Welcome to the Summer edition of MIPS Review. As well as several informative articles relating to claims, and the positive experiences of members practicing in out of the way places, the Hazard Warning article reinforces how simple mistakes can have catastrophic consequences.

**Cancer screening and surveillance**
General Practitioner members will be aware of current recommendations for screening and surveillance for breast, bowel and cervical cancers, however for convenience and easy to access reference we have included the October 2009 Cancer Council Summary.

**Submission to the Productivity Commission**
MIPS provided a submission to the Productivity Commission in respect of the public inquiry into a long-term disability care and support scheme. The full submission can be seen on the Productivity Commission’s website. Such a scheme has the potential to have a profound effect on future indemnity costs of members.

In its submission MIPS notes:
- any initiatives need to be considered carefully to ensure they do not cause or help cause another indemnity crisis
- assessment and access to any scheme needs to be objective, impartial and transparent to ensure fairness and equity
- access to benefits should be timely to ensure the best possible outcome i.e. while there is the greatest opportunity to mitigate the ultimate level of disablement and minimise distress
- in general terms the adversarial process for finding of fault (negligence) is the current ‘trigger’ for access to care and support funding in relation to healthcare incidents
- as well as the financial and time costs of that adversarial process there are very significant emotional costs
- health care practitioners must fund the costs of representation in the various fora (registration and complaints bodies, courts etc) and compensation through the health services they provide.
- all else being equal a higher percentage of that funding is likely to be borne by those who are more frequent users of health services (old, young and sick).
- Improvement in the efficiency and effectiveness of current sources of funding of care and support is required so as to not adversely impact on the costs of providing healthcare.
- we believe that funding of compensation in relation to healthcare events is less efficient than it could be due to:
  - the adversarial nature of the process for determining fair compensation resulting in the majority of funds being expended in process and other parties not compensation of the patient
  - the means of funding those costs and that there is considerable scope within existing funding if more efficient processes for determining access to resources and for funding of those are implemented.

MIPS recommendations include:
- further information and engagement in relation to any proposals
- entry to any disability long-term care and support scheme needs to have clear and timely triggers and not reliant on a presumption/finding of negligence
- Future care and medical costs relating to significant adverse medical events should be funded 100% by the Commonwealth noting:
  - There could be significant savings from both the current High Cost Claims Scheme from process savings and also from a flow-on reduction to the Premium Support Scheme (because of reductions in amount otherwise required to be charged of practitioners because of the reduced liability required to be funded)
- The Commonwealth already contributes significantly to funding such costs either indirectly through Medicare, State funding including intention to take over responsibility for public hospitals or directly through social security (pensions, carer/s allowances etc) for gaps or totally non-compensable matters.
- introduction of a scheme that does not require a presumption/finding of negligence in healthcare, noting;
  - a number of fora, outside of courts, are available to consider issues and concerns arising from the provision of health care
  - that the availability of such fora means that there is negligible risk to the community in introducing such a scheme
- any initiatives should not undo the hard work of tort reform by inadvertently helping to create a new indemnity crisis.

**Dr Troy Browning**
Managing Director, MIPS

**Letters to the editor…**
Recently:
- eligible nurse practitioners and midwives have been provided access to specific items in the Medicare Benefits Schedule (MBS)
- authorised nurse practitioners and midwives have been provided access to items under the PBS.
- where providing health services under a collaborative arrangement. MIPS is interested to hear member’s views. That is – what does a collaborative arrangement actually means to you… your practice… and your patients?

Write to MiPs care of the editor at info@mips.com.au
Hazard Warning: The risk of antiseptic contamination of neuraxial blocks

Two recent reports of major neurological injury (e.g. paraplegia, hydrocephalus) following neuraxial block have highlighted the danger of having containers of antiseptic solutions anywhere near the epidural/spinal needles, syringes or catheters used for such procedures. In both cases patients appear to have developed adhesive arachnoiditis following chemical contamination.

In the Australian case (still sub-judice) was fairly clear-cut in that the patient suffered an accidental injection of not more than 8ml of 70% alcohol and 2% chlorhexidine into the epidural space. The UK case followed a spinal block with hyperbaric bupivacaine¹. Both iodine and chlorhexidine were used for skin cleansing for this patient. The skin prep had been poured “into preformed wells in a tray on the sterile field”. The UK High Court judgment concluded that “contamination... permitted liquid to liquid contact, the injectate was contaminated and... damage (was) sustained as a result.”

To avoid any further unnecessary tragedies, or even the suspicion of contamination by such agents, it appears essential to immediately eliminate the presence of any containers of antiseptic from the sterile field. This can be achieved by either using antiseptic sprays or pre-packaged swab-sticks, by treating skin ‘prep’ as a separate procedure to the block injection or by confining antiseptic solutions to a separate surface and by removing them from the field after skin cleansing.

