

# mips review

winter edition 2011



## from the MDs desk



**Dr Troy Browning**  
Managing Director, MIPS

### 2011 – 2012 membership renewals

I thank the majority of MIPS membership for confirming their trust in MIPS by their prompt renewal. Members who renewed by the 30 June also have the comfort to know that they have avoided any gaps in their membership benefits and therefore helped ensure they continue to meet their Australian Health Professional Regulatory Agency indemnity requirements.

Changes in membership details or categories not advised until renewal take much longer to deal with than those outside of the renewal period because of the flow-on effect on renewal documentation. As a result there is an increased likelihood of delays in service delivery during renewal compared with other times. We are therefore especially appreciative of those members who had queries and/or were able to anticipate changes in their practice and/or membership details and advise those well in advance of renewal. I encourage members to be proactive

and where possible advise of such updates or changes either online through 'my membership' or by contacting Member Services in a timely manner. That will help ensure that the MIPS team can provide the highest possible level of service to our members.

The MIPS team has worked hard over many months to try to make the renewal process as effortless (and painless!) as possible for members. We thank members for their forbearance with any challenges they might have had with the new 'my membership' site log in security requirements, and anticipate that through regular ongoing access to check membership details, membership benefits statement, additional Club MIPS member benefits or print a certificate of currency that process will become second nature to members.

### membership benefits for 2011–2012

**Members should at this time review the 2011 – 2012 MIPS Membership Benefits Book to acquaint themselves with the changes introduced for 2011 – 2012.**

Some of these include:

#### personal accident policy

Comprehensive travel insurance for non-student members providing gratuitous services overseas (such as to aid groups as part of the operations of charitable associations/not for profits), has been included amongst other additional benefits under the policy for 2011 – 2012.

### medical indemnity insurance policy

The MIPS Members' Medical Indemnity Insurance Policy wording has been amended for 2011 – 2012 principally to allow inclusion of student members along with dental and medical members. To date, student members have been covered each year under a similar but separate Student Members' Insurance Policy wording. The change to a single policy wording for all MIPS members aligns with MIPS 'whole of professional life' philosophy and approach to members and also meets our objective to simplify and reduce where possible the paperwork that members need to consider.

### MIPS members' practice entity policy

The definition of 'Practice Entity' has been amended to provide greater clarity.

### membership categories

MIPS has undertaken its annual review of membership categories. The more significant changes for 2011 – 2012 relate to:

- new dental categories for dental specialists and generalists
- separate identification of other dental health professional groups
- further clarification of the definition of obstetric shared care.

Full details of the 2011 – 2012 MIPS membership benefits are found in the MIPS Benefit handbook. Visit [www.mips.com.au](http://www.mips.com.au) for an online copy.

#### articles

mental illness and health professionals – an article by Dr Manjula O'Connor	page 5
down under doc part 2 by Dr Jayant Banerji	page 9

#### news

Enhanced Primary Care Scheme (EPC) sorting or irregularities?	page 10
MIPS launches new website	page 12

#### risk management

risky business – an article by Dr Gerry Clausen	page 6
MIPS webinars – a membership benefit	page 7

# MIPS submission in response to the productivity commission draft disability and support report

**The Productivity Commission's draft National Disability Scheme report released in February foreshadows potential developments that may have very significant consequences for members. In that draft the Productivity Commission proposes:**

- A National Disability Insurance Scheme (NDIS) to be overseen by a new organisation – the National Disability Insurance Agency, and a separate
- National Injury Insurance Scheme (NIIS) to address catastrophic injuries from accidents comprising "... a coherent set of state-based, no-fault arrangements for providing lifetime care and support, building on existing schemes. It would have the same basic goals as the NDIS but would be funded differently ..."

The report proposes that the NIIS:

- be "... primarily funded from insurance premiums and, where appropriate, include experience and risk-rating to help prevent injury".
- be "structured as a federation of separate, state-based schemes" (e.g. medical indemnity injury in Victoria would be managed by TAC).
- financing of claims would be jurisdictionally based.

And that

- "No-fault insurance for catastrophic injury would mean that common law actions for damages associated with lifetime care and support would be extinguished."
- "... no-fault lifetime care of catastrophic medical accidents under the NIIS ... will remove a proportion of the frictional costs associated with determining the quantum of damages in medical negligence claims. Moving to no-fault cover for catastrophic medical accidents is unlikely to come at zero cost, as the savings in the legal process and disputes may not be sufficient to fully meet the increase in coverage. This may place some pressure on medical indemnity premiums if arrangements

for funding the larger number of claims were drawn solely from such insurance."

