GP Update

An update for MDA National
GENERAL PRACTITIONER MEMBERS

Overview

Welcome to another issue of *GP Update*, the publication that's written to address the specific medico-legal needs of you – our GP Members – in mind.

This issue features articles on:

- DORA – Tasmania's risk tool for prescription monitoring
- the importance of documentation and good records
- how to avoid complaints
- medico-legal tips for after-hours doctors
- "free" screening programs and what to watch out for
- tips on what to do before you go on leave.

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

If you have feedback or topic suggestions, we'd love to hear from you at **specialtyupdate@mdanational.com.au**.

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Exploring DORA – Prescription Monitoring in Tasmania

The misuse and abuse of prescription pharmaceuticals is a complex and difficult issue for GPs, and one that seems to be on the increase.[1] This misuse is also a significant wider public health issue across the country that affects many Australians. Tasmania is leading the way by tackling the issue in a practical way and with technology on their side.

Their "secret weapon" is DORA, which stands for Drugs and Poisons Information System Online Remote Access. Created and administered by the Pharmaceutical Services Branch of the Tasmanian Department of Health and Human Services (DHHS), DORA is a web-based information system that allows access to real-time decision support for clinicians and pharmacists. DORA has been available in Tasmania for over five years.

GPs are well aware of issues surrounding patients who present after hours requesting medication with stories of lost scripts, recent moves from interstate or other scenarios. Some of these requests may well be legitimate. So, what does a GP in Tasmania do? What information do they have access to and how does this work?

More about DORA

DORA allows the GP to access a "lite" version of the DHHS Schedule 8 drugs dispensing database. The system displays relevant data on a secure web-based interface, allowing the GP to determine:

- what Schedule 8 drugs have been dispensed for that patient
- whether a doctor holds a state authority to prescribe for the patient
- whether the patient has ever been the subject of a circular restricting their access to drugs that are likely to be misused
- whether the patient has been declared drug dependent or a drug seeker by a medical practitioner under Section 59 of the Tasmanian *Poisons Act 1971*.

Importantly, the system does this in real time. DORA enables secure access to information 24 hours a day, seven days a week for registered medical practitioners who are considering prescribing drugs subject to misuse or registered pharmacists considering the supply of such substances. This gives GPs and pharmacists more information, helping them to more easily decide whether or not a drug is safe and appropriate to make available to a patient.

DORA as a tool

The system is a risk management tool to support sound clinical decision-making. DORA provides practitioners with more information to make a decision around the supply of drugs likely to be misused. It doesn't make the decision for the practitioner – only the practitioner can do that.

DORA is also a useful clinical tool for pharmacists. To date, more than 95% of pharmacies now securely report their Schedule 8 data in real time. The remaining 5% are unable to do so because of technological issues independent of the department.

The intellectual property rights to the DORA suite of software developed in Tasmania has been licensed to the Commonwealth and made available to the states and territories as the Electronic Recording and Reporting of Controlled Drugs (ERRCD) System. Australia does not have a uniform national law regarding the prescribing and supply of scheduled substances. Legislation and regulation of opioids, benzodiazepines and psychostimulants are administered at a state level. So far, Tasmania is the only state with a real-time prescription monitoring system.

Changes since DORA

Before DORA was introduced in 2012, Tasmania averaged 25 deaths per year from Schedule 8 opioids. Since then, the rate has fallen to around 17 deaths per year, a significant achievement and a good result for Tasmania.[2]

For more information about DORA and how it can assist with your clinical decision-making, contact the Tasmanian DHHS, Pharmaceutical Services Branch, on **pharm.services@dhhs.tas.gov.au** or (03) 6166 0400.

References

1. Pilgrim JL, Yafistham SP, Gaya, et al. An Update on Oxycodone: Lessons for Death Investigators in Australia. *Forensic Sci Med Pathol* 2015; 11(1):3-12.
2. DORA Makes a Difference in Saving Tassie Lives. 5 February 2017. Available at: themercury.com.au/news/tasmania/dora-makes-a-difference-in-saving-tassie-lives/news-story/d493634c2cd2b56f542d5ec6b4948141.

