defenceupdate

Quarterly Magazine for MDA National Members

Summer 2012

MDA National
Support Protect Promote

Editor's Note

Continuing Professional Development (CPD) is now mandatory for all medical practitioners who are engaged in any form of medical practice.

For the past 12 months, *Defence Update* has had CPD accreditation to enable you to obtain easily accessible CPD points in the areas of risk management and medico-legal issues, at no cost to you. In response to your feedback, completion of the CPD questionnaire and evaluation form is now available online. You can access the CPD activity at **www.defenceupdate.mdanational.com.au/CPD**

On pages 3 and 4 of this issue of *Defence Update*, A/Prof Julian Rait discusses the impact that *Rogers v Whitaker*, the seminal Australian case on consent, has had on the practice of medicine in the 20 years since this judgment was handed down.

A more recent change in the medico-legal landscape is the introduction of *Good Medical Practice: A Code of Conduct for Doctors in Australia* which is discussed on pages 6 and 7. It will be interesting to reflect on the impact of the Code on medical practice in 20 years' time.

Along with articles about some recent cases and medico-legal questions, and our regular pull-out feature and CaseBook series, I hope you find this issue of *Defence Update* both informative and topical.

Thank you to our many Members, employees and stakeholders who have contributed their knowledge and shared their experiences in *Defence Update* this year. Your input is invaluable.

On behalf of MDA National, I would like to wish you and your family a safe and enjoyable festive season and New Year. I look forward to our discussions in 2013.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

From the President

Informed consent in 2012

This year marks the 20th anniversary of a decision by the High Court of Australia that had far reaching consequences for medical negligence litigation. Indeed, the 1992 decision in *Rogers v Whitaker*[1] was initially received with great consternation by the medical profession.

The question was whether Ophthalmic Surgeon Dr Rogers should have warned a 47 year-old patient undergoing surgery in her previously injured and almost sightless right eye, of the remote chance of sympathetic ophthalmia and consequent bilateral blindness arising from such a procedure.

It was generally accepted prior to *Rogers v Whitaker*[1] that all aspects of a medical practitioner's practice, including the process of consent, should be examined according to the '*Bolam* principle'. That is, the standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill.[2]

Indeed, evidence before the court revealed that Dr Rogers performed the surgery competently and that many Ophthalmologists in Dr Roger's position would not have told their patients about the risk of sympathetic ophthalmia, given that such a complication was exceedingly remote, as low as 1: 14,000.[3]

However, this case asserted for the first time that Australian courts were not bound by the pre-existing principle of *Bolam*[4] and could opine on whether prevailing common professional practice was acceptable or not. Most importantly, the High Court determined that a medical practitioner has a duty to warn a patient of a material risk inherent in the proposed treatment.[5] In defining a 'material risk', the majority of the court stated:

A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[5]

Therefore, in applying this test, the High Court determined that in light of the patient's pre-existing loss of vision in her right eye and her repeated concerns to Dr Rogers during her preoperative consultations about the possibility of losing vision in her 'good' eye, sympathetic ophthalmia was a material risk because it was the only danger whereby both eyes might be rendered sightless.[6]

The High Court has since had an opportunity to review *Rogers v Whitaker*[1] in the case of *Rosenberg v Percival*.[7] In this case, a patient suffered severe temporomandibular joint problems after a maxillofacial surgeon performed a sagittal split osteotomy. The patient alleged that the surgeon failed to warn of this risk and in finding for the appellant (Dr Rosenberg), the Court reaffirmed the principle stated in *Rogers v Whitaker*.[1]

In setting out his reason for the judgment, Chief Justice Gleeson recognised that Australian law is committed to a subjective test in determining whether a patient would have refused to undergo a medical procedure if that person had been warned of the risk of relevant injury.[8] In particular, he warned that:

Recent judgments in this Court have drawn attention to the danger of a failure, after the event, to take account of the context, before or at the time of the event, in which a contingency was to be evaluated. This danger may be of particular significance where the alleged breach of duty of care is a failure to warn about the possible risks associated with a course of action, where there were, at the time, strong reasons in favour of pursuing the course of action.[9]

This is evidenced by the 1998 case of *Chappel v Hart*[10] in which Dr Clive Chappel, an otorhinolaryngologist, performed surgery on Mrs Beryl Hart for the removal of a pharyngeal pouch in her oesophagus. Evidence was given that Mrs Hart had expressed concern to the surgeon about what effect the operation might have on her voice; however, Dr Chappel failed to warn her of a remote risk of vocal damage if the oesophagus was perforated and an infection occurred as a result. During surgery, Mrs Hart's oesophagus was inadvertently perforated, and infection did indeed occur. Even though it ultimately led to paralysis of her right vocal cord, the court determined that Dr Chappel had not been negligent in performing the operation.

Despite this finding, the court held that Dr Chappel's failure to warn Mrs Hart of the risk of damage to her voice resulted in a foreseeable chain of events that affected her voice permanently. Mrs Hart admitted that she would have

continued to next page ►

From the President **Continued**

undergone the operation even if she had been warned of the risk but also claimed that she would have deferred the operation, taken further advice, and would probably have sought the services of the most qualified surgeon available. The court held that although the injury could have occurred without negligence, superior skill and experience could have reduced the risk of injury and that a surgeon had a duty to advise if there was a more skilled colleague available to perform such a procedure.[11]

In light of these decisions and the escalating damages awards (followed by the provisional liquidation of the indemnity insurer UMP in 2002), the Australian Government commissioned a report into tort reform. The recommendations contained in the Ipp Report[12] in 2002 were adopted by the various states and territories, so as to lessen this burden and make the medical indemnity system more sustainable in the face of rising claims costs.

Recommendation 7 of the Ipp Report specifically relates to the duty to inform and the matter of informed consent.[12] According to the Report, the practitioner is required to 'take reasonable care to give the patient such information as the reasonable person in the patient's position would, in the circumstances, want to be given before making a decision whether or not to undergo treatment'. These proposals have since been passed into state law, for example the amendments to Victoria's *Wrongs Act 1958* encompasses the *Bolam* test for matters of medical care and treatment,[13] and explicitly stating that this test does not apply to information disclosure.[14]

Other developments after *Rogers v Whitaker*[1] have also calmed the fears of practitioners.

First, if a patient declines to undergo the treatment because of their unwillingness to accept a risk (after being appropriately informed), then they must bear the consequences of such a decision. Doctors also have a responsibility to make it clear to the patient which of any alternative modes of treatment they recommend.[15] In such circumstances, physicians must explain the consequences of the refusal without creating a perception of coercion in seeking consent. Refusal of the recommended treatment does not necessarily constitute refusal for all treatments, so reasonable alternatives should be explained and offered to the patient.

