

Autumn 2009

MIPS review



National registration and accreditation scheme

The proposed scheme is intended to provide a single registration and accreditation framework for all health professionals. Read more on page 2.

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MIPS

From the CEO's desk



MIPS is regularly involved in activities which are aimed at supporting member interests.

This is in line with its Constitution which states that MIPS seeks to “support and protect the character and interests of members and to consider, originate, promote, support or oppose legislative or other measures affecting members”.

Two areas, where MIPS are involved in ensuring that member interests are considered relate to the proposed National Registration and Accreditation Scheme and the MIPS proposed extension of the Run Off Cover Scheme.

A brief overview of these issues is provided for your information on pages 2 and 8.

MIPS members are invited to send in their written views and commentary on these matters.

Dr Troy Browning
Chief Executive Officer, MIPS

National registration and accreditation scheme

The objective of the proposed national registration and accreditation scheme is to provide a single registration and accreditation framework for all health professionals.

MIPS has submitted that the regulatory framework must effectively protect consumers of health services but must not be designed or interpreted as a mechanism for punishing health service providers.

One of the major areas of concern for health professionals arising from the proposals is that of mandatory reporting of practitioners whose capacity to practice is thought to be adversely affected by health or competence issues.

MIPS believes any mandatory reporting must reflect the degree of risk to health care consumers.

Wide mandatory reporting requirements have potentially counter intuitive effects by increasing risk to some patients. That is because practitioners may avoid seeking medical assistance or speaking to colleagues (including participation in the processes of open disclosure/root cause analysis/morbidity and mortality meetings) because of the potential consequences to their livelihood.

Health care practitioners may also avoid contacting support organisations and insurers (which may mean an early intervention opportunity is lost and a breach of insurance policy requirements occurs). Health care practitioners may also not declare mandatory reporting matters when seeking insurance for fear that health professionals involved in insurance underwriting will be required to advise the Registration Board on such matters. That, in turn, may later result in reduction or cancellation of cover due to non-disclosure.

Wide mandatory reporting requirements may also discourage good samaritan acts, for instance at social events where alcohol may have been consumed or in emergency situations where it may be necessary for practitioners to act outside their normal field of expertise.

MIPS believes that it is important to do all that is possible to promote, encourage and “reward” practitioners who self-notify, particularly health, but also performance concerns.

To that end each State and Territory need to have in place a timely, responsive, well resourced impaired practitioners’ programme that is confidential, sensitive and supportive.

Likewise appropriate resources and support to assist in addressing performance issues need to be in place. We believe that the most beneficial approach is involvement of the professional groups college/training body with the Board to develop appropriate tailored programmes to address any particular problems.

MIPS view is that it is important that not only is there separation of investigation, prosecution and determination functions under the framework, but that it is plainly seen and reinforced. This is especially important to ensure that all stakeholders can be confident in the processes in place.

Noting that the purpose of any immediate suspension powers is to protect consumers of health services, not to punish a practitioner, MIPS recommends that an emergency order from a Tribunal be limited by time.

MIPS has also submitted that there should be no circumstances where notice of an investigation is not given.

Because the object of a Registration Board is to protect the public, not punish or ensure successful prosecution, providing notice in every situation is more likely to ensure there is a positive change in practitioner behaviour and decreased risk to patients. Non-notification will mean that the practitioner remains unaware of concerns and therefore there is the potential of further risk to consumers while a secret investigation process is undertaken.

MIPS supports clear timelines to provide transparency for stakeholders.

A short time-frame for investigations and resolution is also in keeping with an objective of moving quickly to protect patients while keeping to a minimum the financial and emotional impact to health professionals.

Applying for PSS?



Remember to complete your mandatory risk management requirement by June 30

Members who are participating in the Premium Support Scheme (PSS) for 2008/09 would be aware of the Medicare mandatory requirement to participate in a MIPS approved risk management activity within the policy year.

A MIPS approved risk management activity is attendance at one of the risk workshops (presently open for bookings on our website) or completion of one of the three online modules available any time at www.mips.com.au.

Those PSS members who have not yet participated in a workshop or completed a module need to do so by the 30 June 2009. If risk management is not completed you will be asked to repay the PSS subsidy advanced by Medicare Australia. If that subsidy is not repaid you will be prevented from participating in the PSS in subsequent years.

