summarises recent medical negligence claims and investigations.

I do hope you find this issue of *Defence Update* an engaging, informative and topical read.

Your comments and contributions are warmly encouraged. Please contact us at defenceupdate@mdanational.com.au

Dr Sara Bird, Manager,
Medico-legal and Advisory Services

In this Issue

Notification of Incident

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

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

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

How to notify? To notify us of an incident, visit our secure Member Online Services at **www.mdanational.com.au** and complete the Notification of Incident Form. You can also contact our 24/7 Medico-legal Advisory Service on 1800 011 255.

Notice Board

Check Your Medical Registration

With the introduction of the National Registration and Accreditation Scheme for the Health Professions in 2010, the Australian Health Practitioner Regulation Agency (AHPRA) has become the body responsible for the registration of all Australian medical practitioners. Unfortunately, AHPRA has suffered from a number of administrative problems, including difficulties for individual practitioners to contact AHPRA by phone.

At present the registration renewal date for individual medical practitioners varies. MDA National recommends that all Members check the AHPRA website's Medical Register to ensure that they are registered and also check their registration expiry date. The Medical Register can be accessed at:
http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx.

Under the National Law, the registration and name of medical practitioners who do not renew on time (i.e. within one month of their registration expiry date) must be removed from the Medical Register. There is no discretion to extend registration to any medical practitioner who has not renewed within the one month 'grace period'. De-registered medical practitioners must re-apply for medical registration. AHPRA has established a fast track re-application process for those practitioners whose registration has inadvertently lapsed:
http://www.ahpra.gov.au/Forms/Fast-Track-Application-Forms.aspx.

Importantly de-registered medical practitioners cannot continue to practise until they have been re-registered by AHPRA and their patients cannot claim rebates from Medicare during the period of de-registration.

If any Member finds that their medical registration has inadvertently lapsed, please immediately contact AHPRA to fast track your re-application for registration. You are also encouraged to contact MDA National's Medico-legal Advisory Service on 1800 011 255 for advice and assistance.

Highlight: 2011 Medico-legal Forum

You're invited to attend MDA National's 2011 Medico-legal Forum:

Medico-Legal Minefield: Doctors as Leaders From decision-making and consent to supervision

As leaders, how much influence do doctors have?

How does this affect your relationship with your patients, your peers, your juniors and the health care team?

Is leadership a natural trait, or is it learned?

Explore these issues, and more, at our next series of forums.

MDA National Members will receive a formal invitation in the mail. Visit **www.mdanational.com.au** for more information on dates and venues.

Renewal 2011/12: Made Quick and Easy For You...

Preparing for Renewal

Renewal 2011/12 is fast approaching and in preparation for this, shortly you will receive a Pre Renewal Questionnaire to complete if you have any changes to any of the details we currently hold about you or your field of practice.

The Pre Renewal Questionnaire is a great way to tell us about any changes you may have either by completing the questionnaire that you receive or doing this online by following the links on our website: **www.mdanational.com.au.**

Members with a Post Graduate Year between 1 to 4 will not receive the Pre Renewal Questionnaire as you are currently undertaking training and as a result the likelihood of changes to your field of practice is limited.

Whether you receive a Pre Renewal Questionnaire or not, you can make any changes over the phone by contacting our Member Services team at any time during business hours.

Your Renewal Invitation

The revised renewal notice that was introduced last year was well received by Members who tell us the process was very smooth and easy.

Again, this year, if your renewal notice is correct and accurately reflects your practice and your cover requirements and you have no incidents or claims to report, all you need do is make payment or provide us with your payment authority. Renewing can be as easy as going on the MDA National website and following the links or selecting one of the many payment options available. Please refer to your renewal notice for a complete list of these payment options.

Once we have received your payment, we will automatically send you a Certificate of Currency which is often what employers or third parties need for proof of indemnity. We won't automatically send you a receipt as your renewal notice becomes your tax invoice / receipt upon us receiving your premium.

And there remains no need to sign and send back your renewal notice.

Further details about this year's renewal will be provided in the Winter edition of *Defence Update*.

Medico-legal Forum Dates

Tasmania:	10th May
South Australia:	12th May
Victoria:	17th May
Queensland:	19th May
New South Wales:	26th May
Western Australia:	31st May, 2nd and 7th June

In Focus

e-Health

The National e-Health Transition Authority (NEHTA) was established by the Federal Government in 2005 to enable more effective methods of collecting, securing and exchanging health information electronically.

The Federal Government considered Australia's geography, the vast land size, the distribution of its population, representations by many medical practitioners and professional bodies that they required the utilisation of modern technology to improve access to health services in rural, remote and outer metropolitan areas. To date the adoption of e-Health (which includes tele-health) in Australia has been limited.

The principle objective of NEHTA is to develop the essential foundations required to enable e-Health in Australia. Some of this work is outlined below.

Healthcare Identifiers

Working with Medicare Australia, NEHTA has introduced a process across the health sector to accurately identify all parties involved in the healthcare transaction. Healthcare Identifiers is a unique number to accurately identify healthcare consumers, providers and organisations.

One of the objectives of the Healthcare Identifiers (HI) Service is to reduce the risk of adverse events. One of the aims of the HI Service is to engender confidence in individuals and healthcare providers that the right health information is associated with the right individual at the point of care.

It is estimated that 5,000 Australians die each year due to adverse medical events.[1] Up to one in six (18%) medical errors are due to inadequate patient information.[2] The National e-Health strategy[3] considers the Healthcare Identifiers is the most important opportunity to improve the quality and safety of healthcare, reduce waste, inefficiency and improve continuity in healthcare.

- Individual Healthcare Identifiers (IHI) for all Australian residents;
- Healthcare Provider Identifier – Individual (HPI-I) assigned to healthcare professionals;
- Healthcare Provider Identifier – Organisation (HPI-O) assigned to organisations where healthcare is provided.

As at November 2010, 23 million IHIs, 390,000 HPI-Is and 2 HPI-Os have been issued. While all Australians who are enrolled in the Medicare Australia or the Department of Veterans' Affairs programs will be automatically allocated an IHI, an IHI is not a requirement for healthcare in Australia.

Personally Controlled Electronic Health Records (PCEHR)

Personally Controlled Electronic Health Records (PCEHR) will link health data held in GP systems, pharmacies and within hospitals to one another, and will be rolled out from July 2012. The PCEHR is likely to provide a 'patient area' for documentation by the individual, their carer or other authorised representatives/advocates. It is envisaged that this documentation will provide information to the healthcare provider and it is to be used as a 'vital part of the record providing information to guide healthcare'.