C.B. Collier
S.P. Gatt


MIPS Risk Workshop Program – New and Improved

Over recent years several thousand MIPS members have attended free risk management workshops for medical practitioners provided on behalf of MIPS by the Cognitive Institute.

The Spring 2010 program is improved with two additional workshops topics from the Cognitive Institute titled, Mastering Work Life Balance and Healing at the End of Life. Additionally, the program has been expanded. (Members entitled to attend would have received those details in the invitations sent over the past few weeks.)

In addition, Health Legal has been commissioned to present, along with MIPS clinical consultants, two workshop topics specifically for MIPS general practitioner members.

MIPS has also developed a workshop for Internationally Trained Members, to help address the extra risks that may be faced by those members who qualified and trained overseas and have subsequently come to Australia to practice.

Finally, a Hot Topics workshop has been introduced as a general update on issues relevant to the medical indemnity industry and your practice.

The range of MIPS workshop options can be seen at www.mips.com.au/workshop.htm where an online booking facility is available. Please note that limited registrations will be available for the workshops in some locations.

Attendance will not only develop your skills in identifying risks and implementing risk management strategies, but you can also earn CPD points.

A workshop tailored specifically to meet the needs of our dental members will be provided in the 2011 Autumn workshop program. The provision of additional risk management resources for rural and remote members is under active consideration and likely to be in place early in the 2011.

Would you like to be a MIPS presenter?

MIPS is currently seeking additional medical and dental practitioner presenters in (but not limited to) the Brisbane, Townsville and Melbourne regions. Should you be interested in exploring and discussing this opportunity further with MIPS please email your details to dgllagher@mips.com.au

TWO EXTRA RISK MANAGEMENT WORKSHOPS – REGISTER NOW

Due to the overwhelming interest in our current risk management program, we are offering two extra workshops before the end of 2010:

Mastering Difficult Patient Interactions
Location: Rydges on Swanston, Carlton
Date: Tuesday, 30 November, 2010
Time: 7:00pm – 10:30pm

Mastering Your Risk Workshop
Location: Vibe Hotel, Sydney
Date: Saturday, 11 December 2010
Time: 1:00pm – 4:00pm

If you are interested in attending, be sure to register at www.mips.com.au and follow the prompts from the home page.
International Medical Graduates

Case studies and a guide to resources

International graduates are an essential element of the medical workforce especially in rural areas and hospitals. Orientation and integration into the health system and can be quite a challenge. Some Australian culture and values differ, and professionally there may be different ethical and medico legal models of practice as well as additional quality and competence requirements. Potentially this equates to additional risk management challenges and exposures for IMGs.

Case study

In 1992, Dr K relocated to Australia from Bangladesh with his wife and child, to reunite with family settled here. A qualified general practitioner in his country, he spent 2 years completing tertiary and further education (TAFE) courses in English. In 1995, after passing the necessary English tests, he attempted the Australian Medical Council written exam, but was unsuccessful. Further efforts to repeat the tests were unsuccessful. He remained in the medical workforce by taking odd jobs and voluntary positions. He enrolled in numerous bridging courses, finally passing the written exam in 2000 and the clinical exam in 2004. He then enrolled in a 3 year GP training program, eventually passing the RACGP fellowship in 2008. The complete process to fellowship took Dr K 16 years. The registration and accreditation process can be extremely daunting. Early investigation and thorough research will help ease some of the difficulties you might face. Be aware of all requirements and should you encounter some difficulties do not give up hope and try to get some support and assistance from your peers, colleagues or your medical defence organisation. There are also a number of internet resources available to explain the registration and accreditation processes in Australia. Visit www.mips.com.au for a complete list of these.

Resources

Some invaluable web resources include:

- **AHPRA** – registration and accreditation www.ahpra.gov.au
- **AHPRA** – portal for IMGs. Go to National Boards, Medical, click on IMG
- **Medicare** training modules www.medicareaustralia.com/MedicareandYou
  Go to “For Health professionals, go to on line education service. Modules for both the MBS and PBS.
- **Federal Government Department of Immigration** and citizen website www.immi.gov.au
- **Doctor Connect** – work in rural & remote areas www.doctorconnect.gov.au
- **Australian Medical Council** – IMG portal www.amc.org.au
- **Australian Doctors Trained Overseas Association** www.adtoa.org.au
- **Rural Health Workforce Association** www.rhwa.org.au
- **Australian Code of Conduct for doctors** www.goodmedicalpractice.org.au
- **RACGP** Frequently Asked Questions for IMGs www.racgp.org.au

Remember MIPS 24/7 medico legal support Freecall 1800 021 233
Humanitarian trip to Kenya July 2010

Dr Debbie Leong

On the 24 July 2010 dentist Debbie Leong arrived safely home to Brisbane after a humanitarian trip to the slums and orphanage in the highlands of Nyahururu, Kenya. Debbie was accompanied by her dental assistant, Ann Wordford, her oral health therapist, Michelle Burnett and her practice manager, Michael Leong. The following is her account of that experience.