As with documenting the consent discussion, notes should be made about a patient's refusal to accept recommended treatment. A doctor's credibility is increased by clear, contemporaneous notes and these will have evidentiary value if there is any controversy later about why treatment was not given. When documenting the consent process, it is important to include how the consent was obtained, any written material given to the patient, the specific concerns raised during discussion, any other options considered and both general and specific risks relating to the patient.

Second, although Australian courts have held doctors negligent for failure to disclose risks in a number of cases, a doctor who fails to disclose a material risk will not be held liable on that account alone. The patient must prove that if he or she suffered injury or loss, and that the injury or loss was caused by the doctor's negligence.[16] In effect, patients must persuade the court that they would not have agreed to the intervention had they been told about the risk.[17] In considering this, the cases of *Rogers v Whitaker*,[1] *Rosenberg v Percival*[18] and *Chappel v Hart*[10] have affirmed that the test is what that particular patient would have done if warned, not simply a reasonable person in the patient's position.

Over the past 20 years, complex and onerous legal obligations have been imposed upon doctors that have required a higher quality of discussion and medical record keeping. Furthermore, the standards that are required for informed consent and refusal will, in my view, continue to be open to interpretation by the courts and will continue to be viewed from a community as well as a legal perspective.

So although it is incumbent upon each doctor to fully document in the medical record all aspects of a patient's care, including the consent and refusal of treatment, hopefully, the courts will continue to seek a compromise between the actions of a 'reasonable doctor' and the expectations of a 'reasonable patient'.

A/Prof. Julian Rait
MDA National President

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

Reproduced with permission from the Editor of Clinical and Experimental Ophthalmology, the Royal Australasian and New Zealand College of Ophthalmologists and Wiley Publishing Asia Pty Ltd.

Notice Board

Change in Chairmanship

Mr John Trowbridge has been appointed as Chairman of the MDA National Insurance Board succeeding Mr Graham Reynolds OAM, who retired from the role on 13 December 2012.

Mr Trowbridge joined the MDA National Insurance Board as a Director in February 2012. He has held numerous high profile positions and is also well-known for his work with the Australian Prudential Regulation Authority (APRA).

On behalf of the MDA National Insurance Board, MDA National Mutual Board and our employees, we thank Graham for his dedicated service over the past decade and his invaluable support in ensuring competitive insurance premiums, prudent oversight of our financial affairs and the high quality of service we maintain for our Members.

Rose-Hunt Award

Congratulations to Vice President, Dr Beres Wenck on receiving the Royal Australian College of General Practitioners' most prestigious honour – the Rose-Hunt Award – for outstanding commitment to Australian general practice.

Annual General Meeting

Our Annual General Meeting was held on Friday 23 November. The current Board members, Dr Beres Wenck, Dr Andrew Miller, Dr Robyn Napier, Dr Fiona Bettenay and A/Prof Rosanna Capolingua were re-elected to the MDA National Board unopposed.

Business Hours over the Festive Period

Medico-legal Advisory Service

Our Medico-legal Advisory Service is available 24 hours, including throughout the festive period, to provide support and advice to our Members.

Member Services

Our Members Services team will be available*:

Monday 24 December 8:30am to 3:00pm
Tuesday 25 December Public holiday closure
Wednesday 26 December Public holiday closure
Thursday 27 December 8:30am to 8:00pm
Friday 28 December 8:30am to 8:00pm
Monday 31 December 8:30am to 3:00pm
Tuesday 1 January Public holiday closure
Wednesday 2 January 8:30am to 8:00pm

*All times shown are based on AEDST.

To contact our Medico-legal Advisory Service or our Member Services team, call 1800 011 255.

Woman of Influence

The Australian Financial Review and Westpac have recognised outstanding women who are using their influence to improve business and society in the Australia's 100 Women of Influence Awards.

More than 350 women were nominated with the finalists being selected from across the country.

Among the list in the Board and Management category was Director of the MDA National Insurance Board, Ms Eva Skira.

The Code of Conduct for Doctors

Good Medical Practice: A Code of Conduct for Doctors in Australia **(the Code) was introduced in July 2009 and then adopted by the Medical Board of Australia when the National Registration and Accreditation Scheme was introduced on 1 July 2010.[1]**

Three years after its introduction, it is timely to reflect upon the impact of the Code on the medical profession and the provision of medical care. Dr Sara Bird, Manager, Medico-legal and Advisory Services provides an update.

What is the purpose of the Code?

The stated purpose of the Code is to:

- describe what is expected of all doctors in Australia
- set out the principles that characterise good medical practice
- make explicit the standards of ethical and professional conduct expected by doctors by their professional peers and the community.

The Code is used as the basis upon which a doctor's professional conduct will be assessed and judged in the event of a notification or complaint to the Australian Health Practitioner Regulation Agency (AHPRA). In the event that a doctor's professional conduct varies significantly from the Code, the practitioner will be required to explain and/or justify their decisions and actions. Serious or repeated failures to meet the requirements outlined in the Code are likely to result in disciplinary action being taken against the doctor.

Our Medico-legal Advisory Services team regularly refers to the Code when providing advice to Members about specific medico-legal questions and issues.

What is included in the Code?

A wide range of professional issues are covered in the Code as outlined in Table 1.

It is important to be aware that some of the requirements under the Code are quite prescriptive. For example the Code states:

3.10 Adverse events
When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, to review what has occurred and to report appropriately. When something goes wrong, good medical practice involves:

3.10.1 – *Recognising what has happened.*

3.10.2 – *Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.*

3.10.3 – *Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.*

3.10.4 – *Acknowledging any patient distress and providing appropriate support.*

3.10.5 – *Complying with any relevant policies, procedures and reporting requirements, subject to advice from your medical indemnity insurer.*

3.10.6 – *Reviewing adverse events and implementing changes to reduce the risk of recurrence.*

3.10.7 – *Reporting adverse events to the relevant authority, as necessary.*

3.10.8 – *Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant health care complaints commission or medical board).*

Discussion

In the Autumn 2010 edition of *Defence Update*, we outlined the reservations expressed by Professor Komesaroff and A/Professor Kerridge about the draft Code.[2] In particular, the authors noted the draft Code was based on "a narrow culturally specific view of medicine and ethics that does not reflect the multicultural diversity of Australian society". The authors went on to state that it "contributes to an insidious, creeping authoritarianism that – at least in the case of medical practice – threatens to erode the core values of a culture that has developed over many years". Other commentators have asserted that this contention is "mistaken" and "there has always been room for discretion and for context to be taken into account" when using the Code to judge a doctor's conduct.[3]

While it remains to be seen if the Code will provide appropriate guidance or contribute to an erosion of core professional values, all Members are encouraged to ensure they are familiar with its content, and to consider and reflect upon the application of the Code in their own practice.

