defenceupdate

Quarterly Magazine for MDA National Members

Winter 2011

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From the President

"They must often change, who would be constant in happiness or wisdom."

Confucius

I was recently reminded by one of our Members of how my family's medical heritage coincided with the founding of MDA National some 86 years ago. Indeed, I was amazed to receive an image of my late uncle who was amongst a group of young doctors, who with new babies in arms, were pictured outside the Royal Women's Hospital in Melbourne in 1926.

However, I imagine that this group of young doctors would have been equally surprised by the sweeping cultural changes that have occurred in medicine since that time. In particular, the esteem with which doctors are held has diminished. Equally, independent general and specialist practice has also declined while many young doctors are now choosing salaried employment and working fewer hours, often going part time and/or pursuing alternative personal and professional interests outside of medicine.

And pagers and mobile telephones that once tied doctors to their patients and practices at nights, weekends and public holidays, are now being abandoned while medicine becomes more team based, corporatised and hopefully, more family friendly.

Certainly such changes have produced less professional autonomy, but conversely doctors have increasing control over their personal lives, while (hopefully) still permitting personal and proficient care to be provided to their patients.

Older doctors, like my uncle, would probably have viewed these changes with considerable ambivalence, but saying 'no' to endless work-days and creating a better work/life balance can only be seen as an improvement for doctors and patients alike.

Another change over the past 86 years has been the adjustment in the community's expectations of medical care and of medical indemnity. I recall that my uncle practiced for the next 50 years, and delivered more than 5000 babies without being sued. And while I have no idea of the mistakes or errors of judgement that he might have made during that time, he certainly practiced in an era when the public was more trusting and accepting of doctors even when things went horribly wrong!

Today not only are doctors more at risk of litigation, but MDA National has observed that our Members are subject to increasing numbers of complaints to the National Medical Board, and various health care complaints authorities. Changing work practices also mean that doctors are now more likely to be the subject of disputes with employers, and sanctions by the Australian Competition and Consumer Commission for possible breaches of Australian Consumer Law which forms part of the renamed *Competition and Consumer Act 2010*.

Since 1925, MDA National has continued to pursue a time-honoured culture that Supports, Protects and Promotes Members' best interests above and beyond medico-legal matters. Over time, we've built on our strong WA origins – trading as MDA National as a wholly owned subsidiary of MDAWA under the WA Associations and Incorporations Act – and evolved into a formidable national Medical Defence Organisation (MDO) that's withstood the test of time and become a vital part of Australia's medical culture.*

As part of our evolution, Council has resolved that a parent company limited by guarantee and regulated by ASIC is a more appropriate model for MDAWA. Regulators and changing legislation further reaffirms our decision that MDA National's parent organisation should be registered and regulated under Commonwealth law. This will mean that your mutual is wholly aligned with your insurance company, MDA National Insurance, which is incorporated under the *Corporations Act*.

Given our national footprint and growing membership of almost 25% of Australia's medical practitioners, Council is confident this model is a better fit for our MDO going forward. As such, you will soon be notified of an Extraordinary General Meeting to be held on Friday 15 July 2011, to ratify this change and endorse a new constitution for MDA National.

We are committed to continuing to adapt to best suit the needs of our membership. And we're pleased to announce further premium reductions for the majority of our Members again this year - possible due to our group's continued strong financial performance and cost conscious management team. As MDA National remains committed to passing on the good fortunes of your group, dividends will continue to be delivered directly to you through further premium reductions, insurance policy enhancements and extensions to our comprehensive suite of Member services.

Therefore, despite sweeping cultural changes that have occurred in medicine over the past century, we will continue to support Members and provide mutually based and doctor-driven assistance and understanding alongside our professional indemnity insurance; an ethos that remains as important and as generous today as it was 86 years ago.

A/Prof. Julian Rait
President, MDA National

(on behalf of the MDA National Group^)

* MDA National's 2010/11 Member feedback survey.

^ The MDA National Group is made up of MDA National and MDA National Insurance.

Editor's Note

One of the roles of MDA National is to advocate on behalf of our Members about issues which may affect the medico-legal environment in which we practice.

Over the past few months, MDA National has provided submissions to the Senate Inquiry into AHPRA, the Nursing and Midwifery Board about minimum standards for professional indemnity insurance for midwives and the Productivity Commission with regard to the proposed introduction of a no-fault National Disability Insurance Scheme and National Injury Insurance Scheme (the Notice Board on page 5 provides more information about the Productivity Commission's Inquiry).

MDA National was pleased to have been given an invitation to address the Senate Inquiry into AHPRA and, indeed, we were the only Medical Defence Organisation to receive such an invitation. Our President, Associate Professor Julian Rait, appeared at the Inquiry and outlined MDA National's ongoing concerns with regard to the mandatory reporting of colleagues, reiterating our view that the WA exemptions from mandatory reporting for medical practitioners in the course of providing health services to other health practitioners or students should be introduced across Australia.

The focus of this issue of *Defence Update* is on your renewal of membership. On pages 6 and 7, Member Services provides some tips on how to make renewal a bit easier, including our comprehensive Member Online Services. Some Members may not be aware that cover is provided under the Policy for legal costs incurred in employment disputes, whether you are an employee, contractor or employer. An overview of the areas in which employment disputes can arise is on page 8.

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 Professional Indemnity Insurance Policy with MDA National Insurance 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

National Disability Insurance Scheme (NDIS) & National Injury Insurance Scheme (NIIS)

The Productivity Commission has been asked by the Australian Government to examine the feasibility of replacing the current system of disability services with a new no-fault scheme. In February 2011, the Productivity Commission released a Draft Report, after receiving more than 600 submissions in response to their Issues Paper and undertaking of a wide range of public consultations and hearings in the latter part of 2010.

