# defenceupdate

Quarterly Magazine for MDA National Members

Spring 2012

MDA National

Support Protect Promote

# Editor's Note

Over the past few months, there has been a great deal of discussion in the media about the introduction of the National Disability Insurance Scheme (NDIS).

On page 3, A/Prof Julian Rait outlines and analyses the issues associated with the introduction of the NDIS and, in particular, the National Injury Insurance Scheme which will have a direct impact on the medical profession and medical defence organisations.

The fundamental role of MDA National is to advise, protect and support our Members who are involved in a medico-legal matter. This issue of *Defence Update* highlights aspects of this core role. Our Medico-legal Advisory Service receives over 3,000 calls each year from Members who are seeking medico-legal advice. An unusual Member call is discussed on page 5. Two recent medical negligence claims which were successfully defended by MDA National are outlined on pages 6 and 7.

Support for our Members throughout the course of a medico-legal process is an integral and important part of MDA National's role. Our pull-out feature outlines some strategies on how to deal with the stress of medico-legal issues and also how to support a colleague after an adverse patient event. On page 12, one of our Members describes his reactions after an adverse event, including how he personally managed these and the ensuing Coronial Inquest.

Medical registration renewal is due by 30 September 2012 for most medical practitioners. Claims Manager, Yvonne Baldwin, reminds us of the Australian Health Practitioner Regulation Agency (AHPRA) mandatory registration standards on page 8, including the Continuing Professional Development (CPD) requirements. Remember you can obtain CPD points for your College program by completing the *Defence Update* CPD activity. Visit *Defence Update* online at **www.defenceupdate.mdanational.com.au/CPD**

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

# In This Issue

# From the President

## How best do we compensate for accidental medical injuries?

A new medical injury scheme will require realistic costing, careful planning and gradual implementation.

In his recently published book, *The righteous mind*, American psychologist Jonathan Haidt makes the observation that "morality is an emotional issue, not a rational one; and in a contest between what we think is reasonable and what we feel in our hearts, emotion always wins".[1]

Therefore, recent proposals for national disability and injury insurance schemes seem an exciting prospect for many policymakers because most people are emotionally challenged by the suffering of people with disabilities, and see the potential of such schemes to improve these people's lives and ease the burden on their carers. [2]

Recently, the Western Australian Government launched a new project embodying the key hallmarks of the planned National Disability Insurance Scheme (NDIS). The first of its kind in Australia, the My Way project is purported to "improve the choice, flexibility and control that people with a disability have over their supports and services".[3] New South Wales and Victoria have recently joined South Australia, Tasmania and the Australian Capital Territory in agreeing to fund and participate in trials of the national scheme from July 2013, although negotiations will continue as to whether the federal government or the states will provide the extra $10.5 billion a year required for the schemes when they become fully operational in 2018.[4,5]

In The Medical Journal of Australia 2012, Vol 197, Issue 05, Breen and Weisbrot argue that a no-fault compensation scheme for medical error is also long overdue.[6] Their article continues a long tradition of argument, both within and outside the medical profession, seeking an alternative approach to medical accident compensation. One reason for this debate is that the existing tort system and alternative no-fault medical accident compensation schemes have different goals.

The tort system is intended to grant comprehensive compensation to patients who can prove that an adverse outcome arose through a breach of duty by either a practitioner or a health care organisation, and that this breach caused their injuries and disabilities – but such patients who make a claim are few. Conversely, the role of a no-fault scheme is to provide compensation and rehabilitation to the largest number of eligible patients and to reduce the conflict and distress for all involved. Therefore, the former gives weight to deterrence and corrective justice, while the latter seeks to improve communication and transparency within the health care system, and to minimise legal costs.

Certainly, while the existing tort system can lead to the practice of "defensive medicine", it has been efficient at adjudicating and providing compensation for patients' claims that have merit and rejecting those that do not.[7] It also effectively focuses various specialties, their colleges and their liability insurers on specific risk-management strategies that might prevent avoidable injuries and reduce insurance premiums.

In contrast, creating a sound no-fault support scheme appears potentially more complicated. Concern exists that the overall cost of long-term care might rise under a no-fault liability system if the experiences of New Zealand and Sweden are a valid comparison.[8] In Sweden alone, compensation payments for malpractice have doubled in the past decade, and in the past 5 years written complaints over treatment have increased by 80%, with 700 new complaints lodged in the first 3 months of 2011.[9] This is illustrative of the potential additional costs that arise from the inherent increase in eligibility for benefits that occurs when fault is no longer a necessary criterion for compensation. Surprisingly, despite increased eligibility, the findings of a study in New Zealand showed that only 2.9% to 4.8% of patients who suffered an injury and were eligible for compensation under the national no-fault compensation program made a claim by mid 2004.[10] However, in 2005, New Zealand broadened eligibility to include all personal injuries sustained while receiving treatment from health professionals, termed "treatment injury", and this has since led to a much greater utilisation rate.[11]

In New Zealand, medical board investigations also increased in response to patients receiving compensation through the Accident Compensation Corporation.[12] Given this experience, there remains the strong likelihood that, after many so-called accidents, culpability will still be apportioned based on investigations by the Australian Health Practitioner Regulation Agency or the Medical Board of Australia, leading to increasing costs for medical indemnity insurers and the usual anxiety for the practitioners involved. Additionally, the predicted savings in legal expenses under a no-fault scheme might not eventuate if patients are still entitled to sue for non-pecuniary damages, including pain and suffering and loss of future earning capacity.

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# From the President **Continued**

As a consequence of these increasing costs, over time most schemes have imposed limitations on eligibility and benefits. Unless benefits are purely confined to catastrophic injuries (as proposed under the National Injury Insurance Scheme [NIIS]), the end result is that the compensation per patient eventually falls short of being commensurate with the injury suffered. Thus, switching to no-fault liability reallocates compensation from patients injured through negligence to claimants who have been injured despite perfectly sound medical care.

The public policy challenges of changing to no-fault liability cannot be overestimated. The proposed Australian NIIS for catastrophic accidental injury would include injuries arising from medical treatment, but formulating a definition of "medical accident" would be considerably complicated for policymakers. The present tort system could be improved through compulsory mediation in all states and territories.

Despite the efforts of the Productivity Commission in Australia,[5] there is remaining uncertainty as to the ultimate cost of such an accidental injury compensation scheme, how this will work with existing state-based accident compensation schemes, and to what extent doctors will be required to fund the no-fault component of medical accident compensation (in addition to fault-based claims) through their medical indemnity insurance premiums.

Any new measures to support medical injury compensation will need to be carefully costed and planned and to provide at least the same benefits as the existing tort system or those of the proposed NDIS. Australian doctors, in accordance with our Hippocratic principles, will be very likely to support an improved system of care for people injured through medical treatment, provided that we can be reassured of greater justice and equity at reasonable cost to both the profession and the community.