Carrying over 40kgs of dental supplies including dental anaesthetics the team took 24 hours to reach Nairobi and then another four hours along a harrowing pot-holed road before finally reaching our destination. Nyahururu 2,400 feet above sea level is higher than Mt. Kosciusko and altitude sickness is a common problem. Nyahururu is also the birthplace of many world marathon runners! ‘The Heroes of the Nation’ orphanage is home to 530 children and has a staff of 60. Many of the children are there as a result of the AIDS epidemic, tribal wars, accidents and diseases. Together with the help of two Brisbane dentists and two Kenyan dentists, we were able to undertake examinations of all the children and the staff and create dental charts after each examination. Those with immediate dental problems were treated with antibiotics; other procedures performed included extractions and ART (atraumatic restorative treatment) with dental fillings. The latter was specifically designed for the third world by the World Health Organisation. We distributed toothbrushes to every orphan and conducted comprehensive dental health education programmes in every classroom. All equipment and remaining supplies were left behind to aid in the overall dental programme and to assist any future dentists visiting the region.

While at the orphanage we felt humbled by the bright, healthy smiles and happy dispositions of the children despite the trials that life has put them through. Ann Woodford’s torchbearer Bernard was only 12 when he started looking after his three younger siblings following the loss of his mother and sister to HIV. He tilled the ground for his neighbour and the money he received was used to buy corn flour, their only meal of the day. It was three years before he came to the orphanage.

From the orphanage, we ventured to the village of Nyahururu, the slums on Maina, the district health clinic of Ngarua and the slums of Rumuruti. We set up makeshift dental clinics offering free emergency dental services in these regions. An astonishing 20,000 people live in the slums of Maina with no running water, electricity or sewage. They have ‘flying toilets’ (faeces and urine collected in plastic bags is flung on to the roofs in the slums!) The slum dwellers pay rent to live there. At Rumuruti, we were introduced to the nomadic Samburu tribesmen who live in mud huts. Some still wear their traditional colourful garments and neck brace. We witnessed the slaughter of a cow prior to a wedding and participated in a traditional African wedding ceremony.

Our makeshift dental operating tables were sometimes low student desks making our work literally back-breaking. The conditions were far from ideal with no running water or electricity in most places. We worked by torchlight and disinfected our instruments chemically. Due to the never-ending queues of patients we worked through the day, only stopping for water and biscuits. We carried anti-viral drugs in case of an event of a needle-stick injury with a HIV infected needle - HIV is rampant in the slums.

In total, we examined over a thousand patients, extracted over 600 teeth, gave away hundreds of boxes of antibiotics and over a thousand toothbrushes.

The countless happy, grateful, pain-free Kenyan smiles we received in return made everything worthwhile!
Most Australians would know something of the Mutiny on the Bounty – probably the most famous mutiny in history. On the 28th of April, 1789, Fletcher Christian and fellow mutineers seized control of the HMS Bounty and put Captain Bligh and 18 loyalists into a boat 23 feet long, three feet deep and seven feet wide. The boat was so crowded that the water came to within seven inches of the gunwale. In a feat of almost unbelievable seamanship, the iron-willed Bligh took his tiny boat over 5000 km through uncharted seas to reach Timor in 41 days, losing only 1 man to hostile natives in Tofua.

Meanwhile, the Bounty headed back to Tahiti where a group consisting of 9 Englishmen, 6 Tahitian men and 15 Tahitian women then set sail to find a sanctuary to escape the retribution of the British Navy. The Englishmen who stayed in Tahiti were subsequently captured by the HMS Pandora, but the fate of the Bounty remained a mystery for 3 decades.

I can tell you exactly where it is – about 200 metres east of my house here on Pitcairn Island. When the mutineers found that Pitcairn Island had been incorrectly plotted on the admiralty charts, they calculated that the chances of being discovered were minimal. They removed everything of value and burned the ship in “Bounty Bay”. My wife and I walk down the hill everyday to Bounty Bay and back. The tall imposing hill overlooking the bay was called “Ship Landing Point”. From the bedroom of my house I look directly to “Christian’s Cave”, which is where Fletcher spent countless hours scanning the horizon keeping watch for British ships.

