defenceupdate

Quarterly Magazine for MDA National Members

Spring 2011

MDA National
Support Protect Promote

Editor's Note

Our annual Medico-legal Minefield Forum is part of MDA National's commitment to risk management and education. This year's interactive Forum canvassed the issue of doctors as leaders: from decision making and consent to supervision.

We are keen to continue this discussion with you and invite your responses to the topics and questions outlined on pages 6 and 7.

In this issue of *Defence Update* we highlight some areas of medico-legal risk where MDA National has noticed an increase in Member notifications: prescribing in pregnancy is discussed on pages 14 and 15 and the Medicare compliance audit program on page 8.

The use of telehealth is becoming more widespread in medical practice and offers exciting opportunities for improved patient care. The recent introduction of MBS Items for video consultations with a range of specialists and the afterhours GP helpline service are two examples of telehealth initiatives. Page 5 provides an outline of these two programs, including some risk management strategies and tools. MDA National remains committed to working with you and other professional groups to understand and hopefully minimise any medico-legal risks associated with telehealth.

As always, your comments and questions about these and any other medico-legal issues are warmly encouraged.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In this Issue

From the President

"Error is the stuff of which the web of life is woven and he who lives longest and wisest is only able to weave out the more of it." Thomas Jefferson

I am not sure if Thomas Jefferson had doctors in mind when he wrote the above approximately 200 years ago. However, I am sure that Jefferson would have seen the impact of medical error as a lesson about life and how acknowledgment of our errors and imperfections are an integral step to mature self-awareness and a healthy self-esteem.

Likewise, contemporary belief about the systemic nature of error implies that conscientious hospitals and health care systems eschew recrimination and blame, and explore how an error breached their system(s), and how additional defences and/or alternative system design might be required to diminish the incidence of errors and the gravity of harm produced.

Therefore, all Australian hospitals quite properly require staff to report errors in the delivery of medical care. These reports vary in complexity and are supposed to be non-judgmental, factual reports of the problems and their consequences. In some jurisdictions, to encourage reporting and address indemnity concerns these are also protected by qualified privilege. That is, they are not usually discoverable if litigation proceeds because otherwise, only limited information might be provided recognising admissions could compromise the individual's indemnity. Providing privilege encourages important facts to be included and minimises the potential for the report to be simply avoided and the incident being "swept under the carpet".

For example, an incident report might simply indicate that a patient slipped because of water on the floor. Such basic information would not be legally sensitive. However, if the report continued: "the charge nurse warned the cleaners not to leave water on the floor," then this information becomes invaluable for future risk management but could easily assist litigation.

Similarly, in disclosing a serious medication error an incident report might say "a prescription was written for Mrs Brown for 10 mg of X but she was actually given 100 mg, which is why she experienced Y". However, the nurse might want to add: "Dr Smith's handwriting was illegible, so I got together with the other nurses on the floor and we took our best guess".

So while MDA National would discourage individuals from using specific names and ascribing blame for any incident, encouraging factual useful reports based on truthfulness and transparency are always appropriate goals in incident reporting and open disclosure.

Accurate and factual incident reports enable hospital risk managers to understand the full situation, and enable the system to readily respond to any error involving the patient, as well as reduce the risk of such errors being repeated.

If the evolution of error disclosure is to continue, state governments will have to protect the mechanisms that investigate error, and the manner in which these incidents are disclosed. In fact, the psychological tendency to protect one's self-esteem and avoid self-incrimination will only be overcome if disclosure of medical error is more fully protected from recrimination and legal consequences. And it would seem that uniform legislation to provide qualified privilege for incident reporting and open disclosure – in all states and territories – would be a good place to start.

Therefore, the variable and inconsistent approach to incident reporting and disclosure across Australia will need to change. Indeed, an alignment of state and territory laws concerning the disclosure of error could follow those of NSW and the ACT, where any admission of fault is protected and cannot be used in legal proceedings. Hopefully with further changes to state laws, transparent incident reporting with full analysis and open disclosure of error will flourish in the best interests of doctors, patients and the community.

A/Prof. Julian Rait
President, MDA National

Notice Board

Moving from strength-to-strength

We're celebrating a milestone achievement in MDA National's history! Our West Australian team is moving into our new West Perth office this month – delivering on the legacy promise to own and operate our very own Perth office. Purchased for Members in December 2008, the new office is the cornerstone of our national operations – and in conjunction with our offices in Adelaide, Brisbane, Melbourne and Sydney – now supports more than 30,000 Members and Insureds across Australia.

Our new Perth address

Our Perth office is located at Level 3, 88 Colin Street, West Perth WA 6005. Our phone, fax and email details remain the same and we invite Members to visit. Please email **ckimble@mdanational.com.au** to arrange a time, as we would be delighted to provide you with a personal tour of our new office.

Updated Melbourne address: We've relocated our Melbourne office to accommodate the growing Members' services in Victoria. Our new address is: Level 3, 100 Dorcas Street Southbank VIC 3006.

Extraordinary General Meeting – Results

The Extraordinary General Meeting which was held on July 15 has resulted in Member approval of all three of Council's recommended resolutions:

- **That The Medical Defence Association of Western Australia (Incorporated), (MDAWA) be authorised to apply to the Australian Securities and Investments Commission (ASIC) under section 601BC of the *Corporations Act 2001* to transfer its registration under the Associations Incorporation 1987 (WA)** which will result in the Association becoming a company limited by guarantee, and will align it with MDA National Insurance – which is already incorporated under the *Corporations Act 2001*.
- **Subject to regulatory approval by the Commissioner for Consumer Protection in Western Australia and the ASIC of the application to register MDAWA as a company limited by guarantee, that MDAWA change its name** from MDAWA to MDA National Limited.
- **Upon registration as a company limited by guarantee under the *Corporations Act 2001*** that the company adopt a Constitution which meets the requirements of the *Corporations Act 2001* and which is suitable for a company limited by guarantee.

These changes reflect the evolution of the indemnity industry and contemporary regulatory requirements. MDA National continues to evolve and adapt to best suit the needs of our Members.

Our new wholly-owned Perth office

Update: removal of qualified privilege in WA public hospitals

The WA Department of Health issued a notice in June 2011 that Clinical Incident Investigations using the Advanced Incident Management System (AIMS) in WA public hospitals and health services would cease to be protected by qualified privilege under Commonwealth legislation. This was made effective at midnight on 9 June 2011.