Medical indemnity insurers equally look forward to continued dialogue with the Federal Government and the Productivity Commission, and hope to overcome current uncertainty and ensure that any expectation on the medical profession to contribute to the funding of the NIIS will not increase medical indemnity costs, otherwise Australians will pay more for medical treatment.

**A/Prof. Julian Rait**
**MDA National President**

For a full list of references, visit www.defenceupdate.mdanational.com.au/From-The-President



# Notice Board

## Medical Registration Renewal

It's time to renew your registration with the Medical Board of Australia. If you're a medical practitioner with general and/or specialist registration or non-practising registration, you have until 30 September 2012 to renew.

**For more information** about how to renew your registration visit **www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-practitioners.aspx**

## Watch the Medico-legal Forum Online

This year we held a series of forums across the country which featured our new *The Doctor's Life* DVD, a true-to-life case study that facilitated discussion and reflection on how doctors' professional relationships can impact patient care, the patient's experience, and a doctor's personal resilience.

**To view our forum online** log onto our Member Online Services (MOS) via **www.mdanational.com.au** enter your details and experience a multi-media version of our Adelaide Medico-legal Forum – you can watch it by chapter!

## New President for AMA Queensland

**MDA National Member, Dr Alex Markwell has officially commenced her role as President of AMA Queensland for 2012-2013.**

Dr Markwell has been heavily involved with the AMA since graduating from the University of Queensland. She has been a strong advocate for junior doctors having served as Chair of the AMA Queensland Council of Residents and Registrars (2005-2007) and Chair of the Federal AMA Council of Doctors in Training (2007-2009).

## It's an Honour

Congratulations to MDA National Member, Dr Thomas Rex Henderson whose outstanding contribution to our community has been recognised with his inclusion on the Queen's Birthday 2012 honours list.

Dr Henderson received a Member of the Order of Australia (AM) for service to rural and remote medicine in Western Australia, as a paediatrician and a neonatologist, to indigenous health and welfare as a mentor.

# Our Medico-legal Advisory Service

## Where the Truth can be Stranger than Fiction

**MDA National's Medico-legal Advisory Service assists Members with a range of legal and ethical dilemmas. With permission from the Member involved, Medico-legal Adviser, Nerissa Ferrie reviews a recent matter concerning patient confidentiality.**

### The call

When the Member first contacted our Medico-legal Advisory Service, his practice had been approached by the manager of the building who asked staff to identify a person captured on CCTV. The reception staff viewed the footage and confirmed that the person in the video was known to them.

The video showed the patient leaving the Member's rooms, pausing outside the allied health professional's office across the corridor, and walking off with some packages left outside the door.

The building manager reported the theft to the police, but subsequently lost the CCTV footage. The police advised the practice that they couldn't pursue charges against the patient unless the practice staff were 100% sure they could identify the patient as having committed the theft.

### Privacy and ethics

Although practice staff were able to clearly identify the patient, they were careful not to inadvertently breach the patient's privacy by providing personal details to the building manager without consent.

The Member had an additional problem because he was due to perform surgery on the alleged thief that afternoon! He didn't know if it was ethically appropriate to operate given what he now knew about his patient. The Medico-legal Adviser asked the Member whether this knowledge would in any way compromise the medical care he provided to the patient. The Member said no and he appropriately decided to proceed with the surgery. To cancel the surgery at such short notice would require explanation, and at this stage the patient was unaware she had been filmed pilfering packages from outside the allied health provider's office.

### Police statements

One month later, the Member sought further advice when the police contacted the rooms seeking statements from the practice staff. The police advised the Member that in this case they were unable to compel the practice staff by way of a warrant, which would protect the practice from a breach of confidentiality and a potential complaint.

### Our advice

We advised the Member that unless the police could compel the practice staff to provide the information requested, they were not required to do so. If the practice wished to cooperate with the police, they could consider doing so on the basis of National Privacy Principle (NPP) – 2.1(h) "Use and Disclosure and Enforcement Bodies". [1]

NPP 2.1(h) contemplates permitted uses and disclosure relating to suspected unlawful activity, criminal offences or other breaches of law, but the section is not intended to override the duty of confidentiality between a medical practitioner and an individual. The test which should be applied requires the practitioner to look at the seriousness of the situation – for instance, an investigation into an alleged murder or sexual offence would clearly be more serious than property theft.

In this case, the Member decided that the seriousness of the act did not warrant a breach of confidentiality and politely declined to assist the police with their prosecution.

1 NPP 2.1(h) *Guidelines on Privacy in the Private Health Care Sector*, Office of the Australian Information Commissioner. Available at: www.oaic.gov.au

### Have you had any similar ethical conundrums?

Share your comments with us at *Defence Update* online **www.defenceupdate.mdanational.com.au/advisory-service**

# It Is Not All Bad News

While the threat of a medical negligence claim can be one of the most stressful events in a doctor's working life, not all outcomes are bad news. Manager, Professional Services, Philippa Nash and Claims Manager, Dr Helen Havryk examine two separate cases where the outcomes of the claims were good news.

## Claim one

### Background of claim

The plaintiff underwent laparoscopic repair of bilateral inguinal hernias in early 2008. 3D Max Bard mesh was tacked in situ following reduction of the hernial weaknesses during the original laparoscopic surgery. Good haemostasis was achieved and the bleeding was not significant. The count sheet showed that only one pack of five sponges and swabs was used, and accounted for, during the procedure.

Drainage of an abdominal abscess was required six weeks later following a right sided port site infection. Gauze packing was intentionally left in the wound at the time of the second surgery and removed and replaced until the wound healed.

Ultrasound of the left groin and x-ray pelvis and left hip were performed in mid 2008 as the plaintiff had an episode of severe pain in his left groin when rolling over in bed. The report noted surgical clips projecting over the pelvis with no report of any radio-opaque markers.

The plaintiff next saw our Member in late 2009, with a four day history of pain and swelling in his left groin. Ultrasound showed a large mass in the left iliac fossa *suggestive of residual packing material within a chronic haematoma*. Our Member thought the "packing material" was probably mesh floating in a seroma. The seroma was drained and the mesh was removed. Our Member reported no residual packing material and noted it was not possible to confuse the mesh removed with swabs.

The plaintiff commenced proceedings against our Member, a general surgeon, alleging that "swabs and other packing materials" had been left in situ following one of the 2008 surgeries.

### Evidence

The plaintiff relied on the evidence of a general practitioner, who reported that he had reviewed the "x-ray film", although the date of the "film" was never confirmed and it seems the actual mid 2008 x-ray was lost. He stated that radio-opaque inserts were visible. He was also critical that the scrub sister and the surgeon did not perform the final swab count together.

On behalf of our Member, reports were obtained from a professor of radiology, and a laparoscopic surgeon. Our experts thought the appearance on the 2009 ultrasound was consistent with hernia repair mesh within a seroma and in light of the plaintiff's history and absence of any radio-opaque markers reported in the mid 2008 x-ray, the ultrasound appearance most likely represented hernia repair mesh.