- the NIIS to be reviewed in 2020.

Additional statements in the report include:

- "... there are numerous options to extend the scope of cover provided by the NIIS ..."
- "The appropriate funding source would broadly depend on the jurisdiction and the cause of accident and, if appropriate, to enable risk rating of the insurance premium and provide efficient incentives for safety and injury prevention."
- "... funding of residual claims, not specifically covered by insurance would rely on new sources of income. While this would entail additional contributions from state and territory governments, ... a significant source of revenue would be savings in legal costs (which account for a significant component of premiums in fault-based systems ...)"
- "It may be possible to redirect a proportion of ... government subsidies, while still retaining some measures, such as a version of the Australian Governments Premium Support Scheme, to provide an assurance that premiums paid by practitioners would not increase too substantially."
- "Once the scheme is fully established, Australian governments should examine the scope to finance NIIS claims for catastrophic medical accidents from re-weighting government subsidies and premium contributions."

In the Draft report the Commission also seeks feedback on an appropriate criterion for determining coverage of medical accidents under the NIIS and on practical interim funding arrangements for funding catastrophic medical accidents covered under the NIIS.

**MIPS previous submission recommended that the proposed National Disability Insurance Scheme be completely funded by government to ensure the most efficient and sustainable approach to funding.**

MIPS submitted a lengthy and detailed response to the draft productivity commission report. Our response can be summarised as follows:

- MIPS has restated its earlier recommendation for the Commonwealth to fund medical accidents for reasons of process efficiency, transparency and to allow ongoing alignment of social policy with health resource allocation.
- Maintaining the Premium Support Scheme is necessary to ensure that medical practitioners are protected from concerns of unacceptable increases in indemnity funding costs that might arise from removal of the High Cost Claims Scheme HCCS (if not balanced by the transfer to the NIIS of 100% of the lifetime care liabilities).
- MIPS anticipates that additional NIIS funding for medical accidents is likely to be required due to inclusion of no-fault matters. However MIPS believes that additional funding could be substantially met through removal of the adversarial/frictional costs of legal process.
- If however further NIIS funding for medical accidents is required, broad-based non-insurance premium sources should be utilised to avoid, or at least minimise, the inefficient use of healthcare dollars such as occurs when funding via medical indemnity insurance premiums.
- To ensure community equity there should be no difference in qualifying criteria for the NIIS between medical or other accident types.

continued on page 4 ...



continued from page 3 ...

MIPS made a number of comments and recommendations in regard to equity and funding.

In our reply we state that we anticipate that the NIIS proposals will lead to a greatly increased funding need because of the inclusion of the larger number of 'non-negligent' (compared with 'negligent') adverse outcomes. Putting to one side the inefficiency associated with collection of funding via insurance premiums discussed elsewhere in the submission we believe it would be inequitable to expect health professionals to fund the large increase in lifetime care costs arising from inclusion of non-negligent adverse outcomes while forced to continue to fund the wasteful adversarial process associated with the other than lifetime care compensation elements of those catastrophic medical injury claims.

Funding via insurance premiums is inefficient. That is because any funding amount obtained through taxes or levies on insurance premium is further inflated by other existing taxes so that the gross amount that has to be charged as premium is significantly greater than the additional net amount sought.

MIPS' view is that process inefficiency must be avoided wherever healthcare monies are involved (as they ultimately are in funding of medical indemnity insurance). We believe that it is especially important in respect of the NIIS to ensure that funding efficiency is maximised to minimise adverse impacts on available health care funding/access to health care.

Similar to the decision by the Victorian Bushfires Royal Commission in relation to the Fire Services Levy it would seem preferable to implement broad-based community methods of funding of the additional costs of the NIIS.

We believe that such an approach is especially appropriate when the majority of lifetime care costs for medical injury under the NIIS will relate to non-negligent injuries.

It would be, in our view, inequitable to look to narrower sources for funding of the NIIS purely on the basis that those sources were more easily identified. Fair, appropriate, broader based, funding alternatives more in keeping with the move to a "no-fault" scheme should be implemented.

Going forward MIPS suggests High Cost Claims Scheme funding should be redirected to more efficiently and

more directly fund catastrophic claims via the NIIS rather than through the less efficient and less transparent conduit of medical indemnity insurers.

