GP Update

An update for MDA National GENERAL PRACTITIONER MEMBERS

Overview

***GP Update* is written specifically for you – our General Practitioner Members.**

The publication aims to:

- keep you informed of the emerging and perennial medico-legal issues specific to GPs
- equip you with practical medico-legal advice
- support your delivery of quality medical care.

This edition covers:

- GP claims involving breast cancer
- the profile of Emeritus Prof Max Kamien, winner of the Rose-Hunt Award
- current laws on foetal sex selection
- GP mental health treatment plans
- revalidation for GPs
- leaving a GP practice
- Medicare update – the 80/20 rule and care planning
- a case study on failure to examine
- how our new PSS calculator can help you check your eligibility.

Our Medico-legal Advisors are here to support you with answers to any questions on **1800 011 255** or **advice@mdanational.com.au**.

If there are specific issues you would like covered in future editions or if you have feedback, we'd love to hear from you at **specialtyupdates@mdanational.com.au**.

MDA National
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GP Claims Involving Breast Cancer

Delay in diagnosis accounts for about half of all claims against GPs (not only breast cancer claims), and one third of these cases involve a delay in diagnosis of cancer.

At MDA National, we reviewed recently reported cases to examine the reasons for delay in diagnosis of breast cancer and to determine if there were any common themes.

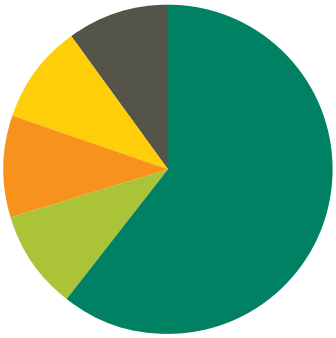
Breast cancer is the most commonly diagnosed cancer in women.[1] Some breast cancers will be detected in asymptomatic women by BreastScreen, but more than half of breast cancers are diagnosed after investigation of a breast change that is found by the woman, or by her doctor.

Pilot study

All cases where a female patient presented to a GP with a new breast symptom and there was a delay in diagnosis of breast cancer were reviewed.

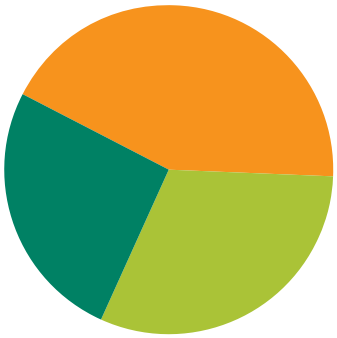
The average age of women in the study group was 49.8 years, which is younger than the average age for diagnosis of breast cancer in the general population (61.3 years).

Presenting complaint of women in the study group[2]



- Breast lump – 68%
- Pain alone – 11%
- Nipple changes – 11%
- Skin changes – 11%
- Nipple discharge – 11%

The way the presenting complaint was managed in the study group was compared with published clinical guidelines[3]



- Some tests ordered (but not all recommended tests) – 43%
- No tests ordered – 31%
- Tests ordered in accordance with guidelines – 26%

The most frequently omitted test was FNA/biopsy. No examination findings were recorded in 26% of cases, and the average delay in diagnosis was 9.9 months.

In 75% of the study group, the reasons for delay were related to failure to perform the correct initial investigation. There were a variety of other issues that led to delay in diagnosis, including follow-up issues, referral delays and patient delays. In more than half the cases, there was more than one cause of delay. There was often poor documentation of a follow-up plan, and/or issues with communication.

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Cognitive errors, or errors due to lack of clinical knowledge, occurred in 75% of the study group. In particular, failure to order the correct test, especially in young women, was a common theme. In women presenting with a breast lump, the triple test approach to diagnosis is recommended – clinical examination, imaging and FNA or biopsy.

Logistical errors (failure to execute a plan or carry out an activity despite a clinically appropriate intention to do so) occurred in 40% of the study group. Errors included failure to follow up test results and/or the patient, communication failure between GP and specialist, and poor documentation.

In some cases, there was misunderstanding of the role of breast screening which was used to investigate a new breast symptom. **It is not appropriate to rely on breast screening services to investigate a new breast symptom.** Breast screening is only for asymptomatic women.