After spending the last 26 years doctoring, mainly in the rural Queensland town of Goondiwindi, I decided to do a sabbatical year and was attracted to the advertisement that I saw for Pitcairn Island. It is 7500 km east of Australia in the middle of the South Pacific Ocean. There is no runway and access is only by sea. It is a British Overseas Territory with a population of 55! Amazingly, there is a British Diplomat on the island. The medical clinic is open for 3 hours each Sunday, Tuesday and Thursday – I’m on call the rest of the time.

My duties include anything vaguely biological – in addition to my general practice work I look after all dentistry, veterinary work, pharmacy and X-rays. I not only interpret the X-Rays, I also develop the films.

Recently a tourist suffered life-threatening injuries after a 150 ft fall down a cliff. I admitted him to my little clinic, inserted IV lines, applied splints, gave IV fluids, gave IV antibiotics, gave analgesia, inserted an IDC, and took X-Rays. The Pitcairn Islanders have a system where they roster all the islanders for shifts overnight in these situations. Under my supervision they cared for him for 48 hours – so every islander was sleep deprived for two nights. Eventually, I was able to talk with the Captain of a French Warship “La Railleuse” and arrangements were made for the patient to be transferred in rough seas from a longboat onto the “La Railleuse” onward to Mangareva in French Polynesia and then by air to Tahiti for a series of operations.

The island is spectacularly scenic. There is still evidence of the Polynesian sailors who came here to mine the unique rock a thousand years ago. As they used the stars to navigate, there are charts carved into rock walls giving navigational instructions to Easter Island and islands in French Polynesia.

My wife Julie and I get around on a quad bike. Mostly the roads are dirt, with a short straight patch of cement in the centre of the town, Adamstown. The Pitcairn Islanders are extremely friendly and include us in all the social activities. It truly is a unique privilege to become part of their lives and live in such beautiful surroundings. The food is fresh and delicious – everyone has gardens and the rich volcanic soil combined with the temperate climate means that virtually anything grows here. The ocean around the island is teeming with fish and lobsters. I’ve never been much of a fisherman, but even I can easily score a decent catch.

In Goondiwindi I estimate that I've performed over 200,000 consultations in my general practice. I’ve been involved with 150 deliveries per year for over 20 years and done probably an average of 20 Caesareans a year during that time. I’ve had lots of experience with Emergency Medicine and performed many anaesthetics. It’s been a great experience to come to a small island and use my skills and knowledge to help some of the most isolated people in the world. The sheer beauty of Pitcairn Island and the amazing history are simply insurmountable and we are so happy we got to be part of this experience.
Congratulations

Dr Paul Abbott of Queensland was the winner at Dentechno.

Jannine De Veau from Lithgow NSW was the winner of the Dell mini laptop at the MIPS stand at GP10.

Dr Geoff Spurling – winner of Dell mini laptop at GPET 2010.

Dr Paul Abbott of Queensland was the winner at Dentechno.

MIPS is continually working to enhance the benefits we provide to members.

Please visit mips.com.au/memberbenefits to view the benefits currently available to you as a MIPS member!

New e-book resource for members

At the AGPN conference in Perth in early November, the innovative MIPS/GPRA/GPSN e-book was launched to great acclaim. The book is a most useful and innovative tool that we believe will prove invaluable for students and junior doctors during their GP and hospital rotations. MIPS has been involved from the e-book’s inception. MIPS Members can find the e-book at www.mips.com.au/memberbenefits.

Erich Janssen, CEO GPET, Dr Chris Mitchell, Immediate Past President RACGP, MR Amit Vohra – CEO GPRA, Dr Rob Walters, GP and Medico-legal Advisor MIPS
## MIPS Risk Management Workshop Schedule