In the Draft Report, the Productivity Commission has proposed the introduction of two new schemes:

1. National Disability Insurance Scheme (NDIS):

- The NDIS will provide cover for all Australians in the event of significant disability to fund their long term care and support
- It is estimated that 360,000 Australians would receive funding under this scheme and the amount needed to fund the NDIS would be an additional $6.3billion, which is proposed to be funded by general revenue
- The NDIS would commence in January 2014 and be fully operational by 2018.

2. The National Injury Insurance Scheme (NIIS):

- The NIIS would provide fully funded lifetime care and support for all new cases of catastrophic injury
- It is estimated that the new incidence of catastrophic injury in Australia is 800 people per year
- Catastrophic injuries in the NIIS would include medical treatment, motor vehicle, criminal and general accidents (but not workplace accidents)
- Common law rights to sue for long term care and support would be removed.

Of relevance to MDA National and our Members is the feedback that the Productivity Commission is seeking in relation to:

a. Practical interim funding arrangements for funding catastrophic 'medical accidents' covered under the NIIS

b. Appropriate criterion for determining coverage of 'medical accidents' under the NIIS and, in particular, whether there should be a notion of 'fault'.

MDA National has provided a submission to the Productivity Commission in response to the Draft Report – available at **www.pc.gov.au/projects/inquiry/disability-support.** The Productivity Commission will provide their Final Report to the Australian Government by 31 July 2011.

MDA National will keep Members informed about this significant policy initiative.

Membership satisfaction survey

During 2010/2011, MDA National conducted the biennial Member satisfaction survey, first undertaken in 2002.

In December 2010, a questionnaire was mailed to Members. It was also made available online.

The results of the survey showed that MDA National continues to provide satisfaction beyond Member expectations. Medico-legal advice and financial stability are the most important areas for MDA National Members with claims handling, price of insurance premiums, Member services and risk management and having localised offices also rating very high in importance.

General perceptions regarding the organisation were:

- MDA National's strong reputation is a key reason for joining
- I would recommend MDA National to others – 89% in agreement
- I am likely to stay with MDA National – 92% in agreement
- MDA National is seen as a part of the medical profession – 69% in agreement.

New: Premium Support Scheme online calculator

You can now assess your eligibility to apply for the Premium Support Scheme (PSS) with our online calculator. Visit **www.mdanational.com.au/insurance/premium-support-scheme.aspx.**

Does your practice need cover?

We know GPs who need a Practice Policy want one that suits their own situation. The investment you make in your practice is as important as your professional reputation.

If you are an owner, director or part of the management of a General Practice, you can't always rely on your personal indemnity to protect your practice from the actions of staff or consultants.

New coverage options

Our Practice Policy has features such as cover for defamation, loss of documents, privacy complaints and infringement of intellectual property. To find out more about the new coverage options of our Practice Indemnity Insurance Policy, contact our Member Services team on 1800 011 255 or visit **www.mdanational.com.au.**

Your Renewal

Well, it's hard to believe it is renewal time again. By now you will have received your renewal pack. Here are some interesting things to note about your renewal that might answer your questions or make renewal quicker and easier.

Paying by direct debit

If you have already set up a direct debit arrangement with us, the only thing you need to do is be prepared for a payment to be made from your nominated account on Friday, 1 July. If you wish to change the account or your payment method, please let us know immediately to allow us to make the change in time.

Renewing online

This is one of the quickest and easiest ways to renew. If your renewal details are correct, then simply visit **www.mdanational.com.au** and follow the link to Member Online Services. You can pay your renewal here as well as print out your Certificate of Currency which is your proof of indemnity. For a full list of Member Online Services, see page 7.

Where's the Policy booklet?

As there have been few material changes to the Policy Wording and in the interests of reducing costs and conserving paper, we have decided to issue a Supplementary Product Disclosure Statement (Supplementary PDS) and Endorsement to the Policy Wording this year rather than reissue a new Policy booklet.

Your Professional Indemnity Insurance Policy from 1 July 2011 will be recorded as version 8.1.

The Supplementary PDS is to be read in conjunction with Version 8.0 of the Professional Indemnity Insurance Policy PDS.

If you still have version 8.0 of the PDS from last year, you may wish to file your Supplementary PDS with it. If you would like another copy, we will happily send you one or you can download it at **www.mdanational.com.au/downloads.aspx.**

Risk Category Guide changes

Every year we review our risk categories to ensure the scope and level of cover we provide is the most comprehensive we can offer. This year we are pleased to advise the following changes:

- A number of procedures that were previously categorised under the Level 3 GP Procedural category are now included under the Level 1 GP Non Procedural category. Please review the Risk Category Guide for the updated list.
- The definition of Gross Annual Billings has been revised to provide further clarity.
- The post graduate and doctors in specialist training categories can now allow significantly higher private billings for surgical assisting, locum or private work undertaken outside their training program. Of course there remains no restriction to the amount of billings that can be generated within the training program.

How to Renew? Step by Step

1. Check your details

On the Renewal Notice, check all your details are correct. In particular, make sure that recent changes to your address, contact details or your practice appear on the Notice. Please let us know if they are incorrect or need updating.

2. Check the Risk Category Guide

There have been a few minor changes to our categories this year, so you need to check the Risk Category Guide to make sure you are in the correct category. It may make a difference to the premium you are paying and your cover under the Policy.

3. Report any matters

Let us know of any claims, complaints, investigations or circumstances that you have become aware of, if you haven't done so already. You need to let us know about these matters as early as possible. We can help prevent many matters from escalating where we have immediate notification.

4. Make payment

If your renewal is correct, you can make your payment. You can do this in a number of ways this year. The easiest and quickest is to do it online at **www.mdanational.com.au** and click the online renewal link. You can print out your Certificate of Currency straight after paying if you need proof of indemnity. Alternatively, you can pay by Bpay or contact us and we can take your annual payment or set up a direct debit arrangement over the phone.