What does this mean for WA medical practitioners?

The AIMS documentation continues to seek comments by medical practitioners on why an incident occurred, yet the information provided in this context is no longer privileged and will be discoverable in court proceedings.

What should I do when completing AIMS documentation?

The AMA (WA) are now liaising with the Minister for Health, with MDA National's support, to ensure that steps are being taken to restore privilege to the AIMS documentation via state legislation. In the meantime, we recommend Members seek advice from MDA National when completing AIMS documentation in the public sector.

MDA National does not wish to impede the AIMS process and the important role it plays in patient safety and quality assurance but instead alert practitioners to be mindful and obtain guidance before making comments which admit or suggest fault on the part of themselves or another medical practitioner.

Update
Telehealth

What is Telehealth?

Telehealth can be defined as the delivery of healthcare services at a distance, using information and communication technology.[1] It is a subset of e-health, which encompasses all uses of information and communication technology in health, including electronic medical records and decision support systems. However, telehealth is particularly characterised by the geographical separation of patient and health care provider.

This article discusses two telehealth programs which were introduced by the Commonwealth government in July 2011 and examines some of the medico-legal challenges that the telehealth initiatives present for doctors today.

Telehealth video consultations

On 1 July 2011, Medicare Australia introduced a number of new Medicare Benefits Schedule (MBS) Items for video consultations with a wide range of specialists. There will also be rebates for a GP or other specified health professional who is with the patient during a video consultation with the remote specialist.

For the purposes of this government initiative, a video consultation is where a patient and eligible specialist, consultant physician or psychiatrist undertakes a consultation via video conferencing equipment; that is, there must be a visual and audio link between the patient and the eligible specialist in order for the patient to claim for a telehealth rebate. For further information about the MBS telehealth video consultations visit **www.mbsonline.gov.au/telehealth.**

Things to consider when participating in video consultations

Some of the medico-legal issues that Members need to consider include:

- The standard of care and professional guidelines that govern traditional medical practice are equally applicable to video consultations.
- Videoconference equipment must be adequate to support diagnostic and/or treatment needs.
- Patient safety, confidentiality, privacy and security of data should be at the forefront of the consultation.
- Delineation of roles and professional responsibilities and any follow up arrangements should be clearly defined prior to and at the end of the video consultation.
- Documentation of the video consultation should be made by the eligible specialist and GP.

After hours GP helpline

A new after hours telephone-based GP medical advice and diagnostic service was introduced through *healthdirect Australia* on 1 July 2011. The service is available in all states and territories, except Queensland and Victoria. The helpline is intended for people who require urgent but not acute medical assistance and are unsure of the health treatment they require.

Incoming calls are initially answered by a nurse who triages the call. If necessary, the nurse transfers the caller to a GP. Depending on their condition, the caller may be provided with self-care advice by the telephone-based nurse or GP, or may be directed to the most appropriate health service in their area.

The helpline is not intended for patients with a life threatening condition that needs to be treated immediately. If the caller requires immediate emergency attention, the call will be transferred to '000' with the telephone-based nurse or GP staying on the line. Information will be collated into a health record which will be sent electronically with the patient's consent to the patient's regular GP on request.

For more information about this service visit **www.yourhealth.gov.au**.

Useful telehealth resources

Members are encouraged to seek advice from their College and our Medico-legal Advisory Services team with questions or concerns about participating in these telehealth initiatives.

RACGP has guidelines on the implementation of video consultations in general practice which are available at **www.racgp.org.au/telehealth**.

Department of Health and Ageing has released Draft Telehealth Technical Guidelines which are available at **www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/consultation-20110909**.

www.mdanational.com.au

We have prepared the following guidelines for our Members:

- *Things to Think About Before You... Participate in MBS Approved Telehealth Video Consultations.* (Available October 2011)
- *Things to Think About Before You... Provide Telephone Consults as a Helpline GP.*

Dr Sara Bird
Manager, Medico-legal and Advisory Services

1. Wade VA, Karnon J, Elshaug AG, Hiller JE. A systematic review of economic analyses of telehealth services using real time video communication. BMC Health Services Research 2010; 10:233. Available from: www.biomedcentral.com/1472-6963/10/233.

Special Report:

2011 Medico-legal Minefield Forum

Doctors as leaders: from decision making and consent to supervision

This year's forum introduced a more conceptual theme to our Medico-legal Minefield series, and a different format from previous years. There was such a wealth of thought and ideas generated from our forums that we would like to offer you a taste of the smorgasbord, and invite you to share your own views and thoughts with us.

We will be offering further opportunities to explore this topic over the next few months, so watch for details as they become available.

www.mdanational.com.au

Available Now! As a Member you'll find the full text of the presentations given by some of our keynote speakers from WA and Victoria online.

Leadership in medicine

It is a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes. Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within healthcare services. They have a responsibility to contribute to the effective running of the organisation in which they work and to its future direction.

Leadership is not only about being seen as a leader; it is also about developing the personal qualities to work effectively with others, hence learning to work within teams and developing followership skills is essential.[1]

Each forum opened with a keynote speaker presenting their own interpretation of leadership in medicine. This was followed by the open forum, assisted by a panel of experts with legal and medical backgrounds, and moderated by an MDA National Board or Council member.

Participants were invited to reflect on the nature of leadership, and as an integral component of medical professionalism; leadership and a doctor's duty of care; how the doctor-as-leader impacts on the doctor-patient relationship and in particular on decision-making and consent, and the role of leadership in supervision.

We also aimed to align these concepts with the medico-legal realities of modern-day medicine: the duties and obligations, and the consequences when expectations are not met, drawing on case studies as examples of some of the pitfalls.

Forum highlights

1. Doctors as leaders

Dr Rosanna Capolingua: doctors are the decision-makers, the leaders in the team; they have authority and responsibility and have a duty of care that is both legally imposed upon them and that is expected of them.

We are bound by law and our own ethical codes to be aware of what we are doing and how we do it; and we must protect the best interests of our patients. That duty confers a leadership status.

This status extends beyond the role of doctor, even to their role in the community, which expects doctors to be exemplary members of society.