MIPS believes any changes to the High Cost Claims Scheme (HCCS) to fund the lifetime care component of medical accidents under the NIIS needs to be carefully considered. In our view any reduction in HCCS support should primarily relate to HCCS recoveries that would but for the NIIS otherwise attach to the lifetime care component of medical accident claims.

MIPS is keen to ensure that practitioners/groups with lower 'catastrophic claims' risk potential not bear an increased and disproportionate claim funding burden. That situation might occur if the HCCS threshold only was raised to fund the lifetime care component of NIIS claims.

A copy of the full submission can be found at [www.mips.com.au](http://www.mips.com.au).



## how can MIPS help you get to work and back home safely?



At MIPS we want to protect more than your career, so we've secured something special for you.

Just visit [www.mips.com.au/clubmips](http://www.mips.com.au/clubmips) to find out more.

\*see webpage for terms and conditions



**mips** where members matter

Login to the My Membership area to view the full suite of membership benefits.

# mental illness and health professionals

Dr Manjula O'Connor



Consultant Psychiatrist and Senior Research Fellow, Centre for International Mental Health, School of Population Health, the University of Melbourne.

Mental illness affects one in seven people within the general population. Of those with major depression, the risk for suicide is increased by 20-fold compared with the general population.<sup>1</sup> This rate increases in those with co-morbid anxiety disorders, e.g. 25% when co-morbid panic disorder is present and 38% in those with co-morbid post-traumatic stress syndrome disorder.<sup>2</sup>

In a recent report, 41% of senior Australian doctors reported psychiatric symptoms worthy of treatment. There is anecdotal evidence of at least one suicide of a health care professional in each state over the past 5 years. **[Suicide has generally been found to be higher for both male and female doctors compared with the general population. Willcock et al (2004)]**

Not a good picture, but what it does show is that the medical profession is not immune to psychiatric problems; in fact quite the opposite applies. Psychiatric morbidity, substance misuse and personal relationship problems are all common issues among medical practitioners. Psychiatric afflictions and/or disorders left untreated or unacknowledged over a prolonged period, especially during early professional life, set the stage for such problems throughout one's career. Many bad behaviours

and co-morbidities begin whilst at medical school: alcohol and drug use, increased stress, lack of sleep, reduced physical activity, and poor diet all of which add to the risk of future mental afflictions and/or disorders.

Avoidance of dealing with these problems is very common and it often goes unrecognised. When in distress, the sick doctor can often go unrecognised by other medicos, and the rate of seeking help among medical practitioners is lower than that of the general public.

Does avoidance of mental distress and treatment reflect the environment in which young doctors work? Well, it may well be so, as they are often too busy and goal focused. Personal characteristics also come into it as doctors are notorious for striving to reach unrealistic self-imposed expectations. It may also be the values of society, the culture they inherit and fear of the stigma of mental illness.

Stigma is defined as "an attribute that is deeply discrediting". Stigma reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman 1963). The process takes effect when the identified person is linked to undesirable characteristics that discredit him or her in the eyes of others. Members of a stigmatised group may accept stereotypes about themselves and view themselves as fundamentally different from and inferior to other people.

So succumbing to the stigma of mental health issues is powerful. Feeling stigmatised can have effects on your education, career, housing and many other areas of your life. Trying to pretend nothing is wrong and refusing to seek treatment can lead to on-going distress for yourself and your family.

Don't let the fear of being 'labeled' with a mental illness prevent you from seeking diagnosis and treatment. Mental illness is real and there is real research and real data to guide accurate and effective treatments. Diagnosis and treatment can provide

relief by identifying what's wrong in concrete terms, and reducing symptoms that interfere with your work and personal life.

If you have a mental illness, it can be hard to decide who to tell, if anyone, and how much to disclose. You may not be comfortable telling anyone anything about your condition. On the other hand, if you tell people you trust, you may find much-needed compassion, support and acceptance. Stigma can lead to social isolation; therefore, it is especially important to stay in touch with family and friends who understand. Isolation can make you feel even worse.

Take advantage of resources available to you. A number of agencies and programs support medical students and doctors who have mental health conditions. Make use of internet resources, the doctors health programs are run in all states, and confidential services are also provided by AMA in all states.

Above all, don't forget your local general practitioner.