Completion of a MIPS approved risk management activity is necessary, make sure you remain eligible for your PSS subsidy.

www.mips.com.au/risk-education.htm

Doctors obligations: patients driving safely

Assessing fitness to drive

Members often contact MIPS with questions surrounding their obligation to deal with patients who because of age, disability or a medical condition probably should not be driving. Also asked is what protection a health professional has in the event of reporting patients to the authorities.

With 1,500 people killed, 22,000 injured and economic costs of \$15b annually, every Australian's fitness to drive is an important consideration and certain medical standards must be met. The Driver Licensing Authority (DLA) in your state or territory should be your first point of contact for specific information (Refer below for State DLA details).

Details of how to assess fitness to drive and the medical standards required for a particular medical condition are provided in an excellent resource for health professionals which can be found at <http://www.austroads.com.au/cms/AFTD%20web%20Aug%202006.pdf>

General guidelines

Below is a general overview of the guidelines involved. It is important to recognise the extent of your professional and legal obligations with respect to "fitness to drive".

All states and territories have laws about reporting health conditions that might affect a person's ability to drive safely. These laws have been created to protect public safety. Drivers are required to report to DLAs if they have a permanent or long term illness affecting driving ability. For confidentiality reasons, health professionals will not normally communicate directly with the DLA. Patients should be counselled and given relevant information for the patient to provide to the DLA.

Confidentiality and privacy are concepts well known to members.

In order to meet your obligation to public safety, the duty to maintain confidentiality is qualified in certain circumstances. In respect to assessing and reporting fitness to drive e.g. continuing to drive despite counselling, being unable to appreciate the impact of a medical condition, inability to understand or take notice of your recommendation due to impairment, any scenario which might endanger the public.

Therefore, should you make a report to your DLA in these circumstances, without your patient's consent but in good faith?

In Victoria, New South Wales, Queensland the Australian Capital Territory and Tasmania there is statutory protection from civil and criminal liability which might otherwise arise. There is mandatory reporting in these circumstances in South Australia and the Northern Territory.

Ideally, any action taken in the interests of public safety should be made with your patient's consent or at the very least they need to be informed why the information needs to be disclosed to the DLA.

These situations require careful assessment and may expose the health professional to criticism or claims. In such circumstances there is no obligation to make a recommendation however you may refer the patient to a colleague or to the DLA without recommendation.

There have been cases where allegations have been made against health professionals on the basis that their recommendation or management of the "fitness to drive" issue was inappropriate and consequent claims for resultant damage or injury resulted. In these circumstances, as the claim arises out of the provision of health care, your medical indemnity insurance would normally respond and MIPS should be contacted immediately.

If you have any concerns about these type of issues please contact MIPS medico legal advisers on 1800 021 223

DRIVER LICENSING AUTHORITY CONTACT DETAILS

ACT	www.urbanservices.act.gov.au	02 6207 7122
NSW	www.rta.nsw.gov.au	02 6640 2883
NT	www.ipe.nt.gov.au	08 8999 3111
QLD	www.transport.qld.gov.au	07 3253 4129
SA	www.transport.qld.gov.au	07 3253 4129
TAS	www.transport.tas.gov.au	03 6233 5221
VIC	www.vicroads.vic.gov.au	03 9854 2666
WA	www.dpi.wa.gov.au	08 9216 6166



Case study

Decriminalisation of abortion in Victoria

Members may be interested in the recent changes to abortion laws in Victoria, particularly as similar reforms are being explored in other states. Mr Rob Perry, Partner, Perry Maddocks Trollope Lawyers provides a critique of the Victorian Act below describing the implications for registered medical practitioners.

Prior to the inception of the Abortion Law Reform Act on 22nd October 2008, the Victorian Crimes Act prohibited unlawful abortion.

It was a criminal offence for a woman with child to intentionally procure her own miscarriage and it was likewise a criminal offence for a medical practitioner (or anyone) to supply or procure any poison, instrument or thing knowing that the same was intended to be unlawfully used or employed with the intent to procure the miscarriage of any woman.