Professor Bernard Pearn-Rowe: is a doctor ever off duty? Does a doctor always have to be available or is it ok to be too tired, have too much wine, or just to sign-off, as those in other professions are able to do? While this is a matter for the individual, in quoting from a retiring WA surgeon in an address to new medical graduates, he says:

You have been given a great gift: your hands feel things that others cannot feel, your eyes see things that others cannot see and your ears hear things that others cannot hear: never squander these gifts but always use them for the good of your fellow man.

Peter Quinlan, SC: the changing nature of medical practice demands greater than ever leadership: trust has been undermined by such factors as commercialisation of medicine, advertising and entrepreneurism, depersonalisation of some practices, especially the large group or corporate-style practices.

Confronting all of these things themselves takes, and requires, leadership. Strong leadership – not just from our leaders but by all members of the profession.

2. Leadership and its impacts on decision-making and consent

Consent and shared decision-making are part of the process that underlies the doctor-patient relationship. But without trust, there is no relationship, just a commercial transaction. Trust is at the heart of the professional relationship: trust in applying one's judgement and acting in a patient's best interests.

In engaging a professional, I do not abandon my own prudence: I do not delegate my prudence to someone else, but I do blend my prudence with that of the professional, or the professional's with mine.[2]

In other words, the patient does not have to relinquish their autonomy and the doctor does not require them to do so, but assumes a leadership role in applying their judgement to what is best for the particular patient. In determining the "best" for a patient, the professional responds to the real person: their fears, beliefs, their culture, their life histories, and applies that understanding to guide the patient but not to make the final choice for them.

Continued...

It is a way of bringing into relief what is of real significance to the patient, and making the patient aware of that significance (Peter Quinlan). This will both satisfy the legal requirements and retain the patient's autonomy.

However, in recognising that when a doctor provides an opinion as to what is best, they may be unwittingly imposing their own values on the patient. Professor Pearn-Rowe reminds us to consider the rights of the doctor.

Each of us has a moral compass which is the result of our own unique spiritual, ethical and cultural beliefs. Each of us will have our own personal response to the many difficult questions that clinicians face.

Clinicians may also face difficult questions when dealing with patients whose expectations are unachievable, or to the clinician, unwise. The forum explored these questions through case studies of how such situations can be dealt with in order to retain one's integrity.

3. Legal obligations relating to consent

Consent is a legal requirement. But this is not the whole picture: to define the doctor-patient relationship in legal terms only erodes the trust relationship, promotes a wariness in patients and an approach to practice that is about avoiding being sued. Consent is an integral part of treatment:

The satisfaction of the legal requirement is merely an incident of proper professional practice (Peter Quinlan).

4. Leadership and supervision

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.[3]

Where do trainees learn to be "like doctors": not only having clinical skills and knowledge, but how to communicate, being empathic, having cultural sensitivity, insight and patience?

How does one create the right environment as a supervisor in which these skills can best be learned? Professor Pearn-Rowe drew on his own experience: sarcasm and belittling do not work but being human and admitting fallibility do, as well as being an available mentor and role model.

One of the more surprising facts that came out of the forum was how few doctors receive formal training, or ever receive feedback, on supervision. How does one ever gain competence in this important role, and in fact, what are the competencies of a "good" teacher?

Share your thoughts with us

We invite you to consider these points as they relate to you or those you work with:

- Do you agree that as doctors, you are leaders (and in what contexts)?
- How does this influence how you relate to patients, your junior colleagues, other health care practitioners?
- How does one respect patient autonomy while retaining leadership in the transaction: does "leadership" mean coercion or paternalism in decision-making and the consent process?
- What is your own experience in assuming a leadership role?
- What is your own experience in supervision (include trainees, junior medical officers, nursing staff in your practice, etc.)?

To share your contribution or receive more information about our forums, please email us at **defenceupdate@mdanational.com.au**.

Elizabeth van Ekert
Program Manager and Professional Services Adviser (Partnering your Professionalism)

1. NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, UK. Extract from Medical Leadership Curriculum, from Medical Leadership Competency Framework; July 2010.
2. Sokolowski R. Quoted by Quinlan P. Georgetown University; 1991.
3. Lasagna L. Modern version of the Hippocratic Oath. School of Medicine, Tufts University; 1964.

In Focus

Medico-legal Advisory Services

"This might be a silly question, but..."

There is no such thing as a silly question when it comes to Medico-legal Advisory Services.

Our Medico-legal Advisers are available to answer your queries 24 hours a day, 7 days a week. We deal with a wide variety of medico-legal questions from different specialities and workplaces. You may have a question about medical records, patient confidentiality, or fitness to drive – or perhaps you have an ethical dilemma and require a confidential "sounding board" to assist you to work through your options. If the question is important to you, then it is important to us.

Where to keep your medico-legal advice?

When seeking medico-legal advice, it is natural to take notes, including the name of the person providing the advice, but where do you save this information? More importantly, where shouldn't you save this information?

Medico-legal advice should never be saved, stored or noted on a patient's medical records. Although there is provision under the Privacy Act to allow doctors to seek medico-legal advice without the patient's express consent, many patients would be surprised to see an entry which refers to private medical information being discussed with a third party. This can also cause difficulties should your notes be subpoenaed by a Court or a notice served by an authority seeking copies of your records.

If you do keep a note of the advice you receive, please maintain a separate piece of paper or electronic medico-legal file for this purpose. Also, any correspondence to and from MDA National should not be kept in the patient's medical records. It should be retained in a separate medico-legal file.

Nerissa Ferrie
Medico-legal Adviser

You can contact our Medico-legal Advisory Services team in a way that best suits you, including:

Phone: 1800 011 255 (24 hours)
Fax: 1300 011 235
Email: advice@mdanational.com.au

Increased Medicare Compliance Audits

Medicare Australia (Medicare) undertakes a range of audit and investigation activities to deal with varying types of non-compliance. These include:

- Compliance audits
- Practitioner Review Program
- Criminal investigations.

Recent legislative amendments to the *Health Insurance Act 1973* have introduced important changes to the way in which Medicare conducts audits of health professionals. As part of the Increased Medicare Compliance Audits program, Medicare has increased the number of audits being undertaken to cover 4% of medical practitioners. The new legislative provisions enable Medicare to:

- Issue a notice to health professionals, or a person in charge of the health professional's records, requiring them to produce documents to substantiate claims made under Medicare.
- Impose an administrative penalty with a base rate of 20% for any unsubstantiated amounts that total more than $2,500. This penalty can be automatically increased or decreased in certain circumstances.