## references

- Harris EC, Barraclough B. Suicide as an outcome for mental disorders. A meta-analysis. *Br J Psychiatry*. 1997;170:205–228. Abstract.
- Bruce SE, Weisberg RB, Dolan RT, et al. Trauma and posttraumatic stress disorder in primary care patients. *Prim Care Companion J Clin Psychiatry*. 2001;3:211–217.
- Goldsmith S, Pellmar T, Kleinman A, Bunney W, eds. *Reducing Suicide: A National Imperative*. Washington, DC: Institute of Medicine National Academies Press; 2002.
- Simon M Willcock, Michele G Daly, Christopher C Tennant and Benjamin J Allard MJA • Volume 181 Number 7 • 4 October 2004.



# risky business

Dr Gerard Clausen

General dental practice covers a broad spectrum of treatment modalities. Procedures ranging from a simple one-surface direct restoration to a difficult third molar removal can all be part of a 'routine' working day. Some of these clinical procedures have a minimal or even negligible risk profile, whilst others fall into the high-risk category. How does the practitioner recognise this relative risk?



Should this case have been referred?

Many indemnity providers keep an active list of reported incidents and these can be categorised according to type, location and the treating practitioner's status (e.g. GDP or Specialist). In this way a profile can be developed regarding those procedures that may have an increased risk of generating a claim, or areas where the cost of a claim, if incurred, can be significant.

As an example, endodontic procedures contribute to a noticeable number of claims. Fortunately however, the costs associated with re-treatment or remedial management are generally moderate. The risk element associated with endodontic treatment can therefore be quantified, and to some degree contained.

Certain procedures do exhibit both a claims incidence (frequency) and cost (severity) that requires comment. In particular, implant surgery and extensive cosmetic dental treatment are two areas that generate claims which are invariably complex, costly and time consuming. No member would ever wish to have a protracted matter hanging over their head; and the best way to avoid this is to recognise high-risk sectors and take appropriate preparatory action.

## what does this mean in everyday clinical practice?

Firstly, it requires the practitioner to be honest with him/herself. Am I adequately trained, equipped and skilled to be undertaking, for example, surgical implant placement? If not, would this be a procedure that might for the sake of both treader and patient, be better referred to a colleague with appropriate expertise in this area?

Secondly, if one is prepared to undertake treatment, recognising that the proposed management falls into the high-risk category, is the standard of diagnostic data, communication and record keeping, both pre and post operatively, as good as it should be?

Whilst one does not condone poor records, or inadequate diagnostic data or pre-treatment records, the absolute importance of these records cannot be over emphasised in the complex clinical case. In an instance where, for example, extensive cosmetic reconstruction is planned using ceramic veneers, by the very nature of the tooth preparations required, the changes made will be irreversible. Should the patient complain, post-treatment, that the teeth are now bulkier on the labial aspect than before, or incisally longer (even if this was intended, and/or explained), how can the patient's assertion be accurately evaluated if there were no appropriate pre-operative warnings,

cost indications, photographs, or other records. In the absence of such records, the treating practitioner has little defence, and his indemnity provider has even less.

In the ideal world every case, from simple to complex would be thoroughly documented and recorded, with written records, radiographs, photographs, vitality tests, study casts and numerous other visual and written records.

It would however be unreasonable to impose this burden on already busy practitioners for every clinical interaction, especially in situations where the time and money spent collecting data well outweighs the potential risk.

Real-life risk management is all about recognising when it is reasonable and appropriate to 'go that extra mile' in terms of records and data. Understanding and being aware of the higher-risk areas in practice is critical to this process.

For any advice on procedures, always feel free to contact your MIPS Dento-Legal Advisor on 1800 061 113.

*'is the standard of diagnostic data, communication and record keeping, both pre and post-operatively as good as it should be?'*

## webinars

MIPS is now running a series of webinars (web seminars) throughout the year for members mainly in rural or remote locations throughout Australia. For further information, please visit [www.mips.com.au](http://www.mips.com.au).

**February 24, 2011:** Dr Rob Grenfell in Melbourne and Dr Jayant Banerji via teleconference in Bendigo presented to International Medical Graduates in rural and remote Western Australia. A number of medico-legal issues were addressed and some potential risks were also covered for overseas trained doctors now living and practicing in Australia.

**May 05, 2011:** Dr Gerard Clausen presents to dental members in New South Wales. The webinar covered issues of dento-legal interest including financial consent, record keeping, complaints handling, adverse outcomes and claim trends.

Both sessions included a question and answer component where members online were able to either ask or type in questions for the presenters to respond. Please look for your invite to one of these sessions soon.

If you would like to be part of any of MIPS' presentations or webinars, visit [www.mips.com.au](http://www.mips.com.au) for our upcoming events.