1 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

2 Komesaroff PA, Kerridge IH. *The Australian Medical Council draft code of professional conduct: good practice or creeping authoritarianism?* Med J Aust 2009; 190:204 – 205.

3 Parker M. *Normative lessons; codes of conduct, self-regulation and the law.* Med J Aust 2010; 192:658-660.

What do you think?

Share your comments with us at *Defence Update* online **www.defenceupdate.mdanational.com.au/Code-of-Conduct**

TABLE 1

Providing good care
- Shared decision-making.
- Decisions about access to medical care.
- Treatment in emergencies.

Working with patients
- Doctor-patient partnership.
- Effective communication.
- Confidentiality and privacy.
- Informed consent.
- Children and young people.
- Culturally safe and sensitive practice.
- Patients who may have additional needs.
- Relatives, carers and partners.
- Adverse events.
- When a complaint is made.
- End-of-life care.
- Ending a professional relationship.
- Personal relationships.
- Closing your practice.

Working with other health care professionals
- Respect for medical colleagues and other health care professionals.
- Delegation, referral and handover.
- Teamwork.
- Coordinating care with other doctors.

Working within the health care system
- Wise use of health care resources.
- Health advocacy.
- Public health.

Minimising risk
- Risk management.
- Doctors' performance – you and your colleagues.

Maintaining professional performance
- Continuing professional development.

Teaching, supervising and assessing
- Assessing colleagues.
- Medical students.

Professional behaviour
- Professional boundaries.
- Reporting obligations.
- Medical records.
- Insurance.
- Advertising.
- Medico-legal, insurance and other assessments.
- Medical reports, certificates and giving evidence.
- Curriculum vitae.
- Investigations.
- Conflicts of interest.
- Financial and commercial dealings.

Ensuring doctors' health
- Your health.
- Other doctors' health.

Undertaking research
- Research ethics.
- Treating doctors and research.

It's Beginning to Look a lot Like Christmas

Our Medico-legal Advisory Service receives over 3000 calls a year. The team discuss some of the dilemmas MDA National Members may face over the festive season.

Q. I have just received a subpoena to give evidence in a compensation case. I will be away for four weeks over Christmas and won't be in Australia for the hearing. Can I ignore the subpoena?

A. You should never ignore a subpoena. If you cannot comply with the subpoena due to pre-planned travel outside the state/country, contact the issuing party immediately. It may be possible for you to provide your evidence in writing, via the telephone or by video conference. If your evidence is vital to the case, the parties may agree to an adjournment until your return.

Q. A patient I have treated for a number of years has recently separated from her husband. Last week she sent me a Christmas card suggesting we catch up for a drink. I know my patient is very distressed at present – how do I decline without causing her embarrassment?

A. It is always complex and difficult when a patient starts to show interest in becoming friends (or something more) outside the doctor/patient relationship. If you do not feel comfortable having the conversation in person, you could send a polite letter to the patient, pointing out that the Medical Board of Australia has strict guidelines in respect of doctor/patient boundaries.[1] At MDA National we have experience in assisting Members with this difficult situation and would be happy to assist in preparing you for the conversation with the patient and/or drafting a response.

Q. I have a six year old patient who comes in with her mum. On Christmas Eve, the mum brings the child in with swimmers ear. I prescribe ear drops, and mum mentions it is dad's turn to have the child on Christmas Day. She has asked me to write a letter saying the child is sick and needs to stay in her care. Should I write the letter?

A. Young patients who are the subject of custody arrangements need to be managed carefully. Even though you may only see one of the parents regularly, it is important that you are not seen to advocate for one party over another. You should always use your clinical judgement and keep in mind the best interests of the child. If dad is equally able to administer the drops and care for the child on Christmas Day, you should decline the request. Family disputes are highly emotive and any decision you make which may alter court ordered custody arrangements should be clinically justified.

Q. A new patient came in on 2 January requesting a First Medical Certificate for a workplace injury sustained on 24 December. She has been off work since the accident and has asked me to write 24 December as the date the certificate was issued. She had trouble making an appointment over Christmas and wants her sick leave reimbursed. What should I do?

A. You can enter the date of injury as advised by the patient, which in this case is 24 December, if you reasonably believe the information provided to you by the patient is true. When it comes to signing and dating the certificate, you should write the date that the certificate was actually completed and issued to the patient, which is 2 January. If you sign and date the medical certificate as the patient has requested, and the insurer later requests a copy of the patient's medical records, it will be clear that you did not see the patient on 24 December, and this could lead to a complaint and disciplinary action against you.[2]

---

1 *Sexual Boundaries: Guidelines for Doctors*. Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

2 Section 8.8 *Good Medical Practice: A Code of Conduct for Doctors in Australia*. Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Open Disclosure

"Open disclosure is the process by which patients and those that support them can be informed of adverse events resulting in harm that arises from the provision of health care."

What is **Open Disclosure?**

Open disclosure is the process by which patients and those that support them can be informed of adverse events resulting in harm that arises from the provision of health care. Open disclosure can occur as part of a formal hospital clinical governance process or, more commonly, it refers to a potential interaction that health practitioners can have with their patients.

This article principally addresses the latter process. The more formal process that is usually adopted for more severe injuries will be referred to using capitals – "Open Disclosure".

Australia has amassed internationally recognised expertise in this field following the endorsement of an "Open Disclosure Standard" (the Standard) in 2003 by Australian Health Ministers. The Standard was developed by the former Australian Council for Safety and Quality in Health Care. In 2008, Australian Health Ministers agreed to work towards universal adoption of the Standard in all health care facilities. Currently all State Health Services (with the exception of NT) have incorporated the Standard into health care policy. It has similarly been adopted in the UK, Canada, New Zealand and many states in the USA. Considerable research has continued in Australia into the impact that open disclosure has on a range of outcomes. A national review of the Standard is currently being undertaken by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and this article incorporates recommended changes to the Standard.

Open disclosure recognises that adverse events, defined as an incident in which a person receiving health care is harmed, are inevitable and unavoidable outcomes arising from the provision of health care. Harm is defined as including physical, social or psychological injury.

The process of Open Disclosure involves:

1. An open and timely acknowledgement to the patient and/or their support person(s) that an adverse event has occurred.
2. An apology or expression of regret that includes the words "I/we are sorry".
3. A factual discussion of the event and consequences, including an opportunity for the patient to relate their experiences.
4. An explanation of the steps being taken to manage and investigate the incident and prevent recurrence.