Proof of indemnity

Your Renewal Notice becomes your Policy Schedule upon payment of your premium. However this contains premium and billings information you may not want revealed to others. For this reason, we have enabled you to print out a Certificate of Currency online once you have paid. If you renew and pay your premium through Member Online Services, you can print out your Certificate of Currency immediately after making your payment. For those who elect to pay a different way, we will send you your Certificate of Currency.

Your Renewal Notice now becomes your tax invoice/receipt upon receipt of payment. Unless you specifically request a receipt, we won't send you one.

Your membership card

The introduction of our new style membership card last year was well received. The card is more durable and longer lasting and as a result you will not receive a new card each year upon renewing.

If you have misplaced or damaged your membership card and require a new card, please let us know so that we can reissue you with a new one.

Tonya Timpano
Manager, Member Services

Spotlight

MDA National's Member Online Services

As a Member of MDA National you have access to our Member Online Services. Member Online Services is your personalised online Member area. It's designed to help you easily access your personal details, policy information, change and update information as well as make the most of your Membership with Member-only resources.

What services do we offer on Member Online Services?

- **Renew and pay online:** in a few easy steps you are able to renew and make a payment for your Professional Indemnity Insurance Policy online.
- **Report an incident:** please inform us as soon as possible of any incident.
- **Certificate of Currency:** for evidence that you have Professional Indemnity Insurance in place, you can print a Certificate of Currency online.
- **Premium Support Scheme (PSS) application:** if you wish to apply for the PSS, you can complete and submit your application online.
- **View your Risk Category history:** you can review the risk category history associated with your insurance cover for the past three years.
- **View and update your details:** update your personal details such as your address, practice address or provider number online.
- **Overseas cover request:** if you are planning to practice overseas and require indemnity insurance, you can complete and submit an overseas cover request online.
- **Education and support resources:** you have access to a wide range of risk management and medico-legal publications.

Not registered for Member Online Services yet?

The benefits of using Member Online Services are:

- ✔ Access us anytime
- ✔ All your important information is in one place
- ✔ Access to Member-only resources and events.

Register now. It's quick and easy!

1. Visit **www.mdanational.com.au** and click on the "Register for Member Online Services" tab.
2. Complete the registration form with your Member number, surname and date of birth.
3. Your interim access details will be emailed directly to the email address you have provided to us.

Already registered but forgotten your password?

Follow the prompts and you can reset your password online. You will receive email advice of your new password straight away, any time day or night.

Want to speak with someone? Of course it's not all about the technology. If you would like to speak with someone, we'd love to hear from you. Contact our Member Services team on 1800 011 255.

In Focus

Employment Matters

While the most commonly thought of manner in which medical practitioners and their staff will come into contact with the legal system is when a complaint or claim is made by a patient, simply conducting a medical practice gives rise to a number of legal issues that often are not thought of until they arise. MDA National may be able to assist you with some of these issues.

Unfortunately, while a happy harmonious workplace is the ideal, in reality, this will not always be the case. Employees should preferably be engaged under a written contract of employment, however, even if there is no written contract there will be a contract in place between employer and employee and it is this contract that will determine the rights and liabilities of the parties in the event of a dispute. Issues that need to be considered when an employment relationship takes a turn for the worse include:

- What is the source or sources of each party's rights and responsibilities? Is there a written contract or a verbal contract? Does an award apply and if so, which one? Does the Fair Work Act apply, or is the employee covered under the applicable State or Territory legislation?
- Has there been a breach of the employment contract? If so, does that give rise to a right to terminate? If the contract is terminated does a claim for damages arise?
- Are there any rights and obligations which survive the termination of the relationship? For example, non-solicitation clauses which may prohibit a medical practitioner from approaching staff and/or patients to leave a practice and go elsewhere to work or seek medical treatment (as the case may be), confidentiality and indemnity provisions (for example, will you be obliged to hold professional indemnity insurance for a certain period of time after you leave a practice to cover any claims that may be in the future arising from your time practising medicine at that practice).

In addition to employment relationships, many medical practices now engage medical practitioners (and perhaps others) under contracts of service rather than employing staff. Or a medical practitioner may be a party to a Partnership arrangement or Associateship arrangement. Again, it is preferable that the terms of such a relationship be documented, but if they are not, there will be implied terms and conditions which will govern the relationship. For example, the conduct of the parties may determine the terms and conditions of the arrangement and certain conditions may be implied at law such as an obligation of good faith to act in the best interests of your partners or associates. The rights and entitlements of the parties in the event of a dispute will largely be determined by the terms and conditions of the contractual arrangement.

If a claim is made against you by an employee or contractor, or you believe you may have a claim against an employer or principal, you should contact MDA National. There may be time limits within which you may have to bring a claim and therefore early notification can be very important. A claim might arise from the contract itself (be it employment or otherwise) or may be a claim under anti-discrimination legislation, equal opportunity legislation or other legislation.

In addition to the contractual relationships within a practice, medical practitioners also contract with public and private hospitals to provide services as a visiting practitioner. Depending upon the jurisdiction, some of those arrangements may be documented in the form of a written service contract. In the public hospital system, the terms of engagement are found in the hospital by-laws, letters of appointment and hospital policies and procedures rather than a written service contract.

While in the event of a dispute with a hospital it may not be immediately evident based on the terms of a contract what your rights and entitlements may be, there may well be remedies available to you and again, seeking the assistance of MDA National as early as possible may assist you to resolve a dispute or if resolution is not possible, to assist you to manage any dispute.

Dominique Egan, Partner
TressCox Lawyers

Am I covered for... employment disputes?

Not only can MDA National help resolve employment disputes with sound and timely advice, Members have the added comfort of being protected subject to the Policy's terms for legal costs to resolve the issue. The Policy provides cover up to $150,000 for legal costs relating to employment disputes and this is available to Members no matter whether you are an employee, contractor or employer.

For more information, contact our Member Services team on 1800 011 255.