These changes only apply to professional services provided on or after 9 April 2011.

What should you do?

The introduction of this legislation is a timely reminder of the importance of being aware of the MBS descriptors and relevant Explanatory Notes for all Item numbers used in your practice. The Medicare Benefits Schedule is available from **www.mbsonline.gov.au.**

We encourage you to contact our Medico-legal Advisory Services team for advice if you are asked to participate in a Medicare audit or investigation.

Confidentiality

'All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal'.[1]

Confidentiality

Doctors have an ethical, professional and legal duty to protect the confidentiality of the information acquired as a result of the management of their patients. This duty forms the basis of trust and honesty in the doctor-patient relationship.

It has long been recognised that a relationship of complete trust is essential for any effective therapeutic relationship between doctors and their patients. The duty of confidentiality encourages patients to fully disclose all personal information truthfully so that they can receive appropriate medical care.

Patients should be able to divulge information to their doctors without fear of embarrassment, harm or discrimination that may arise from the widespread dissemination of the information. The duty of confidentiality extends to all information that arises out of a doctor's professional relationship with patients. A patient's right to confidentiality survives the doctor-patient relationship and the patient's death, as stated in the World Medical Association's Declaration of Geneva:

I will respect the secrets that are confided in me, even after the patient has died.[2]

The Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia states:

"Patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations.

Good medical practice involves:

- Treating information about patients as confidential.
- Appropriately sharing information about patients for their health care, consistent with privacy law and professional guidelines about confidentiality.
- Being aware that there are complex issues related to genetic information and seeking appropriate advice about disclosure of such information".[3]

A doctor's legal obligation of confidentiality arises out of common law. There is also a wide range of legislation which provides for the protection of confidences. The reported case law suggests that civil actions based on breach of confidentiality by doctors are very infrequent but doctors may be the subject of a complaint and disciplinary action for a breach of confidentiality.

Exceptions to the Duty of Confidentiality

A doctor's duty of confidentiality is not absolute. Doctors can provide information about a patient to a third party without it constituting a breach of confidentiality in the following situations:

1. Express or implied consent of the patient to the release of the information

This includes the disclosure of information to another health professional to ensure the appropriate medical care and treatment of the patient.

2. Mandatory disclosure under compulsion of law

This may include a subpoena, summons, search warrant or other Court order requiring the provision of information.

There is also a wide range of legislation which varies in each state and territory and requires doctors to disclose information about their patients. This legislation includes:

- Mandatory notification of child abuse – legislation exists in all states and territories, although in WA there is mandatory reporting of child sexual abuse only.
- Reporting of "notifiable diseases" – these are generally infectious diseases where notification is required for public health purposes and the identity of the patient is not always disclosed.
- Notification of births and deaths.

3. Overriding duty in the "public interest" to disclose information

These are often difficult and complex cases. The doctor has to decide whether their duty to the community outweighs that to their patient. The legal scope of the public interest exception to the duty of confidentiality is often unclear. However, for certain disclosures there is legislation that protects and indemnifies the doctor from the patient taking civil action against them.

As a general principle, the public interest exception recognises that there may be a need to breach patient confidentiality in exceptional circumstances because of an overriding public interest favouring disclosure of information to an appropriate third party. This arises in limited circumstances where there is a serious and imminent threat to an individual's life, health or safety; or a serious threat to public health or public safety. This exception generally relates to emergencies.

The Privacy Commissioner states:

"A 'serious and imminent' threat to an individual's life, health or safety relates to a harm that could be done to any person (including the patient seeking treatment and care).

A 'serious' threat must reflect significant danger, and could include a potentially life threatening situation or one that might reasonably result in other serious injury or illness. Alternatively, it could include the threat of infecting a person with a disease that may result in death or disability. A threat could also relate to an emergency, following an accident, when an individual's life or health would be in danger without timely decision and action.

A threat is 'imminent' if it is about to occur. This test could also include a threat posed that may result in harm within a few days or weeks. It is much less likely to apply to situations where the risk may not eventuate for some months or longer.

A 'serious' threat to public health or public safety relates to broader safety concerns affecting a number of people. This could include the potential spread of a communicable disease, harm caused by an environmental disaster or harm to a group of people due to a serious, but unspecified, threat."[4] In this situation, the disclosure should only be made to a responsible authority with a proper interest in receiving the information. The exception also allows for disclosure to an individual whose life, health or safety is threatened.

An example of the requirement to disclose

Probably the most common example of the requirement to disclose in the "public interest" is that of a patient who refuses to stop driving despite medical advice to do so. In this case, the doctor can report the patient to the relevant Driver Licensing Authority (DLA).

In every state and territory, a doctor who notifies the DLA in good faith is protected from civil and criminal liability (note: in the Northern Territory and South Australia doctors have a mandatory obligation to report to the DLA if they believe a driver is physically or mentally unfit to drive).

Additionally, under amendments introduced in October 2009 to the Privacy Act, a doctor can disclose a patient's genetic information, without the patient's consent, in circumstances when there is reasonable belief that disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of his or her genetic relatives.[5] Importantly, these amendments do not oblige disclosure of the information but allow disclosure to occur if needed.

Conclusion

Confidentiality is a fundamental basis of the doctor-patient relationship. Complex issues can arise for doctors in balancing the duty of patient confidentiality and the doctor's duty to society at large. Members are encouraged to seek advice from an experienced colleague and our Medico-legal Advisory Services team in these circumstances.