Content of initial disclosure discussion

The initial discussion should occur as soon as possible, even if all the facts are not yet known, and may be the first step of an ongoing communication process. Points raised in the initial disclosure discussion may need to be expanded upon in any subsequent meeting with the patient and their support person.

It is important not to speculate, attribute blame to yourself or other individuals, criticise individuals or admit liability.

Depending on the severity of the adverse event and the formality of the disclosure process, the following points may require consideration:

a. preliminary multidisciplinary team discussions (agreed facts, responsibilities for discussions, staff support, timing, availability, legal and insurance issues)

b. an introduction to the patient and/or support person(s) of all people attending, including their role

c. disclosure of facts known at that time (this may require prior multidisciplinary team agreement)

d. listening to the patient's and/or their support person's understanding of what happened and address any questions or concerns they may have

e. indicating to the patient and/or their support person that their views and concerns are being heard and considered seriously

f. a discussion about what will happen next (return to the operating theatre, need for more investigations, see another specialist, etc.)

g. information on likely short-term effects (and long-term effects if known, however this information may need to be delayed to a second or subsequent meeting)

h. assurance to the patient and/or their support person that they will be informed of further investigations that will take place to determine why the adverse event occurred, the nature of the proposed process and expected timeframe. Also provide information on how feedback will be provided on the findings of the investigation, any changes made to prevent recurrence and, if delays in the process are experienced, the reasons for those delays

i. an offer of support to the patient and/or their support person

j. information to the patient and/or support person on how to take the matter further, including any complaint processes available to them

k. documentation.[1,2]

Why is open disclosure important?

The Medical Board of Australia's *Code of Conduct* states: *Good medical practice in relation to risk management involves being aware of the importance of the principles of open disclosure and a non-punitive approach to incident management.*

Open disclosure is thought to strengthen the doctor/patient relationship through promotion of trust and improved communication. Ethical considerations also dictate that patients should remain informed of their health care outcomes, allowing them to make informed decisions about subsequent treatment.

Perhaps the most important role of open disclosure is that it fosters the reporting of adverse events and promotes a cultural change that recognises that blame is unhelpful. This in turn allows system improvements that help to understand and reduce future adverse events.

Although there is some support in the literature that Open Disclosure reduces patient litigation, the evidence is still unclear. Several US centres have adopted Open Disclosure and early settlement protocols, and these have been successful in reducing litigation costs. It is likely that Open Disclosure has little impact on litigation frequency for high severity adverse events.

Open Disclosure or open disclosure?

A more formal process is indicated where the outcome includes death or permanent loss of function or where the adverse event has resulted in a major escalation of care/change in clinical management. Relevant health department and hospital policy documents may provide assistance in triaging adverse events to one or other process. Irrespective of the process ultimately adopted, clinicians are able to follow the general open disclosure principles as soon as they are aware of an adverse event.

When should open disclosure occur?

Open disclosure should be considered whenever there is a perception (by the patient or treating clinicians) that an adverse event has occurred. Low level adverse events may require nothing more than a brief informal discussion.

Conclusion

MDA National is supportive of the open disclosure process. Members should seek our assistance if an adverse event occurs and they are required or wish to participate in a formal Open Disclosure session as this will usually relate to a significant adverse outcome. Early advice can assist in supporting the Member through what can be a difficult and stressful time, provide a better understanding of important legal issues such as the implications of any apology, and facilitate appropriate communication with other parties involved in the process.

We believe that adequate training and support for practitioners are critical components to the success and acceptance of Open Disclosure. We advise our Members to always familiarise themselves with the Open Disclosure policies in their workplace.

Our aim is to ensure that our Members' interests are protected while they focus on the interests of their patients.

---

1 *Open Disclosure Standard 2003*. Australian Commission on Safety and Quality in Health Care.

2 Section 9 and 10 Australian Open Disclosure Framework Consultation Draft 2012. Australian Commission on Safety and Quality in Health Care. Available at: www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-standard

A Medical Administrator's **View of Open Disclosure**

The phrase "Open Disclosure" is intended to describe a formal process generated in response to a serious adverse event, usually in a hospital setting. It is therefore a rare occurrence even within large teaching hospitals, perhaps performed once or twice per year.

As a medical administrator, I have been involved in two Open Disclosure processes. These events required a small team who were able to offer an initial apology, instigate an immediate response, including ensuring no financial cost to the patient, investigate the event, using Root Cause Analysis processes, and report back to the patient the outcomes, explaining why the event occurred and what was to be done to prevent future similar events. On one occasion the relevant clinician was deeply involved. On the other occasion the clinician declined direct involvement, and therefore some of the questions posed by the patient could not be answered.

Both times the patient was very grateful to have been properly informed and to learn of steps to prevent a recurrence. Each time, however, there was much emotion (tears) from all sides especially during the final meeting. On both occasions it was the patient's support person who was most upset to go back over the incident, the patient remaining calm and interested to find out what had happened.

From start to finish each process took about a month. When done well, Open Disclosure is difficult, time consuming, and emotional. Support is needed not only for the victim but also staff, especially the doctor.

It seems though that the term has come to mean any process applied to the handling of complications that occur in health care.

All clinicians, especially proceduralists, have felt the discomfort of explaining unintended poor outcomes or surgical complications to patients. This discussion is expected, fair and a far better approach than avoiding the conversation. Call it Open Disclosure if you wish, but it is just the right thing to do.

Is there evidence that Open Disclosure reduces claims?

Studies have surveyed a variety of populations to determine their views as to the impact that open disclosure would have on litigation (US health insurer members[1], parents of children presenting to ED[2], medical outpatients, German citizens). The findings in these studies generally reflect a view that open disclosure reduces litigation. However, all these studies are subject to significant criticism in that they deal with hypothetical scenarios in simulated populations rather than observing actual outcomes following open disclosure adoption. A similar study by Studdert in 2007[3] found that the study population (senior experts in health care risk management) predicted that in cases involving serious injury, claim numbers would increase. Other studies have looked at the motivation to litigate and sought to extrapolate these results to open disclosure outcomes.

The most widely cited study followed the Lexington (Kentucky USA) Veterans Hospital in 1987[4] where a full disclosure policy was implemented. The policy also included an early offer of compensation where sub-standard care resulted in harm, which potentially confounded the effect that open disclosure had on a variety of litigation outcomes. The study found that the costs of litigation were reduced, although the number of claims were not.

The University of Michigan Health System[5] adopted a similar approach providing open disclosure coupled with an early offer of settlement if substandard care was found to be causal to the harm. Significant improvements were also made to risk management handling as well. They experienced a reduction in the absolute number of claims, litigation costs were more than halved and time to settlement was reduced. Whether these laudable outcomes were related to open disclosure or to a variety of other factors is not clear.