The PCEHR will contain a patient health summary which may be drawn from existing data sources. The PCEHR will include current medications, allergies and any chronic health conditions. Over time, the PCEHR may incorporate a range of health information such as the patient's general history, pathology, radiology and prescription information.

NEHTA fulfils a managing agent role for the PCEHR to support the Government in delivering an e-Health record for all Australians who choose to have one, by June 2012.

Security

NEHTA has initiated secure messaging which will protect the data from malicious interference. It requires the highest level of information security and aims to provide improved interoperability to ensure providers can share health information.

eReferrals

To facilitate seamless exchange of information from one treating healthcare provider to another, the electronic referrals could be sent directly to the treating specialist. The objective is to ensure sharing of accurate, comprehensive and relevant information to improve systems for creating and reviewing clinical information and reduce adverse events caused by delayed, inadequate responses or referrals or results that 'go missing'.

Electronic Transfer of Prescriptions

This form of e-communication provides a method of digitally creating, storing, signing and dispensing prescriptions. It will link GPs' clinical information system with a pharmacy dispensing system. The electronic transfer of prescriptions may potentially result in less adverse drug events, more efficient, safer dispensing, more appropriate prescriptions, and improved information flows which will result in increased patient engagement.

eDischarge Summaries

eDischarge Summaries aim to provide electronic exchange of comprehensive and accurate patient reports between hospitals and primary healthcare sectors. It is envisaged that a Discharge Summary will be sent electronically from a hospital to a patient's GP. The objective is to reduce adverse events by ensuring the exchange of relevant information between the hospital and GP to enable the GP to receive consistent, complete, accurate and reliable information.

The process of receiving and utilising electronic medical records (EMR) creates unique medico-legal risks and implications for the practice of medicine particularly in relation to general practice. These issues will be addressed by MDA National in later publications.

Deborah Jackson,
Manager, Claims and Advisory Services (Solicitor)

References

1 Australian Patient Safety Foundation, www.consultmagazine.net
2 Australian Institute of Health and Welfare, Australia's Health 2002
3 National E Health strategy developed by Deloitte, together with key stakeholders, provided a basis to guide the further development of e-Health in Australia. www.health.gov.au/internet/main/pubilshing.nsf/content/national+Ehealth

In Focus

Investigations

Most medical practitioners are aware of the ever-present threat of medical negligence claims. Claims can be expensive and stressful, and the risk of being involved in a large claim is often at the forefront of a medical practitioner's mind as they pay their annual premium to MDA National Insurance.

But what about investigations? Over 45% of MDA National's open files are made up of investigations.

"Surely doctors who are being investigated are simply bad doctors – this won't happen to me". Sadly this is not the case.

Investigations arise in a number of jurisdictions, but the ones that we most commonly deal with are:

- Australian Health Practitioner Regulation Agency (AHPRA);
- Coronial inquiries; and
- Medicare Australia.

So how can we help you, and what can you do to ensure we can give you timely advice?

AHPRA

Following the introduction of the National Registration and Accreditation Scheme for the Health Professions (the Scheme) in July 2010, AHPRA is the organisation responsible for the implementation of the Scheme, supporting the 10 National Boards. Part of AHPRA's role involves managing investigations into the professional conduct, performance and health of medical practitioners on behalf of the Medical Board of Australia (except in NSW, where this is done jointly by the NSW Medical Council and the Health Care Complaints Commission).

If you receive a complaint from AHPRA, time is of the essence. Generally, a response is required from you 14-21 days from the date of AHPRA's letter. You should contact us for advice as soon as possible, and start preparing your draft response. Depending on the nature and seriousness of the complaint, the Claims Manager may request a face to face meeting, and will almost certainly need a copy of the clinical notes. We know medical practitioners are busy, so the sooner we know about the complaint, the sooner we can start to assist you. AHPRA will occasionally grant an extension of time, but this is by no means guaranteed and should only be requested if necessary. In most cases, the provision of a response to AHPRA will bring the matter to a conclusion.

Coronial Inquiries

If you receive a request from the Coroner for a report or statement, please contact us for advice. After discussion with a Claims Manager, it is likely that you will be asked to prepare a draft report/statement in accordance with the request and forward it to us along with a copy of the patient's clinical notes. Depending on the complexity of the matter, the Claims Manager will often liaise with a member of our in-house medical advisory team to ensure a full understanding of the clinical aspects of the case. The Claims Manager can provide any suggested amendments to the draft report/statement and highlight any potential areas of concern. Early involvement gives the Claims Manager an opportunity to familiarise themselves with the case in the event the matter is referred to a Coronial Inquest (hearing). The Coroner usually provides a fairly generous timeframe for response, and may grant extensions if required.

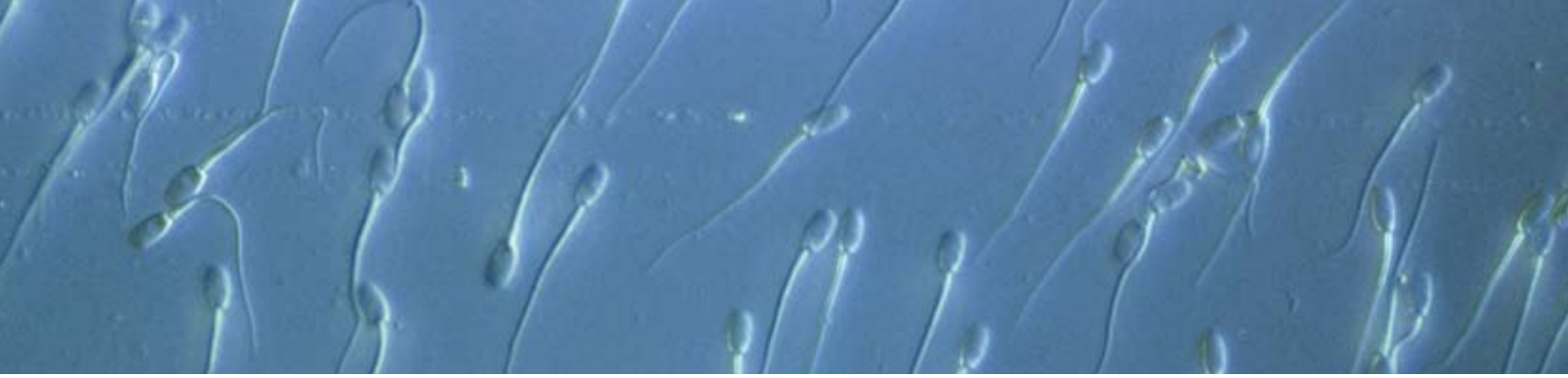
Medicare Australia

Investigations can arise out of statistical data collected by Medicare Australia. If you are contacted by Medicare Australia and advised that your practice profile is drawing attention, this is the best time to do something about it. Contact us so our Claims and Advisory Services team can assist you to understand the process and, if necessary, alter your practice profile to minimise the possibility of further scrutiny from Medicare Australia. Referral to the Professional Services Review can have serious financial implications, and there is also the possibility of referral to the criminal jurisdiction if Medicare Australia has evidence to support a charge of fraud.