Our surgical expert noted that surgeons had not been involved in swab counting over the last 30 years, and this is international gold standard. He could find no evidence that swabs and/or packing material were retained. If a residual pack or gauze swab had been left in situ during the original operation, it would have been evident at the subsequent surgery and would not have taken 15 months to present as an issue.

### Outcome

The plaintiff was invited on four occasions to agree to a verdict in our Member's favour on the basis that each party pays their own legal costs, along with detailed explanations as to why the plaintiff's claim would fail, including the quality of the plaintiff's expert evidence. There was no response to the offers.

Just before the hearing, the plaintiff's solicitors invited our Member to agree to a verdict in the defendant's favour on the basis that each party pays their own costs. The plaintiff's offer was rejected. After further negotiations, the plaintiff agreed to (1) a verdict in favour of the defendant and (2) pay a significant proportion of our Member's legal costs.

The firm of solicitors instructed in the plaintiff's matter frequently acts on behalf of plaintiffs in medical negligence matters. It is hoped that our stance in not accepting the plaintiff's offer of a verdict in favour of the defendant on a "walk away" basis, but seeking a significant proportion of our costs, will send a strong message that we will be vigorous in seeking our legal costs under similar circumstances.

## Claim two

### Jordan v Lee & Baker [2012] WADC 74

On 25 May 2012, the District Court of WA dismissed a claim against a neurosurgeon and a paediatric oncologist for an alleged failure to advise the parents of a child with a brain tumour that other neurosurgeons would have resected the tumour.

### Background of claim

The plaintiff first presented to Mr Lee, neurosurgeon, with a long-standing tumour in the basal ganglia in August 1996. Due to the location of the tumour, presence of leptomeningeal metastases and the plaintiff being largely neurologically intact, Mr Lee advised the parents that the risks of surgically removing the tumour outweighed the benefits.

Mr Lee referred the plaintiff to Dr Baker, oncologist, for adjunctive management.

Mr Lee next saw the plaintiff in May 1998. An MRI indicated a slight increase in the cystic component of the tumour which, coupled with some worsening symptoms, led Mr Lee to surgically aspirate the cyst in 1999. The tumour itself showed little change over this time.

The plaintiff's situation changed significantly in May 2000 when further cystic growth caused dramatic neurological decline. The risks were now more evenly balanced with the potential benefits of surgery. An increase in cyst size meant that Mr Lee could now approach the tumour from the cyst without having to go through normal functioning brain. Mr Lee proceeded to surgery but was unable to complete the procedure for reasons beyond his control.

The plaintiff's parents sought referral to an interstate neurosurgeon, who undertook three operations over the next month removing 98% of the tumour.

### The plaintiff's case

It was alleged that the parents of the plaintiff should have been advised that surgical resection was a treatment option that other surgeons, acting reasonably, would have performed in 1996, 1998 and 1999 and the defendants knew of such surgeons.

The plaintiff alleged that had his parents been told in 1996 that there was a potentially curative surgical option this would have been their treatment of choice.

The only expert called on behalf of the plaintiff was the interstate neurosurgeon, who presented as both a witness of fact and of opinion. This surgeon gave evidence that he would have recommended an attempt at complete removal of the plaintiff's tumour at all times from 1996. He reported that a large body of surgeons in the USA were removing tumours like the plaintiff's in 1996 and would have recommended surgical removal of the tumour.

He concluded that most, if not all, of the plaintiff's disabilities would have been avoided by earlier aggressive surgical intervention.

### The defendants' case

Six experts called on behalf of the defendants gave detailed evidence that they were not aware of any neurosurgeon who, in 1996, would have given advice to the effect that the benefits to be obtained from an attempted gross total resection of the plaintiff's tumour outweighed the risk of that procedure. The same opinions were expressed for 1998 and 1999.

### District Court findings

The judge preferred the evidence of the experts for the defence, finding that an attempt at resection in 1996, 1998 and 1999 would not have been reasonable.

He held that *To retrospectively impose a duty mandating the giving of advice between 1996 and 2000 that other neurosurgeons, acting reasonably, would have resected Daniel's tumour would be wrong on the facts of this case. Such other neurosurgeons would not have been acting reasonably in resecting Daniel's tumour. Further, there is no or no sufficient evidence that there were then such surgeons resecting tumours of the kind Daniel suffered. Given that, it would be too obtrusive to impose a duty to advise that an unnamed and unknown surgeon somewhere in the world, acting reasonably, would have resected the tumour. Further, to impose a duty to have enquired whether radical resection might have been reasonably undertaken in the circumstances of Daniel's tumour would have been too onerous and productive of great uncertainty as to the duty of care owed by a medical practitioner to the patient.*

The judge was not persuaded by the plaintiff's expert evidence on a number of issues of fact and opinion. He was not persuaded that the underlying foundation for the expert's opinion to resect the tumour before 2000 had been satisfactorily explained in his evidence, nor was it supported by the literature.

The judge noted that the plaintiff's expert was clearly passionate about the resection of brain tumours as providing the best chance of a cure, but that it was this passion and his subjective involvement in the plaintiff's treatment that was interfering with his objectivity and impartiality as an expert witness.

### Outcome

Of note is that in finding there is no obligation on a surgeon to advise that, contrary to their view, other surgeons would recommend surgery, the trial judge made the factual conclusion that there were no such surgeons who would have reasonably recommended proceeding to surgery in this case. This involved the trial judge's rejection of the evidence given by the plaintiff's expert. This case highlights that regardless of an expert's qualifications and experience, their opinion will be of little use if they are unable to furnish the judge with the necessary scientific criteria for testing the accuracy of their conclusions.

The decision also highlights the potential pitfalls for a practitioner appearing both as a witness of fact and as an expert. The trial judge noted that it was one thing to give evidence as the treating neurosurgeon, but quite another for a highly skilled medical expert to give evidence requiring independence and objectivity, with the primary obligation being to the court when giving that expert evidence.

### What do you think?

Share your comments with us at *Defence Update* online **www.defenceupdate.mdanational.com.au/not-bad-news**

# The New Regime: **Continuing Professional Development**

Claims Manager/Solicitor, Yvonne Baldwin provides a timely reminder about the Medical Board of Australia's continuing professional development (CPD) requirements under national registration.

Prior to the inception of national registration, only registered medical practitioners who were Members or Fellows of AMC-accredited Colleges had to undertake annual CPD. The advent of national registration has resulted in a number of mandatory registration standards being applied to all applicants for registration and registered medical practitioners (except medical students and medical practitioners with non-practising registration) – including a CPD standard.

The Medical Board of Australia (the Board) requires medical practitioners to regularly participate in CPD if they are engaged in any form of medical practice. Any CPD undertaken needs to be relevant to the medical practitioner's scope of practice.