Risk management strategies

- Know and follow the Cancer Australia guidelines for the investigation of new breast symptoms. Available at: **canceraustralia.gov.au**
- Have a clear and documented plan for the follow-up of patients with breast symptoms and/or signs to a definitive diagnosis or resolution of symptoms.
- Ensure that your patient has a clear understanding of the need for investigation and how to obtain their results.
- Do not discount the possibility of breast cancer in younger women – low risk does not mean no risk.

References

1. Cancer Australia. Report to the Nation: Breast Cancer 2012. Sydney: Cancer Australia, 2012. Available at: canceraustralia.gov.au/sites/default/files/publications/ca_report_to_the_nation_breast_cancer_2012_d15_508de9ff41cae.pdf
2. MDA National unpublished study.
3. Cancer Australia. The Investigation of a New Breast Symptom: A Guide for General Practitioners. February 2006. Available at: canceraustralia.gov.au/sites/default/files/publications/ibs-investigation-of-new-breast-symptoms_50ac43dbc9a16.pdf

Around the World in Eighty Years

The most important long-term doctor for an individual person should be their General Practitioner.

Last year Emeritus Prof Max Kamien, a Western Australian General Practitioner, was awarded the Royal Australian College of General Practitioners' (RACGP) most prestigious honour – the Rose-Hunt Award. This special feature looks at Emeritus Prof Kamien's achievements.

Tell us how you got started in medicine.

I'm a doctor and I've enjoyed being a doctor. Medicine is a very serious business but it can be a lot of fun. Originally, I wanted to be a school teacher but was told I wouldn't get on well with the bureaucracy of the Education Department! Initially, I had to go to Adelaide to study but was able to do the last two years in Perth. It was a privileged time with 15 students enrolled in medicine – more teachers than students in fact!

And your first jobs...

My first job was at Fremantle hospital and I loved it. In those early years I also worked in Melbourne, New Guinea and Israel, where I met my wife Jackie at a language school. She was the top and I was the bottom student! After that, I wanted to work in the UK and finally got a job there – on my 63rd application. I was the only applicant for a position as resident medical officer in child psychiatry, and I got the job on the second interview. I kept studying and received further qualifications and started teaching while at Warwick Hospital.

If you do general practice properly, it is the hardest of disciplines and should have a higher status.

What are your views on the importance of medical education?

The most important long-term doctor for an individual person should be their General Practitioner. A person who doesn't have a GP runs the great risk of being abandoned, and I see a lot of elderly people who are literally abandoned. In previous times, a person's GP would know everything that was happening to a patient, but that's not always the case now. If you do general practice properly, it is the hardest of disciplines and should have a higher status.

You're known for your work in Bourke, NSW. Tell us a bit about it.

In Bourke, I became a General Practitioner to the community, though the people there often thought of me as a mad psychiatrist! Originally, I was mapping the psychiatric epidemiology of that part of NSW, but the Aboriginal people had many other more immediate problems. They needed a multifaceted approach to their problems. One example was trachoma that needed the basic hygiene of warm running water and protection from flies, as you would get in low-cost housing. I then went to Sydney looking for an architect and an eye doctor and came back with Dr Fred Hollows. I can't say there's one particular thing about the Bourke experience that was amazing. The whole thing was amazing. When I left, 450 Aboriginal people came to say goodbye. I've been back there this year, working in the Bourke Aboriginal Health Service. I'm treating the grandchildren and great-grandchildren of my 1970s friends and Aboriginal advancement colleagues.

Tell us about your work in Perth.

I've been a professor for 27 years and started a Department of General Practice at UWA in 1979. I loved teaching the students and also worked at Sir Charles Gairdner hospital. After Bourke, working in a teaching hospital was very tame and predictable.

What about some of the surprises in later life?

I've always wanted to go to Antarctica. I applied for a medical position to go to Antarctica twice – and got a call seven years later! Because I was 70 years old at the time, they were concerned about whether I was sportive enough to handle it. I reassured them by explaining I'd just ridden the Gibb River Road on my bicycle – 688km off road.

I must say the Rose-Hunt Award surprised me, especially since I was in my 80th year. Though I don't aspire to winning awards, it's always good to be recognised.

And retirement?

No, I don't think I'll ever retire completely, but in deference to my family, I think I should soon retire from clinical practice.