This list is certainly not exhaustive, but all investigations should be taken seriously and acted upon as soon as possible. If in doubt, please feel free to contact our 24-hour medico-legal advisory line on 1800 011 255 or e-mail advice@mdanational.com.au so we can provide you with advice and support.

Nerissa Ferrie,
Claims Manager

If you receive a complaint from AHPRA, time is of the essence. Generally, a response is required from you 14-21 days from the date of AHPRA's letter.



Legal

Court Finds Stored Semen to be "Property"

A recent Queensland Supreme Court decision represents a significant departure from the long-held legal principle that there are no property rights in human tissue or body parts. While this case may not seem particularly controversial on its own facts, it could have significant ramifications for legal rights relating to the use of all human tissue and body parts.

The general proposition at common law – based on public interest considerations – has been that the human body cannot be viewed as property. However, this principle has come under challenge in recent years with the commercialisation of tissue and cell therapies for medical treatment, as well as the increasing use of assisted reproductive technology (ART) to enable human gametes and embryos to be stored for long periods of time. Difficult issues arise when a person dies leaving gametes or embryos in storage, or when a couple separates and the future of an unused embryo becomes the subject of dispute.

The Posthumous Use of Semen

A number of cases have gone to court over the issue of when stored semen can be used posthumously. In one Queensland case in 2004, the court authorised the urgent removal of semen from the body of a deceased man at the request of his wife. Other high profile cases have brought posthumous conception into the public domain, most notably the case of Diane Blood in the UK, who had two children using sperm removed from her critically ill husband prior to his death.

There is now ART legislation in NSW, Victoria, South Australia and Western Australia which governs the posthumous use of gametes and embryos. The legislation generally permits them to be used only if the deceased person has provided specific written consent to this prior to his or her death, but falls short of stating that a person "owns" his or her gametes. However, the recent decision of *Bazley v Wesley Monash IVF Pty Ltd* has suggested that there may in fact be property rights in human gametes.

Mr Bazley stored semen prior to undergoing chemotherapy due to liver cancer. After his death, his wife informed the IVF provider that she required them to continue to store his semen. They responded that Mr Bazley had left no directions in relation to the use of his semen, and that they would destroy the semen within 28 days unless directed otherwise by a court.

Mrs Bazley sought and obtained an order from the Queensland Supreme Court that the IVF provider continue to hold the semen. White J stated that the semen currently stored with the respondent was property, the ownership of which vested in the deceased while alive and in his executor (in this case, Mrs Bazley) after his death. Mrs Bazley was therefore entitled to continue the storage contract, or to request the return of the stored semen to her in good order and capable of being used.

Discussion

This decision that semen forms part of a person's estate is new and could lead to complex disputes. What should happen if there is disagreement between the executor and the deceased person's spouse about the use of stored semen or embryos? Does the executor's view prevail? What if the executor is the deceased's lawyer or accountant, or his adult children by a previous marriage? To what extent will this principle be applied to other human tissue or body parts?

The other conundrum in this case is that Mr Bazley did not provide consent for the use of the stored semen after his death, and the orders made by the court related only to the ongoing storage of the semen not its use. Under NHMRC Guidelines, semen cannot be used posthumously, which presumably means that Mrs Bazley would need to make a further application to the court if she wishes to use the semen to attempt to achieve a pregnancy. It remains to be seen what principles the court would apply when determining this question.

Emma Slaytor, Julie Hamblin
HWL Ebsworth Lawyers

Ending the Doctor-Patient Relationship

The provision of advice about ending the doctor-patient relationship accounts for 3% of the general medico-legal advisory calls received by MDA National from Members. In most cases, the decision to terminate a doctor-patient relationship is a difficult one for a doctor to make. By the time Members contact MDA National for advice, they have generally tried a range of strategies to try to preserve the relationship and the decision to end the doctor-patient relationship is the only option available. For many doctors, acknowledging that they are no longer able, or willing, to look after a patient is not easy and goes against their understanding of their professional obligations as a doctor. However, it should be noted that it is acceptable and, in fact, sometimes advisable in certain circumstances to terminate a therapeutic relationship with a patient.

Grounds for Ending the Doctor-Patient Relationship

There are a variety of reasons why medical practitioners decide the doctor–patient relationship has irrevocably broken down. These include:

- Unacceptable patient behaviour – this includes verbal abuse, threatened or actual violence, harassment and other boundary violations, including "lovelorn" patients. The behaviour may also involve unacceptable behaviour towards practice staff, rather than the doctor;
- A loss of mutual trust and respect and/or a breakdown in communication;
- Continual non-compliance with management recommendations;
- Being a "doctor-shopper"; and
- Trying to coerce you to provide medical treatment you disagree with.

Not all therapeutic relationships are going to be successful. It is important to remember that one doctor's difficult or "heartsink" patient is not necessarily another practitioner's difficult patient. In circumstances in which a doctor feels either anxious, fearful or angry about a particular patient, it is generally appropriate to terminate the therapeutic relationship and enable another practitioner to take over the patient's care.

Legal Issues

In general terms, there is no legal obligation imposed upon a doctor to see any particular patient, except in a genuine emergency situation. Therefore, there is no legal duty to continue a doctor-patient relationship once it has commenced. However, it should be noted that some employed practitioners may be under a contractual obligation to see certain patients e.g. in an Emergency Department setting.

It is also important to be aware that practitioners must not refuse to treat patients based on unlawful discrimination e.g. treating a particular patient (or group of patients) less favourably than they would a patient without a particular characteristic, including disability, race or sex.

Doctors should comply with the Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia with regard to ending a professional relationship. The Code states:

"In some circumstances, the relationship between a doctor and a patient may become ineffective or compromised, and you may need to end it. Good medical practice involves ensuring that the patient is adequately informed of your decision and facilitating arrangements for the continuing care of the patient, including passing on relevant clinical information."[1]

Ending the Doctor-Patient Relationship: Steps to Follow

So how should a medical practitioner end a therapeutic relationship? Depending on the circumstances, the doctor-patient relationship can be terminated in a face to face meeting/consultation with the patient, by phone and/or in writing. Regardless of the method used, it is important to:

- Inform the patient and, if appropriate, the referring practitioner that the doctor-patient relationship has irrevocably broken down and that it is therefore in their best interests to seek ongoing medical care from another medical practitioner;
- Advise the patient (and referring practitioner) of any outstanding clinical issues that require follow-up and a timeframe for doing this; and
- Ask the patient to inform the practice (in writing) of the name of the patient's new treating doctor so that a copy of their medical records can be promptly forwarded, to facilitate continuity of the patient's medical care.