Each year at renewal of registration, all medical practitioners are asked to declare that they have met the Board's CPD standard. The Board is relatively flexible in what it deems a CPD activity to be i.e. participation in knowledge-enhancing activities (such as online learning, courses and conferences) and practice-based reflective activities (such as clinical audits, performance appraisals and peer reviews).

### CPD requirements

All registered medical practitioners who are required to undertake annual CPD must fulfil the requirements in whichever of the following categories is applicable to them:

- Members or Fellows of an AMC-accredited College need to meet the CPD standards that have been set by their particular College.
- Medical specialists and general practitioners who are on the specialist register but are not College Members or Fellows need to meet the CPD standards set by the relevant College.
- The following medical practitioners need to participate in the supervised training and education programs that are associated with their position:
  - Those holding provisional registration (such as interns).
  - Those with limited registration for post-graduate training or supervised practice.
  - Those with general registration who are pre-vocational trainees or College vocational trainees.
- Medical practitioners who hold limited registration for "area of need" must complete the CPD activities that are set out in their supervision plan.
- Medical practitioners who hold limited registration for research or teaching need to complete a minimum of 10 hours CPD per annum, and this needs to be relevant to their teaching or research position. Medical practitioners who work in academia must complete the 10 hours CPD in addition to their teaching load.
- Medical practitioners who hold limited registration in the public interest need to ensure that they complete CPD activities as specified in their conditions of registration. Any medical practitioner who holds such registration for occasional practice, prescribing and referral must complete a minimum of 10 hours CPD per annum and ensure that it focuses on the particular nature of their practice.
- Any medical practitioner who is not on the specialist register and does not fit into any of the other categories above needs to complete 50 hours CPD per annum by way of self-directed learning.

Each year, AHPRA will conduct a random audit of medical practitioners to ensure that they have complied with the Board's CPD requirements. Accordingly, medical practitioners need to keep a record of the CPD activities they have undertaken. The Board requires CPD records to be kept for three years.

### Failure to comply

Any failure to comply with the Board's CPD registration standard will be treated as a breach of the legal requirements for registration, and although it "does not constitute an offence [it] may constitute behaviour for which health, conduct or performance action may be taken".[1]

The other mandatory registration standards relate to:

- criminal history
- English language skills
- recency of practice
- professional indemnity insurance.[2]

If you have any queries about any of the mandatory registration standards, please contact MDA National's Medico-legal Advisory Service on 1800 011 255.

1 Section 128(2) Health Practitioner Regulation National Law Act 2009.
2 Available at: www.medicalboard.gov.au/Registration-Standards.aspx

# Dealing with the Stress of Adverse Events and Medico-legal Issues

"...very little attention has been devoted to healthcare workers involved in adverse events to help them cope with their responses."

# Dealing with the Stress of Adverse Events and Medico-legal Issues

**A recent editorial in the Journal of Quality and Safety asked: are we doing better at investigating and minimising the frequency of adverse events, but feeling worse? The authors noted that despite the developments in adverse event investigations "very little attention has been devoted to healthcare workers involved in adverse events to help them cope with their responses".[1]**

Over the past decade, there has been an exponential increase in the number of processes available to investigate and manage adverse patient events. An adverse patient incident in a hospital setting may result in a root cause analysis, an open disclosure process, a hospital investigation, a complaint to AHPRA and/or a Health Complaints Entity, a coronial investigation and, on occasion, a medical negligence claim. All of these processes take time and it may be several years before they reach an end.

Appropriately, the focus of these processes is on the management of the patient and their family, and also ensuring that any lessons learned result in improved patient outcomes. But what about the medical practitioners who are involved in these adverse events and medico-legal processes? What are their reactions and needs? How can they best cope? How can we assist our colleagues who are involved in these events?

### Doctors' reactions to adverse events

The initial reactions of doctors to adverse patient events include numbness, detachment, distress, confusion, anxiety, grief and depression, withdrawal or agitation, and re-experiencing the event. Added symptoms which are related to medical errors include shame, guilt, anger, self-doubt and loss of confidence.[1] Difficulty concentrating is also common, and the medical practitioner may be significantly impaired in performing their usual role. These symptoms may last from days to several weeks.

A few medical practitioners go on to suffer long-term consequences, such as flashbacks, avoidance of situations associated with the trauma and increased arousal, including sleep disturbance and irritability. Some doctors consider leaving the profession.

**Six stages of "recovery" have been identified after an adverse patient event:**

1. Chaos and accident response.
2. Intrusive reflections.
3. Restoring personal integrity.
4. Enduring the inquisition.
5. Obtaining emotional first aid.
6. Moving on: dropping out, surviving or thriving.[2]

### Doctors' reactions to medico-legal issues

A claim or complaint against a medical practitioner also causes emotional and physical stress, regardless of the outcome. Research has shown that the threat of a medical negligence claim is one of the most severe sources of stress in medical practitioners' working lives.[3] A survey of medical practitioners who were the subject of a medical negligence claim found the following reactions:

- 96% of medical practitioners acknowledged an emotional reaction for at least a limited period of time.
- 39% experienced depression, including symptoms such as depressed mood, insomnia, loss of appetite and loss of energy.
- 20% experienced anger, accompanied by feelings such as frustration, inability to concentrate, irritability and insomnia.
- 16% described the onset or exacerbation of a previously diagnosed physical illness.
- 2% of medical practitioners engaged in excessive alcohol consumption.
- 2% experienced feelings of suicidal ideation.[4]

Symptoms may last for only a short period, recur with each step in the process, or persist throughout the entire claim or complaint.

A recent Australian survey examined the differences in psychological morbidity between general practitioners who have experienced a medico-legal matter and those who have not.[5] Those practitioners with a current medico-legal matter reported increased levels of disability in work, social or family life, and higher prevalence of psychiatric morbidity, compared to those with no current matter. Those respondents with a history of past medico-legal matters

reported increased levels of disability and depression subscores. Male respondents with a current or past medico-legal matter had significantly higher levels of alcohol use than male respondents with no experience of medico-legal matters.

### Managing adverse events and medico-legal issues

The ability to cope with stress is highly individual and medical practitioners need to reflect on their own means of coping. There are a number of strategies that medical practitioners can use to deal with the stressful nature of an adverse event, claim or complaint. Effective coping responses include both problem solving and emotionally focused coping. Practitioners need to learn to switch between the two, when appropriate. Problems can arise if the medical practitioner tries to apply the wrong response in a given situation, for example, trying to solve an unsolvable problem.

One of the first steps in coping is to obtain sufficient information about the process in which the medical practitioner is now a participant. MDA National's Claims and Advisory Services team can provide detailed information about the particular medico-legal process that a Member is involved in. Additionally, medical practitioners need to understand what can be expected psychologically and, throughout the process, they need to observe their emotional and physical reactions. If any symptoms develop, such as depression, physical illness or substance abuse the practitioner should consult their general practitioner. Self-medication should be avoided, even if faced with the common symptom of insomnia.