Emeritus Prof Max Kamien

Current Laws on Foetal Sex Selection – Your obligations as a medical practitioner

By Guest Writer - Dr Michelle Emmerson, B Med Sci, MBBS (Syd), DCH, FRACGP
Current GP Adviser for the Statewide GP Obstetric Shared Care Program SA, and MDA National PMLC Member

Some GPs have been faced with an increased frequency of foetal sex selection presentations – an increase that has likely come about due to the availability of NIPT (Non-Invasive Perinatal Testing)[1] which allows sex identification at 9-10 weeks of gestation.

My recent professional experience is that I have had as many requests for this test for gender selection as for chromosomal abnormalities. The majority of these presentations have been for male preference, but have not all been limited to this. I have also become acutely aware that some communities in Australia still face pressure to have sons. "Family balancing" has also been cited by patients as a reason for wanting to know sex early.

Foetal sex selection used to be a rare presentation. Until recent changes in screening technology, it was difficult for patients to select the sex. It was not revealed until the 20-week morphology scan (unless invasive testing was indicated by a high-risk result on first trimester screening). By this point, termination was not impossible but much harder, and the woman had usually started to bond with her unborn foetus and she had started to "show".

Policies on sex selection

As a country we do have a few policies on sex selection. There are regulations set by the National Health and Medical Research Council on IVF embryo sex selection, essentially outlining that sex selection can only be carried out during the process if there is a sex chromosome related abnormality that the family is trying to screen out.[2] As these organisations need to conform to the regulations to be accredited, this is how it is enforced. It is not the law. Outside of reproductive technologies, there is no current legislation on gender selection.

The finer points of abortion law are state-based, but essentially a woman can procure an abortion for any health or social reason[3] before 20 weeks of gestation. This means a woman can present to one of the clinics stating "social reasons" for wanting a termination – the social reason can be a gender-based one. These clinics run on the ethos that it is the woman's right to choose as she typically bears the burden of the outcome.

GP obligations for this type of presentation

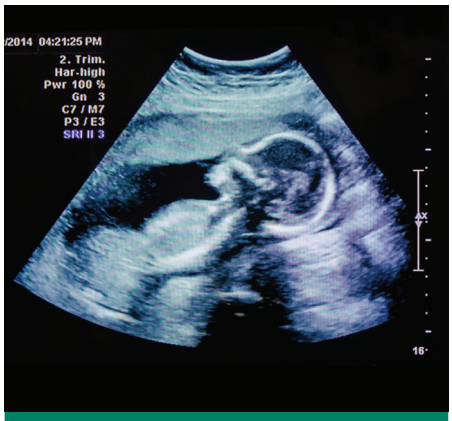
As abortion is legal, GPs need to work within the current legal framework and refer these patients appropriately. If you object to making this type of referral, you are obliged to send the woman to a non-objecting doctor or service. In 2013 a doctor was brought up before AHPRA for disciplinary action for not referring in such a circumstance.[3,4]

You should be aware of the Medical Board's *Good Medical Practice: A Code of Conduct for Doctors in Australia*:[5]

> **2.4 Decisions about access to medical care**
> Your decisions about patients' access to medical care need to be free from bias and discrimination. Good medical practice involves:
> ...
> 6. Being aware of your right to not provide or directly participate in treatments to which you conscientiously object, informing your patients and, if relevant, colleagues, of your objection, and not using your objection to impede access to treatments that are legal.
>
> 7. Not allowing your moral or religious views to deny patients access to medical care, recognising that you are free to decline to personally provide or participate in that care.

The larger population

Is gender selection likely to be a larger population issue? An SBS report last year stated that the United Nations figures suggest that worldwide there are 100 million girls "missing" due to never being born.[6] However, the sex ratios in Australia are unlikely to be significantly affected by the relatively small numbers of people currently seeking sex-based termination.



If you object to making this type of referral, you are obliged to send the woman to a non-objecting doctor or service.