The key issues are to communicate the termination of the therapeutic relationship in clear and unambiguous terms, "drawing the line in the sand", and confirming that the decision has been made in the best interests of the patient.

It is also important to inform the practice staff that the doctor-patient relationship has been terminated, so that further appointments are not made for the patient.

A sample template letter for ending a doctor-patient relationship is provided below.

If you find yourself in the difficult situation of having to end a doctor-patient relationship, you are encouraged to contact our Medico-legal Advisory Service for advice and support. In particular, we are happy to assist you in drafting a letter to the patient informing them about the end of the doctor-patient relationship, to ensure that your legal and ethical obligations in this situation are met.

PRIVATE & CONFIDENTIAL

ADDRESSEE ONLY

[Insert Name & Address]

Dear X,

As discussed with you on [insert date], I am writing to confirm that I am unable to continue as your treating doctor.

As discussed, our doctor-patient relationship has broken down and it is in your best interests to seek ongoing care from another doctor [this paragraph can be altered to suit the particular circumstances].

I would be grateful if you would let our practice know in writing of the name and address of your new treating doctor and we will promptly forward a complete copy of your medical records to your treating doctor to ensure continuity of your medical care.

Yours sincerely,

Dr Y.

An Obstetrician's View

Terminating the doctor-patient relationship is rarely easy. It can be more difficult for the private obstetrician.

Obstetricians enjoy an advantage over other proceduralists, even ourselves when it comes to Gynaecological surgery, with our opportunity for 3-10 'pre-operative' visits, setting the agenda, discussing expectations, possible complications and outcomes. This gives the majority of our patients at least an idea of what might lie ahead, our personality and our approach.

Of course nothing can truly prepare women for their first labour, nor for the trials and joys of parenthood.

The massive resource of information available to women can result in unrealistic expectations being set. One might like to think that these come from more 'wholemeal' web-sites. However, when seemingly authoritative resources like the Health Department of Western Australia's 'Having a Baby' website produce testimonials to 'orgasmic' birth at home, the expectant mother and her Obstetrician might find themselves drifting apart!

The Renal Physician with the rude patient can make arrangements for clinically safe transfer of the patient's care to a colleague. If the crusty arthritic patient throws a pen at the Orthopaedic Surgeon's receptionist, then planned surgery might reasonably be cancelled and alternative arrangements for the patient's care made. But the patient with the at risk fetus who refuses induction of labour might represent a greater challenge in timely and safe transfer of responsibility.

What does a Member do at 0300 hours with a mother at 3cm dilatation, refusing caesarean section, her fetus with a complicated fetal tachycardia?

This is clearly a complex clinical situation. It is also a complex legal situation. In legal terms, a competent adult patient has a right to accept, or refuse, offered medical treatment. A decision to refuse treatment may occur in a situation where the patient's capacity to make such a decision may be impaired, and the medical practitioner must form a view as to whether the patient has capacity at the time to make the decision. As with any right, however, there are limits to the right to refuse treatment. Some exceptions to the right to refuse medical treatment are based on the protection of third parties. In cases involving pregnant women who are refusing offered medical treatment, the interests of the patient and the unborn child need to be considered. There have been some American and English cases where women who have refused to undergo caesarean section or other types of treatment late in pregnancy have had their decisions overridden by the courts.

In March 1997 the English Court of Appeal (in Re MB [1997] 8 Med LR 217) upheld a judgment that a women was suffering from a mental impairment when she refused an anaesthetic necessary for her caesarean section because of a fear of needles. The court held that medical treatment could be undertaken in an emergency even if, through lack of capacity, no consent had been competently given, provided the treatment was a necessity and did no more than was reasonably required in the best interests of the patient. The court set out the following principles for consideration to assist future decision makers:

1. Every person was presumed to have the capacity to consent to or to refuse medical treatment unless and until that presumption was rebutted.
2. A competent women who had the capacity to decide might, for religious or other reasons whether rational or irrational or for no reason at all, choose not to have medical intervention even though the consequence might be the death or serious handicap of the child she bore or her own death. In that event the court did not have jurisdiction to declare medical intervention lawful and the question of her own best interests, objectively considered, did not arise.

3. Irrationality connoted a decision that was so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it. Although it might be thought that irrationality sat uneasily with competence to decide; panic, indecisiveness and irrationality in themselves did not as such amount to incompetence, but might be symptoms or evidence of incompetence. The graver the consequences of the decision the commensurately greater the level of competence was required to take the decision.
4. A person lacked capacity if some impairment or disturbance of mental functioning rendered the person unable to make a decision whether to consent to or refuse treatment.
5. Temporary factors such as confusion, shock, fatigue, pain or drugs might completely erode capacity but only if such factors were operating to such a degree that the ability to decide was absent.
6. Another such influence might be panic induced by fear. Again careful scrutiny of the evidence was necessary because fear of an operation might be a rational reason for refusal to undergo it. Fear might also, however, paralyse the will and thus destroy the capacity to make a decision.[2]

It should also be noted that in an emergency situation, to preserve the life or health of an individual, it is not necessary to obtain consent if it is impractical to do so. However, as noted above, this does not allow a medical practitioner to override a competent adult patient's objection to the proposed medical treatment.

Is the answer any different when the indication for caesarean section is maternal e.g. failure to progress at 6cm dilatation, with no suggestion of fetal compromise?

Yes, as noted above, at common law a competent adult patient may refuse medical treatment and continuing to give treatment when the patient has clearly refused constitutes assault and battery. Assuming the patient was competent at the time, and there was no suggestion of fetal compromise, the performance of a caesarean section in this situation would be unlawful.

After ending the doctor-patient relationship, what is an appropriate response to any patient request for a refund of antenatal fees already levied?

There is no obligation on the Obstetrician in this situation to refund fees for services already provided to the patient and there is no single "correct" way of managing this situation. If Members are considering refunding fees for services provided, MDA National recommends that you contact our Medico-legal Advisory Service to discuss the situation and obtain advice about the best way of doing this. In general terms, if any fees are being refunded, it is advisable to include a statement that this is being done as a "gesture of goodwill".