For many medical practitioners, a feeling of being "out of control" pervades the onset of a claim or complaint process. Medical practitioners often feel like they are on a roller coaster ride, with alternating feelings of confidence and loss of self-esteem, of assurance and self-doubt. Regaining a sense of mastery and control is important. Medical practitioners often have difficulty identifying their strengths but are well practised in identifying their weaknesses. By identifying strengths, medical practitioners are then in a position to develop them and look at shaping their life and work to feed those strengths. Engaging in activities that make the practitioner feel in better control of their personal and professional lives will assist in restoring a sense of balance (see Table 1).

### Assisting colleagues after an adverse event

Peers are the most popular source of support after an adverse patient event.[7] Strategies for assisting a colleague in this situation include:

- Encourage a description of what occurred.
- Begin by accepting this assessment.
- Do not minimise the importance of the event.
- Acknowledge the emotional impact of the event: "This must be very difficult for you. How are you doing?" [8]
- Assist the colleague in identifying other supports, including contacting their medical defence organisation.

**Table 1 – Strategies for coping with claims and complaints[6]**

| Social support |
|---|
| • Discuss your feelings with a trusted person – a colleague, family member, friend, GP and/or your MDA National Claims Manager. |
| **Restore mastery and self-esteem** |
| • Ask your Claims Manager to describe each step of the process.<br>• Clarify the anticipated time required to conclude the matter.<br>• Take an active role in the preparation of the case, including participating in the choice of any medical experts.<br>• Put aside the necessary time to deal with the case.<br>• Prepare yourself for the unpredictability of the process.<br>• Identify areas of your practice that cause anxiety or feelings of "loss of control" and find ways to diminish them.<br>• Engage in activities that increase your sense of competence e.g. teaching, CPD activities.<br>• Review the amount of time spent on professional and family activities, and make appropriate changes.<br>• Participate regularly in physical and other leisure activities. |
| **Change the meaning of the event** |
| • Review your career objectively and reinforce your sense of competence.<br>• Seek the advice of trusted family members, colleagues, friends and professionals about your feelings and the progress of the case. |


1 Wu A, Steckelberg RC. *Medical error, incident investigation and the second victim: doing better but feeling worse?* BMJ Qual Saf 2012; 21:267-270

2 Scott SD, Hirshinger LE, Cox KR et al. *The natural history of recovery for the healthcare provider "second victim" after adverse events.* Qual Saf Health Care 2009; 18:325-330.

3 Schattner PL, Coman GJ. *The stress of metropolitan general practice.* Med J Aust 1998; 169:133-137.

4 Charles SC, Wilbert JR, Kennedy EC. *Physicians' self reports of reactions to malpractice litigation.* Am J Psychiatry 1984; 141:563-565.

5 Nash L, Daly M, Johnson M et al. *Psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter: cross sectional survey.* Aust N Z J Psychiatry 2007; 41:917-925.

6 Charles SC. *Coping with a malpractice suit.* West J Med 2001; 174:55-58.

7 Hu Y, Fix M, Hevelone ND, et al. *Physicians' Needs in Coping With Emotional Stressors.* Arch Surg 2012; 147: 212-217.

8 Wu A. *Medical error: the second victim: The doctor who makes the mistake needs help too.* BMJ 2000; 320: 726-7.

# The role of MDA National

When dealing with a medico-legal issue, MDA National's aim is to obtain the best possible outcome for our Member. Unless the Member is well and able to cope with the process, then the best result for that Member is difficult to achieve. Therefore, providing support to our Members is an integral part of MDA National's role. Our Claims and Advisory Services team has extensive experience in supporting Members throughout the course of a claim, complaint or other medico-legal process.

Every Member will have their own individual needs, depending on their personality and the nature of the matter they are dealing with. Some Members find it relatively easy to implement strategies to cope with the stressful nature of the process, while others may be reluctant or unable to obtain the support they need.

To ensure our Members are provided with an appropriate level of support when dealing with a medico-legal issue, MDA National has two additional programs to provide support to Members:

1. **Doctors for Doctors Program**

- The aim of this program is to provide understanding and support to a Member, and enable the Member to share their experience with another doctor during the course of an incident notification, claim, complaint, investigation or other process.
- The Claims Manager will discuss the program with the Member and provide a prompt referral if the Member would like to use this service at any stage during the case.
- The program complements the role of the Claims Manager and offers the Member additional support from a colleague throughout the course of the case.

2. **Professional Support Service**

- The aim of the Professional Support Service is to provide a Member with direct access to a psychiatrist who can give professional support to the Member during the course of an incident notification, claim, complaint, investigation or other process.
- The service is completely confidential and details of any discussions between the psychiatrist and Member will not be disclosed to MDA National.
- MDA National will pay for the cost of up to 10 consultations per membership year.

MDA National is here to advise, protect and support you throughout the process, to ensure that the best possible result is achieved.

# A Doctor's Perspective

**Dr Cameron Knott**

During my training in Intensive Care Medicine I was part of a team that treated a middle-aged man for cardiogenic shock. In the process of treating this man, the team was required to emergently reintubate him for respiratory failure. A series of unfortunate events followed that resulted in an unrecognised oesophageal intubation. The man sustained a severe hypoxic brain injury from which he died about a week later.

This was a catastrophic day for the man, his family and all the staff involved in his care. Despite the post-event management and open disclosure being well executed, my colleagues and I suffered in our own ways as we worked out how to function under the burden of such a confronting situation.

My responses to my first time in this situation were feelings of terror, shame, incompetence, self-loathing, despair and anger. In the subsequent weeks and months I suffered flashbacks to these events. I felt like an abject failure and an incompetent doctor. I chose to share my experience and I spoke confidentially to colleagues, friends, family and professionals. It took a long time to process the chaos of that day.

The turning point for my recovery from this difficult time was when I actively chose to take this on as a learning experience. I chose to address the communication and technical factors in my practice that had contributed to this event. I also committed to honour this man by teaching people about my experience. I do not want others to experience this, if possible. I discovered many others, including my clinical role models, had been through similar experiences. I gradually made my peace with that terrible situation.

During the subsequent coronial hearing I was well briefed by a compassionate legal team. I presented my evidence and had an opportunity to offer suggestions about how to prevent this happening again. I spoke with the bereaved family and my colleagues. The legal team organised another debriefing of the intensive care team after the hearing. We shared the experience again and we healed further.

This event has been a powerful driver of the development of my practice and teaching. It has also made me realise that I am part of a large, caring community, which despite all the difficulties, strives for the best possible care for people, even after the worst possible circumstances. The process was hard emotional work and I could not have thrived alone.

Dr Cameron Knott is an Intensivist and a MDA National Member.

# **Report:** AMA 2012 National Conference

The Australian Medical Association (AMA) held its annual National Conference in Melbourne on 25-27 May. The conference was a milestone event for the AMA as it celebrated its 50th anniversary of being established since it became independent from the British Medical Association in 1962. Dr Andrew Perry Reports.