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1. Sonic Genitcs. The Harmony Prenatal Test. Available at: sonicgenetics.com.au/nipt/patients/harmony-prenatal-test/?gclid=CI-ipdugzssCFUsGvAod534LwQ The NIPT test is not Medicare or health fund rebatable and it currently costs between $400 and $500 AUD.
2. National Health and Medical Research Council. Ethical Guidelines on the Use of Assisted Reproductive Technology in Clinical Practice and Research (2007). Available at: nhmrc.gov.au/guidelines-publications/e78
3. Library of Congress, Law Library. Sex Selection & Abortion: Australia. Available at: loc.gov/law/help/sex-selection/australia.php
4. Devine, M. GP in Strife Over Abortion Beliefs. The Telegraph, Australia Saturday, 5 October 2013. Available at: blogs.news.com.au/dailytelegraph/mirandadevine/index.php/dailytelegraph/comments/gp_in_strife_over_abortion_beliefs/
5. The Medical Board of Australia Good Medical Practice: A Code of Conduct for Doctors in Australia 2014. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
6. SBS. Could Gender-Selective Abortions be Happening in Australia? SBS Radio, sbs.com.au/news/article/2015/08/17/could-gender-selective-abortions-be-happening-australia aired 28 August 2015.

GP – Clairvoyant or Clinician?

Since the introduction of the Federal Government's Better Access to Health Care Scheme in March 2012, General Practitioners have been asked to determine whether or not a patient has a "mental health disorder" for the purpose of making a GP Mental Health Treatment Plan (MHTP). This generally requires the GP to make a diagnosis, plan a treatment, and then prepare the MHTP and refer the patient to allied mental health services. It is not uncommon for doctors to be pressured into writing the MHTP, either by the patient or the allied health provider.

It can sometimes feel like doctors working in general practice are expected to act as clairvoyant as well as clinician! These expectations can cause anxiety for a doctor whose primary concern is making the correct diagnosis and formulating an appropriate treatment plan.

What advice is a doctor required to give a patient who presents with a request for a MHTP?

The logical first step is for the doctor to be satisfied that the patient has a "mental health disorder". Sounds obvious, right?

But what if the patient also has a life insurance policy which specifically excludes coverage for mental health disorders? To what extent is the doctor required to consider this issue when deciding whether or not to refer the patient for psychiatric or psychological care? Should this influence the decision whether or not to make the referral? And is the doctor then required to advise the patient that engaging with a MHTP may have the effect of voiding the insurance policy?

A doctor's role, first and foremost, is to listen to a patient's medical concerns, make a diagnosis, offer advice and, where necessary, provide treatment or refer to an appropriate practitioner.

In the context of mental health, a GP should be satisfied that there is a clinical diagnosis to support the making of a MHTP. As part of this process, the patient needs to be advised regarding the need (or not) for the MHTP. However, the GP's decision should not be influenced by the possibility that the diagnosis of a mental health condition will have the potential to affect a patient's insurance.

Ultimately, the doctor's role is to determine whether the MHTP is clinically indicated. This needs to be clearly noted (one way or the other) on the patient's medical record. A doctor who fails to record relevant information, due to the fear that doing so will affect a patient's insurance, runs the risk of committing a criminal act. In other words, by attempting to assist the patient beyond the treatment room, you may be jeopardising your career.

In the end, the doctor's decision must always be made with the patient's best medical interests in mind. This remains the case even when there is the potential for a patient's personal insurance to be adversely affected.

Revalidation – Validation Lessons

By Guest Writer Adj Prof Janice Bell
Chair RACGP Expert Committee Post Fellowship Education
Chief Executive Officer WA GP Education and Training (WAGPET)

In 1996, the RACGP decreed a validated ticket was required in order to practise as a General Practitioner. The days of completing an internship and setting up a shingle, organising your own training or undertaking the voluntary family medicine program (FMP, later the RACGP training program) were gone.

Validation

Twenty years on, we can assess that brave move to validation – but we must also assess the cost of and the lessons learned on the journey to validation. Of course, this validation story belongs to general practice alone, and revalidation potentially to all healthcare professionals. But the lesson is that revolution is rarely without its bounty and debts, winners and losers.

With validation, training has been reworked and reshaped, and assessment likewise. We have two fellowships for ostensibly the one end point, perhaps recognising previously opaque genuine differences within general practice. Rural clinical schools with regionalised GP training providers have changed the face of our rural workforce dramatically.

Revalidation

As we reflect on validation, we contemplate the case for revalidation. There is little doubt that again too much may be asked of it, by too many competing interests, and that the lessons afforded us in GP validation may be forgotten in another simple, neat, and – in some versions – unsuitable solution.