## advertising your practice

There has been an increase in medical practice advertising and problems flowing from it. AHPRA have published guidelines for advertising regulated health services and these provide a useful checklist.

Members should always be cognisant that advertising cannot:

- create unrealistic expectations about a treatments effectiveness
- encourage the indiscriminate use of services
- mislead, by use of emphasis, comparison, contrast or omission
- use testimonials or purported testimonials
- compare health professionals without evidence
- claim services provided are better, as safe as or safer than others
- promote unrealistic recovery times
- encourage inappropriate self-diagnosis or self treatment
- abuse the trust or lack of knowledge by patients
- fail to disclose the health risks

- omit the warning statement
- cause undue fear or distress
- contain price information that is incomplete.

Anyone advertising must also exercise appropriate caution regarding claims they make, and be aware that they must not make claims that the:

- treatment is infallible, magical, certain, guaranteed or a sure cure,
- practitioner has an exclusive skill or remedy that is exclusive or contains a secret ingredient
- practitioner has superior services to those of others
- results are always effective
- services are a substitute for vaccination and immunisation.

Finally, health service advertising must never purport to fully inform the public and/or replace informed consent. It must not be sensational, contrary to public standards or bring the health profession into disrepute.



## use of interpreters

MIPS was recently approached by General Practice Victoria, specifically the Refugee Health GP working-group, to promote to members the use of interpreters. The Divisions of General Practice Program is a key component of the Commonwealth's General Practice Strategy to encourage systems change.

There is no doubt that the effective use of interpreters promotes patients' health by improving the quality of clinical consultations and patients' understanding of treatment plans. Currently, the majority of general practices do not use this resource and according to survey data only just over half are aware that it exists.

Poor communication has long been a precursor for complaints or claims against health professionals. Belonging to a multicultural and multilingual community, you are likely to face the challenge of effectively communicating with some patients. Members may possibly be reluctant to use specialist interpreters however, there is the possibility of some increased medico-legal exposure being attached to consultations where communication is an issue.

### consider the following scenario:

A Sudanese mother who spoke little English and her 14 year old daughter attended a practice. The daughter acted on her mother's behalf in communicating with the doctor. During the consultation,

the GP explained to the daughter that her mother was required to either undertake urgent blood tests (GP provided the referral) or to go to the Hospital Emergency Department. Neither of these options was acted upon and as a result the patient died a few days later. A complaint was filed by the family against the GP on the basis the patient had not understood the doctor and an interpreter had not been provided. Because of this the urgency of the treatment was not successfully communicated and, no further treatment was sought.

## national free telephone interpreter service to doctors

In the year 2000, the Translating and Interpreting Service (TIS) introduced the **Doctors Priority Line (1300 131 450)**. Open 24/7 this service provides medical practitioners with access to interpreters who are generally available within minutes for common community languages.

Further details can be found at: [www.immi.gov.au/living-in-australia/help-with-english](http://www.immi.gov.au/living-in-australia/help-with-english)

Members are reminded of the **Medical Board of Australia's Good Medical Practice: A code of Conduct for Doctors in Australia. At 3. Working with patients, 3.3 Effective communication, 3.3.9** which states:

*"Familiarising yourself with, and using whenever necessary, qualified language interpreters or cultural interpreters to help you meet patients' communication needs."*

## congratulations to our e-reader winner!

**Dr Amol Dabholkar** was the winner of the MIPS Kobe e-reader. He attended the April ADA Conference and has been operating his own dental practice in Margate, Qld since January this year. (pictured here with his staff)



# down under doc... part two

Beyond the Work Visa, on the road to Fellowship, and finally to Permanent Residency

Dr Jayant Banerji

After my last article, I pondered on the most memorable occasions in an IMG's life in Australia. Undoubtedly the most important event is the recognition of your skills and the acquisition of the coveted permanent resident visa. As it comes via the college exam, this in itself becomes a significant milestone. Life 'Down Under' actually starts after these two events and you feel safe, wanted and a part of a new world that has accepted your skills and welcomed you. Moving to Australia and this process is the subject of this piece.

The first thing that struck me was that I had been able to order a car by email. My employer had vouched for me, the financier had asked for a few papers – and lo and behold – I was the owner of a gleaming new, red CRV! I got off the plane with my work visa and a few dollars, called the car company and they handed me the keys, even though they had never set eyes on me before. They did not even ask for a proof of identity! Obviously, implicit trust was going to be the defining way of life here.