DORA in Action – A GP's perspective

Tasmanian GP, **Dr Alexandra Seidel** of the Huon Valley Health Centre, tells us about her professional experience using DORA.

How long have you been using DORA?

Our practice has been using DORA for over four years. We were one of the first practices to start using the program, largely thanks to my practice partner who has a keen interest in IT and was on the steering committee for the development of DORA. To begin with, it was a matter of trying the program out – as both a quality and safety initiative – to see how it worked in day-to-day practice. The usefulness of the program became obvious to us quickly, particularly during the summer when we have a transient population with people who are unfamiliar to us asking for S8 drugs.

What was life like before DORA?

Before DORA, the systems were less streamlined – we used the Doctor Shopping Hotline; pharmacists would use a separate system; and we would also receive faxed circulars about drug-seeking patients. This last method relied on us seeing the fax and remembering the names. With DORA, I can look up patient information on my computer immediately, particularly if I'm unfamiliar with the patient or if they've presented to us before asking for S8 drugs.

What are the benefits?

DORA is an information portal and useful clinical decision-making tool. It allows me to search for patients, see when that patient last had S8 drugs dispensed, check for any circulars or alerts, and also check on the authorities to prescribe. It has improved my workflow from the point of view that I can keep track of my authorities to prescribe. Importantly, it helps with knowing in advance if there's an issue with a particular patient, such as an alert on their file (i.e. they need to pick up their medication daily from the pharmacy), or any reason for me to contact the Pharmaceutical Services Branch before prescribing.

How does DORA work in practice?

For us, a scenario may be a new patient from Hobart who has come to our practice in the Huon Valley requesting prescriptions. This raises the question of why they've travelled to see a doctor. We can then search DORA, see whether the patient has a file and/or is prescribed S8 medications. If there is a regular, authorised prescriber, this allows us to decline to prescribe. Very occasionally, patients try to threaten or blackmail GPs into prescribing restricted medications, and DORA helps from a personal safety perspective by making it easier for us to say no. From a patient safety point of view, there is less risk of us prescribing increased quantities. For example, authorities to prescribe give limits on amounts and this minimises the risk of overdose to the patient.

Any general comments about DORA?

DORA works because it enables us to be more informed about what we're prescribing. It's very easy to use and I would encourage all Tasmanian GPs to use the system.

Close Encounters of the Patient Kind

By guest writer Dr Brian Morton

How well do you document your patient encounters? I don't just mean consultations, but all encounters including telephone calls, emails and dual consults on a ward round with registrars, residents or interns.

The case

Mrs X had two to three episodes of dysphasia reported by her family which were brief and she recovered fully. Her GP who was consulted 24 hours after the last episode found no abnormality. Some 36 hours later she was admitted to hospital with a CVA. Her family submitted a complaint that her GP should have diagnosed a TIA and referred her on for investigation. Furthermore, they alleged that the GP had not performed an appropriate examination.

The Medical Board, on receipt of the complaint, requested the GP to respond and supply the record of the consultation.

It's important to understand that the complaint and initial response are dealt with on the written statements of the doctor and the documentation provided. It's at this point that the complaint will proceed or fail. The documentation of that encounter will support a decision of no further action or lead to further proceedings.

The documentation

For this hypothetical case, the GP did have computer entries of history and examination. There was no management plan documented. The GP's statement indicated a verbal plan given to the patient and family member present.

Reviewing the notes, the history documented the word dysphasia, the past history was noted, and the examination was documented with BP recorded and "neuro intact, walking normally".

The GP's statement indicated a more detailed history and examination. This represented a significant divergence from the family's written complaint which also alleged that no advice was given for further management.

The investigator's point of view

Play the above scenario as if you were an investigator looking at the evidence presented. In the history, wouldn't you expect to read a record of the episode duration, confirmation with the patient and family that it was a true dysphasia, and questions about other neurological accompaniments such as sensory or motor symptoms? Is there documentation of the examination: power, tone, reflexes, cranial nerves, cardiac rhythm? Would you also expect a documented plan of further management, such as a referral for an ECG and carotid duplex?