For instance, while validation and revalidation as processes can drive professional competence, they will not prevent patient complaints, the best proxy we have – albeit a negative and lag indicator – of inappropriate, unsafe, poor quality and downright dangerous care. Robust evidence exists for this. We know that 49% of all patient complaints in Australia relate to about 3% of all doctors.[1] We also know that the best predictor of a patient complaint is a previous patient complaint. Revalidation will not change this reality and it hasn't changed this where it has been implemented already.

The Australian experience

Fortunately this time Australia has not followed blindly into revalidation but has stepped back, watched and learned from the experiments in other developed countries. It appears AHPRA, with its role in protecting the public from poor healthcare interventions and outcomes, is taking revalidation very seriously. There are lessons to be learned in our own history of regulation, as well as in the history of others. And as with most complex questions, input from those likely to be affected can be invaluable.

Unlike in 1996, the government and the profession are pre-emptively acknowledging the strengths and limitations of any revalidation process, the challenges of contextualisation, the cost of redirecting of the health dollar away from frontline service, and the risks of perverse disincentives – all of which stand to impact patient care negatively.

The future

There are boundaries that doctors must work within, a performance level they must achieve, and competencies they must be able to demonstrate on demand. It is too late to wait for the first complaint – much too late to wait for later ones – to require the doctor in question to prove they can and do provide safe quality care in the discipline in which they are trained, recognised and remunerated. The days of unquestioning faith in the medical profession are hardly the ones for us to reminisce upon fondly, and neither are the ones where we may have been truly out of our depth, absent of feedback, direction and support.

Both validation and revalidation can and do develop transparently our capacity for and comfort with reflective learning, because the reflective learner lives on feedback – multisource feedback. Whether we call it validation, revalidation or something else, most of us continually question ourselves, our patients and our colleagues in order to learn; in order to keep practising our craft.

We know that 49% of all patient complaints in Australia relate to about 3% of all doctors.

Our challenge is to provide the evidence that we do just this and that we act on what we learn. It is this evidence that – in my view – the public, the profession and the funders are entitled to know. It may not always be outcomes focused – but it must be valid and reliable proxies for what patients can expect from the doctors who serve them.

For more information, see the article UK Revalidation: A Valid Model for Australia? in *Defence Update* Spring/Summer 2015: **defenceupdate.mdanational.com.au/articles/uk-revalidation**

Reference

1. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. *BMJ Qual Saf* 2013;0:1-9. Available at: qualitysafety.bmj.com/content/early/2013/02/22/bmjqs-2012-001691.full

Please note: The views expressed in this article belong to the author, not any organisation with whom she is associated.

Medicare Update

The 80/20 rule

Medicare regulations specify that a practitioner is deemed to have practised inappropriately if he or she has rendered 80 or more professional attendances on each of 20 or more days in a 12-month period.

The number of professional attendances claimed per day may not be the same as the number of patients seen in a day. Professional attendances include most of the "Group A" items, e.g. consultations, after-hours attendances, health assessments, care planning and mental health, among others.

Medicare monitors your claiming patterns. If you are approaching 80/20 you may be reviewed, and your "practice profile" of claiming compared to other practitioners in a similar role/region.

If you do exceed 80/20, you will be reviewed and, if you have breached regulations, you will be referred to the Director of Professional Services Review.

Please contact our Medico-legal Advisory Services team for assistance if you are contacted by Medicare, or if you have any concerns regarding your Medicare claims history.

Care planning – chronic disease management

The current components of chronic disease management within the Medicare Benefits Schedule (MBS) are:

- GP Management Plans (MBS item 721)
- Team Care Arrangements (item 723)
- Review of either of the above (item 732)
- Contribution to a Multidisciplinary Care Plan being prepared by another Health or Care Provider (item 729)
- Contribution to a Multidisciplinary Care Plan for a Resident of a Residential Aged Care Facility (item 731)

Why do care planning?

These items aim to help GPs consolidate the management of patients with chronic diseases, particularly those with "complex" care needs. A well written care plan (GPMP +/- TCA) can motivate and help patients to manage their condition(s), and also assist others involved in their care.