**September – November 2010**

### VICTORIA

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider</th>
<th>Topic</th>
<th>Date</th>
<th>Location</th>
<th>Time</th>
<th>Venue</th>
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<tbody>
<tr>
<td>HL1</td>
<td>Health Legal/ MIPS</td>
<td>Documentation: the importance of keeping good notes</td>
<td>Tuesday 5 October</td>
<td>St Kilda Road</td>
<td>7.00 pm – 9.00 pm</td>
<td>Health Legal Office, Level 12, 484 St Kilda Road Melbourne 8004</td>
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<tr>
<td>MP1</td>
<td>MIPS</td>
<td>Internationally Trained Member Workshop</td>
<td>Tuesday 12 October</td>
<td>Box Hill</td>
<td>7.00 pm – 9.00 pm</td>
<td>Tudor Box Hill Edward Room 101 Whitehorse Road Box Hill 3128</td>
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<tr>
<td>HL2</td>
<td>Health Legal/ MIPS</td>
<td>Consent and Informed Decision Making</td>
<td>Wednesday 20 October</td>
<td>St Kilda Road</td>
<td>7.00 pm – 9.00 pm</td>
<td>Health Legal Office, Level 12, 484 St Kilda Road, Melbourne 8004</td>
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<tr>
<td>4128</td>
<td>Cognitive Institute</td>
<td>Mastering Your Risk</td>
<td>Saturday 23 October</td>
<td>Carlton</td>
<td>9.00 am – 11.30 am</td>
<td>Rydges on Swanston, Argyle Room 701 Swanston Street, Carlton 3053</td>
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<tr>
<td>4129</td>
<td>Cognitive Institute</td>
<td>Mastering Difficult Patient Interactions</td>
<td>Saturday 23 October</td>
<td>Carlton</td>
<td>1.00 pm – 4.30 pm</td>
<td>Rydges on Swanston, Argyle Room 701 Swanston Street, Carlton 3053</td>
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<tr>
<td>MP2</td>
<td>MIPS</td>
<td>MIPS: Hot Topics</td>
<td>Wednesday 10 November</td>
<td>Richmond</td>
<td>7.00 pm – 9.00 pm</td>
<td>Amora Hotel Riverwalk, Hawthorn Room 649 Bridge Road, Richmond 3121</td>
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<tr>
<td>4135</td>
<td>Cognitive Institute</td>
<td>Mastering Shared Decision Making</td>
<td>Saturday 20 November</td>
<td>Carlton</td>
<td>9.00 am – 12.00 pm</td>
<td>Rydges on Swanston, Argyle Room 701 Swanston Street, Carlton 3053</td>
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<tr>
<td>4136</td>
<td>Cognitive Institute</td>
<td>Mastering Work Life Balance</td>
<td>Saturday 20 November</td>
<td>Carlton</td>
<td>1.00 pm – 4.00 pm</td>
<td>Rydges on Swanston, Argyle Room 701 Swanston Street, Carlton 3053</td>
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<tr>
<td>4139</td>
<td>Cognitive Institute</td>
<td>Healing At the End of Life</td>
<td>Wednesday 24 November</td>
<td>Dandenong</td>
<td>6.30 pm – 9.30 pm</td>
<td>Chiefly Doveton Hotel Monash Room, cnr Princes Hwy &amp; Doveton Ave, Dandenong 3177</td>
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<tr>
<td>4103</td>
<td>Cognitive Institute</td>
<td>Mastering Difficult Patient Interactions</td>
<td>Tuesday 30 November</td>
<td>Carlton</td>
<td>7.00 pm – 10.30 pm</td>
<td>Rydges on Swanston, Argyle Room, 701 Swanston Street, Carlton 3053</td>
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### NEW SOUTH WALES / ACT

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<th>Provider</th>
<th>Topic</th>
<th>Date</th>
<th>Location</th>
<th>Time</th>
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<tr>
<td>4127</td>
<td>Cognitive Institute</td>
<td>Mastering Difficult Patient Interactions</td>
<td>Saturday 18 September</td>
<td>Parramatta</td>
<td>11.00 am – 2.30 pm</td>
<td>Crowne Plaza Parramatta, Marsden Room 30 Philip Street, Parramatta 2150</td>
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<tr>
<td>MP3</td>
<td>MIPS</td>
<td>Internationally Trained Member Workshop</td>
<td>Tuesday 21 September</td>
<td>Chatswood</td>
<td>7.00 pm – 9.00 pm</td>
<td>The Sebel Residence, Chatswood 1 37 Victor Street, Chatswood 2067</td>
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<td>MP4</td>
<td>MIPS</td>
<td>MIPS: Hot Topics</td>
<td>Wednesday 13 October</td>
<td>Sydney CBD</td>
<td>7.00 pm – 9.00 pm</td>
<td>Norton Rose Australia, Level 1B, Grosvenor Place 225 George Street, Sydney 2000</td>
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<td>Health Legal/ MIPS</td>
<td>Documentation: the importance of keeping good notes</td>
<td>Tuesday 19 October</td>
<td>Sydney CBD</td>
<td>7.00 pm – 9.00 pm</td>
<td>Vibe Hotel Sydney, Inner Space – 1st Floor 11 Goulburn Street, Sydney 2000</td>
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<tr>
<td>HL4</td>
<td>Health Legal/ MIPS</td>
<td>Consent and Informed Decision Making</td>
<td>Tuesday 26 October</td>
<td>Parramatta</td>
<td>7.00 pm – 9.00 pm</td>
<td>Crowne Plaza Parramatta, Marsden Room 30 Philip Street, Parramatta 2150</td>
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<tr>
<td>4130</td>
<td>Cognitive Institute</td>
<td>Mastering Your Risk</td>
<td>Saturday 6 November</td>
<td>Sydney CBD</td>
<td>9.00 am – 11.30 am</td>
<td>Vibe Hotel Sydney, Inner Space – 1st Floor 11 Goulburn Street Sydney 2000</td>
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<td>4131</td>
<td>Cognitive Institute</td>
<td>Mastering Shared Decision Making</td>
<td>Saturday 6 November</td>
<td>Sydney CBD</td>
<td>1.00 pm – 4.00 pm</td>
<td>Vibe Hotel Sydney, Inner Space – 1st Floor 11 Goulburn Street Sydney 2000</td>
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<tr>
<td>4134</td>
<td>Cognitive Institute</td>
<td>Healing At the End of Life</td>
<td>Wednesday 17 November</td>
<td>Chatswood</td>
<td>6.30 pm – 9.30 pm</td>
<td>The Sebel Residence, Chatswood 1 37 Victor Street Chatswood 2067</td>
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<tr>
<td>4138</td>
<td>Cognitive Institute</td>
<td>Mastering Work Life Balance</td>
<td>Tuesday 23 November</td>
<td>Canberra/ACT</td>
<td>6.30 pm – 9.30 pm</td>
<td>Crowne Plaza Canberra, The Glebe Room 1 Binara Street, Canberra 2601</td>
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<td>4204</td>
<td>Cognitive Institute</td>
<td>Mastering Your Risk</td>
<td>Saturday 12 December</td>
<td>Sydney CBD</td>
<td>1.00 pm – 4.00 pm</td>
<td>Vibe Hotel Sydney, Inner Space – 1st Floor 11 Goulburn Street, Sydney 2000</td>
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### QUEENSLAND