The importance of records

Adequate documentation needs only to be simple and basic with relevant pertinent details which evidence appropriate clinical input. It's also important to indicate your diagnostic thinking.

The reality is that during our careers, we may all have a complaint made against us. The reality check is that bad things do happen to patients whether preventable or not, and patients and families want an explanation or sometimes need to blame someone or something.

Even if you mentally go through a differential diagnosis and use experiential shortcuts to arrive at a provisional diagnosis, it is important to document that process, albeit in a brief but appropriately recorded manner.

When two or more versions of an encounter are presented, your documentation provides a contemporaneous record of the accuracy of your version. Remember, if there are multiple presentations there is likely to be a disparity in the histories taken, but good records will confirm your version of the content of the consultation.

Simple entries, perhaps using SOAP (an acronym for subjective, objective, assessment, and plan) headings in your electronic record – history/examination/diagnosis/plan will aid in ensuring you have adequately documented the consultation and protected yourself.

No adequate record, no adequate defence!

Avoiding Complaints

By guest writer Dr Natalie Sumich

"To err is human, to forgive, divine." Alexander Pope

Each day, thousands of medical practitioners head to work with the sole purpose of helping their fellow human beings. The job is rewarding, diverse and at times frenetic, with a vast array of problems presenting in any one shift. So how do we avoid the downside of this wonderful occupation, the inherent risk of medico-legal complaints?

Transparency, compassion, apology, and accountability – these are the keys to avoiding the prolonged and stressful process of litigation. The truth is that most of our patients will forgive us our mistakes if we are honest and humble when we inadvertently make them. They accept we are doing our best and that negative outcomes are sometimes unavoidable despite our best efforts.

Complaints

So why do some patients sue and not others? Generally, complaints occur when our patients feel their concerns are unheard or dismissed. This brings about feelings of mistrust and the need to blame medical professionals for an adverse outcome. Contrary to the belief that greedy patients and their greedier lawyers are after compensation, the most common reason for litigation is for patients and their families to receive acknowledgement that an error occurred and an explanation of the incident with a view to preventing a similar incident in the future.[1]

Consultations and communication

How can we achieve this in a ten-minute consultation? The University of Toronto's Dr Wendy Levinson revealed in a landmark study in 1997 that the chief difference between General Practitioners who had never been sued and their peers who had been sued more than twice was entirely in how they talked to their patients.

The doctors who had never been sued spent more than three minutes longer with each patient, and they were more likely to make orienting comments such as, "First I'll examine you, and then we will talk the problem over" or "I will leave time for your questions." They were more likely to engage in active listening, saying things such as, "Go on, tell me more about that." And interestingly, they were far more likely to laugh and be funny during a visit.[2]

Claims

So, despite doing our best to communicate with our patients, what do you do if you are facing a claim?

Contact your medical defence organisation (MDO) as soon as you are concerned about a possible adverse outcome that may arise in a claim. MDA National is here to support you, and will help collate information to assist with defending a claim at a time when the details of the event are still fresh in your mind.

Contacting your MDO is not an admission of error. It is an opportunity to discuss your case with a non-judgemental peer, who will help you come to terms with an adverse outcome to your patient with the aim of preventing the case proceeding to litigation. This can often be avoided by simply acknowledging that the patient and/or family has suffered an unfavourable outcome, which we all wish could have been avoided.

The importance of records

Do not alter your records. This is as good as admitting liability!

I cannot emphasise the importance of good record-taking, despite how busy our day gets. It is only with good records that any potential case can be adequately defended. Particular emphasis on recommendations given to the patient if the condition is not improving is an essential part of the medical record.

This fact is highlighted by a recent case of a 12-month-old girl who developed meningococcal septicaemia more than 12 hours after presenting to her GP. Experts agreed it was not predictable that the child would go on to suffer catastrophic injuries including bilateral amputations. Despite this, the case was settled for a large sum without proceeding to a court hearing. The doctor said he provided clear and concise information to the parents on the appropriate action to take if the condition was not improving. The girl's parents disputed this and, unfortunately, it could not be substantiated in the GP's notes.