What conditions are eligible for a care plan?

Medicare defines a chronic or terminal condition as one that has been (or is likely to be) present for six months or longer – for example, asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

If a patient requires at least two other health providers (in addition to his or her usual GP) regularly involved in their disease management, then they are eligible for a Team Care Arrangement (TCA). This TCA then triggers eligibility for a maximum of five Medicare rebatable Allied Health Professional (AHP) visits.

How often can I claim?

The minimum claiming period for a GPMP and/or TCA is once every 12 months (recommended period is every two years) with reviews claimable a minimum of every three months (recommended every six months). If claiming a review of a TCA, you require feedback from at least two other providers involved in the patient's care during the preceding period.

Can I coordinate and claim a TCA even if the patient is not accessing rebateable allied health items?

Yes, if your patient has at least two health care providers involved with their care (e.g. through a local hospital outpatient setting) then they are still eligible for a TCA.

Can a patient access more than five allied health rebatable visits per year?

No, the maximum per calendar year (January–December) is five. These visits are referred to as "rebatable" as it is up to the individual AHP if they bulk bill or not. Note: you need agreement from the AHP that they will accept your referral – and if you have not referred previously you may need to confirm that the AHP is registered as a Medicare provider. Please note that more than five visits are possible but are not rebatable in a calendar year.

Can I use a "pre-filled" template for common conditions?

If you choose to use a pre-filled template it is very important to personalise and alter it according to the specific patient's history, examination, circumstances and requirements.

For further information see:

- The Australian Government Department of Health website: **health.gov.au/internet/main/publishing.nsf/content/mbsprimarycare-chronicdiseasemanagement**
- Questions and Answers on the Chronic Disease Management (CDM) items: **health.gov.au/internet/main/publishing.nsf/content/mbsprimarycare-chronicdiseasemanagement-qanda**

GPs are required to gain AND record the patient's consent to complete a GPMP/TCA, and be offered a copy of the plan.

MEDICO-LEGAL CASE STUDY

Failure to Examine

The Queensland Court of Appeal found a GP had breached her duty of care in failing to refer a patient to a specialist or the local hospital in a timely manner.[1] The patient was awarded $6.7 million in compensation for the delay in diagnosis of cryptococcal meningitis, the highest personal injury award in Queensland's history.

Case history

In September 2008, the 43-year-old patient, Ms M, developed neck pain and headaches.

5, 8, 11 September 2008 – Ms M saw a chiropractor who ordered x-rays and performed spinal manipulations.

12 September 2008 – the patient saw her GP who recorded:

Intermittent neck pain, worse 6/52, causing headache and flushing to face

Chiropractor did XR C spine, showed loss of normal curvature

Is finding that massage is resolving symptom

Nil head injury, nil neurological def, nil visual disturbance

FH CVA both Grandmas

BP 180/80

IMP

Cervical spondylosis

Plan

Simple analgesia

Cont physio

R/V if any changes or concerns.

The GP did not perform a physical examination of the patient's neck.

12, 15, 17 September 2008 – Ms M saw the chiropractor for further spinal manipulations.

18 September 2008 – the patient saw her GP who recorded:

Neck remains painful

Getting dizziness

Reduced ROM

Plan

Reasons for contact

Neck – pain

Actions:

Diagnostic imaging requested: CT cervical spine

Prescription added: STEMAZINE TABLET 5 mg 1 t.i.d. p.r.n.

Prescription added: PANADEINE FORTE TABLET 500mg/30mg 2q.6.h. p.r.n.

r/v here immediately after imaging.

The GP did not perform a physical examination of the patient. Nor did the GP ask the patient about her symptoms of headaches and facial flushing.

The CT scan showed posterior disc bulges at C2/3 and C3/4, a slight posterior bulge at C5/6 and a mild broad-based posterior spondolytic protrusion at C6/7.

19 September 2008 – the GP informed Ms M of the results of the CT scan. The GP prescribed ibuprofen and valium, and provided a certificate for one week off work.

The GP did not perform any physical examination of the patient.

23 September 2008 – Ms M saw a physiotherapist who performed neck traction.

24 September 2008 – the patient was taken to the local hospital by ambulance, complaining of increasingly severe neck pain. She was seen by a RMO. A FBC revealed a WCC of 15.7. She was prescribed tramadol, maxolon and amoxycillin for a possible chest infection.