Consent

'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages'.[1]

Obtaining Consent

Obtaining consent is a fundamental part of good patient care and of a doctor's duty to exercise reasonable care and skill. Patients are entitled to make their own decisions about medical treatment or procedures and should be given adequate information on which to base those decisions. The aim of obtaining consent should be to enable the patient to determine whether or not to undergo the proposed intervention.

How do you obtain consent?

The NHMRC's General Guidelines for Medical Practitioners on Providing Information to Patients provides useful guidance for medical practitioners on obtaining patient consent for interventions.[2]

In part, the Guidelines state: "Doctors should normally discuss the following information with their patients:

- the possible or likely nature of the illness or disease;
- the proposed approach to investigation, diagnosis and treatment:
  - what the proposed approach entails
  - the expected benefits
  - common side effects and material risks of any intervention
  - whether the intervention is conventional or experimental
  - who will undertake the intervention
- other options for investigation, diagnosis and treatment;
- the degree of uncertainty of any diagnosis arrived at;
- the degree of uncertainty about the therapeutic outcome;
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all;
- any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention;
- the time involved; and
- the costs involved, including out of pocket costs.

Informing patients of risks

Doctors should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare. A doctor's judgement about how to convey risks will be influenced by:

- the seriousness of the patient's condition; for example, the manner of giving information might need to be modified if the patient were too ill or badly injured to digest a detailed explanation;
- the nature of the intervention; for example, whether it is complex or straightforward, or whether it is necessary or purely discretionary. Complex interventions require more information, as do interventions where the patient has no illness;
- the likelihood of harm and the degree of possible harm more information is required the greater the risk of harm and the more serious it is likely to be;
- the questions the patient asks, when giving information, doctors should encourage the patient to ask questions and should answer them as fully as possible. Such questions will help the doctor to find out what is important to the patient;
- the patient's temperament, attitude and level of understanding; every patient is entitled to information, but these characteristics may provide guidance to the form it takes; and
- current accepted medical practice."[2]

What are 'material' risks?

A risk is material if:

- a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
- if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (Rogers v Whitaker).[3]

In general terms, a known risk should be disclosed when:

- an adverse outcome is a common event even though the detriment is slight;
- an outcome is severe even though its occurrence is rare;
- the particular patient requests or requires the information.

Discussing benefits and risks with patients ('informed' decision making)

The narrower the margin between the benefits and risks of a particular intervention, the more fully should patients be informed. There is a greater recognition of patients' autonomy and a move away from a 'paternalistic' model of medical care. There are a number of factors that have contributed to this change – not least of which is the legal framework within which medical practitioners work. However, the way in which medical practitioners diagnose and treat diseases has become more complex. There is not necessarily a simple or clear cut choice about the most appropriate investigation or treatment for a specific condition. Instead there may be a range of options, each with their own benefits and risks. Some aspects of modern medicine are also becoming like a commodity: patients are influenced by media and friends, and may arrive having a very clear idea of what they want, particularly in the fields of cosmetic and other elective practice.

A common myth surrounding the discussion of benefits and risks is that decisions are based on a rational weighing up of relevant information. However, most patients' assessment of risk is primarily determined not by facts, but by emotions.[4] Patients want to know whether and how they will be affected as individuals, and if the consequences will impact on their family. They do not necessarily equate this with an explanation of risk as derived from population studies and medical research. The way in which risk is presented to patients influences their subsequent decisions:

- 'there is a 99% chance of surviving' vs 'there is a 1% chance of death';
- an investigation that reduces a patient's risk of dying from cancer from 2% to 1% can be said to reduce their risk by 1% or half.

Presenting information to patients in natural frequencies (eg one patient out of every 100) is an effective method of reducing any confusion resulting from the provision of numerical risk information.

Additionally, the presentation of both positive and negative frames, rather than only one perspective, contributes to the effectiveness of communicating risk information.

References

1 Schloendorff v Society of New York Hospital 195 NE 92 (1914).
2 General Guidelines for Medical Practitioners on Providing Information to Patients. NHMRC 2004. Available at http://www.nhmrc.gov.au
3 Rogers v Whitaker (1992) 175 CLR 479.
4 Paling J. Strategies to help patients understand risks. BMJ 2003;327: 745-8.

Resources

MDA National. Consent: What It Is and What It Isn't. Available at www.mdanational.com.au

The Consent Procedure

Some thoughts from a Reconstructive and Cosmetic Surgeon

Not only must the patient give informed consent but the surgeon must also consent to perform the surgery. This particularly applies to cosmetic surgery requests. It implies that the surgeon can decline to operate and acknowledges that the patient will be no worse off the next morning, albeit disappointed. Just because a patient requests a cosmetic procedure is no reason to perform it.

Dr Richard Barnett

To make such a decision involves understanding whether the patient has realistic expectations about the particular procedure and helpful questions are: "When did you first decide that you would like to have a…?" and "What difference will it make to your life if you have a…?" Listen carefully to the answers and satisfy yourself that these fit with the perceived problem. Patients with dysmorphic disorders often claim they will obtain the largest benefits from correcting the smallest defects.

If you are struggling to say "no", then try to engage the patient in a discussion about risks and benefits. Tell them that the risks outweigh any perceived benefits and that to operate would therefore be very unwise. If they persist in wanting surgery as soon as possible, then you have definitely made the right decision not to operate.

When it comes to giving informed consent about cosmetic surgical procedures, Edward de Bono's advice to "never close a deal" is extremely wise in this context. Start the consultation by telling the patient that they will only be given information about the procedure, including risks, benefits, alternatives and costs, and then they must go away and decide at leisure whether they wish to proceed. They should then book another consultation, prior to any planned surgery, to go over any questions they may have and to ensure that they understand the risks involved.

Documentation of all this is vital and you should put yourself in the position of someone else, e.g. a judge, trying to decipher why you decided to operate on this particular patient and whether they had enough information to adequately consent to the procedure.