So do not go forth and conquer. Go forth and communicate, and be compassionate and caring.

References

1. Taylor J. The Impact of Disclosure of Adverse Events on Litigation and Settlement: A Review for the Canadian Patient Safety Institute. 2007. Available at: patientsafetyinstitute.ca/en/toolsResources/disclosure/Documents/The%20Impact%20of%20Disclosure%20on%20Litigation%20a%20Review%20for%20the%20CPSI.pdf
2. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons. *JAMA* 1997;277(7):553-559.

Working After Hours – What doctors should know

GPs working for an after-hours doctor service experience all the usual medico-legal issues which arise in general practice, plus some additional issues specific to treating patients out of hours.

Medicare billing

If you regularly bill MBS Items 597-600,[1] you may have received a letter from Medicare last year asking you to review your billing to ensure compliance with the MBS descriptors.

One issue requiring clarification was whether the "urgency" of these MBS Items is assessed prospectively or retrospectively. Our understanding is that the urgency should be assessed prospectively, i.e. based on the patient's assessment of urgency, not your retrospective assessment after the event.

The Medicare letter was a wake-up call to doctors routinely billing urgent items when an urgent visit is not indicated. The guidance provided on prospective assessment does not give doctors carte blanche to bill urgent items when there was no indication the consultation was urgent. You are responsible for your billings, not the after-hours service, so you should know what is being billed to your provider number.

It's also worth noting that the urgent attendance after-hours item numbers only allow attendance on "not more than one patient on the one occasion".

Chaperone issues

In the event an intimate examination is clinically indicated during an after-hours visit, we suggest you seek written consent from the patient, including confirmation that the patient has been offered a chaperone and declined, or the name (and relationship to the patient) of a support person present during the examination. You should consider having a pre-prepared consent form or an addendum to the after-hours consent papers.

Phone triage

All services should have a triage policy which is suitable for a range of staff, from reception staff through to medical practitioners. The policy should address a variety of scenarios such as:

- patients calling from outside the callout range
- urgent calls that require an ambulance
- semi-urgent calls that require a doctor to call back immediately
- standard after-hours calls
- non-urgent calls, where the patient may be advised to see their own GP the following day.

If a patient requests an ambulance and is not capable of making the call, ensure patient consent is obtained and documented.

If the patient terminates the call to ring an ambulance, request a call back once the ambulance has been called, and document the callout.

If a patient refuses an ambulance, and opts for an alternate form of transport, make sure this is clearly documented in the notes.

Treatment refusal

Provided a patient has capacity to make health decisions, the patient can refuse treatment against medical advice. If this happens, you should:

- reinforce the reasons why you are recommending treatment
- engage with a friend or family member, with the patient's consent
- advise the patient, friend or family member about signs of deterioration and where to seek further medical advice
- ask the patient to sign a "refusal of treatment" form and/or document the refusal clearly in the notes
- inform the patient's usual doctor of your visit and the treatment refusal.

If you experience a medico-legal emergency after hours, you can contact our 24-hour Medico-Legal Advisory Service on 1800 011 255. Otherwise, contact us in normal business hours for non-urgent advice.

Reference

1. MBS Online: Medical Benefits Schedule. Available at: www9.health.gov.au/mbs/fullDisplay.cfm?type=note&qt=NoteID&q=A10

If It Sounds Too Good to be True...

Have you ever been approached by a colleague, or answered an ad placed by an agency, for a job that sounds too good to be true?

Most jobs in medicine are highly regulated and therefore adhere to the numerous codes and guidelines in place to protect the public. Despite strict regulatory frameworks, doctors occasionally find themselves on the receiving end of an AHPRA complaint or Medicare investigation due to unscrupulous employers offering profitable positions which can leave the doctor at risk, both financially and professionally.