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<td>MPS</td>
<td>MIPS</td>
<td>Internationally Trained Member Workshop</td>
<td>Tuesday 26 October</td>
<td>Herston</td>
<td>7.00 pm – 9.00 pm</td>
<td>Victoria Park Function Centre, Quartz Room Herston Road, Herston 4006</td>
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<td>Wednesday 3 November</td>
<td>Herston</td>
<td>7.00 pm – 9.00 pm</td>
<td>Victoria Park Function Centre, Quartz Room Herston Road, Herston 4006</td>
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<td>MP6</td>
<td>MIPS</td>
<td>MIPS: Hot Topics</td>
<td>Tuesday 9 November</td>
<td>Herston</td>
<td>7.00 pm – 9.00 pm</td>
<td>Victoria Park Function Centre, Quartz Room Herston Road, Herston 4006</td>
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<td>4133</td>
<td>Cognitive Institute</td>
<td>Mastering Your Risk</td>
<td>Saturday 13 November</td>
<td>Cairns</td>
<td>2.00 pm – 4.30 pm</td>
<td>Rydges Trade Winds, Trinity Room 137 The Esplanade, Cairns 4870</td>
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<td>4137</td>
<td>Cognitive Institute</td>
<td>Mastering Work Life Balance</td>
<td>Saturday 20 November</td>
<td>Herston</td>
<td>3.00 pm – 6.00 pm</td>
<td>Victoria Park Function Centre, Marble Bar Herston Road, Herston 4006</td>
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### TASMANIA

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<td>4132</td>
<td>Cognitive Institute</td>
<td>Mastering Adverse Outcomes</td>
<td>Wednesday 10 November</td>
<td>Hobart</td>
<td>6.30 pm – 9.30 pm</td>
<td>Hobart Conference &amp; Function Centre, Marina Room, 1 Elizabeth Street Pier Hobart 7000</td>
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<td>HL6</td>
<td>Health Legal/ MIPS</td>
<td>Documentation: the importance of keeping good notes</td>
<td>Thursday 25 November</td>
<td>Launceston</td>
<td>7.00 pm – 9.00 pm</td>
<td>Hotel Grand Chancellor, Chancellor 4 &amp; 5 Room 29 Cameron Street, Launceston 7250</td>
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### CANCELLATION POLICY:
If, after registering for a workshop you are unable to attend, please notify MIPS of your cancellation at least 5 working days before the workshop, so that another member will have the opportunity to attend.
**Breast cancer**

**Recommendation:** Good evidence for population based screening.

**Method and frequency of screening**

Mammography every two years is recommended for average risk women aged 50-69.

| OR | two or more second-degree relatives on the same side of the family, diagnosed with breast cancer
| OR | one second-degree relative on the same side of the family with a history of breast cancer before the age of 45 or younger

**References**

- National Breast and Ovarian Cancer Centre
- Department of Health and Ageing – National screening programs

**Government programs**

BreastScreen Australia aims to reduce mortality and morbidity from breast cancer by actively recruiting and screening women aged 50-69 years for a free mammogram.