25 September 2008 – the patient was reviewed by the GP, and reported worsening neck pain and feeling weak. The GP organised for Ms M to be admitted to a private hospital.

26 September 2008 – the patient was seen by a Physician who made a provisional diagnosis of Guillain-Barré Syndrome and ordered, among other investigations, a lumbar puncture. The lumbar puncture revealed cryptococcal meningitis. The patient was transferred to the ICU of a tertiary hospital for ongoing management.

Ms M suffered sensorineural hearing loss, cortical blindness, impaired balance and an adjustment disorder with depressed mood.

Medico-legal issues

The Court found the GP had breached her duty of care to the patient in the consultations on 18 and 19 September 2008 for failing to perform a physical examination of the patient's neck. The Court stated "a neck examination was a simple exercise to undertake".

The Court also found the GP should have enquired about the progress of Ms M's previously reported symptoms of headache and facial flushing at the consultations on 18 and 19 September 2008.

Based on the expert evidence, the Court found that if the GP had performed a neck examination and enquired further about Ms M's symptoms on 18 and 19 September 2008, this would have led the GP to refer her for specialist review. The Court found that a neck examination, suggestive of meningeal irritation, would have led the GP to recognise the potential presence of a serious central nervous system condition, rather than the musculoskeletal disorder which the GP thought the patient was suffering from.

Based on the expert evidence of Infectious Diseases Physicians, the Court found that if the meningitis had been diagnosed and treated before 24 September 2008, the catastrophic consequences of the disease would have been prevented. By 24 September 2008, the evidence suggested the consequences of the meningitis were irreversible.

Discussion

In this case, the GP acknowledged that she had not performed any physical examination of the patient on 18 and 19 September 2008. This failure to perform a physical examination was a breach of her duty of care.

While there was argument as to whether or not an examination of the neck would have detected signs which were suggestive of meningeal irritation, the Court ultimately found that a physical examination and elicitation of further history about the patient's symptoms would have resulted in the GP referring the patient to a specialist or hospital on 18 or 19 September 2008.

Reference

1. *Mules v Ferguson* [2015] QCA 5. Available at: archive.sclqld.org.au/qjudgment/2015/QCA15-005.pdf

Leaving a Group Practice

What are my obligations if I am leaving a group practice to work elsewhere?

If you have an employment contract, before accepting a new position or starting your own business, check for restraint of trade clauses, exit requirements and other relevant contract terms.

Your professional obligations as stated in the Medical Board's *Good Medical Practice: A Code of Conduct for Doctors in Australia*[1] are:

> *3.15.1 Giving advance notice where this is possible.*
>
> *3.15.2 Facilitating arrangements for the continuing medical care of all your current patients, including the transfer or appropriate management of all patient records. You must follow the law governing health records in your jurisdiction.*

How much notice do I need to give the practice owner?

If not specified in an employment contract, you can negotiate with the practice owner, but two to four weeks' notice is generally considered reasonable. In rural and remote areas, longer notice periods may be needed. You should provide your notice in writing and you may consider independent legal advice.

What can I tell my patients?

It's best to agree with the practice owner about communication to patients. Consider a letter or email to all your regular patients, or a notice in the waiting room or on the practice website. You should also tell patients during consultations.

Current patients should be told you are leaving and when, and that other doctors at the practice will be able to take over their care. Unless contractually stated, agree with the practice owner about whether you can tell patients where you are going.

Do not use the practice database of patient details to solicit patients to follow you to your new practice. This would be a privacy breach and a misuse of the practice's commercially sensitive information. An exception would be if the practice owner agreed and patients consented to you using their information for this purpose.

The NSW Supreme Court[2] found a doctor breached his implied duty not to use confidential information for a purpose beyond the practice's function, when the doctor had taken copies of pathology results to contact patients and tell them where he was now working.

Who else should I notify?

- Specialists and other health professionals you refer to, or who refer to you
- Medicare – you will need a new provider number
- AHPRA
- Anyone from whom you receive mail or email at the practice address
- MDA National

How do I arrange continuing medical care of my patients?