As I was going to work in the country, I needed to be mobile. A three hour drive took me to a tiny sheep town called Peshurst - south of the Grampians. This was going to be my new place of work for the next six months as I waited for the practice in Bendigo to be readied. My new home was a furnished unit in Hamilton, 30kms from the practice, found by our charming and very helpful receptionist. The keys were under the mat, the fridge was stocked with food for a week, and all I had to do was move in. What a stress-less introduction to a new country!

I walked in to the practice the next morning and found patients waiting. I was to look after 5 in-house patients and 15-odd nursing home residents. There was an experienced Australian GP working with me, which is one of the best experiences when you start work. I also had a supervisor who was available 24/7 on the phone.

Peshurst has a population of 500 people and soon everyone became a known acquaintance. I met my patients at the post office, the petrol station, the deli and even the pub! The hospital and clinic staff was supportive and friendly, and soon I was settled in my role of a GP and the VMO of the hospital. There is nothing as wonderful as breaking into Australian general practice in a small town and working with an experienced GP. One does sweat the small stuff, which is usually regarding rules, referral pathways, computer software etc. but a slow start is one of the most comfortable ways to move forward. Some IMG's may find the jargon used difficult, but patients are happy to clarify any bits you do not understand...just ask! I was even drawing blood samples on behalf of the visiting pathology service and performing minor procedures...all very exciting and welcome additions to practice, which can get quite specialised and monotonous in my home country.

Six months flew by and I was asked to join the practice in Bendigo. The local population seemed to resent the news and drew up a signed petition. The hospital sent a letter to my employers asking that I stay. All this was a morale booster and I felt chuffed but, as I had a teenage son, my wife and I decided that it would be in his best interests if we did finally move to a larger town. It was heart breaking to leave such a wonderful and responsive patient population, who were also good friends but, with a heavy heart and meager belongings, we did so.

Bendigo was a baptism of fire. There had been a long-term shortage of doctors and people were just waiting to get on to our books. I worked 12-13



hours a day and every third weekend. Even then, we were swamped and the 3 of us could not really cope with the load. We were in a new place. Every patient was a new face. The referral pathways were different. The receptionists were new. The practice nurse was yet to start work. We had help from a very senior GP but he was swamped as well. There was the usual mix of "heart sink" patients and drug seekers. It was a bigger town and I missed the comfort of my small town friends. However, Bendigo is a town with a lot of facilities, a good school, a big hospital to back us up and plenty of opportunities. It is a different world where we have to fend for ourselves. The small personal touch and the friendliness of the truly rural country folk was missing. My wife and son joined me from India and they too had to settle in to a new world.

Soon things improved. It was great to be in a town with every conceivable facility and the convenience of access to the bright lights and rich culture of metropolitan Melbourne. There was the opportunity to go to the theatre, the movies and musicals. There were opportunities to explore the variability of Victoria.

continued on page 10 ...

*"There is nothing as wonderful as breaking into Australian general practice in a small town and working with an experienced GP."*



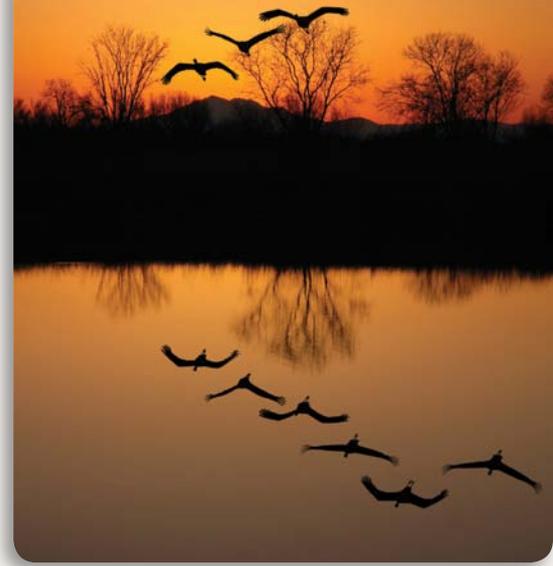
continued from page 9 ...

Nevertheless, at the end of the day the light at the end of the tunnel was only after the Fellowship. Education sessions arranged by my employer, the local division and opportunities to attend similar workshops and CME's, formed the focus of my life for the following year. I made sure I attended every possible educational event. Soon we managed to reduce hours and increase doctors in the practice. There was a life after work and the family seemed to settle in to a routine. My wife Charu, managed to clear the AMC, AKT and PESCI, all three because no one was sure what the new requirements for an outsider in a job Down Under were! She seemed to thrive on the challenges thrown at her.