**Cervical cancer**

**Recommendation:** Good evidence for population based screening.

**Method and frequency of screening**

Cervical smear (Pap test) every two years

**Who should be screened?**

All women who have ever been sexually active should commence having Pap tests between the ages of 18 to 20 years, or one to two years after commencing sexual activity, whichever is later. In some cases, it may be appropriate to start screening before 18 years of age.

**Who could benefit from Pap tests?**

- Women with a family history of cervical cancer.
- Women with a personal history of cervical cancer.
- Women who have been treated for sexual transmitted infections.
- Women who have had an abnormal Pap test result in the past.

**Bowel (colorectal) cancer**

**Recommendation:** Good evidence for population based screening.

**Method and frequency of screening**

Faecal Occult Blood Screening (FOBT) at least every two years for average risk people aged over 50.

**Who should be screened?**

For people of average risk (98% of the population), two-yearly screening should occur from the age of 50. In addition, it is acceptable to offer flexible sigmoidoscopy every five years.

**Who could benefit from FOBT?**

- Women with a personal or family history of bowel cancer.
- Women with a family history of FAP.

**References**

- Department of Health and Ageing – National screening programs
- Cancer Council Australia

This resource was published in October 2009. The recommendations stated here were correct at time of printing, however may be subject to review.
Melanoma

Recommendation: Insufficient evidence for population based screening.

Method and frequency of screening

Regular whole body visual examination of the skin by a medical practitioner, or by self has been suggested but there is no conclusive evidence that such examinations are effective in reducing mortality.

Who should be screened?

There is low grade evidence that individuals at high risk of melanoma could benefit from education to recognise and document lesions suspicious of melanoma, and to be regularly checked by a clinician with six-monthly full body examination supported by total body photography and dermoscopy as required. High risk individuals are not well defined but may include combinations of the following factors: age and sex; history of previous melanoma or non-melanoma skin cancer; family history of melanoma, including age of onset and multiplicity of any melanoma cases; the number of common melanocytic naevi; number of atypical naevi; skin and hair pigmentation type and response to sun exposure; and evidence of actinic skin damage.

Individuals with known inherited mutations in the genes encoded by the CDKN2A locus, p16INK4A and p14ARF have an increased melanoma risk, especially in the context of a family history of melanoma. Screening for a mutation in the CDKN2A gene be contemplated only after a thorough clinical risk assessment by a familial cancer or melanoma clinic.

References:

Clinical practice guidelines for the management of melanoma in Australia and New Zealand
www.cancer.org.au/clinicalguidelines

Melanoma: A aide memoire to assist diagnosis
www.cancer.org.au/clinicalguidelines

Ovarian cancer

Recommendation: Insufficient evidence for population based screening.

Method of screening

Ultrasound (abdominal, transvaginal, Doppler) and serum CA125 have been suggested, however none of these have the sensitivity or specificity to be recommended as a screening test.

Who should be screened?

Screening is not recommended for women at average risk (99% of the population).

Women at potentially high risk of ovarian cancer and perhaps other cancers comprise 1% of the population and should be referred to a familial cancer clinic for assessment and management. This group comprises women with the following:

- One first-degree relative diagnosed with epithelial ovarian cancer in a family of Ashkenazi Jewish ancestry; OR
- Two first or second-degree relatives on the same side of the family diagnosed with breast or ovarian cancer, especially if one or more of the following features occurs on the same side of the family:
  - breast cancer diagnosed before the age of 40;
  - bilateral breast cancer;
  - breast and ovarian cancer in the same woman;
  - breast cancer in a male relative; OR
- Three or more first or second-degree relatives on the same side of the family diagnosed with any of the cancers associated with hereditary non-polyposis colorectal cancer (HNPCC): colorectal cancer (particularly if diagnosed before the age of 50), endometrial cancer, ovarian cancer, gastric cancer, and cancers involving the renal tract; OR
- A member of a family in which the presence of a high risk ovarian cancer mutation in a gene such as BRCA1, BRCA2 or one of the DNA mismatch repair genes, has been demonstrated.

References:

Clinical practice guidelines for the management of women with epithelial ovarian cancer
www.cancer.org.au/clinicalguidelines

Assessment of symptoms that may be ovarian cancer: A guide for GPs
www.cancer.org.au/clinicalguidelines

Prostate cancer

Recommendation: Insufficient evidence for population based screening.

Men should be informed about prostate cancer and the pros and cons of testing and from this make an individual decision based on their personal preferences and individual risk factors.