- All recalls, reminders and other patient follow-up should be entered into the practice's follow-up systems, with responsibility assigned to remaining staff.
- If the practice does not have follow-up systems, provide (and keep a copy of) a written handover. List outstanding test results, results requiring action, specialist referrals, and conditions requiring review. Indicate the urgency of any follow-up which may need to take into account critical patient needs and direct handover to a specific colleague in some cases.
- Generally the medical records remain the property of the practice, unless there is a specific agreement to the contrary.
- Seek an agreement that the practice will provide you with a copy of the relevant records if there is a claim, complaint or coronial investigation involving you.
- A patient who wants to see you at your new practice can request in writing that a copy of their records be provided to them or to your new practice. The "old" practice may charge the patient a reasonable fee for providing the copy, and has up to 30 calendar days to respond to the request.[3]

Current patients should be told you are leaving and when, and that other doctors at the practice will be able to take over their care.

References

1. The Medical Board of Australia Good Medical Practice: A Code of Conduct for Doctors in Australia 2014. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
2. *Mid-City Skin Cancer and Laser Centre v Zahedi-Anarak* [2006] NSWSC 844 (13 September 2006). Available at: austlii.edu.au/au/cases/nsw/NSWSC/2006/844.html
3. Australian Privacy Principle 12 – Access to personal information, from the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*, which amends the *Privacy Act 1988*.

Premium Support Scheme (PSS) Are You Eligible?

The Australian Government offers the PSS to eligible medical practitioners to assist them in meeting the costs of their medical indemnity insurance. Our *PSS Important Information* booklet can help you determine whether you wish to be considered for the PSS.

Visit our website today to:

- determine whether you're eligible for the PSS with our new PSS Calculator on our website under Insurance Products
- download the Application for PSS form.

Contact our Member Services team on **1800 011 255** or **peaceofmind@mdanational.com.au** with any queries about the PSS.

More for You

MDA National provides GP Members with even more cover in 2016/17 with the following policy enhancements effective from 1 July 2016:

More cover for you

More communicable disease cover

We've added an additional three communicable diseases to our Professional Indemnity Insurance Policy should you have to cease practice permanently or substantially alter your practice due to a diagnosis of:

- HIV
- Hepatitis B
- Hepatitis C
- extremely drug resistant tuberculosis (XDRTB) – ***new***
- multi-drug resistant tuberculosis (MDRTB) – ***new***
- New Delhi Metallo enzyme enterococci – ***new***

Expansion of employment disputes cover

We have also expanded our legal costs cover for employment disputes with an employer or employee in relation to pursuing or defending allegations of sexual harassment should you be faced with such an issue.

More cover for your practice

Clinical trials cover

MDA National's Practice Indemnity Policy now covers civil liability claims against the Practice or an insured person for health care provided as part of a clinical trial or research project carried out with approval of an ethics committee in accordance with the National Health and Medical Research Council (NHMRC) guidelines. The cover does not cover the trial itself or liabilities arising from the sponsorship or administration of the trial, as these would be covered by the trial's indemnity.

Defence costs for employment disputes

The Practice Indemnity Policy has also been expanded to cover defence costs for disputes against the entity by employees or contracted staff relating to their employment contracts with the entity.

The Policy terms and conditions apply. Please read the relevant Combined Financial Services Guide, Product Disclosure Statement/ Important Information and Policy Wordings available on our website **mdanational.com.au** or contact Member Services on **1800 011 255** or **peaceofmind@mdanational.com.au** for details.

More online resources

Check out our **Resources** section at **mdanational.com.au** for more convenient access to articles, blogs, case studies, medico-legal FAQs and videos. Our new **Medico-legal Blog** provides information on breaking and key medico-legal issues – recent cases, court judgments and legislative updates.

More education for GPs

All our education is complimentary for Members, and most is accredited with The Royal Australian College of General Practitioners and The Australian College of Rural and Remote Medicine.

Visit **mdanational.com.au** for details on the education events we're hosting in your state.

Contributors

Thank you to the following editorial contributors:

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

Daniel Brand
Claims Manager (Solicitor), MDA National

Dr Jane Deacon
Medico-legal Adviser, MDA National

Gae Nuttall
Risk Adviser, MDA National

Karen Stephens
Risk Adviser, MDA National

Specialty reviewer:

Dr Reg Bullen
MDA National Member

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

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