The Menhennitt Ruling (the case of R v Davidson [1969] VR 667) defined what was meant by “unlawful” abortion in the Crimes Act. This case involved a medical practitioner charged under the Crimes Act with four counts of unlawfully using an instrument or other means with the intent to procure the miscarriage of a woman. The Menhennitt Ruling concluded that an abortion could be legal if it was both “necessary” and “proportionate”.

The term “unlawfulness” was defined as follows:

“For the use of an instrument with intent to procure a miscarriage to be lawful, the accused must have honestly believed on reasonable grounds that the act done by him was:

- a) Necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and
- b) In the circumstances not out of proportion to the danger to be averted.

The Abortion Law Reform Act 2008 now removes from debate the issue of whether the performance of a termination of pregnancy by a registered medical practitioner in any circumstances is a criminal offence.

Section 4 provides that a registered medical practitioner may perform an abortion on a woman who is not more than 24 weeks pregnant.

The Abortion Law Reform Act 2008 removes the application of Sections 65 and 66 of the Crimes Act and means that it is no longer a criminal offence for a registered medical practitioner to perform an abortion on a woman who is not more than 24 weeks pregnant.

Furthermore, it is not a criminal offence to perform a termination of pregnancy on a woman who is more than 24 weeks pregnant however in such circumstances a medical practitioner must:

- a) Reasonably believe that the abortion is appropriate in all the circumstances; and
- b) Has consulted at least one other registered medical practitioner who also reasonably believes that the abortion is appropriate in all the circumstances.

In considering whether the abortion is appropriate, a registered medical practitioner must have regard to:

- a) All the medical circumstances; and
- b) The woman’s current and future physical, psychological and social circumstances.

The Act also deals with the obligations of a registered health practitioner who has a conscientious objection to the performance of an abortion.

It provides that if a registered health practitioner has a conscientious objection to abortion he or she must:

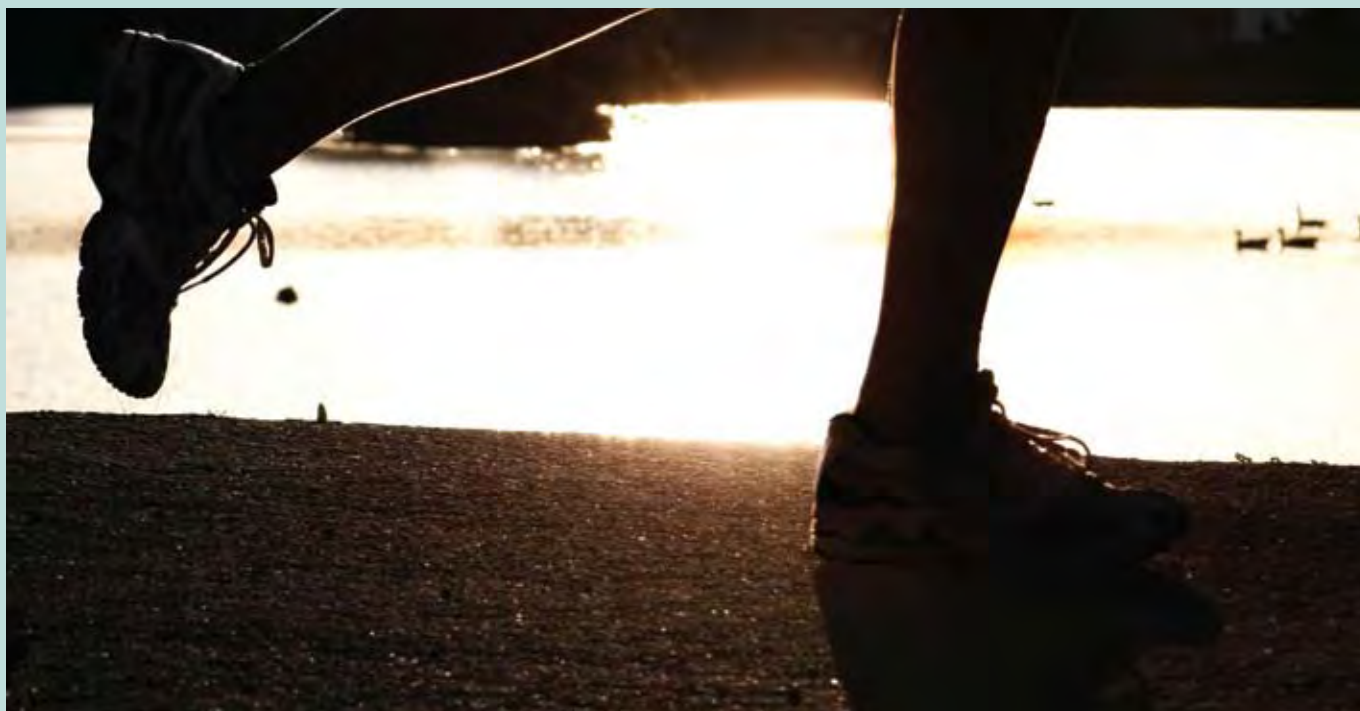
- a) inform the woman that the practitioner has a conscientious objection to abortion; and
- b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.