In keeping with its ethos of supporting the medical profession MDA National was heavily involved in this significant event for the AMA. We provided two speakers for the academic program and sent a large delegation consisting of members of the Mutual Board, President's Medical Liaison Council (PMLC) and senior employees.

### MJA, MDA National Prize for Excellence

MDA National President A/Prof Julian Rait awarded the 2011 MJA, MDA National Prize for Excellence in Medical Research – an award that honours the authors of the best original clinical research article published in the Medical Journal of Australia each calendar year.

To find out the winners, visit *Defence Update* online at **www.defenceupdate.mdanational.com.au/excellence-award**

The conference's theme was "Leading in Medical Care" and this was explored through a combination of plenary and break-out sessions.

### Leading for Difference

The first day commenced with the session "Leading for Difference" and featured Dr Christine Bennett, former Chair of the National Health and Hospital Reform Commission who reflected on how medicine has developed, likening its evolution to the transformation from a solo cowboy to a race car pit crew. This was followed by Hon. Jim McGinty as Chair of Health Workforce Australia who put forward the view that the medical training pipeline needed to be organised and controlled by one organisation. He said currently there is a mismatch between graduating doctors and the amount of doctors we need, with the number of interns gaining registration being out of kilter with available specialty training places.

In what has become an annual tradition, and one which is often the highlight of the conference, the Health Minister, Hon. Tanya Plibersek, and Shadow Minister Hon. Peter Dutton, took to the stage to give their take on Australia's health system and the role of the AMA and doctors within it – as well as vigorously critiquing the performance and credentials of both their own and the other speaker's political party.

### Global Health on our Doorstep

Other plenary sessions included "Global Health on our Doorstep" where three perspectives were provided on this issue including the health needs of Australia's refugee population, how, where and why Australia's foreign aid is being spent in the area of health, and the changing nature of global health issues with mental health and chronic disease becoming more of a challenge for aid agencies like Medecins sans Frontieres.

### Health and the Environment

The session "Health and the Environment" featured former Australian of the Year Professor Tim Flannery who said medical systems had to prepare for the challenges that will eventually arise from climate change, such as developments in infectious diseases and increases in heat stroke.

Additional sessions included "The AMA and Indigenous Health", "Mental Health, where to from here?", "e-Health" and "MBBS vs MD".

The keynote address was delivered by a highly distinguished international guest, Professor the Lord Darzi of Denham PC KBE, urologist and former UK Health Minister under Tony Blair who contrasted the UK's health system and reform agenda with that of Australia. He also shared some anecdotes about what it was like to work as a politician with a medical background, including the time he successfully defibrillated an opposition politician out of cardiac arrest during a session of parliament.

### Professionalism in the Workplace

In addition to these plenary sessions there were a number of breakout sessions, two of which featured MDA National speakers. In a panel session entitled "Professionalism in the Workplace" Dr Sara Bird, Manager, Medico-legal and Advisory Services, gave the perspective of a medical defence organisation on the issue of professionalism including how to help maintain it and what can happen if unprofessional behaviour is alleged to have occurred.

In a separate session this author delivered a workshop on "How to be an effective meeting participant".

All in all the conference was a very informative and enjoyable event with MDA National able to make a significant contribution to the occasion.

### Did you attend this conference?

View our images from the event and share your comments with us at *Defence Update* online at **www.defenceupdate.mdanational.com.au/ama-conference**

Dr Andrew Perry is an advanced trainee in emergency medicine and a Member of MDA National and our President's Medical Liaison Council (SA).

CaseBook

# Medical Records: the Only Source of Truth?

Dr Sara Bird, Manager, Medico-legal and Advisory Services, reviews a case that highlights the importance of good medical record keeping in successfully defending claims.

## Case history

On 18 September 2007, the patient saw his GP, Dr Ferguson, who made the following record of the consultation:

*Low back pain with coccyx pain.*

*Low range tinnitus. SI (sacroiliac) joint pain.*

The patient had a past history of Reiter's syndrome. Dr Ferguson thought the patient's current back pain was associated with this condition and referred him for a bone scan.

The patient underwent the bone scan on 27 September 2007. This revealed increased uptake in the right sacroiliac joint and the sacrum. The GP considered the result as being consistent with Reiter's syndrome.

On 8 and 18 October 2007, the patient was seen by a physician, Dr Fowler. Dr Fowler made a provisional diagnosis of obsessive personality disorder, Reiter's syndrome and associated polyarthritis. In his letter to the GP, Dr Fowler concluded:

*Following a full physical examination there is a very low probability of major organic disease apart from those previously defined. I will review his results and further communicate with you.*

On 25 July 2008, the patient returned to Dr Ferguson who recorded:

*Chronic lower lumbar back pain. Requesting injection. CT ordered.*

The CT was performed on 28 July 2008. The report noted mild degenerative changes only.

On 19 August 2008, the patient saw Dr Ferguson again who recorded:

*No relief with L and R injection. Claims legs numb, muscle wasting (which he believes is due to simvastatin). Nerve conduction studies ordered.*

Nerve conduction studies were performed on 10 October 2008, which revealed no abnormality.

On 14 and 23 October 2008, the patient saw the physician, Dr Fowler, again. He complained of pain in his coccyx, numbness in his right upper thigh and right testicular pain. At this time, the patient was referred to a neurosurgeon.

On 2 December 2008, the patient was seen by a neurosurgeon and an MRI was ordered. The patient was subsequently diagnosed with a sacral chordoma in the region of S4.

## Medico-legal issues

The patient commenced legal proceedings against the GP, Dr Ferguson, alleging a delay in diagnosis of the sacral chordoma.[1] In particular, the patient (now a plaintiff) alleged that at the consultation with Dr Ferguson on 18 September 2007, he had complained of severe pain in the coccyx and altered sensation and feelings of electric shocks in his legs.

The claim proceeded to trial in May 2012. At the hearing, the plaintiff referred to diary entries he had reportedly made during 2007. There was a dispute about whether these diary entries were made by the plaintiff contemporaneously or at a later time. Of note, the plaintiff's diary entry under the heading of 18 September 2007 was as follows:

*12.00 (Michael Ferguson) if not sooner:*

1. *Pain in testicles – started approx six months ago. – disappeared then reappeared – sharp, stabbing pain.*
2. *Fluid in legs, pain legs walking up slopes, fluid at top of behind and pain in coccyx when walking up hills…*
3. *Tightness in chest and dry cough.*
4. *Frequent urination (sometimes every few minutes).*
5. *Where can I get my arm/elbow fixed – straightened?*
6. *Palpitations – heart.*

Medical records are critically important in establishing the facts.

The judge noted that a portion of the diary entry had been cut out. During the hearing, the barrister for the defendant GP put to the plaintiff that he had cut out a portion of the 18 September 2007 diary entry because he did not think it would assist his case if it remained. The plaintiff was adamant that all notes in his diary were contemporaneous.