An excellent Canadian review article by Jill Taylor[6] summarises the major publications on this topic (at Appendix A) up until October 2007.

Dr Patrick Lockie is a medical administrator and a Member of MDA National and our President's Medical Liaison Council (VIC).

---

1 Mazor, KM et al. *Disclosure of medical errors: what factors influence how patients respond?* J Gen Intern Med. 2006 Jul; 21(7): 704-10

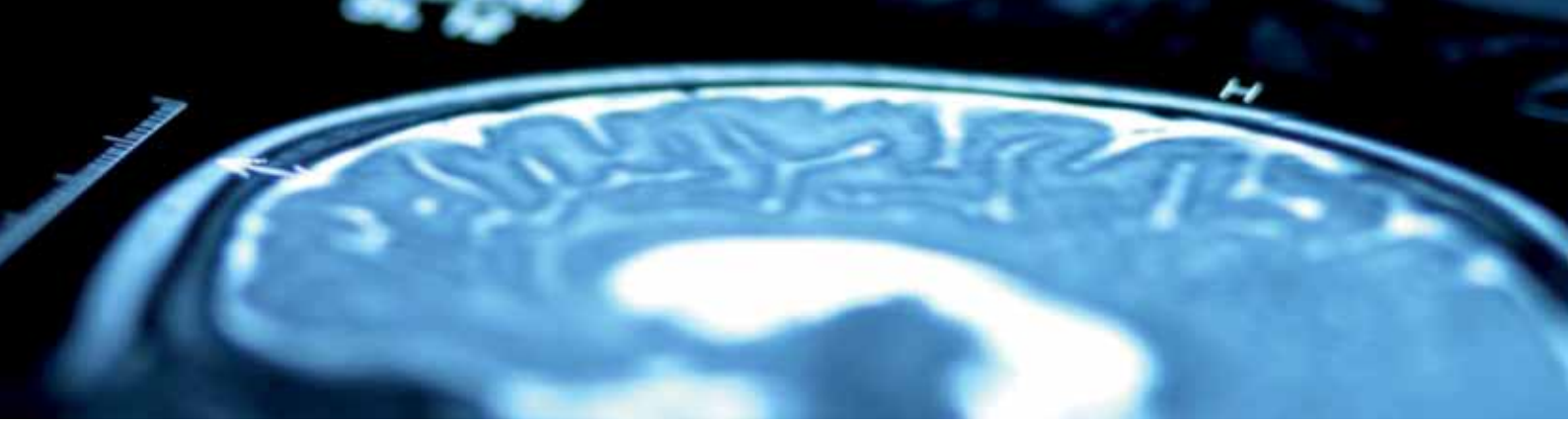
2 Hobgood, C et al. *Parental preferences for error disclosure, reporting, and legal action after medical error in the case of their children.* Pediatrics. 2005 Dec; 116(6): 1276-86.

3 Studdert, DM et al. *Disclosure of medical injury to patients: an improbable risk management strategy.* Health Aff (Milwood)2007; 26:215-226

4 Kraman SS, Hamm G. *Risk Management: extreme honesty may be the best policy.* Ann Intern Med. 1999 Dec 21; 131(12): 963-7.

5 Boothman RC et al. *A better approach to medical malpractice claims?* The University of Michigan experience. J Health Life Sci Law. 2009 Jan; 2(2): 125-59

6 Taylor, J. *The impact of disclosure of adverse events on litigation and settlement: A review for the Canadian Patient Safety Institute.* Available at: www.patientsafetyinstitute.ca/English/toolsResources/disclosure/Documents/The Impact of Disclosure on Litigation a Review for the CPSI.pdf



Complexity of Causation

Enore Panetta reviews a claim against a radiologist for failure to diagnose a cerebral aneurysm which was dismissed when the plaintiff failed to prove causation.[1]

Background

In 2006 the plaintiff, Mrs Paul, underwent coiling for an aneurysm in her right anterior cerebral artery. During the procedure, the aneurysm ruptured, as a result of which she suffered a stroke and sustained permanent disabilities.

The defendant, a radiologist, was not involved in the 2006 procedure, but in 2003 had reviewed and reported on a cerebral angiogram performed on the plaintiff, when he negligently failed to detect the presence of the aneurysm.

The plaintiff sought to recover from the defendant damages for the injuries she sustained in 2006, alleging that his negligence in 2003 caused the injuries that she suffered in 2006.

Breach of duty was admitted.

The plaintiff alleged that, if the defendant had diagnosed her aneurysm in 2003, she would have obtained treatment for it then, and that had she done so then (on the probabilities) the aneurysm would have been permanently obliterated, without any adverse consequence. She would have avoided the rupture and the consequential injuries she suffered.

The defendant submitted that his duty of care did not extend to taking reasonable care to avoid harm occasioned by treatment of a diagnosed condition. The loss and damage suffered by the plaintiff was not caused by his admitted breach of duty. The rupture was an inherent risk of the coiling procedure.

Decision

Factual causation

In this first aspect of the court's inquiry into causation, the court compared what would have occurred if the plaintiff's aneurysm had been diagnosed in 2003 with what in fact occurred in 2006.

The court had no doubt that the plaintiff would have had treatment in 2003 had the defendant diagnosed the aneurysm then. More probably than not, she would have acted on the advice of her treating doctors as to the procedure to be undergone and would have had the aneurysm treated by clipping (the preferable option in 2003). She would have accepted the associated risks of intra-procedural rupture (5-10%) and consequential stroke (5%). The probabilities were overwhelmingly against those risks materialising.

On the probabilities, therefore, but for the defendant's negligence, the aneurysm would have been obliterated by clipping in 2003 without rupture. She would not have suffered the stroke and the consequent disabilities.

Factual causation was therefore established.

Scope of liability

The more complicated aspect was the scope of liability element of causation.

The scope of liability inquiry involves a policy judgment as to whether it is appropriate, having regard to the relevant circumstances, for the defendant's liability to extend to the harm in question. For this purpose the court must consider (amongst other things) why responsibility for the harm should be imposed on the defendant.

The court stated that the duty of care in the diagnosis of suspected aneurysms serves to enable an aneurysm, once diagnosed, to be treated, in particular to remove the risk that it will spontaneously rupture. Harm from spontaneous rupture was harm of the kind from which the relevant duty of care was intended to protect the patient. However, the very treatment that diagnosis would enable – whether clipping or coiling – itself carried risks, including of intra-procedural rupture. Harm occasioned by the materialisation of those risks was not harm of the kind from which the relevant rule of responsibility was intended to protect.