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1 Hippocratic Oath. Available from: en.wikipedia.org/wiki/Hippocratic_Oath

2 World Medical Association. Declaration of Geneva. August 1968. Available from: www.wma.net/en/30publications/10policies/g1/

3 Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia; 2009. Available from: www.medical-board.gov.au/codes-and-guidelines.aspx

4 Office of the Federal Privacy Commissioner. Guidelines on Privacy in the Private Health Sector. 8 November 2001. Available from: www.privacy.gov.au/materials/types/guidelines/view/6517

5 NHMRC and Office of the Privacy Commissioner. Use and disclosure of genetic information to a patient's genetic relatives under Section 95AA of the Privacy Act (Cth). Guidelines for health practitioners in the private sector. Issued by the NHMRC on 27 October 2009. Available from: www.nhmrc.gov.au/guidelines/publications/e96

Confidentiality

A Psychiatrist's Perspective

As a practicing psychiatrist, confidentiality is at the core of what I provide for my patients to enable them to speak freely, openly and trustingly, confident that they can share their sensitive problems and concerns with a trained medical professional who will help them make sense of their issues and develop a collaborative management plan to address those issues.

By Dr Gary Galambos
MBBS FRANZCP
Consultant psychiatrist in private practice,
Chair of RANZCP Private Practice Network

Because confidentiality is such an important component in the therapeutic relationship – really, what's allowing me to perform my professional role – any breaches need to be taken very seriously. The information provided by the patient, which is documented, may relate not only to their symptoms, some of which may be very embarrassing, but also predisposing factors (such as family history), precipitating factors and propagating factors (like relationship issues, personal and material losses, failures and stressors, unmet goals) and protective factors. Obviously, such sensitive information could devastate a patient should they fall into the public domain or be released to certain others. Therefore, patients may be quite anxious and fearful about disclosing such information.

Is it reasonable to emphasise the confidentiality of the therapeutic relationship without scaring the patient away by highlighting the exceptions? Can we assume patients know medical practitioners are bound by law to breach their patients' confidentiality in instances of public interest, mandatory disclosure, subpoena, other health professionals, health emergency and when consent is generically given?

It is not generally necessary to highlight the exceptions to the duty of confidentiality during a consultation. However, depending on the patient and the circumstances, it may be prudent in some situations to inform a patient of the exceptions. For example, if a patient prefaces a consultation with a demand that everything that is disclosed during the consultation must be kept confidential, it would be appropriate to discuss the circumstances in which a medical practitioner has an obligation to breach confidentiality. The patient then has the option of deciding whether or not to disclose information. Your practice should have a privacy policy which documents how personal information is handled. This policy could outline in general terms any requirements to disclose information to third parties.

For current patients, I can always seek their guidance as to how much information I provide to other health professionals, including their GP. But I do sometimes find myself in a dilemma if they ask me not to provide their GP or referrer with some diagnoses but they are okay to provide others! Do you have any suggestions about how to handle such requests? Would it be reasonable to speak to their GP in person and leave out such information in correspondence or could that get me into trouble somehow down the track?

If the diagnosis or information is necessary for the other medical practitioner to appropriately manage the patient, then you may be required to disclose the information even without the patient's consent. Ideally in this situation you should explore the reasons why the patient does not want the information disclosed and hopefully obtain their consent to provide this information. Simply omitting the information from any correspondence and only disclosing the information verbally is not good practice.

Consent for release of information tends to arise more as an issue for past than current patients, for me. How much information is it reasonable to provide to health professionals who seek information about a past patient, such as a GP who rings up stating the patient has come to them for the first time? Do I need written consent to pass on information to health professionals phoning or writing to me seeking information, such as a copy of a letter to a previous referrer or discharge summary?

It is not considered a breach of confidentiality to provide information to a treating health practitioner to ensure continuity of the patient's care. Written consent is not required, but you should satisfy yourself that the requestor is making a legitimate request.

What about requests from insurers who request reports or specific information and opinions about past patients? Often the insurer provides a signed consent for release of information by the ex-patient, but the consent was a generic request, not specific to me, and sometimes the consent was signed by the patient before they ever consulted me? Am I obliged to ask for a current and specific consent? How do you suggest I handle such requests?

In this situation, you should contact the insurer, and request a specific and contemporaneous consent from your former patient. The consent should outline the nature of the information to be provided, including any request for medical records and/or a report.

Legal

The Criminality of Treatment

Dr Patel & Beyond (Part 2)

In our first article[1] we reviewed the background to the charge of "medical manslaughter" in the context of the Queensland Supreme Court trial against Dr Jayant Patel. A jury found Dr Patel guilty of three counts of manslaughter and one count of grievous bodily harm. He was sentenced to seven years jail.

Dr Patel unsuccessfully appealed the decision of the Supreme Court. Unless a High Court special leave application is successful he will serve out his seven year sentence.

The grounds of his appeal largely turned on the correct interpretation of s288 Queensland *Criminal Code* and perceived lack of procedural fairness. Section 288 of the Code provides:

It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.

At trial the jury accepted that Dr Patel competently performed surgery but his decision to do so gave rise to the error. So in one case the health of the patient was found to be too precarious, in another the patient did not have colon cancer, and in another the patient's sigmoid colon was removed unnecessarily as the cancer was in the rectum. It was argued and accepted that the breach of duty imposed upon Dr Patel by s288 of the Code arose when he proceeded to operate upon the patient/s.

On appeal Dr Patel argued that he was entitled to be acquitted because the prosecution cases were not within the meaning of s288. He contended that upon the proper construction of s288 it applies only in relation to the absence of skill or the failure to use reasonable care in the course of surgery and it does not apply in relation to a surgeon's decision to operate or to commend surgery to a patient. The Court of Appeal found no ambiguity in the interpretation of the section and said it applied both in relation to criminally negligent acts or omissions in the course of performing surgery and criminally negligent acts or omissions in performing surgery at all. The trial judge's construction of s288 was affirmed.

In respect of the finding that Dr Patel breached his s288 duty the Court of Appeal did not disturb the following findings:

1. The way in which many of the procedures were actually carried out was relevant to the argument that Dr Patel lacked reasonable skills and ought to have known that.
2. In none of the procedures did Dr Patel, as he should have done, seek a second opinion.
3. Dr Patel did not, as he should have done, disclose or address his imposed and inherent restrictions.
4. In none of the procedures did he reflect on whether the procedures were necessary or whether alternatives were available.
5. In respect of patient Mervyn Morris, Dr Patel lacked reasonable skills and knew or ought to have known of his limitations regarding the surgery proposed. He should have known that the bleeding point was not identified and other non-invasive treatments were available.
6. In respect of patient James Phillips the jury established that Dr Patel's oesophagectomy caused Mr Phillips' death and that his decision to perform it was criminally negligent. He should have known that the patient was frail and had too many complications for an oesophagectomy to be performed on him.
7. In respect of patient Gerardus Kemps, Dr Patel's decision to perform an oesophagectomy was criminally negligent. Mr Kemp's health was too precarious for an oesophagectomy and the oesophageal cancer was far too advanced, making other palliative treatment preferable.
8. In respect of patient Ian Vowles, Dr Patel wrongly assessed that Mr Vowles was most likely suffering from familial colon cancer. The surgery was completely unnecessary and further investigations should have been performed, and other less dangerous procedures were available. This was the only patient for which there was no allegation regarding the procedure itself as being criminally negligent, just the decision to proceed and the knowledge of his skills being inadequate.