More and more patients brought more experience and up skilling. Acceptance by the community, colleagues and the forging of relationships led to a comfort level that made work easier

and improved outcomes. The subtle nuances of understanding a different way of practice made for lesser risks for both the doctor and the patient. Finally, it dawned on me that this rather complex health system worked well for improving the quality of life for patients and reduced the risk of adverse outcomes. I realized that I had managed to walk the rather complex minefield of a new health care algorithm. There is no doubt that the first year of practice is the toughest and exposes you to the maximum chances of error, and this is the time when you need maximum support and awareness.

The most important step into Australian practice is to make sure that you are well supported. The money, lifestyle and everything else will follow. The second most important step is to integrate oneself in to the local medical and non-medical communities. This is done best by



attending as many community and educational events as you can. If you have children, involve yourself in their school and activities. Kids are great in integrating themselves and helping you do the same.

The third step is to get the exam over and done with and then apply for your Permanent Residency. It is tough and expensive, but once that is over then the best part of your life lies ahead of you. That makes for another article.

## Enhanced Primary Care Scheme (EPC) – rorting or irregularities?

Medicare Australia has increased surveillance of the dental Enhanced Primary Care (EPC) scheme, with particular regard to irregularities in the dentist's claims for payments under the scheme.

The scheme was established to enable chronic disease patients to receive up to a maximum of \$4,250 dental treatment over 2 years. Entitlement was determined by the GP when they established a health care plan incorporating the need for dental treatment. The GP was then required to forward a copy of the plan to the patient's dentist who, after examining the patient, was required to produce a copy of the proposed care plan to both the patient and the GP.

Figures recently tabled in parliament indicate this scheme has blown out by \$1 billion. In total, dentists have billed \$1.4b over the 4 year life of the scheme, which was anticipated to cost \$377m.

An audit investigation conducted by Medicare Australia has found one Victorian dentist was paid \$2.1m in non compliant claims after being referred more than 1,000 patients. Another NSW dentist claimed \$1.9m for treating 525 patients. Overall, Medicare audits are understood to have shown that 59% of those investigated so far have failed to fully comply with the rules.

The Medicare audit is now being expanded and will also focus on Medical Practitioners (GPs). Those that have referred patients under the scheme will be identified from the dentist's documents and will come under similar scrutiny. The Human Services Minister (Tanya Plibersek) stated *"Evidence suggests some GPs referred more than one family member to the same dentist for services which did not comply with the scheme's legal requirements. I am concerned patients have been referred by doctors even though their dental state had no relation to the illness that brought them to the doctor"*.

Data indicates that not only has the EPC scheme blown out by 325%, the GPs who wrote the chronic disease management plans have earned \$914m since the scheme was introduced in July 2005. Podiatrists, physiotherapists and dieticians appear to have claimed the most in rebates to date.

The Minister went on to say that if the Labor government had its way, the scheme (established in the dying days of the Howard government) would have been scrapped by now, potentially saving taxpayers up to \$63million per month.

It is understood that Medicare is now launching a year long crackdown on health professionals to stop this alleged 'rorting'.

**'59% of those investigated so far have failed to fully comply with the rules'**

# obligations for prescribing

Pharmaceutical Benefits Scheme (PBS) Medicines can only be prescribed by doctors, dentists, optometrists, midwives and nurse practitioners who are approved to prescribe PBS medicines under the National Health Act 1953.

Personalised PBS prescription forms are available from Medicare Australia for doctors who have a Medicare provider number.

This process enables an effective checking mechanism for pharmacists and meets legislative requirements for tracking of prescribing history by regulatory authorities. There are strict controls around prescribing and the trend is one of increased surveillance by the authorities.

Apart from some exposure around the prescribing bureaucracy which may potentially effect your professional standing if you don't comply (and where MIPS should be promptly notified), when you have prescribed you are potentially responsible under common law for the consequences that might flow from that act. It is therefore of some concern that MIPS has received anecdotal details of general practitioners prescribing simply on the basis of a recommendation of an allied health professional, i.e. social workers, psychologists and occupational therapists are not permitted to prescribe. This results in the real possibility of those general practitioners having heightened medical negligence risk should there be an adverse outcome arising out of their decision to prescribe on this basis.