The judge then considered the credibility of the medical records. He concluded that the clinical records of the medical practitioners to be the *most reliable evidence in these proceedings. There is no doubt that each was contemporaneous in that they were made in the course of each consultation with the plaintiff. Furthermore they were made by persons who had, at the time the record was created, no interest in doing so other than making a record of what had occurred.*

In relation to the defendant GP's medical records the judge noted:

*Although the defendant agreed that he did not always record all the symptoms and complaints made by the plaintiff, he said, and I accept, that he recorded all the complaints that he adjudged to be serious... He said that if the plaintiff had told him of altered sensation and a feeling of electric shock in his legs he would have regarded that as a significant matter and he would have ordered a different test, namely a CT scan, rather than the bone scan... It was apparent from the defendant's evidence that much of which he purported to recall was, in fact, reconstruction from his usual practice and from what was recorded in his clinical notes. This is understandable in the context of a medical practitioner who sees several patients every day. It does not make his evidence unreliable. Indeed... his notes are likely to be more reliable than any vestiges of recollection he may have.*

Judgment was handed down on 15 May 2012 in favour of the defendant GP. The plaintiff was ordered to pay the defendant's costs of the proceedings.

## Discussion

Interestingly, in this case the patient had his own "records" (personal diaries) which were found to be inaccurate and not made contemporaneously. This contributed to the court's finding that the evidence given by the patient was not entirely credible. In contrast, the medical records made by the defendant GP, Dr Ferguson, were found to be contemporaneous and, while not entirely "comprehensive", these records were found to be accurate. This fact, in conjunction with the GP giving evidence in court as to his usual practice and the veracity of the GP's evidence, meant that the GP's version of events was accepted as accurate and judgment was entered in his favour.

### Summary Points

- This judgment highlights two important issues arising in medical negligence claims: Many medical negligence claims involve two versions of events – the patient's version and the doctor's version of what actually happened. Ultimately, a decision as to whether there is any negligence will depend on which version of events is accepted by the court as "fact", and all the expert medical evidence will be aligned once the facts have been determined.
- The medical records are critically important in establishing the facts. Indeed, the existence of a record made contemporaneously at the time of the consultation is often the difference between the court preferring the doctor's evidence to that of the patient in medical negligence claims. This court decision highlights the importance of good medical record keeping in successfully defending claims.

1 Peden v Ferguson [2012] NSWSC 492

CaseBook

# Exercising Prudence with Respect to Clinical Photography

## With the increasing use of portable technology, Dr Patrick Mahar explores a topical medico-legal issue.

### Case history

Dr P, a JMO, was enjoying a day off when he received notification of a complaint from AHPRA in the mail. The complaint alleged that Dr P had shown clinical photographs of a patient to guests at a function he had attended two weeks earlier. Dr P was distressed by this allegation and immediately called MDA National for assistance.

### Discussion

Clinical photography has become a component of many areas of medical practice. The increasing use of the internet and mobile electronic devices for the sharing of information has made clinical photographs an efficient way of conveying clinical information for the purposes of patient management, clinical education and research.

This notwithstanding, a clinician has a duty to maintain a patient's right to privacy of their personal and health-specific information, as well as how that information should be used. This may not always be given the weight it deserves in the context of the rapid evolution of electronic communication and the ease by which information can be transmitted. A recent study undertaken in the United Kingdom described only 36% of emergency departments surveyed having policies about the use of clinical photography, and where no policy exists, only 8% document consent.[1] In Australia, an appreciation for the legal position regarding confidentiality should be sought with respect to handling of patient information despite the benefits conveyed by clinical photography.

There is an entitlement for health practitioners involved in a patient's management to have access to a patient's medical records and to obtain information about a patient's condition, set out in both state specific provisions [2] and supported by influential cases in common law.[3] Where information is de-identified and not published or available for publication, this may extend to the use of training of staff. It has, however, been proposed that patients may be identified via clinical photography as a consequence of revealing demographic information, individual likeness, by virtue of the rarity of their condition or the identity of the medical team or institution involved.[4] As such, images considered "de-identified" on face value may in fact be easily identifiable by third parties. Without question, in Dr P's case, showing clinical photographs to guests at a function, even if the photographs appeared to be de-identified and the guests were medical practitioners themselves, goes well beyond the consideration described above.

The Privacy Act (Cth) states that patient information must not be collected for inclusion in a record unless it is necessary for the purpose for which it is collected[5] and in such cases, the person concerned must be informed or be aware beforehand of the reason for the collection of the information and to whom it is likely to be disclosed.[6] Consent for clinical photographs, for instance, may be given for clinical management purposes with other treating clinicians, however this would not necessarily apply to the photographs being used for the education of junior colleagues. Thus, informed consent for the purposes of clinical photography should include an explanation for what purpose a photograph is to be used, and to whom the photograph is likely to be shown, and this should be recorded in the patient's record.

States and territories have similar legislative provisions and schemes dealing with these provisions and relevant institutions and clinicians should take note of their local provisions when drafting policies and consent forms. In general a prudent approach for Members is to obtain purpose-specific consent, preferably written, prior to taking photographs. The use of clinical photographs should then be limited to these purposes.

1 Bhangoo P, Maconochie IK, Batrick N, Henry E. *Clinicians taking pictures – a survey of current practice in emergency departments and proposed recommendations of best practice.* Emerg Med J 2005;22:761-5.

2 *Health Records Act 2001* (Vic) HPP 2.2(f); *Health Services Act 1988* (Vic) s 141 (3) (eb);

3 Duncan v Medical Practitioners Disciplinary Committee 1986 1 NZLR 513.

4 Frizelle F. *Consent for case reports and medical images.* NZ Med J 2009;122: 8-10

5 Privacy Act s. 14 IPP 1; Sch 3 NPP 1.

6 Privacy Act s. 14 IPP 2; Sch 3 NPP 2.

Dr Patrick Mahar is a dermatology registrar and a Member of MDA National and our President's Medical Liaison Council (VIC).

CaseBook

# Prescribing for Self and Family

## One National System, Eight Different Rules

Medico-legal Adviser, Dr Julian Walter navigates the complexities of drug prescribing under inconsistent state and territory legislation.

### Case history

A Member, who was moving to Victoria, sought advice about whether they could, while seeking a new GP, write scripts for their own antihypertensive medications.

### Medico-legal issues

Calls to MDA National's Medico-legal Advisory Service from Members seeking information about restrictions on prescribing for themselves or their family are not uncommon. Despite medical practitioners in Australia being registered under AHPRA's National Registration and Accreditation Scheme, most drug prescribing is still regulated under inconsistent state and territory legislation. Such fragmented and disparate legislation places Members at risk of inadvertent, yet serious, breaches of the law.