The exposure to the risk of intra-procedural rupture had nothing to do with the defendant's failure to diagnose the aneurysm. It was a consequence of the aneurysm being diagnosed, whenever it was diagnosed.

Accordingly, scope of liability was not satisfied and there was judgment for the defendant.

Enore Panetta is a partner at Panetta McGrath Lawyers.

1 Paul v Cooke [2012] NSWSC 840

The Criminality of Treatment

In part three of the feature on Dr Patel, Kerrie Chambers and Feneil Shah consider the significance of the High Court of Australia's decision to uphold Dr Patel's appeal.

Dr Jayant Patel has finally had his case determined by the High Court. In a unanimous decision the High Court of Australia[1] upheld Dr Patel's appeal for convictions of manslaughter and unlawfully doing grievous bodily harm under the Queensland Criminal Code[2] (the Code). A new trial was ordered, so the matter will return to the Queensland Courts for re-hearing. Dr Patel has been granted bail ahead of the re-hearing. What does the decision mean for Dr Patel, and what does it mean for the remainder of the profession?

Dr Patel had been convicted of three counts of manslaughter and one count of unlawfully doing grievous bodily harm in the course of surgery on four patients while at Bundaberg Base Hospital. Until day 43 of the trial the prosecution had focused its case on seeking to establish Dr Patel had been grossly negligent and incompetent in the performance of the surgery. As the case progressed it was clear the evidence would not support findings that the surgery was performed incompetently. On day 43 the prosecution re-cast its case and sought to establish a criminal act arising from the decision to perform each of the surgical procedures. The High Court determined that the prosecutions' conduct, in changing their focus mid trial had led to a miscarriage of justice.

While Dr Patel has been given a "reprieve" and is permitted a retrial he does so knowing the High Court has dealt him somewhat of a legal blow. Dr Patel was unsuccessful in persuading the court that s.288 should be restricted in its application to the performance of surgery alone and not expanded to the decision to operate or to advise. S.288 of the Code enshrines a legislative obligation to preserve life, and, until this case, it was thought only applied to the actual performance of the surgery – requiring that surgery be performed with a reasonable standard of care and skill.

In a joint judgment the High Court said that s.288 extended to a duty in respect of a *decision* as to whether the contemplated surgery be undertaken. The court said that the phrase "surgical treatment" as used in s.288 encompasses all that is provided in the course of such treatment *from giving of an opinion relating to surgery to the aftermath of surgery*. This is supported by the duty in s.288 in respect of surgical and medical treatment which refers to a person who undertakes to administer, not just administer, the treatment.

The court did however say that s.288 could not apply to establish criminal responsibility for death/manslaughter or grievous bodily harm without the physical act of surgery. So there can be no finding of criminal responsibility in medical management without the physical act of surgery.

The High Court judgment does make it very clear that a medical practitioner can be prosecuted for gross negligence for recommending surgery that, even though performed competently, should not have been performed.

The High Court judgment is significant for Dr Patel in the ongoing conduct of his re-hearing. The court's interpretation of s.288 would seem to create a significant obstacle in circumstances where the medical evidence did tend to point to concerns around Dr Patel's decision to recommend the surgery.

While Dr Patel was successful in overturning the Court of Appeal's judgment he has achieved little more than a temporary reprieve. On re-hearing, the High Court has removed the ambiguity in s.288 that his legal team seized on in the lower courts. Dr Patel's team has a challenge before them.

Should fellow practitioners be concerned about the High Court's findings? As the court was interpreting a section of the Queensland Code, a section that is perhaps unique to that Code, it is arguable the judgment only applies to conduct in that state. Moreover the Patel "circumstances" that brought him to court were perhaps created by a perfect storm – medically, bureaucratically and politically. Finally it should be noted that any assessment of potential criminal conduct must be to the very high criminal standard, beyond reasonable doubt. It really does require grossly incompetent decision making. When considered in context the risk to fellow practitioners, of a criminal investigation, is perhaps not as significant as the media hype had led us to believe.

Kerrie Chambers is the senior partner in the Health Group at HWL Ebsworth Lawyers and Feneil Shah is an associate.

1 [2012] HCA 29 (24 August 2012); French CJ, Hayne, Kiefel and Bell JJ (joint judgment) and Heydon J

2 Sections 291, 303 and 320 of the Code create the offences of unlawful manslaughter and grievous bodily harm

Are you concerned about the High Court's findings?

Share your comments with us at *Defence Update* online **www.defenceupdate.mdanational.com.au/Criminality-of-Treatment**

CaseBook

Patient Gifts
Navigating from mince pies to Porsches

Helen Baxter, Medico-legal Adviser, highlights the timely medico-legal issues surrounding the receipt of gifts from patients.

Case history

The surgeon saw the patient on one occasion and discussed the benefits and risks of an elective surgical procedure. A few weeks later the patient sent a gift of a dozen bottles of expensive wine to the surgeon's rooms.

Discussion

Nearly every doctor will at some stage receive a gift from a patient, and at this time of the year, it is not uncommon for patients to give gifts to their doctors.

In Australia gift giving is usually motivated by gratitude or cultural customs. Many patients have no expectation of preferential treatment in response to their gift. However, a small number of patients may assume (or intend) that their gift entitles them to additional services such as appointments on demand, favourable insurance reports, flexibility in other practice rules etc. If you accept such a gift you may feel it is difficult to refuse such requests. Gifts can also be portentous of serious professional boundary transgressions.

Although largely benevolent, it may be difficult to identify the patient's motivation. It is useful to ask: Is the giving and receiving of this gift in the best interests of the patient? If I accept the gift will I feel compromised in managing the patient in the future?[1]

An MJA article states there is *general human impulse to "reciprocate" for even small gifts, and that those receiving such gifts are often unable to remain objective "as they reweigh information and choices in light of the gift".*[2]

Token and trivial gifts of appreciation in proportion to the service you have provided are probably not of great concern unless offered frequently. Acceptance of non-trivial gifts may be regarded by patients and colleagues as unethical.

Good Medical Practice: A Code of Conduct for Doctors in Australia[3] states:

8.12 Financial and commercial dealings
Doctors must be honest and transparent in financial arrangements with patients. Good medical practice involves:
...

8.12.2 Not encouraging patients to give, lend or bequeath money or gifts that will benefit you directly or indirectly.

Risk management strategies

We recommend you reflect upon the motivation of the gift giver and its timing.[4]

Consider the following issues which should raise concern:

- gift's timing e.g. a gift on Valentine's Day versus Christmas time
- gift's monetary value – a value of less than $75 constitutes "trivial and token"[5]
- gift's personal specificity
- meaning to the patient as more than simple gratitude.