Dr Michael Gannon
MBBS MRCPI FRANZCOG
MDA National PMLC Member (WA)

Dr Sara Bird, Manager,
Medico-legal and Advisory Services

References

1 Good Medical Practice: A Code of Conduct for Doctors in Australia. Available at: http://www.medicalboard.gov.au/Codes-and-Guidelines.aspx
2 Kerridge I, Lowe M, Stewart M. Ethics and law for the health professions. 3rd edn. Sydney: The Federation Press, 2009:302-303.

If Members have any questions or comments about ending the doctor-patient relationship, please contact our Medico-legal Advisory Service on 1800 011 255 or email us at advice@mdanational.com.au. For urgent medico-legal advice, Members can contact us 24 hours a day, 7 days a week on 1800 011 255 and speak to an experienced Medico-legal Adviser.

MDA National CaseBook

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

Failure to Diagnose: Aortic Dissection

Case History

On the afternoon of 31 October 2006, Mr Harry Coxell, 61 years, had finished mowing his lawn and just sat down in front of TV when he experienced the sudden onset of central chest pain. He phoned his GP and was told to go to the practice immediately. Mr Coxell drove himself the short distance to the surgery, where he was seen immediately. After a brief assessment by the GP, he was given some nitrolingual spray and an ambulance was called. The ambulance officers saw Mr Coxell at 1530 and he arrived at hospital at 1603.

On arrival in the Emergency Department (ED), Mr Coxell was assessed by an RMO. The patient gave a history of sudden onset of central chest pain at rest, with the pain then shifting to the right upper chest. His past medical history included longstanding hypertension. He described the pain as severe and continuous from its onset, with only partial relief from the nitrolingual spray. Cardiovascular examination was unremarkable and no cardiac murmur was detected. An ECG, CXR and cardiac enzymes were normal.

The chest pain severity was recorded as follows:

- 1615 – 4/10;
- 1700 – 6/10, Anginine given;
- 1705 – 5/10, morphine 5mg IVI given;
- 1830 – 5/10;
- 1905 – 5/10, panadol and Somac given.

The ED physician reviewed the test results and completed the hospital's Chest Pain Emergency Management Guide form, which classified the patient as an intermediate likelihood of suffering from ischaemic heart disease (IHD). Part of the pathway on the hospital's flowchart was for intermediate risk patients to be admitted and, if no recurrent chest pain, then an exercise stress test was to be undertaken.

The ED physician rang the on-call cardiologist and discussed the findings. A decision was made to admit the patient to the Cardiac Care Unit (CCU), and he was admitted to the unit at 2030 on 31 October 2006.

On arrival in the CCU, the patient experienced further chest pain which was documented as follows on 1 November 2006 by the nursing staff:

- 0030 – 3/10, Anginine given;
- 0050 – no chest pain;
- 0200 – chest pain and unable to sleep;
- 0630 – 4/10, pain radiating to right arm, 3 Anginine given;
- 0650 – 8 - 9/10, morphine 5mg IVI and Anginine given;
- 0715 – chest pain, Anginine given;
- 0730 – no chest pain.

At approximately 0900 on 1 November 2006, the cardiology RMO examined the patient. She recorded a presenting history of "sharp stabbing central chest pain radiating to the head" and "right sided pain only". On examination, the RMO also noted an early diastolic cardiac murmur. This was a new sign, which had not been noted in the earlier physical examination of the patient.

The patient was seen by the cardiology registrar at approximately 1100. The registrar was in his first year of training and he was undertaking a second three month term in cardiology. The patient told the registrar that he was pain free. On examination, the registrar also noted the presence of the cardiac murmur. The registrar recorded a management plan, including the performance of an exercise stress test and transthoracic echocardiogram, in accordance with the hospital's chest pain protocol. The RMO completed the request forms for these diagnostic investigations.

Later that afternoon, the patient underwent an exercise stress test. At 2 minutes into stage 1 of the test, the patient indicated a pain rating of 4/10. As the test continued, the pain escalated to 5 – 6/10. At 7 minutes the patient was becoming fatigued and asked for the test to stop. He was given an Anginine tablet for pain relief but a short time later he lost consciousness and collapsed to the floor.

continued...

He was transferred to the CCU where an emergency echocardiogram suggested the possibility of a pericardial tamponade, but the patient failed to respond to resuscitation and died.

The death was reported to the Coroner. The post-mortem revealed an intimal tear in the aortic arch, immediately proximal to the origin of the brachiocephalic trunk and left common carotid artery. The aortic arch dissection had ruptured into the pericardial sac, resulting in a cardiac tamponade.

Medico-legal Issues

A Coronial Inquest was held in April 2010 and the Coroner's findings were handed down on 2 September 2010.[1] The Coroner found that the patient had died as a result of a cardiac tamponade caused by an aortic dissection after undertaking an exercise stress test.

At the Inquest, evidence was given by the ED physician, cardiologist, cardiology registrar, the RMO and the cardiac technicians who were present during the exercise stress test. An independent expert cardiologist also gave evidence at the Inquest.

Some of the issues considered at the Inquest included:

What was the evidence for and against aortic dissection, following the patient's presentation at hospital?

Both the treating and independent expert cardiologists agreed Mr Coxell's aortic dissection commenced on the afternoon of 31 October 2006 with the onset of severe central chest pain while at rest. Evidence was given that aortic dissection can be diagnosed by:

a. the presence of severe chest pain;
b. the pain being intense from onset and described as sharp in nature;
c. pulse deficit on physical examination;
d. the presence of a cardiac murmur of aortic regurgitation;
e. CXR, although this may be normal;
f. echocardiogram, chest CT, angiogram or MRI may be required to confirm the diagnosis.

The ED physician gave evidence at the Inquest that he did consider the possibility of aortic dissection as part of his differential diagnosis of Mr Coxell's chest pain. However, he ultimately made a provisional diagnosis of IHD, significantly relying on the fact that in patients presenting with chest pain to hospital it is approximately 1,000 times more likely to be due to IHD than to aortic dissection.

However, it was noted that there were a number of features of the patient's presentation which were not typical of IHD. These included:

- no ECG changes;
- no increase in cardiac enzymes;
- inadequate response to Anginine;
- no gradual onset of pain or pain subsiding at rest;
- no family history of IHD;
- no diabetes;
- no sweating;
- no nausea;
- no shortness of breath.

Was the patient's aortic dissection diagnosable and treatable?