If the patient is given a printed information sheet or booklet does this make up for a less than adequate discussion about the risks involved?

The provision of a printed information sheet or booklet should ideally reinforce the content of the consent procedure and discussion with the patient. However, written information should not be used as a substitute for a meaningful discussion, but instead as a learning tool for the patient and as an aid during a doctor's explanation. In circumstances in which a second consultation is planned (e.g. for a cosmetic surgical procedure), it is useful to provide printed information to the patient at the first consultation to supplement the discussion and then confirm at the second consultation that the patient has read and understood the information, and has no further questions. A notation should be included in the medical records that the information sheet or booklet has been given to the patient (including the version of the booklet provided, if relevant).

Does watching a video or talking with the practice nurse constitute part of the consent procedure?

The medical practitioner who performs the intervention is legally responsible for obtaining consent. While other members of the treating team, such as a practice nurse or registrar, may participate in the consent process, it remains the responsibility of the practitioner performing the intervention to confirm that valid consent has been obtained.

The use of a video can supplement the consent process, especially in the case of elective or high risk procedures where it is also ideal to offer a 'cooling off' period in which the patient can make a decision as to whether or not to proceed with the intervention. The medical practitioner should also discuss any issues or concerns with the patient after they have viewed the video.

Does every risk discussed need to be documented or can it be included under the heading 'My usual practice'?

At the conclusion of the consent procedure, documentation of the process should occur. That is, once you are satisfied that the patient has understood the nature of the proposed treatment, and the benefits and risks, a record should be made about how the patient's consent was obtained. As noted above, this will include details of any written material given to the patient, any specific concerns raised by the patient, options considered, general risks and specific risks relating to the patient. Depending on the nature of the intervention, this may involve a relatively brief entry in the records. However, the more elective and the more high risk the procedure, the more detail should be included in the medical records.

For proceduralists who routinely perform the same procedure or who undertake cosmetic surgical procedures, MDA National recommends you have a range of procedure specific consent forms. Each form should include a description of the procedure, the general risks, the specific risks pertaining to that procedure and some free space to record material risks discussed with the patient (that is, any risks, side effects or other consideration that pertains to that particular patient, including anything the patient has mentioned that concerns them or that may affect recovery, or restoration of normal function).

Dr Richard Barnett
F.R.A.C.S., F.A.C.S.

The Case of Baby 'D'

Who has the right to decide to withdraw treatment?

The Family Court of Australia was recently petitioned to define the rights of parents to decide what, if any, treatment should be offered to an unwell, severely disabled child.

Baby D, a twin, was born at 27 weeks gestation. She required intubation and mechanical ventilation due to a breathing problem. As a result of the prolonged intubation she developed an upper airway obstruction from inflammation and narrowing of her larynx. Extubation, although difficult, ultimately proceeded however following extubation her condition deteriorated again requiring intubation. A 35 minute delay in intubation brought about what was believed to be widespread and severe injury to Baby D's brain, ultimately confirmed on MRI. For approximately three months after, the endotracheal tube remained, without any further attempts to remove it.

The future of baby D came before the Hospital Clinical Ethics Committee who decided that the provision of intensive care support was not in the best interests of Baby D. They approved removal of the endotracheal tube and administering palliative treatment in the event Baby D developed respiratory distress. The parents accepted and relied on this advice but applied to the Family Court for findings.

Under the Family Law Act 2004 (Cth) ("the Act") parents have authority to decide on the welfare (and current and long term health) of their children under the age of 18 (unless the child is sufficiently competent[1]) in the child's best interests. In these cases the court still may, but is extremely hesitant to, interfere in the decision. The High Court in *Marion's* case[2] decided that there were "special cases" where parental responsibility did not empower parents to consent to medical decisions; in *Marion's* case it was the sterilisation of a child with an intellectual disability. *Marion's* case decided that treatment which was invasive, irreversible and involved major surgery may be outside the bounds of parental responsibility if other factors also existed; such as a significant risk of making the wrong decision (considering the child's future consent) and the consequences of a wrong decision are grave – the list is open. In these "special cases" as defined by *Marion's* case, the court cannot empower parents to consent and must decide what is actually in the child's best interests – the parents (or the physician) must apply to the court for orders.

In Baby D's case the Judge noted that under the Act a Medical Procedure Application for "special medical procedures" could be made for a major procedure that is "not for the purpose of treating a bodily malfunction or disease". Special medical procedures in the past have included non-therapeutic tissue transplants, gender re-assignment and the use of an experimental drug on a child; where the child's best interests may be unclear.

In Baby D's case, after detailed consideration of the medical evidence, including details of the extubation and the medication for palliative care, the court found these were not "special cases" as defined by *Marion's* case nor would they qualify for a Medical Procedure Application under the Act; this was despite the likely outcome being the death of Baby D. The procedures fell within the ambit of procedures capable of parental authorisation. The court found the procedures were routine, not major or irreversible and not special medical procedures. However, the court noted that authorisation should still be obtained for medical procedures for children where there are difficult ethical issues, irreversible procedures, a life threatening risk by the procedure or conflict between parties.

In Baby D's case the courts findings largely turned on its facts – it was an instance where the court decided the parents could make the decision to withdraw treatment. The Family Court of Australia has published guidelines following *Marion's* case providing guidance on special medical procedures under the Act for children.[3] It is important to recognise that with some medical procedures, the decision to proceed may involve not only the interests of the child but also the possibly conflicting interests of parents and other family members. This decision highlights the court's role as an arbiter of last resort for procedures with complex ethical and/or clinical issues where parental consent is available. The court has also established itself as a procedural safeguard for medical treatment decisions where parents have no power to consent.

Feneil Shah, Associate
Kerrie Chambers, Partner
HWL Ebsworth

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1 "Gillick competent": if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed (1992) 175 CLR 218

2 (1992) 175 CLR 218

3 "A Question of Right Treatment The Family Court and Special Medical Procedures for Children - an introductory guide for use in Victoria – 1998" http://www.familycourt.gov.au/wps/wcm/resources/file/eba9c049d2a7cc1/Question_of_right_treatment.pdf

How is Grace Going?