One cannot help but wonder whether Dr Patel's errors – as heinous as they were – were assessed, analysed and dealt with in the undercurrent of a politically charged Queensland Health Department.

It is also true that as the Queensland Code enshrines a duty to preserve human life – *...which is or may be dangerous to human life or health... and the person is held to have caused any consequences which result to the life...* – the threshold to establish a finding of medical manslaughter in Queensland, is arguably lower than in other states and territories.

Was the seven year jail sentence "too tough"? The Court of Appeal also dismissed the Attorney-General's appeal calling for a tougher sentence. We have so little guidance or precedents upon which to assess the penalty for a finding of medical manslaughter.

By way of comparison, and perhaps of some interest, in a recent NSW case, a 60 year old doctor who indecently assaulted two patients, removed a woman's genitals without her consent and committed fraud has been sentenced to imprisonment for a minimum of two years and a maximum of three and a half years.

The lawyers for Dr Patel have lodged a special leave application in the High Court which may not be heard before the end of the year.

Feneil Shah, Associate
Kerrie Chambers, Partner
HWL Ebsworth Lawyers

1. MDA National. Defence Update Spring; 2010. p6.

MDA National CaseBook

Prescribing in Pregnancy

Mrs Newlywed, aged 34 years, presented to Dr Young for removal of her Implanon rod. Mrs Newlywed was a regular patient at the practice, but this was the first time that Dr Young had met her, as Mrs Newlywed usually saw Dr Young's colleague, Dr Old.

Mrs Newlywed told Dr Young that she would like to have her Implanon rod removed as she felt the time was right for her to have a baby. Mrs Newlywed had only booked a single appointment, and it was Dr Young's usual practice to allow a double appointment for this procedure, as removal of Implanon can sometimes take a little time. Nevertheless, Dr Young wanted to be helpful, so she took the patient into the treatment room, and with her nurse's assistance removed the Implanon without too much difficulty.

Mrs Newlywed was rather intense and had numerous questions and concerns about her planned pregnancy, including blood tests, Listeria, exercise during pregnancy and choice of hospital and obstetrician etc. Dr Young answered all Mrs Newlywed's questions, and Mrs Newlywed left, with Dr Young feeling rather stressed as she was aware that she was now running quite a bit behind schedule.

A few weeks later, Dr Young received a letter of complaint from Mrs Newlywed.

Mrs Newlywed wrote:

When I took my routine scripts for my blood pressure medication to the chemist, he told me that ramipril should never be used during pregnancy and may have harmed my baby, if I had become pregnant while taking it. Why did you not advise me to stop this medication when I saw you recently about pregnancy? I thought that you would have checked my records and medication as part of our discussion about me wanting to be pregnant. I can't believe you have been so careless! I am also very disappointed with Dr Old for prescribing this medication in the first place and not warning me that it was not good in pregnancy!

Dr Young realised that when she saw Mrs Newlywed, the entire consultation had taken place in the treatment room, and she had not checked the computer records until after Mrs Newlywed had left, when she just noted the details of the removal of the Implanon. She had not reviewed her past history, or regular medications, and Dr Young now noted that Mrs Newlywed's most recent consultation was for repeat scripts for her medication for hypertension, which she had been on for quite some time.

Dr Young was aware that angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) are category D in pregnancy, and she was concerned that this had been a "near miss" in terms of adverse events.

Discussion

Medicine use in pregnancy and lactation

Recent notifications to MDA National have highlighted the need for all medical practitioners to review the use of all drugs in pregnancy and breastfeeding.

There is some value in the old adage that "all women between the ages of 15 and 50 years should be assumed to be pregnant," and doctors should take care when prescribing to women in this age group.

The use of prescribed medicines, complementary medicines and substances of dependence has become more wide-spread in the general community and as a result many women trying to conceive and those who are pregnant or breastfeeding are exposed to prescribed, natural and illicit drugs.

It is the treating doctor's responsibility to obtain a detailed history of all drugs that a patient is taking and to ensure the patient is aware of the safety of all substances they are using during pregnancy.

The Australian Drug Evaluation Committee (ADEC) Prescribing Medicines in Pregnancy and Therapeutic Goods Administration has set up a detailed assessment of all medications available on the PBS giving them a safety rating:

Category A

Medicines which have been taken by a large number of pregnant women and women of childbearing age without any proven increase in the frequency of malformations or other direct or indirect harmful effects on the foetus having been observed.

Category B1

Medicines which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformations or other direct or indirect harmful effects on the human foetus having been observed.

Studies in animals have not shown evidence of an increased occurrence of foetal damage.

Category B2

Medicines which have been taken by a limited number of pregnant women or women of childbearing age, without an increase in the frequency of malformations or other direct or indirect harmful effects on the human foetus having been observed.

Studies in animals are inadequate or may be lacking. However, available data shows no evidence of an increased occurrence of foetal damage.

Category B3

Medicines which have been taken by only a limited number of pregnant women and women of childbearing age, without an increase in the frequency of malformations or other direct or indirect harmful effects on the human foetus having been observed.

Studies in animals have shown evidence of an increase of foetal damage, the significance of which is considered uncertain in humans.

Category C

Medicines which, owing to their pharmacological effects, have caused or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects may be reversible.

Category D

Medicines which have caused are suspected to have caused or may be expected to cause, an increased incidence of human foetal malformations or irreversible damage. These medicines may also have adverse pharmacological effects. Accompanying manufacture's texts should be consulted for further details.

Category X

Medicines which have such a high risk of causing permanent damage to the foetus, that they should not be used in pregnancy or when there is a risk of pregnancy.