The independent expert cardiologist gave evidence that the patient's aortic dissection could probably have been detected by an echocardiogram on 1 November 2006. The treating cardiologist stated that if either the RMO or registrar had consulted him on 1 November 2006, he would have directed that an echocardiogram be performed as soon as possible. Had the aortic dissection been diagnosed, urgent surgical intervention was required to repair the dissection. The cardiologists gave evidence that there was a 74% chance of a successful surgical outcome for a type A dissection. If left untreated, the mortality rate of aortic dissection is generally high in the first 48 hours. It progresses at a morality rate of about 1% per hour from the commencement of the dissection. The Coroner concluded:

"Mr Coxell's death could have been avoided if he had undertaken a diagnostic test such as an echocardiogram or CT aortogram" and "death was also likely to have been avoided by not doing the exercise stress test".

The expert cardiologist stated that the exercise stress test was the "precipitating factor that altered a contained aortic dissection into a lethal cardiac tamponade".

Should the registrar have contacted the on-call cardiologist?

The registrar did not contact the consultant following his examination of Mr Coxell on the morning of 1 November 2006 and he made a clinical decision to proceed with further investigations, of which the exercise stress test was one. He did not require approval for carrying out the investigations and he was aware he could access the on-call consultant, if needed. The Coroner commented that the "circumstances as to when he should be contacting the consultant had not been made clear to him in his training".

The registrar gave evidence that his decision as to whether to call the consultant was based on his own assessment of the patient's stability. He acknowledged that he may not have reviewed the nursing notes before or after seeing the patient. In hindsight, he accepted that he should have contacted the consultant, particularly because of the patient's changed clinical status. This included the ongoing chest pain following his admission to the CCU. He also accepted that the identification of the cardiac murmur was a significant new clinical finding that should have been recorded and discussed with the on-call cardiologist.

Discussion

It has been estimated that 6.4% of all adverse events in hospital are related to diagnostic errors and 83.3% of these errors are preventable.[2] In diagnostic errors, more human and organisational causes related to lack of knowledge or problems with transfer of knowledge are identified compared with other adverse events. Lack of knowledge, inappropriate application of knowledge, inadequate information transfer, urgency of decision making and lack of supervision all contribute to diagnostic errors.

Identifying and implementing strategies to minimise diagnostic errors is complex and difficult. Cognitive factors are thought to contribute to about three quarters of diagnostic errors in medical practice.[3] Cognitive factors include:

- Availability – tendency to judge diagnoses as more likely if they are more easily retrievable from memory;
- Base rate neglect – tendency to ignore the true rate of disease, and pursue rare but more exotic diagnoses;
- Representativeness – tendency to be guided by prototypical features of disease without appropriate consideration of base rates of disease and the tendency to miss atypical variants;
- Confirmation bias – tendency to seek data to confirm, not refute the hypothesis;
- Premature closure – tendency to stop too soon without a appropriate consideration of alternative possibilities.[4]

A taxonomy for the cognitive component of diagnostic error has been proposed:

- Faulty knowledge;
- Faulty data gathering;
- Faulty information processing;
- Faulty verification.

In this taxonomy, the majority of errors are the result of reasoning deficits, and most of these involve 'premature closure' – closing the interview or diagnostic process before the correct diagnosis had emerged. Studies of the diagnostic process have revealed that, within a few seconds to minutes of first seeing a patient, the clinician advances one or more diagnostic hypotheses. The single best predictor of diagnostic success is the occurrence of the correct diagnosis as a hypothesis early in the consultation. For medical practitioners this occurred approximately six minutes into the clinical encounter, and for medical students it was closer to 10 minutes. Thus, the critical aspect of the diagnostic thinking occurred with minimal information early in the clinical encounter.

A study of 464 patients who presented to hospital with a type A aortic dissection revealed that while the sudden onset of severe sharp pain was the single most common presenting complaint, the clinical presentation was diverse.[5] Classical physical findings such as aortic regurgitation and pulse deficit were noted in only 31.6% and 15.1% patients respectively. The initial CXR and ECG were frequently not helpful (no abnormalities were noted in 12.4% and 31.3% of patients, respectively). CXRs showed an absence of mediastinal widening in 37.4% of patients with type A dissection and abnormal aortic contour was noted in the minority of those patients. Of note, severe pain was the most common presenting symptom and 84.8% recorded abrupt onset of pain. The pain was described as sharp more often than tearing or ripping. Indeed, it has been suggested that medical practitioners can improve their diagnostic accuracy of aortic dissection by specifically asking about the quality of the patient's pain, the radiation of the pain and the intensity of its onset. The authors of the study concluded:

"Acute aortic dissection is uncommon, but complications develop rapidly and the outcome is often fatal. The typical presentation is characterised by acute onset of severe pain. However, clinical manifestations are diverse, and what were previously considered to be classic symptoms and signs are often absent. Therefore, a high clinical index of suspicion is necessary".

Dr Sara Bird, Manager,
Medico-legal and Advisory Services

References

1 Inquest into the death of Harry Coxell, File Number 312/08; State Coroner's Court, Glebe.

2 Zwaan L, de Bruijne M, Wagner C et al. Patient Record Review of the Incidence, Consequences, and Causes of Diagnostic Adverse Events. Arch Intern Med 2010; 170(12):1015-1020.

3 Graber ML, Franklin N, Gordon R. Diagnostic Error in Internal Medicine. Arch Intern Med 2005;165:1493-1499.

4 Norman GR, Eva KW. Diagnostic error and clinical reasoning. Medical Education 2010;44:94-100.

5 Hagan PG, Nienaber CA, Isselbacher EM et al. The International Registry of Acute Aortic Dissection (IRAD): New Insights Into an Old Disease. JAMA 2000; 283(7):897-903.

MDA National

CaseBook

Beware the Helpful Referral

Background

Doctors are often asked to provide 'corridor consultations' for hospital staff members or fellow medical colleagues. Although such consultations are usually for minor ailments or complaints, a recent disciplinary matter highlights the importance of doctors maintaining professional boundaries with their medical, nursing and allied health colleagues.

Case History

Dr X, a specialist was approached informally by Mrs A, the secretary of one of his colleagues, to write a referral for her 23 year old daughter to undergo blood tests and abdominal tap under CT guidance. Mrs A, who Dr X knew well, said that her daughter had developed increasing abdominal pain over the preceding 3 months and that Dr Y, her daughter's GP, had ordered an abdominal and pelvic ultrasound. The ultrasound was reported as showing pockets of fluid throughout the daughter's pelvis and abdomen, with the report concluding "cannot rule out ovarian primary."

Mrs A told Dr X that she had been reviewing various internet sites and was concerned that her daughter may have ovarian cancer. Mrs A said that her reading had led her to conclude that the fluid collections needed to be drained for cytology and that her daughter should also have blood tests.