Case history

"It has been 7 solid months since the hospital epidural blunder made Grace Wang change from a healthy young woman to a wheelchair trapped patient. She still cannot stand and walk by herself, she had 2 brain surgeries, seizure, hands getting more numbness, still need 3 adults to help her go to bathroom and bed, which all due to the epidural accident in June 2010. Since then, she has never been back home. The whole family still live in St George Hospital Patients Lodge on Short St. Alex is 7 months old, he is mum's little helper, makes mum smile every day."[1]

According to many media reports Grace Wang was in labour when allegedly she received an epidural where clear chlorhexidine solution was inadvertently injected instead of local anaesthetic.[2, 3] The two had apparently been decanted to galley pots on the epidural trolley, where the solutions would have appeared very similar if not indistinguishable to the anaesthetist performing the procedure.

Discussion

Whether or not these reports are entirely accurate, there is a long and catastrophic list of case reports of inadvertent administration of damaging agents into the intrathecal and epidural space. These are merely a subset of damaging medication errors, which occur less often than relatively common benign errors. In the latter it is only good luck that prevents harm to the patient.

It would be comforting and intuitive to think that what is required is for system changes to be implemented that would prevent these maladministrations recurring.

However there has been reluctance from both practitioners and administrators to adopt suggestions to minimise such incidents. Professor Alan Merry, a leader in anaesthesia, argues that denial of the problem, misplaced optimism ("it won't happen to me"), and nihilist defeatism have obstructed the adoption of many simple safety improvements that have sound theoretical bases.[4] Platt and Roberts echo this frustration in their recent editorial about anaphylaxis from patent blue dye.[5] This reaction is predictable with appropriate preadministration skin testing; so they ask when will this graduate from misadventure to misdemeanour?

Changes have long been suggested in many areas including but not only:

- presentation and packaging – to prevent identical appearance of different drugs;
- storage – to separate items that can be confused, and remove lethal doses from bedsides;
- administration checking protocols – such as double checks;
- technological systems – including bar coding and syringe incompatibility.

Some have been adopted widely, others not. The NHS is implementing a patient safety initiative in the UK[6] that will mandate:

- from April 2012 that devices used to inject intrathecal medications will not be compatible with Luer lock intravenous systems;
- from April 2013 that devices used to inject intrathecal, epidural and regional medications will not be compatible with Luer lock intravenous systems or intravenous spikes.

This will be a welcome step forward, but many non-medical people may find it difficult to believe it has taken this long.

As Alan Merry points out, there is no single answer to "safe medication management", but as many barriers as possible must be added to the administration of the wrong drug or agent.

Perhaps the advent of facebook will go on the list as a cultural development that improves patient safety. In days gone by, a disabled patient might have disappeared from public view as the news cycles. Easy publication of the sobering reality of outcomes might instead refresh our own diligence and professionalism, not only in our practice but also in our advocacy for safety. Next time someone complains about a "time out" to check patient details, or how much we are spending on systems for medication safety, we might tell them to look up how Grace Wang is going.

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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.

Intimate Examinations

Intimate examinations are a not infrequent cause of complaints from patients, and these cases serve as a reminder to all doctors to take care when conducting such examinations. Although the most common scenario is a female patient complaining about such an examination by a male doctor, care should be taken with all patients as well.

An intimate examination refers to an examination involving the genital, groin or anal region in any patient, and includes breasts in female patients.

Case history one

Dr Ocky was a GP whose work consisted mainly of pre-employment medical examinations. Ms Taylor, a 25 year old woman, attended him for a pre-employment medical for a position that involved a certain amount of physical work. Dr Ocky conducted his usual examination, which included a thorough examination of the patient's chest, as she gave a history of asthma. He also conducted his usual examination of back flexion, which involved asking Ms Taylor to bend over in front of him. On this occasion Dr Ocky noted that Ms Taylor was wearing a G-string and seemed a bit embarrassed. However this part of the examination was the final part, so he concluded the examination and provided his report.

A short time later Dr Ocky received a letter of complaint from Ms Taylor. She stated that:

'I had no idea that I would need to remove my clothes for the pre-employment check. I was shocked and embarrassed that you asked me to remove my bra, and also when I had to bend over in front of you I nearly died of embarrassment. I have had pre-employment medicals in the past and the doctor has never asked me to take off my clothes, he has just poked his stethoscope down the front of my top'.

Dr Ocky contacted MDA National for assistance in replying to Ms Taylor's letter. He considered her comments very seriously and was keen to avoid any future complaints of this nature. He was also surprised to learn that his colleagues conducted such examinations in a different way. Dr Ocky felt it was essential that he continue to examine his patients in the same way to do a thorough job and ensure that any physical problems were properly identified.

However, he decided that in future when patients arrived for a pre-employment medical he would provide them with written information that included:

- the nature of the examination, including the fact that they would be required to strip down to their underwear, and remove their bra for a thorough examination of the lungs and heart;
- modesty gowns were provided;
- a chaperone could be arranged; and
- if they were uncomfortable undergoing such an examination with a male doctor, they could rebook with his female colleague.

In his letter back to Ms Taylor, Dr Ocky apologised for her embarrassment, but outlined why the examination was conducted. He then informed her of the changes he was making to his practice as a result of her comments. He heard no further from Ms Taylor.

MDA National CaseBook

continued...

Case history two

Mr Young, aged 29 years, was referred by his GP to a rheumatologist, Dr Joint. Mr Young had a history of chronic back pain, which he attributed to a MVA some 5 years previously.

Mr Young attended his appointment with Dr Joint. He gave a history of pain and swelling of his right knee and ankle, stiffness and swelling of some of the joints of his fingers and very troublesome back pain radiating to his buttocks. His GP had been treating him with NSAIDs, which gave him some temporary relief, but the symptoms did not seem to be settling.