The use of complementary and alternative medicines in pregnant and lactating women is growing. Patients may not perceive complementary medicine use as medicines. There is limited information on the safety and efficacy of most complementary medicines. In addition the preparations of complementary medicine are usually not standardised with its concentration and purity.

Women should be informed that the use of complementary medicine in pregnancy and lactation has not been subjected to scientific evaluation and that the risks to the developing foetus and breast fed baby are unknown (for example Echinacea).

The use of substances of dependence and alcohol should be discouraged during pregnancy. Illicit drugs are known to cause infertility, early miscarriage, premature labour, growth retardation and placental abruption. Alcohol is a known teratogen and the risks of alcohol related birth defects increases with the amount of alcohol consumed.

When counselling women of child-bearing age, pre-pregnancy, pregnant or lactating regarding drug use it is important to have easy access to the side effects and the safety of all substances she may be exposed to, so an informed decision can be made. Medical software packages will have the safety rating for medications readily available, as does MIMS. The main tertiary referral hospital for women's services in each state has a pharmacy department, whose staff are usually helpful if more specialised knowledge is required.

Postscript

Dr Young discussed Mrs Newlywed's letter of complaint with Dr Old. At the next practice meeting they raised the issue with all the doctors at the practice, so they could all be more aware of prescribing to women in this age group. They also ensured that the practice software had warnings turned on for prescribing to women of childbearing age.

With the assistance of MDA National staff, Dr Young replied to Mrs Newlywed's letter. Mrs Newlywed took no further action and continued to attend the practice for management of her pregnancy.

Further information

Royal Women's Hospital. Pregnancy & Breastfeeding Medicine Guide. Available from: www.rch.org.au/chas/pubs/index.cfm?doc_id=1003

Hale TW. Medications and Mothers' Milk, 13th ed. Hale Publishing; 2008.

Contact Information[1]

Pregnancy drug information centres

New South Wales
Mother Safe at Royal Hospital for Women
Tel: 02 9382 6539, Toll free (NSW) 1800 647 848

Queensland
Queensland Drug Information Centre
Health professionals only
Tel: 07 3636 7098

South Australia
Women's and Children's Hospital
Tel: 08 8161 7222

Victoria
Royal Women's Hospital
Tel: 03 8345 3190

Western Australia
Women's & Newborn Health Services
at King Edward Memorial Hospital
Tel: 08 9340 2723

Dr Jane Deacon, Medico-legal Adviser
Dr Tim Jeffery, MBBS FRCOG FRANZCOG CU

1. Australian Medicines Handbook. July 2011.

MDA National

CaseBook

Chest Pain, Clinical Guidelines and Telephone Consultations

Case history

On 4 November 2008 at 11:33am Ms Rebecca Lawrence, aged 41 years, attended the Emergency Department (ED) of the Royal Adelaide Hospital (RAH) complaining of chest pain.

A nursing assessment at 11:35am recorded her presenting complaint as "chest pain for the last hour that radiated to the neck with burning and tightness."

An ECG was performed and the computer printout reported minimal ST elevation in the inferior leads. A further ECG was performed at 12:36pm and the printout reported ST elevation but otherwise the ECG was described as normal. Both ECGs were signed off by a nurse who wrote on the second ECG that there was no change from the first. A CXR was also performed and bloods were taken at midday. The troponin result was <0.02.

Following Ms Lawrence's nursing assessment, she was seen by a medical student who queried a diagnosis of reflux.

Ms Lawrence was then reviewed by the ED registrar. Physical examination was normal. The registrar checked the CXR and blood tests which were also normal. The registrar discussed Ms Lawrence's presentation with the ED physician. He reported that the blood tests were all normal and he did not think the patient's chest pain was of cardiac origin.

Based on the view that the patient met the criteria in the RAH's Suspected Ischaemic Chest Pain Management Guidelines of "very low risk" of her chest pain being of cardiac origin, the patient was discharged home that afternoon with a sample pack of Somac.

At 7:12pm, Ms Lawrence phoned Telehealth Services, a telephone health advisory service staffed by nurses. Ms Lawrence reported that she was suffering from chest pain that radiated to her neck and she had been evaluated earlier that day at hospital. She told the nurse that she had had ECGs and blood tests and the tests were all fine. During the course of the conversation, Ms Lawrence suggested she might go to the ED again and the nurse initially agreed but later in the call the nurse said "given that you've had all those tests" the symptoms were unlikely to be cardiac related.

Ms Lawrence made a second call to Telehealth Services at 8:35pm. At the conclusion of this call the nurse referred her to a GP deputising service.

The patient phoned GP Solutions, a medical deputising service, at 8:57pm. She asked for a home visit from a GP because she had chest pain and the medication she had been given at the hospital was not working. The operator asked if she wanted to go back to hospital but the patient declined to do so. When the GP arrived at 11:20pm, the patient was dead.

Ms Lawrence's death was reported to the Coroner. An autopsy revealed an acute myocardial infarction with >90% occlusion of the proximal portion of the left circumflex artery. The remaining coronary arteries were normal. Histological examination of the occluded artery showed features suggestive of giant cell arteritis. The damage to the left ventricle showed features of myocardial infarction of 12 to 24 hours in age.

Medico-legal issues

The case proceeded to a Coronial Inquest in May 2011 and the Coroner handed down his findings on 22 June 2011.

The ED registrar, ED physician, telephone operator at GP Solutions and an independent expert cardiologist all gave evidence at the Inquest.

In his evidence, the ED registrar said he thought that he had personally reviewed the ECG traces at the time of Ms Lawrence's presentation to RAH. However, in his earlier written statement to the Coroner, he had stated that he did not recall if he had actually seen the first ECG.

The registrar said both ECGs had been reviewed by a cardiology nurse who had reported there was no change between the two ECGs. He said he had relied on this assessment, noting that the cardiology nurses are highly trained. On review of the ECGs at the Inquest, the registrar acknowledged there were subtle abnormalities in the first ECG which were not present in the second ECG. In retrospect, he said if he had seen the changes from the first to the second ECG on 4 November 2008 he would have been alerted to the possibility of an ischaemic event.