Although Dr X thought it odd that the daughter was not going to follow up with her GP, he nevertheless ordered a CT-guided tap of the fluid collections and various blood tests (including tumour markers for ovarian and bowel cancer). When Dr X asked for the GP's details so that the results could be sent to Dr Y, Mrs A asked that the results be sent to her instead and that she would "take things from there".

Two months later, Dr X was attending a ward round at the hospital when he ran into Dr Z, radiologist. Dr Z asked how Mrs A's daughter was going "in light of her dreadful pathology". When Dr X said he did not know what Dr Z was referring to, Dr Z informed him that the fluid deposits in the daughter's abdomen had been diagnosed as peritoneal mesothelioma.

When Dr X contacted Mrs A to find out how her daughter was, he was informed that the daughter's condition was terminal and that the peritoneal mesothelioma was in its advanced stages.

Medico-legal Issues

Several weeks later, Dr X received a letter from AHPRA informing him that Mrs A had lodged a complaint about his failure to follow up the investigations that he had initiated. Dr X was asked to provide a written response to the complaint, in addition to a copy of his clinical notes for the patient.

Dr X found he was unable to provide a comprehensive response to the complaint, and was forced to concede the circumstances in which he had referred the patient for pathology and radiological investigations. The Medical Board was extremely critical of Dr X's conduct in relation to:

(i) Dr X ordering diagnostic tests in circumstances where he had not consulted with the patient;

(ii) Dr X not following up the results of the investigations he ordered; and

(iii) Dr X breaching the patient's privacy by noting that the investigation results were to go to Mrs A – and not Dr Y or the patient.

Discussion

This case exemplifies the importance of being careful when informally facilitating the care or management of a friend or colleague. In this instance, Dr X ordered diagnostic tests of a serious nature knowing there was a likelihood that the results could be sinister and in circumstances where he was not assured that the GP (or another doctor) would be involved in the patient's ongoing management.

In addition to this, by noting on the forms that the results were to go to Mrs A, Dr X breached the patient's privacy, as health information was going to be provided to her mother without her express consent.

The Medical Board of Australia has published Good Medical Practice: A Code of Conduct for Doctors in Australia that sets out what is expected of all doctors registered to practice medicine in Australia. Although the Code is not intended to be an exhaustive study of medical ethics, it contains guidance for doctors who find themselves in situations such as Dr X. For instance, in addition to patient assessment and formulating and implementing a suitable management plan, the provision of good patient care includes facilitating continuity of care and maintaining adequate records (neither of which Dr X did). The Code also reminds doctors that in most cases, it is inappropriate to provide care to close friends, colleagues and/or family members for various reasons – including possible discontinuity of care.

In addition to the ethical issues surrounding the treatment of friends and family, Members should be aware that their Professional Indemnity Insurance Policy does not indemnify them for claims that arise out of the provision of elective medical treatment to immediate family members.

If Members are put in a position such as this and are uncertain as to whether they should write a script or referral for a colleague, friend or family member, they are encouraged to contact us for advice. Please feel free to contact our 24-hour Medico-legal Advisory Service on 1800 011 255 or e-mail advice@mdanational.com.au.

Yvonne Baldwin,
Claims Manager (Solicitor)

The Perils of Warfarin

Case History

Mrs Antoinette Papa, 45 years of age, underwent a mechanical mitral valve replacement on 11 July 2001. Post operatively she was commenced on warfarin. Her cardiothoracic surgeon recommended that her INR be maintained between 3.0 to 4.0. Her warfarin dosage was managed by Sullivan Nicolaides' Warfarin Care Service (WCS). The table below outlines the test results and instructions given to the patient with regard to her warfarin therapy between December 2001 and February 2002.

Date	INR	Dose Instruction	Next test
6.12.01	3.00	7.7 mg daily	3.01.02
3.01.02	5.90	Nil Thursday, Friday 6.0 mg others	7.01.02
7.01.02	2.80	5.5 mg	10.01.02
10.01.02	5.70	Nil Thursday, Friday 4.0 mg others	14.01.02
14.01.02	3.40	4.0 mg daily	17.01.02
17.01.02	3.80	4.0 mg Monday – Friday 3.0 mg others	22.01.02
24.01.02	6.50	Nil Thursday, Friday	26.01.02
26.01.02	3.30	3.0 mg daily	30.01.02
30.01.02	2.00	4.0 mg Monday – Friday 3.0 mg Saturday, Sunday	06.02.02
09.02.02	7.00	Nil Saturday, Sunday, Monday	12.02.02
13.02.02	2.40	2.5 mg daily	15.02.02
16.02.02	1.50	3.0 mg daily	19.02.02
19.02.02	1.60	3.0 mg Monday, Wednesday, Friday 3.5 mg Tuesday, Thursday, Saturday, Sunday	22.02.02
22.02.02	1.50	3.5 mg Monday – Friday 4.0mg Saturday, Sunday	25.02.02
25.02.02	1.80	4.0 mg daily	Discharged

On 27 February 2002, the patient received a phone call from the WCS. She was told "I am sorry we are not able to manage your warfarin any more" and advised to go and see her GP.

The patient saw her GP on 28 February 2002. The GP had also received a phone call from the WCS on 27 February 2002 and notified of their decision not to monitor the patient's warfarin any longer because her INR levels were erratic and they felt it was a consequence of non-compliance. During the consultation with the patient on 28 February 2002, the GP phoned the WCS and obtained that day's INR result which was 1.7. He increased her warfarin dose to 4.5 mg daily. The GP referred her to another warfarin service provider, QML, and asked her to see him again after she had her next blood test. The GP said that if her INR remained sub-therapeutic he would refer her to a haematologist.

On 1 March 2002 the patient suffered a large right middle cerebral artery embolic infarct which left her with a dense left hemiplegia, dysarthria and cognitive impairment.

Medico-legal Issues

The patient subsequently commenced legal proceedings against the WCS (the defendant). The claim proceeded to hearing in April 2009 and judgment was handed down on 24 September 2010.[1]

In her Statement of Claim, the patient (now a plaintiff) alleged the WCS had breached its duty of care to her by failing to appropriately manage her warfarin therapy during the period 13 to 27 February 2002.

At the hearing, evidence was given by Dr Beverley Rowbotham, a haematologist, who managed the WCS, the patient's GP and her cardiologist. Expert evidence was heard from four haematologists, a GP and a cardiologist.