### Medical Board

Under the Medical Board of Australia's Code of Conduct [1] (the Code) practitioners must conform to their relevant state or territory legislation in relation to self-prescribing. The Code also notes that practitioners, wherever possible, avoid providing medical care to anyone with whom they have a close personal relationship because of the risks, such as lack of objective assessment, potential poor provision of continuity of care and issues of confidentiality. Medical practitioners should have their own GP and avoid self-diagnosis and treatment.

### Indemnity cover

The MDA National Professional Indemnity Insurance Policy excludes cover for claims arising from elective medical treatment provided by a Member to their immediate family (which includes a current or former spouse, de facto or domestic partner, children or the children of a current or former spouse, de facto or domestic partner, brother, sister or parents). This would include situations where Members had electively prescribed for their family. It is also important to be aware that claims or inquiries arising out of use, supply or administration of a substance that is deemed illegal or unlawful would not be covered under the policy.

### State and territory legislation

**Self-prescribing** – This is a complex area and there are significant variations between states and territories. As a general rule, S8 self-prescription is not permitted except in a very limited set of emergency situations.

In Victoria, *no* self S4 or S8 prescribing is allowed under any circumstances.

**Prescribing for family** – There are no specific legal restrictions for prescribing S4 drugs for a practitioner's family.

Similarly, S8 drug prescriptions are not restricted for family *except* in South Australia where the legislation does not permit S8 prescription, except in a verifiable emergency (penalties of up to $5,000 apply).

To view the state and territory differences for prescribing for self and family, visit **www.defenceupdate.mdanational.com.au/drug-prescribing**

**Summary Points**

- Given the legal complexities in this area and the propensity for their revision, a sensible starting point for all practitioners is to avoid self-prescribing of S4 and S8 drugs.
- Legislation prohibits S8 prescribing for family members in SA only. There are no specific legal restrictions on a practitioner prescribing S4 drugs for his or her family. However, prescribing for family members should be avoided as a matter of good medical practice.

If you have further questions or require specific advice, contact our Medico-legal Advisory Service on 1800 011 255 or email advice@mdanational.com.au.

1 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: www.medicalboard.gov.au

# What's On?

MDA National is sponsoring and attending a number of state and local conferences and events in collaboration with colleges and associations. We also offer Members access to a range of MDA National events.

View our events listing in full at **www.mdanational.com.au**

## September 2012

| | |
|---|---|
| 29–2 Oct | ASA National Scientific Congress (including sponsorship of the GASACT Conference)<br>**Hobart, TAS**<br>www.asa2012.com |

## October 2012

| | |
|---|---|
| 16–19 | Australian Association of Practice Managers National Conference<br>**Brisbane, QLD**<br>www.aapm.org.au |
| 25-27 | RAGCP Conference for General Practitioners<br>**Gold Coast, QLD**<br>www.gpconference.com.au |

## November 2012

| | |
|---|---|
| 1-3 | Provincial Surgeons Australia Annual Scientific Conference<br>**Mount Gambier, SA**<br>www.surgeons.org |
| 15–16 | MPS International Conference 2012<br>**London, UK**<br>www.mpsinternationalconference.org |
| 18–21 | Prevocational Medical Education Forum<br>**Perth, WA**<br>www.prevocationalforum2012.com |

### Medical Protection Society (MPS) International Conference

We've partnered with the MPS to deliver this two day international conference –*Quality and Safety in Healthcare: Making a Difference* – that will see leading international experts in healthcare addressing quality, patient experience, safety culture, cost and professionalism.

MDA National Vice President, Dr Beres Wenck and A/Prof Rosanna Capolingua, along with Dr Sara Bird, will be hosting a breakfast session on *Tort Law Reform: 10 Years On, Where Are We Now?*

**Register Now**
**www.mpsinternationalconference.org**

### Cognitive Institute Workshops

Due to popularity, we are continuing to provide a range of Cognitive Workshops in 2012 to meet the needs of our Members. A number of workshops have also been confirmed for 2013. Popular topics will include:

- Mastering Difficult Patient Interactions
- Mastering Adverse Outcomes

**Register Now** Find a Cognitive Institute Workshop near you and register at **www.mdanational.com.au**

### 2012 Medico-legal Forum

See the forum online at **www.mdanational.com.au** and log into our Member Online Services to view our digital forum.

### Our Members have their say!

Watch what our Members had to say about the 2012 Medico-legal Forum at **www.facebook.com/mdanational.com.au**

# MDA National Limited (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:

**Mutual Board Director (5)**

Nominations will be accepted from **Monday 17 September 2012**.

Nomination forms are to be completed in accordance with the *MDA National Limited Election Rules* and must reach me no later than 12.00 noon on Friday 12 October 2012. Should an election be necessary, voting will close at 10.00 am on Wednesday 21 November 2012.

**Candidate Statement:** In accordance with rule 11(2) of the *MDA National Limited Election Rules*, included with the nomination form may be a statement in the English language not exceeding 200 words in length. The statement must be confined to biographical information about the candidate and statements of the candidate's policies or beliefs and is not to contain information that refers to other candidates or the Returning Officer considers to be false, misleading or defamatory. The statement is to be hand written, typed or printed on a single A4 page, or if it is delivered electronically, is capable of being printed on a single A4 page. The statement is to include the candidate's full name as requested on the ballot paper and details of where and how he or she can be contacted. Other contact details such as telephone numbers or email addresses may also be included. The candidate may include a passport size photograph of the proposed candidates head or head and shoulders. The photograph should be recent, taken less than six months before the date of the nomination form. The Returning Officer may accept a less recent photograph if he or she considers that the photograph shows a reasonable likeness of the candidate.

**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 the MDA National website at 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

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# Would you like to read *Defence Update* via your PC, smart phone or tablet?

You can now read *Defence Update* online at **www.defenceupdate.mdanational.com.au.**

If you would prefer to read *Defence Update* online, email us at defenceupdate@mdanational.com.au putting the word "subscribe" in the subject line and include your name and Member number in the body of the email.

You will be able to change the way you receive *Defence Update* at any time by simply logging into Member Online Services (MOS) at www.mdanational.com.au and noting your preference on your Membership record. If you need assistance logging into MOS, contact our Member Services team on 1800 011 255.

# Have you moved? Have your practice details changed?

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

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

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


**Perth**
Level 3
88 Colin Street
West Perth WA 6005
Ph: (08) 6461 3400
Claims Fax: 1300 011 235

**Melbourne**
Level 3
100 Dorcas Street
Southbank VIC 3006
Ph: (03) 9915 1700
Fax: (03) 9690 6272

**Sydney**
Level 5
AMA House, 69 Christie Street
St Leonards NSW 2065
Ph: (02) 9023 3300
Fax: (02) 9460 8344

**Brisbane**
Level 8
87 Wickham Terrace
Spring Hill QLD 4000
Ph: (07) 3120 1800
Fax: (07) 3839 7822

**Adelaide**
Unit 7
161 Ward Street
North Adelaide SA 5006
Ph: (08) 7129 4500
Fax: (08) 7129 4520