## negligence

In negligence cases around prescribing there are likely to be allegations such as inadequate consent, inadequate warning of the risks and side effects, inappropriate

dosage, inappropriate mix and reaction of medication and inappropriate type of medication. To be held liable, an assessment of care as being below the required reasonable practice standard that led to injury or loss would need to be proven.

In the above scenario the prescriber would be the individual to be targeted. Although the medical practitioner had simply complied with the request of an allied health professional, the medical practitioner would ultimately be held accountable for any adverse outcome.

## risk management

Medical practitioners should not simply follow the recommendation of an allied health professional. On all occasions before prescribing you should take or have conducted an appropriate full history, examination, considered other medications and recorded the details in your notes. It is by all means appropriate to consider recommendations made to you but ultimately it is up to you to make the proper therapeutic choice based on all the necessary information required for that while remembering that you carry the liability if something goes wrong. A defence based on following a recommendation of an allied health professional (who may not have the necessary clinical expertise to make such a recommendation) is unlikely to be successful. The focus as always should be on patient safety.

## prescribing resources

[www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au)

– Select 'for health professionals'. Go to menu, PBS, PBS education.

[www.pbs.gov.au/pbs/home](http://www.pbs.gov.au/pbs/home) – Pharmaceutical Benefits Scheme

[www.tga.gov.au](http://www.tga.gov.au) – Therapeutic Goods Administration.

[www.tga.gov.au/ndpsc/](http://www.tga.gov.au/ndpsc/). For contact details of the drugs and poisons agency in each jurisdiction, go to State/Territory scheduling information – with links to all State and Territory websites.

## News

*The Health Insurance Amendment (Compliance) Act 2010* recently passed without amendment.

The Act amends the *Health Insurance Act 1973* in order to implement the Increased Medicare Compliance Audit (IMCA) initiative. This includes an increase in the number of Medicare compliance audits undertaken (from 500 to 2,500 pa). The Act will also increase the powers of Medicare Australia to compel practitioners to present documents to substantiate billing claims.

A Medicare report tabled in parliament indicated that whilst the majority of practitioners cooperated with Medicare auditors, 20% did not. The non cooperation ranged from either refusing to cooperate at all, to not responding to any requests for documents. An Australian National Audit Office report found that non-compliant Medicare payments equated to around 1.3%–2.3% of expenditure in 1996–97. Given the growth in Medicare payments since then, Medicare now estimates the total annual non compliant payments to range from \$170m–\$300m per annum.

Unlike the Professional Service Review process, Medicare Australia was previously unable to compel practitioners to produce documents such as clinical records to substantiate billing practices. This has now changed.

The resulting key changes are:

- to enable the CEO of Medicare to issue a notice to a practitioner (or others) to produce documents within a specified time that may include patient records
- where documents are required to substantiate a claim, the CEO of Medicare must consult with a medical adviser employed by Medicare concerning the type of documents required and who the only person authorised to view them will be
- clinical records are not required unless these would be necessary to substantiate a claim
- imposition of civil penalties for failure to comply except where this is not within the control of the practitioner
- produced documents are not admissible in evidence in civil or criminal proceedings except in cases relating to false and misleading statements and a practitioner cannot claim self incrimination as a defence to producing documents
- administrative penalties may be imposed to deter non-compliance and recidivist behaviours.

The Act is not retrospective and applies only to services provided on or after 09 April 2011.

# welcome to our new website

The Medical Indemnity Protection Society (MIPS) launched a refreshed version of its web site [www.mips.com.au](http://www.mips.com.au) on Thursday, May 12, 2011, with a dynamic, new look. The new website provides members and online visitors with improvements in navigation and functionality.

With more convenient navigation, members now have better access to information and the ability to book online for various education and training events throughout the year. Members can also process a library of forms, useful links and other reference material to help them on their career journey.

Enhancements to the website include:

- **Improved navigation** – web pages work in intuitive and consistent ways, making it easier for members and online visitors to find what they are looking for and know where they are within the web site.
- **Improved structure** – enhanced graphics and the new page layouts provide members and online visitors with an improved user experience.
- **New features** – new features on the web site include print-friendly versions of the web pages, news and events notices, easier access to all important membership forms including applications for membership.
- **Improved accessibility** – the new website is designed to give members greater and easier access to their online membership details.

The appearance and high-level organisation of the MIPS website has been enhanced but it still retains all the information from the previous MIPS website.

For additional information, please contact the MIPS Member Services on **1800 061 113** or by email to [info@mips.com.au](mailto:info@mips.com.au).