The Judge drew the following conclusions from the expert medical evidence:

a) That the warfarin dosage management process necessarily involved the balancing of the risk of under anticoagulation and over anticoagulation;

b) That there was a known risk of thromboembolic event in the case of sub-therapeutic INR levels and that this risk magnified when the INR was at or below 1.5;

c) That there was a known risk of haemorrhagic event in the case of supra-therapeutic INR levels, and that this risk magnified when the INR was at or above 6.5;

d) That in relative terms, the risk of haemorrhagic event at INR 6.5 or higher was significantly greater than the risk of thromboembolic event at INR 1.5 or less;

e) That the process of keeping the INR within target range, and thereby minimising these risks, necessarily involved a significant component of clinical judgement on the part of the warfarin care haematologist;

continued...

f) That it was accepted practice at the time that the anticoagulants Clexane or heparin could be used on a patient with an artificial mitral valve as "bridging therapy" by way of a substitute for, or supplement to, warfarin in a peri-operative setting;

g) That neither the medical literature then available nor the standards of practice among warfarin care haematologists at the time support a conclusion that it was appropriate for a warfarin care haematologist, when dosing a patient with an artificial mitral valve who had a persistent sub-therapeutic INR, to supplement the prescription of warfarin with either;

   i. The administration of Clexane or heparin; or

   ii. The administration of "stat" doses of warfarin.

Accordingly, the Judge found that it had not been established that the defendant failed to exercise and observe the standards of a reasonable warfarin care haematologist in the management of the plaintiff's warfarin dosage level in the period 13 to 27 February 2002.

However, the separate question on liability was quite different. It went to whether, according to the relevant professional and practising standards at the time, the defendant, when presented with this patient with an artificial mitral valve and a recent history of INR instability and persistent sub-therapeutic INRs, ought to have given advice to the plaintiff, her GP or her cardiologist, and if so, what the content of that advice ought to have been and when it ought to have been given.

The defendant gave no advice to the plaintiff's medical practitioners until Dr Rowbotham's call to the GP on 27 February 2002. The only information being provided to the plaintiff was her dosage instructions and the dates for her next tests. She was not routinely advised of her actual INR levels.

The Judge concluded it would have been reasonably appropriate for the defendant at least to raise the prospect of investigating an alternative or supplementary form of anticoagulation and also to raise the prospect of this needing to be done in consultation with the plaintiff's cardiologist. He then went on to find that if this had occurred, then according to the evidence of her cardiologist, he would have commenced anticoagulation with Clexane or heparin. The cardiologist would have recommended this on receipt of the second sub-therapeutic INR on 19 February 2002.

Therefore, the Judge was satisfied on the balance of probabilities that the defendant's failure to give advice to the plaintiff and her GP by about 22 February 2002 in respect of the matters outlined above was a breach of the defendant's duty of care to the plaintiff which was causative of her suffering the stroke on 1 March 2002. Accordingly, the plaintiff had proved her case of liability against the defendant.

The Judge awarded the plaintiff $2,201,982.00 plus legal costs. Past and future care costs formed the largest component of the award of damages.

Discussion

Warfarin is one of the medications most commonly involved in claims arising out of medication errors. The Threats to Australian Patient Safety (TAPS) study collected 648 reports from GPs about threats to patient safety.[2] Warfarin errors comprised 7% of these reports. Of the errors involving warfarin, over 20% resulted in hospitalisation and a further 7% resulted in the death of the patient.

Lessons from the TAPS study in preventing errors related to warfarin therapy include:

- Patient education on commencing warfarin is an important responsibility of the clinician who initiates therapy. When therapy commences in hospital, GPs should also reinforce messages relating to safety and monitoring;
- Clinicians and patients should clearly record warfarin dosages and INR levels in medical records (which may be electronic) and in a patient's personal diary;
- Details of when the next INR is due should be discussed with the patient at the same time as the latest result and any dosage change is discussed;
- INR results and warfarin doses should be communicated to the patient on the day of the testing, and patients and their carers should be educated to follow up with their treating doctor if this does not occur.

Dr Sara Bird, Manager,
Medico-legal and Advisory Services

References

1 Papa v Sullivan Nicolaides Pty Ltd [2010] QSC 364. Accessed at www.austilli.edu.au/au/cases/qld/ASC/2010/364.html

2 Makeham M, Saltman D, Kidd M. Lessons from the TAPS study. Warfarin: a major cause of threats to patient safety. Aust Fam Physician 2008; 37:817-8.

MDA National Workshops

April 2011

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May 2011

Mastering Shared Decision Making
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Mastering Difficult Patient Interactions
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Sydney

Mastering Shared Decision Making
Saturday 21
9.00am - 12.00pm
Perth

Mastering Difficult Patient Interactions
Saturday 21
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.

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Spotlight

Eeeek! Risk Management?

Risk management did you say? Images appeared before me... clipboards, ticks and crosses, stern letters and detailed instructions to describe every step of every process known to mankind, in triplicate - just in case!! As fear rose and my body tensed for what I was sure would be the 'you've done something wrong moment', I was surprised to hear a friendly voice on the other end of the phone asking me - 'How may we help you?'

Supporting Members in practice - that is what MDA National Risk Management is all about. Providing one on one risk management advice, education services, practice visits and resource materials, all to encourage our Members and their staff to consider the issues that contribute to safe medical practice and to reflect on what may be making some patients unhappy with their care. These issues are often overlooked amongst more pressing 'clinical' needs, therefore, we are happy to assist with the provision of advice and support.

To support you in practice, MDA National offers a range of support points, where you can select what suits you and your situation best.

Individual Member Risk Management Advice

Provided to Members who have specific concerns or who have been referred for assistance from one of our other business areas. Individual assistance can be as simple as phone or email advice, but can also extend to written advice and practice visits.

Education Activities

MDA National offers a range of educational activities and resources. There is a wide range of materials to choose from with more becoming available in the near future.

Access to workshop bookings and print materials is via the MDA National website. Please log in to Members Online Services (MOS) to access these services, or if you are unable to do so, please call us on 1800 011 255.

Print materials such as the following are available for you to download:

- How to keep good medical records
- Patient and test tracking systems
- Responding to complaints in your practice
- Retirement from medical practice
- Specialty-specific practice self-assessment checklists

Orders can be placed online for mail-out of hardcopy resources (free to Members) such as:

- Medico-legal handbook for general practice
- Practice Self-Assessment Handbook - available in 4 versions: Medical, Surgical, Anaesthetic and Obstetrics & Gynaecology

Practice Visits

Members can request a visit from a Practice Advisor to work with you and your staff to identify key medico-legal risks and to consider strategies relevant to your practice to address these risks.

Eeeek! Risk Management? No... Practice Support with your best interests at heart.

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Support Protect Promote

Have you moved? Have your practice details changed?

If so, please take a moment to notify us of your new information. To update your details, please call Member Services on 1800 011 255 or log on to the Member Online Services section of our website **www.mdanational.com.au**

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

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