If you believe a gift is inappropriate, you should politely decline while avoiding offending or embarrassing the patient. Explaining the rejection in terms of a general policy and/or ethical obligation will hopefully enable a patient to understand that the rejection is not personal. For example: *I am sorry, I appreciate your gesture, but our practice policy does not permit us to accept gifts of this value.*[5] From time to time patients will not accept your refusal, and another option is to accept the gift but advise them that it will be donated to a charity.

If you are unsure about whether the gift is trivial, or the patient's motivation concerns you, contact our Medico-legal Advisory Service on 1800 011 255.

Summary Points

- Acceptance of non-trivial gifts may be regarded by patients and colleagues as unethical.
- If you receive a gift from a patient, it is useful to ask: Is the giving and receiving of the gift in the best interests of the patient? If I accept the gift will I feel compromised in managing the patient in the future?
- Good medical practice involves not encouraging patients to give, lend or bequeath money or gifts that will benefit you directly or indirectly.

1 Gaufberg E. *Should Physicians Accept Gifts from Patients?* Am Fam Physician 2007; Aug 1;76(3):437-438. Available at: www.aafp.org/afp/2007/0801/p437.html

2 Mitchell P B. *Winds of change: growing demands for transparency in the relationship between doctors and the pharmaceutical industry.* MJA 2009; 191 (5): 273-275

3 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

4 Spence S A. *Patients bearing gifts: are there strings attached?* BMJ 2005; 331:1527-9

5 NSW Health Directive: Conflicts of Interest and Gifts and Benefits. Available at: www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_010.pdf

CaseBook

When Medicare Comes Knocking

Yvonne Baldwin, Claims Manager highlights two cases that exemplify the importance of medical practitioners understanding the nature and purpose of the Medicare audit process.

Medicare conduct annual compliance audits to determine if claims made by health professionals are appropriate and correct. Previous compliance audits have targeted practice nurse item numbers, wound care item numbers and immunisations. In recent months, Medicare has been targeting skin excision item numbers and the rendering of consultation and procedure item numbers on the same day.

Under the previous audit system, Medicare could not compel a medical practitioner to provide copies of his or her clinical notes to substantiate services rendered for a particular MBS item number. *The Health Insurance Amendments (Compliance) Act 2001* came into force on 9 April 2011 and applies to all Medicare services provided on or after this date. Although the legislation has been in force for over 12 months, Medicare is only now starting to review services and issue audits for services that post-date April 2011.

Under the new provisions, Medicare has the power to request that a medical practitioner provide documents to substantiate the provision of a service and subsequent rendering of an MBS item number. In the case of skin excision item numbers, the most commonly requested document is a copy of the histopathology report or a specialist's letter confirming a previous diagnosis of SCC or BCC (in cases of serial excision).

Case history 1

Dr A received a letter from Medicare informing him that he was being audited in respect of serial curettage excision items. The audit was triggered because Medicare's analysis of Dr A's claims for the period 1 May 2011 to 1 May 2012 identified that he was claiming items that did not have an associated histopathology item on the patient's Medicare history within 90 days prior to the service. This indicated to Medicare that the item descriptor may not have been met, which in Dr A's case required malignancy to be proven by histopathology or confirmed by specialist opinion.

Dr A was provided with a 12 page audit schedule that contained the names, dates of birth, Medicare card numbers, date(s) of service, the MBS item claimed and the MBS benefit claimed in respect of each of the patients listed. To complete the audit, Dr A needed to review the clinical notes of each of the patients listed in the schedule of services and the date of service in respect of each patient and then ascertain whether he had proof of malignancy for each patient and if so, provide a copy to Medicare.

When he reviewed his clinical notes, Dr A noted that he had proof of malignancy for all but four patients in the schedule.

Dr A sought advice from MDA National in relation to finalising the audit and was assisted to draft a cover letter to send to Medicare when he returned the audit. Dr A's letter provided an explanation for the patients for whom he did not have documentary proof of diagnosis – in each case the patient had previously been treated elsewhere and Dr A had relied on the history given by each patient, namely that they had been treated for recurrent skin lesions by their previous doctor. In relation to a fifth patient, Dr A realised that he had inadvertently claimed the wrong MBS item number and on the audit form he noted the item number that should have been used.

Several months later, Medicare wrote to Dr A to advise that they accepted his explanation in relation to the services which did not comply with the relevant MBS item descriptor and he was asked to repay approximately $400. Medicare provided a Voluntary Acknowledgement of Incorrect Payments form for Dr A to sign and return with payment of the sums incorrectly claimed.

Medicare conduct annual compliance audits to determine if claims made by health professionals are appropriate and correct.

Case history 2

Dr B received a letter from Medicare informing her that she was being audited for the period 1 January 2011 to 1 January 2012. The audit was triggered because Medicare's analysis of Dr B's claims showed that she had rendered consultation and procedural items for the same patients on the same day. Instead of being asked to complete an audit schedule, Dr B was informed that a medical advisor from Medicare would be attending her practice to interview her.

Dr B telephoned MDA National for advice, as she was unsure why she was being interviewed when other colleagues had received audit schedules to complete. The claims manager who assisted Dr B informed her that Medicare's concerns could not be addressed by a paper audit, and that Medicare would need to know whether the consultations had any connection with, or relevance to, the procedures performed on the same day. The claims manager advised Dr B that Medicare needed to be satisfied that there was no connection between the services (or this may be viewed as a "double dip") and that Medicare may ask to see clinical notes to substantiate Dr B's assertions that all services were properly rendered. The claims manager also told Dr B that Medicare had the power to request to review relevant clinical notes, but only for services that post-dated 9 April 2011.

After being advised about the purpose of the audit meeting, Dr B met with Medicare's Medical Advisor. Dr B explained to the medical advisor that all of the patients identified were elderly and had difficulty travelling to and from her practice. When such patients required a general consultation and treatment or excision of a skin lesion, she would arrange to perform this on the same day so that the patients did not have to see her twice. The medical advisor was satisfied with Dr B's explanation and the matter was closed.

Discussion

Although it can seem intrusive, Members are encouraged to cooperate with the compliance audit system. Under the new compliance audit regime, if a medical practitioner refuses to provide information to Medicare to substantiate the services he or she has rendered, Medicare has the legislative power to serve a Notice to Produce on the medical practitioner to compel production of the requested material (usually clinical notes). Administrative penalties* may be levied against a medical practitioner who fails to substantiate services claimed, where the unsubstantiated services total more than $2,500. Similarly, a civil penalty may be levied against an individual or corporation (e.g. a practice owner) who is responsible for documents relating to claimed Medicare services but has not complied with requests in a Notice to Produce documents.