After taking a full history, Dr Joint instructed Mr Young to remove his clothing down to his underpants so he could perform the examination. Mr Young did not make any comment during the examination.

Dr Joint then told Mr Young that he was considering a number of possibilities that may be causing his continuing symptoms and he advised Mr Young to undertake some blood tests and further imaging and he would review him after those results were to hand.

Mr Young did not say much as Dr Joint outlined his treatment plan and then left.

A short time later, Dr Joint received a letter of complaint from Mr Young via the Medical Board. The complaint stated:

'I was totally shocked when you examined my genitals. I found it a shameful and deeply embarrassing experience. You gave no explanation as to why you did it, and considering you are a rheumatologist and I had not told you about any symptoms in that area, it was a total surprise. I did not challenge you at the time, as I was so confused and embarrassed that I could not speak at all. The fondling of my genitals was not related to the presenting medical condition and was totally unnecessary. I am never coming back to see you and have asked my GP for a referral to another specialist'.

Dr Joint rang MDA National for advice on how to respond to the letter. He was very upset at receiving such a letter, especially as he considered that he had obtained a thorough history and performed a very thorough and appropriate examination. He had told the patient that he was going to examine his genitals, in his usual way.

The Medico-legal Adviser at MDA National assisted Dr Joint with his initial response. In this response, it was outlined that Dr Joint had advised Mr Young that he needed to perform a general, whole body examination of him to try and establish the cause of his joint problems. Dr Joint then proceeded with his examination in his usual systematic way, beginning with Mr Young's back, then neck, limbs, joints, chest and abdomen. It was while he was examining the patient's abdomen that he advised Mr Young that he needed to check 'down there'. He felt that he had implicitly sought Mr Young's permission in this process, and as Mr Young had not said anything, he had taken that as consent. Dr Joint had been considering the possibility of reactive arthritis and psoriasis when he had examined the genital area to check for balanitis and other rashes.

The Medical Board then wrote back to Dr Joint. They accepted the reason for the examination, but they alleged that prior to the commencement of the physical examination Mr Young was not advised that he was going to have his genitalia examined. Further, Dr Joint had not given Mr Young sufficient opportunity to consent to the examination of his genitals, and Dr Joint had not given Mr Young any explanation as to the reason why he needed to examine his genitals.

For the next four years this matter was the subject of further correspondence between Dr Joint, with the assistance of MDA National and external lawyers, and the Medical Board. Finally the Medical Board determined that they would take no further action in relation to this complaint.

However, the Medical Board asked Dr Joint that in future when conducting an examination of a patient, particularly an examination of the genital area he:

- explain the purpose of the examination to the patient;
- explain why it is necessary to examine the patient in that way;
- inform the patient of his intention to carry out the proposed examination; and
- ensure that the patient consents to examination in the manner proposed.

Although this matter ended without an adverse finding against Dr Joint, it was a very lengthy and stressful process for him.

Before conducting an intimate examination you should explain to the patient why an examination is necessary and give the patient an opportunity to ask questions, and also the opportunity to decline the examination.

Discussion

What may be obvious and routine to doctors i.e. examination of the genitalia, or removing the patient's bra to listen to the heart and lungs, may come as an unwelcome surprise to patients.

Good Medical Practice: A Code of Conduct for Doctors in Australia states: effective communication between doctor and patient involves informing patients of the nature of, and need for, all aspects of their clinical management including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment (Section 3.3.3).[1] It further states that good medical practice involves obtaining informed consent or other valid authority before you undertake any examination, investigation or provide treatment (except in an emergency) (Section 3.5.3).

All doctors are reminded to take care with such examinations regardless of the sex of the patient. Patients may be particularly critical of a doctor's behaviour when undergoing a medical examination, which is an examination that has been requested by a potential employer, and not by the patient themselves.

It is particularly important to maintain a professional boundary and intimate examinations can be embarrassing or distressing for patients. Whenever you examine a patient you should be sensitive to what they may perceive as intimate. This is likely to include examinations of breasts, genitalia and rectum, but could also include any examination where it is necessary to touch or even be close to the patient.

Before conducting an intimate examination you should explain to the patient why an examination is necessary and give the patient an opportunity to ask questions, and also the opportunity to decline the examination. The patient should be given privacy to undress and dress and should be kept covered as much as possible to maintain their dignity. Do not assist the patient in removing clothing unless you have clarified with them that your assistance is required.

During the examination you should explain what you are going to do before you do it and, if this differs from what you have already outlined to the patient, explain why and seek the patient's permission. You should also be prepared to discontinue the examination if the patient asks you to and keep discussion relevant without unnecessary personal comments.

Good medical care should not be compromised by fear of conducting intimate examinations, but doctors should ensure that patients are fully informed. All doctors are reminded to take care with such examinations regardless of the sex of the patient.

Dr Jane Deacon
Medico-legal Adviser

Reference

1 Good Medical Practice: A Code of Conduct for Doctors in Australia – www.amc.org.au/index.php/about/good-medical-practice

Resources

Maintaining Boundaries, General Medical Council UK – www.gmc-uk.org/guidance/ethical_guidance/maintaining_boundaries.asp

Patient Examination Guidelines. AMA – www.ama.com.au/node/514

Consent to Medical Treatment: the Mature Minor

Can children and young people consent to their own medical treatment? Consent issues involving children and young people are complex. This article examines the legal obligations of medical practitioners when obtaining consent to medical treatment from patients who are under the age of 18 years.

Case history

The 15 year old patient asked her GP if everything she said during the consultation would be kept 'secret'. The GP replied that she could not provide an absolute guarantee but, generally, any information provided to her by a patient would be kept confidential. The patient then told the GP that she had a 16 year old boyfriend and she would like to start the oral contraceptive pill. She was adamant that she did not want her parents to know that she was sexually active and on the pill. The GP was uncertain of her legal position in treating a 15 year old patient without the consent of her parents.