Method and frequency of screening

Digital Rectal Examination (DRE) and Serum Prostate Specific Antigen (PSA) are used as screening tests, although the accuracy of these tests is not high. The likelihood that a man has prostate cancer if his PSA is above 4ng/ml is about 30% (positive predictive value). For every 100 men who actually have prostate cancer, between 10 and 30 will have a PSA below 4ng/ml.

Who should be screened?

The issue of population screening for prostate cancer remains controversial, as current evidence suggests the harms associated with screening outweigh the benefits. Cancer Council Australia’s position is that in the absence of direct evidence showing a clear benefit of population based screening for prostate cancer, a patient centred approach for individual decisions about testing is recommended. Ideally this takes the form of an informed, shared, decision-making process between the doctor and man, discussing the benefits, risks and uncertainties of testing, and discussion about treatment options and side effects. Screening discussions and decisions should always include and take into account, age and other individual risk factors such as a family history of the disease.

References:

Cancer Council Australia position statement on prostate screening
www.cancer.org.au/positionstatements

Andrology Australia position statement on prostate screening
http://www.andrologyaustralia.org/docs/Andrology_Australia_PSAPosition_webversion_140909.pdf

Early detection of prostate cancer in general practice: supporting patient choice - GP Patient showcard
www.cancer.org.au/HealthProfessionalSS/PrimaryCareResources.htm

Testicular cancer

Recommendation: Insufficient evidence for population based screening.

Method and frequency of screening

Regular palpation of the testicles by self or physician is suggested but there is no evidence that this will decrease mortality.

Who should be screened?

No evidence exists on which to base a recommendation for or against screening for testicular cancer.

Males with undescended testicles, gonadal dysgenesis, Klinefelter’s syndrome, father or identical twin with testicular cancer, or a history of testicular cancer in the contralateral testes are at increased risk.

References:

Cancer Council Australia position statement on testicular cancer
www.cancer.org.au/positionstatements

Western Australian Clinical Oncology Group

This resource was published in October 2009. The recommendations stated here were correct at time of printing, however may be subject to review.
## CPD Points for Risk Management Workshops

All participants who complete a Proof of Attendance at the workshop will receive a certificate detailing the duration of the event, and CPD Accreditation points where applicable.

### Cognitive Institute - Mastering Adverse Outcomes – 3 hours

<table>
<thead>
<tr>
<th>College/Institute</th>
<th>CPD Points</th>
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<tbody>
<tr>
<td>Australian and New Zealand College of Anaesthetists</td>
<td>6 Points – Category 3, Level 1</td>
</tr>
<tr>
<td>Australasian College for Emergency Medicine</td>
<td>1.5 MOPS Points</td>
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<tr>
<td>Australian College of Rural and Remote Medicine</td>
<td>3 PDP Core points</td>
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<tr>
<td>Royal Australasian College of Surgeons</td>
<td>3 Points – Category 7</td>
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<tr>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
<td>3 PR &amp; CRM Points</td>
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<tr>
<td>Royal Australian College of General Practitioners</td>
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<tr>
<td>Royal Australian and New Zealand College of Ophthalmologists</td>
<td>3 Points</td>
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### Cognitive Institute - Mastering Your Risk – 2.5 hours

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<tr>
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<tr>
<td>Australasian College for Emergency Medicine</td>
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<tr>
<td>Royal Australian and New Zealand College of Obstetricians and Gynaecologists</td>
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<td>Royal Australian and New Zealand College of Ophthalmologists</td>
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### Cognitive Institute - Mastering Shared Decision Making – 3 hours

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### Cognitive Institute - Mastering Difficult Patient Interactions – 3.5 hours

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<tr>
<td>Australian and New Zealand College of Anaesthetists</td>
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<td>Royal Australian College of General Practitioners</td>
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### Cognitive Institute - Mastering Work/Life Balance – 3 hours

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<tbody>
<tr>
<td>Australian and New Zealand College of Anaesthetists</td>
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### Cognitive Institute - Healing at the End of Life – 3 hours

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<tr>
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### Health Legal Solicitors - 2 hours

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<tr>
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### MIPS – Hot Topics & Internationally Trained Member Workshop – 2 hours

<table>
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<tr>
<th>Suitable for all members</th>
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<tbody>
<tr>
<td>Points may be claimed through self directed learning</td>
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Royal Australasian College of Medical Administrators
Royal College of Pathologists of Australasia
Australasian College of Dermatologists
Royal Australian College of Physicians
Royal Australian and New Zealand College of Psychiatrists

Fellows of these colleges (and fellows/members of any college or other professional body not listed above) may apply at the workshop for a certificate that will specify the duration of education undertaken and/or assist them to individually claim CPD credit with their college or other professional body.

Current at August 2010
MIPS membership

24 hours a day, 7 days a week providing members with...

Protection!
Support!
Advice!