These cases exemplify the importance of medical practitioners understanding the nature and purpose of the Medicare audit process before they engage in any communications with Medicare. We recommend that Members seek early advice if they are contacted by Medicare, so that they ensure that they "put their best foot forward".

Summary Points

- Medicare has the power to request that a medical practitioner provide documents to substantiate the provision of a service and subsequent rendering of an MBS item number.
- Members are encouraged to seek advice from MDA National if they receive any correspondence from Medicare in relation to a compliance audit or review of their practice profile.

* Such penalties are calculated on a sliding scale and can be increased or decreased (to zero) depending on various factors. The base rate of the administrative penalty is 20% of the amount repayable.

1 Peden v Ferguson [2012] NSWSC 492

CaseBook

Deceased Patients
Who can access their records?

Dr Jane Deacon, Medico-legal Adviser, reviews the legislation surrounding access to deceased patients' medical records.

Case history

Dr Z received a letter from the widow of one of his patients. Mrs W wrote that she wanted a complete copy of her husband's medical records. Mrs W was not known to the practice, and she did not give any reason for her request.

Medico-legal issues

It has long been considered that the duty of confidentiality in the doctor/patient relationship survives the death of the patient.

While medical records are the property of the doctor or the practice, the introduction of amendments to the *Privacy Act* (Cth) in December 2001 established a specific regime for patients to access their records. However, the *Privacy Act* (Cth) only applies to living persons and so does not address the situation of the deceased patient's medical records.

In the ACT and Victoria there is specific legislation to deal with the situation of a request for access to the medical records of a deceased patient. In the ACT the legislation[1] states that a right (that is a right to access health records) passes to a legal representative of the deceased. In Victoria the legislation[2] applies to a person who has been dead for less than 30 years. This legislation allows that the legal representative has the right of access to the records of the deceased patient.

Legal representative is defined as a person who is the executor of the will where probate has been granted, or the administrator of the estate.

Therefore in ACT and Victoria access to the medical records would generally be given to the executor of the will once probate has been granted, or the administrator of the estate.

In all other states there is no specific legislation, and in the absence of any apparent dispute or clear inconsistency with the deceased's wishes, it is reasonable to give access to the medical records of a deceased patient to the named executor of the will.

Where the doctor is clearly aware of a dispute about the will or about the executor's access being counter to the deceased's wishes, the doctor should decline to provide access, but make it clear that the doctor will produce the records to a court on subpoena, or after grant of probate.

Special circumstances arise in the case of bereavement where access can be given to limited and relevant parts of the record at the discretion of the doctor to affected family members. This is in accordance with *Good Medical Practice: A Code of Conduct for Doctors in Australia*[3] which states:

When your patient dies, being willing to explain, to the best of your knowledge, the circumstances of the death to appropriate members of the patient's family and carers, unless you know the patient would have objected.

Where information is requested for the provision of health care to relatives of the deceased, e.g. genetic information, access to limited information may also be provided at the discretion of the doctor.

A request for a copy of the records of a deceased patient should be in writing and include the relevant documentation, such as a certified copy of the will proving his/her appointment as executor. The doctor should make a brief note that the records have been provided, and to whom and on what basis they were provided.

In the case above, the practice manager rang the widow and tactfully explained the situation. Mrs W advised that her son was the executor and that the records were required for possible legal proceedings against Mr W's former employer. Mr W had died of mesothelioma, which may have been linked to his employment. Mrs W's son then provided a request in writing, along with the necessary documents, and the medical records were provided to him.

If in doubt, call our 24 hour Medico-legal Advisory Service on 1800 011 255 for further advice.

Summary Points

- Access to the medical records of a deceased patient can generally be provided to the executor of the will, or the administrator.
- In ACT and Victoria, general access to the medical records should only be given to the executor or administrator of the estate upon receipt of a written request accompanied by the grant of probate or court appointment of the administrator.
- Special circumstances apply where access to medical records or health information is requested in a bereavement situation, or for the purpose of the provision of health care to relatives of the deceased patient.

1 *Health Records (Privacy and Access) Act* 1997 (ACT)
2 *Health Records Act* 2001 (VIC)
3 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx

Corporate Social Responsibility

Contributing to our Community

Our Corporate Social Responsibility (CSR) Program has continued to grow in terms of reach and impact since its launch in 2011. The Program continues to provide a framework for managing our fundraising efforts and involvement with charitable organisations that are aligned with our Member activities and medical interests.

Left: Our 2012 Perth City to Surf event ambassador, West Coast Eagles player, Mark Le Cras with MDA National Relationship Manager, Pip Brown.
Centre: Lee-Anne Britten, Kerrie Lalich and Michael Halliday. **Right:** Happy to receive our computers and laptops, Ms Ena Hamon, Country Director, One Girl.

Making a difference in the community

In 2012 MDA National raised funds, along with our employees, by participating, donating or providing sponsorship to a number of initiatives including:

- **Australia's Biggest Morning Tea** – raised funds for cancer research and support.
- **Daffodil Day** – growing hope for people living with cancer.
- **Movember** – raised funds and awareness for men's health.
- **One Girl** – donated our fleet of outdated computers and laptops.
- **Perth City to Surf** – hosted 100 Members, friends and family.
- **Think Pink Foundation** – donated to supporting women living with breast cancer.

Gareth running 250km self-supported across the Atacama Desert, Chile.

Polar Challenge 2013

Doctors Gareth Andrews and Richard Stephenson are taking part in the 2013 Polar Challenge – a 600 kilometre competitive race across the Arctic sea ice to the Magnetic North Pole. It is one of the world's toughest endurance races in one of the world's most inhospitable and endangered regions. The doctors' goal is to inspire, educate and empower the youth of Australia and New Zealand to make a positive change in the world through the medium of adventure.

To find out more about this grueling race to the magnetic north pole, read our interview with Dr Gareth Andrews at *Defence Update* online.

Visit **www.defenceupdate.mdanational.com.au/contributing-to-our-community**

Think Pink Foundation Chair, Irene Hendel and her husband David.

Think Pink Foundation

The Think Pink Foundation is an independent, volunteer based charity whose focus is to raise funds to provide financial and emotional support to breast cancer patients. They fund worthy projects that help provide breast cancer patients with information and counselling and also provide funds to patients who are in financial need to help them through their journey with breast cancer.

To find out more about the Think Pink Foundation, read our interview with Think Pink Foundation Chair, Irene Hendell at *Defence Update* online.

Visit **www.defenceupdate.mdanational.com.au/contributing-to-our-community**

MDA National
Support Protect Promote

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
Fax: (08) 9415 1492

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