Medico-legal issues

The age at which a person becomes an 'adult' in Australia is 18. Consent for the medical treatment of patients under 18 years of age is generally provided by parents. However, there are circumstances in which patients under the age of 18 can consent to their own medical treatment.

The common law recognises that a child or young person may have the capacity to consent to medical treatment on their own behalf, and without their parents' knowledge. This common law position is based on a 1986 English House of Lords judgment, *Gillick v Wisbech Area Health Authority*.[1] In this case, the issue to be determined was whether a medical practitioner could provide contraceptive advice and prescribe contraceptives to a patient under the age of 16 years, without the prior knowledge or consent of her parents. The Department of Health and Social Security had issued guidance to area health services in England that medical practitioners could prescribe the oral contraceptive pill to a girl below the age of 16 without the consent or knowledge of her parent, if acting in good faith to protect the best interests of the patient. Mrs Gillick, who was the mother of five daughters, sought a declaration from the Court that the guidance was unlawful on the basis (in part) that a health practitioner could not give advice or treatment about contraception to a person below the age of 16 without the consent of his or her parent(s) because this would be inconsistent with parental rights. The majority of the House of Lords ultimately rejected her claim. The Court determined that there were circumstances in which a child or young person could consent to their own medical treatment. In order to do so, the child or young person must have a 'sufficient understanding and intelligence to enable him or her to fully understand what is proposed'. This is often referred to as '*Gillick* competence' or the 'mature minor'.

The level of maturity required to provide consent will vary with the nature and complexity of the medical treatment. For example, the level of maturity required to provide consent for the treatment of a superficial graze will be much less than that required to provide consent for the commencement of the oral contraceptive pill. In *Gillick*, the judges determined that the concept of absolute authority by a parent over a child or young person was no longer acceptable. Because this absolute authority no longer existed, the House of Lords held that even though it will, in most cases, be in the patient's best interests to have parental consent, there may be special occasions when the best interests of the child or young person may be served without it.

These principles, as established in *Gillick*, were endorsed as part of Australian common law in *Marion's* case.[2]

In another case in the UK in 2006, the High Court considered an application seeking a declaration that medical practitioners were under a positive duty to consult parents where a patient under the age of 16 was seeking advice about contraception, abortion or sexual health issues[3]. In this case, Mrs Axon, a divorced parent with five children, made an application that a medical practitioner is under no obligation to keep confidential advice and treatment provided to patients under the age of 16 about contraception, sexually transmitted infections and abortion, and must not provide such advice and treatment without the parents' knowledge, unless to do so would prejudice the child's physical or mental health so that it is in the child's best interests not to do so. The judge confirmed the principles established in *Gillick* and concluded that a medical practitioner is 'entitled to provide medical advice and treatment on sexual matters without the parents' knowledge or consent provided he or she is satisfied of the following matters:

1. that the young person although under 16 years of age understands all aspects of the advice... that understanding includes all relevant matters and it is not limited to family and moral aspects as well as all possible adverse consequences which might follow from the advice;

2. that the medical professional cannot persuade the young person to inform his or her parents or to allow the medical professional to inform the parents that their child is seeking advice and/or treatment on sexual matters;
3. that (in any case in which the issue is whether the medical professional should advise on or treat in respect of contraception and sexually transmissible illnesses) the young person is very likely to begin or continue having sexual intercourse with or without contraceptive treatment or treatment for a sexually transmissible illness;
4. that unless the young person receives advice and treatment on the relevant sexual matters, his or her physical or mental health or both are likely to suffer; and
5. that the best interests of the young person require him or her to receive advice and treatment on sexual matters without parental consent or notification'.[3]

There is also specific legislation in NSW and SA that relates to the medical treatment of children. In NSW, the *Minors (Property and Contracts) Act 1970* provides some guidance regarding the medical and dental treatment of children and young people. Section 49 of this Act states that a medical practitioner who provides treatment with the consent of a child 14 years or over will have a defence to any action for assault or battery. This Act does not assist a medical practitioner in a situation where there is a conflict between a child and their parent and a parent can still potentially override a child's consent to treatment. In SA, the *Consent to Medical Treatment and Palliative Care Act 1995* outlines the legal requirements for obtaining consent by medical and dental practitioners. The Act states that a child 16 years and over can consent to their own medical treatment as validly as if an adult. Additionally, a child under the age of 16 years can consent to medical procedures if:

- the medical practitioner is of the opinion that the patient is capable of understanding the nature, consequences and risks of the treatment and the treatment is in the best interests of the health and wellbeing of the child; and
- that opinion is corroborated in writing by at least one other medical practitioner who has personally examined the child before the treatment was commenced.

Risk management strategies

It is important that medical practitioners are aware of the legal position with respect to consent to medical treatment of a child or young person, especially in circumstances in which the patient requests that their parents are not informed.

Depending on the specific circumstances, consent to medical treatment of a patient under the age of 18 years may be provided by either the:

- patient;
- parent or legal guardian;
- court e.g. for permanent sterilisation procedures;
- other agencies e.g. in NSW the consent of the Guardianship Tribunal is required for 'special medical treatment'. Special medical treatment includes sterilisation, vasectomy or tubal occlusion.

It should be noted that no consent is required in emergency situations if it is impractical to obtain it. In the case of a medical emergency (where treatment is immediately necessary to save the life of a patient or to prevent serious injury to their health), and the patient is not able to consent to the required treatment at the time, a medical practitioner may perform emergency treatment.

Whilst in many cases it is preferable to obtain the consent of both the child and the parent for medical treatment, there may be specific circumstances in which the best interests of the child or young person may be served without the parents' consent. If you are uncertain about your legal obligations in a particular situation involving the consent to medical treatment of a child or young person, seek advice from a colleague and/or MDA National's medico-legal advisory service.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

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