There has been significant media interest[1] in "free" screening programs, which involve the bulk billing of tests for otherwise healthy individuals, assessing the risk for conditions such as stroke or heart disease. Doctors should be aware that unless specified, Medicare benefits are not payable for health screening services. The concern for doctors is that billing for screening is usually billed to Medicare using a doctor's provider number, for which they are financially responsible. Even though doctors may only derive a set fee per consultation, or receive a percentage of the billings, they can be responsible for 100 per cent of the repayment if Medicare deems the service to have no clinical basis.

Another area of concern is cosmetic injectables. A substantial increase in the number of facilities offering Botox and fillers has seen an increase in the need for doctors to prescribe the drugs for the clinics to inject. Again, this may seem like easy money. However, you need to be aware of the dangers involved in prescribing Schedule 4 drugs outside of your usual practice. If you undertake any practice outside your usual field of practice, you should check whether you are covered under your Professional Indemnity Policy.

AHPRA released *Guidelines for Registered Medical Practitioners who Perform Cosmetic Medical and Surgical Procedures*[2] in October 2016. The guidelines state that while doctors can prescribe Schedule 4 "prescription only" cosmetic injectables after a video consultation, they cannot prescribe cosmetic injectables by phone or email. Doctors must not prescribe Schedule 4 cosmetic injectables unless they have had a consultation with the patient, either in person or by video.

Helpful Tips

If you are approached with an offer that sounds too good to be true, here are some tips:

- Do your homework on the organisation offering the job. A quick Google search may turn up valuable information about the company offering the position, or other companies with a similar structure.
- Don't assume that an agency is responsible for doing due diligence in relation to the legalities around the job being offered.
- Each individual doctor is responsible for ensuring they are appropriately trained and registered for the role they accept, and for assessing whether the tasks within the role are clinically indicated for the purposes of billing to Medicare.
- Don't accept any role which requires you to hand your provider number over to an organisation so they can bulk bill screening services, or any other services which are not clinically indicated or do not meet the MBS descriptor.
- Regardless of where you work, each doctor should know exactly what is being billed to their provider number.[3]

References

1. Medew J, Spooner R. Doctors Sound Alarm on Controversial 'Strokecheck' Results. Available at: theage.com.au/national/health/doctors-sound-alarm-on-controversial-strokecheck-tests-20170324-gv5vko.html
2. Medical Board of Australia. Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Cosmetic-medical-and-surgical-procedures-guidelines.aspx
3. Ferrie N. Staying on the Right Side of Medicare. Available at: http://www.mdanational.com.au/en/Resources/Blogs/Staying-on-the-Right-Side-of-Medicare

When Doctors Go on Leave

Taking leave from work? Congratulations on looking after your own health.

Before you go, you must take steps to maintain continuity of your patients' care. These steps will vary depending on practice circumstances, but there are some commonly applicable measures.

Tips when going on leave:

- Another doctor (or doctors) should be tasked with checking all your results and letters, and documenting actions following from these.
- It is more sensible to have a single nominated GP look at all incoming items, rather than a GP for results and a non-GP for clinical correspondence.
- Make sure you have flagged all patients requiring follow-up in the practice's system (for example, using the recalls function in Medical Director or Best Practice). Those requiring follow-up include patients you are concerned may have a serious condition and you have sent for tests or to see a specialist.
- Another doctor(s) should be tasked with monitoring this follow-up. Make a list of these patients and discuss them with the doctor taking this role before you go. Emphasise any patients you are particularly concerned about or who are particularly anxious themselves.
- Contact arrangements for mature minors needing follow-up should be relayed to staff, e.g. "Only call mobile – not home phone – issue being treated with patient only".
- Arrange for an appropriate staff member to read and action any mail, email and faxes that come in for you.
- Tell patients that you will be away, who will be available for them, and when you will be back.
- Allocate time on your return for going through the list of patients of concern and seeing what eventuated while you were away.
- Remember your notes will be looked at by other doctors if they see the patient or need to confirm details – ensure your documentation is thorough enough to allow another doctor to take over care of the patient.
- Advise administrative and nursing staff who will be looking at your results and letters.

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