In his statement, the registrar also referred to the RAH's Suspected Ischaemic Chest Pain Management Guidelines (the Guidelines). Based on the Guidelines, he thought the patient had presented as a very low risk of a cardiac episode. The Coroner noted the conclusion was erroneous, even having regard to the Guidelines. The Guidelines required all of the positive features for ischaemic chest pain to be absent but also the presence of two or more negative low risk features. Ms Lawrence actually had none of the negative low risk features.

The ED physician also gave evidence at the Inquest. He stated he had discussed the case with the registrar but had not examined the patient or the records and other test results. At the Inquest, the ED physician said he may have been concerned if he had appreciated at the time that the patient's chest pain had been described as "tightness", stating that such a presentation would be a "bit of a red flag".

The Coroner reported that the ED physician had relied on the view that the registrar had already formed about the patient and he "did not in any meaningful way apply his own mind to the diagnosis".

The independent expert cardiologist gave evidence at the Inquest about the ECGs. He stated that the changes between the two ECGs were of diagnostic significance and "would certainly suggest that the pain that was occurring was cardiac in nature".

The Coroner concluded that it was clear that the ECG results alone should have resulted in the patient being admitted and undergoing further investigations. As well, and quite independently of the ECGs, if the Guidelines had been followed correctly this also would have resulted in the patient's admission to hospital.

With regard to Telehealth Services, the Coroner noted that both of the nurses had placed considerable weight on the fact that the patient had been medically evaluated earlier in the day. He felt the nurses might have thought the blood testing had involved repeat troponin testing, rather than a single test.

The Coroner reported that the medical deputising service had a protocol for operators which stated that the recommended action for chest pain was that a "000" call be made.

In his final conclusions, the Coroner found that the patient's death would have been preventable if her symptoms had been properly evaluated, the results of the two ECGs had been properly interpreted and/or the hospital's Guidelines had been adhered to.

Ms Lawrence's death may also have been prevented if, as a result of the telephone conversations she had with operators at Telehealth Services and GP Solutions, she had called an ambulance. The Coroner noted that the outcomes of these telehealth conversations had been heavily influenced by the knowledge that the patient had already been examined in hospital earlier that day.

Risk management strategies

The Coroner made the following recommendations with regard to the hospital:

1. That consideration be given to including reference to risk factors and the quality and duration of chest pain as being important considerations in assessing whether patients are at very low risk in the Guidelines.
2. That instructions be given to all medical staff in the ED that:

(a) requirements and protocols set out within Guidelines should be strictly adhered to and, in particular that a direction be given to strictly adhere to the requirements for the very low risk criteria

(b) regardless of whether the very low risk criteria are satisfied, medical staff should only discharge patients where an alternative explanation exists for their chest pain, and where the explanation has a high degree of certainty.

3. That ongoing training and education be provided to medical staff regarding chest pain management, including ECG interpretation.
4. That direction be given to junior medical staff that a patient who has presented with chest pain should not be discharged under the very low risk pathway unless and until:

(a) the patient has been examined by a medical practitioner at a consultant level (b) any ECGs have been reviewed by a consultant.

The Coroner made the following recommendations to Telehealth Services, GP Solutions and any other organisations that provide similar services:

5. That telephone operators providing advice to callers or who arrange locum medical services for callers, should advise callers who seek advice about chest pain to immediately call an ambulance or take themselves to hospital and that they should do so regardless of whether there has been any recent presentation to hospital.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

Inquest into the death of Rebecca Mary Lawrence. Inquest Number 10/2011 (1628/2008). Coroner's Court, SA; 22 June 2011.

What's On?

MDA National Event Dates for Your Diary

Make sure you come and say hello to us at the conferences where we have a trade stand to get the latest updates from MDA National & have the chance to win a fantastic prize!

September 2011

Neurosurgical Society of Australasia Annual Scientific Meeting

21-24
MDA National sponsorship of Risk Management Workshop
Nadi, Fiji
www.nsa.org.au/annual_meeting.php

October 2011

The Royal Australian College of General Practitioners Annual Scientific Congress – GP11

6-8
Trade Stand 44
Hobart, TAS
www.gp11.com.au

PIAA International Section Conference
Registrations still open!

6-8
Melbourne, VIC
www.piaa2011.com

The Royal Australian and New Zealand College of Radiologists 62ND Annual Scientific Meeting – RANZCR 2011

6-9
Trade stand 61
Melbourne, VIC
www.ranzcr2011.com

Want more information about these events?

Please visit event websites or contact the event organisers directly.

Want more information about what MDA National will be doing at these events?

Contact our Events and Sponsorship team on events@mdanational.com.au or 1800 011 255.

Australasian Integrative Medicine Association Annual Conference

14-16
Trade stand 32
Sydney, NSW
www.aima.net.au

Australian Association of Practice Managers National Conference

18-21
Trade stand 54
Perth, WA
www.cdesign.com.au/aapm2011

Rural Medicine Australia Annual Conference

28-30
Trade stand 31
Alice Springs, NT
www.acrrm.com.au/home

November 2011

Medical Council of New Zealand 16th Pre-Vocational Medical Forum

6-9
Auckland, NZ
www.prevocforum.org.nz

Internal Medicine Society of Australia and New Zealand Annual Scientific Meeting

11-13
Trade stand 3
Lorne, VIC
www.imsanz2011.org.au

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

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

ELECTION NOTICE

Nominations are called from eligible candidates for the election of:

Councillor (3)

Nominations will be accepted from Friday 23 September 2011.

Nomination forms are to be completed in accordance with the *MDA National Election Rules* and must reach me no later than 12.00 noon on Wednesday 12 October 2011. Should an election be necessary, voting will close at 10.00 am on Wednesday 9 November 2011.

HOW TO LODGE NOMINATIONS

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

By Post: GPO Box F316
PERTH WA 6841

By Fax: (08) 9226 0577

Nomination forms are available either from any MDA National office, or by downloading them from www.mdanational.com.au or from me at the Western Australian Electoral Commission. Originals of faxed nominations must be mailed or hand-delivered to the Returning Officer.

All Members! Have you changed your address?

If so, please advise MDA National of your new address.

Cathy King
RETURNING OFFICER

Phone: 13 63 06
Email: waec@waec.wa.gov.au

WESTERN AUSTRALIAN
Electoral Commission

MDA National
Support Protect Promote

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