In addition, the Act provides that despite any conscientious objection to abortion, a medical practitioner is under a duty to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

Questions have been raised as to whether a medical practitioner who fails to follow his or her statutory duty in regard to conscientious objection might be guilty of a criminal offence. There is nothing in the legislation to suggest that this is in fact the case.

Any legal exposure arising from a failure to comply with this new legislation might involve an allegation of a failure to comply with professional standards before the Medical Practitioners’ Board of Victoria and/or a civil claim for damages by a patient.

In summary, the Abortion Law Reform Act 2008 removes any criminality in respect of any act or omission of a registered health practitioner in relation to the performance of a termination of pregnancy and in respect to the failure of a registered medical practitioner to satisfy his or her obligation pursuant to the legislation if the practitioner has a conscientious objection to the performance of an abortion



Case study:

Pulmonary embolism from achilles tendon repairs

Melchior & Ors v Dr Newman & Anor

These proceedings, against an orthopaedic surgeon and the Sydney Adventist Hospital (SAH) alleged a failure on the part of the defendants to administer an anticoagulant following an achilles tendon repair. Approximately 4 weeks post-operatively the patient suffered a pulmonary embolism and died.

The proceedings were for loss of dependency and nervous shock.

At the time the patient was admitted, he gave no relevant history nor family history of clotting disorders. At the time of the surgery, it was Dr Newman's intention for the patient to receive one pre-op dose of Clexane and post-op, one dose for every day he remained in hospital. Due to an oversight, he did not receive the pre-op dose and was discharged the day post-op, therefore not getting a post-op dose either.

The patient apparently spent a few days at home and then returned to work. He was seen approximately 2 weeks later, was recovering well, had no calf or leg pain and his sutures were removed without incident. Thirteen days after this consultation, he collapsed at home and was admitted back into SAH where he was diagnosed with a massive saddle PE and he died nearly 2 weeks later.

The case turned on the expert evidence. Five experts gave concurrent evidence and His Honour noted that there was a marked contrast in the level of experience and knowledge in the areas under discussion.

Ultimately, His Honour preferred the evidence of the defendant's doctors. They practiced regularly in the relevant field, exhibited a thorough knowledge and understanding of relevant studies and were unanimous in their views. The plaintiff's experts understanding of the literature was only gleaned in order to give evidence in the case.

The defendant's experts stated that it was not standard practice to administer Clexane after achilles tendon repairs in 2004 and there were sound reasons for that view. The patient was low risk. The use of the drug was outweighed by its risks. The duty of care owed to the patient by the surgeon did not include as part of its content, an obligation to administer Clexane.

There was a breach with regard to the pre-op dose, however the Court was not persuaded as to causation. It was found that the surgeon had acted in a manner that was widely accepted by his peers at the time.

His Honour Justice Hoeben was not satisfied that a loss of chance had been established and the claim failed.

Findings

- Lawyers did not attempt to make a finding which flew in the face of how orthopaedic surgeons use anticoagulants
- It was a matter where concurrent evidence was lead – where a number of witnesses are sworn together and give evidence as a panel rather than one after the other. This certainly flushed out the opinions of merit and gave emphasis to the use of appropriately experienced and current, practicing expert opinion

The full case is available at: http://www.austlii.edu.au/au/cases/nsw/supreme_ct/2008/1282.html

Mystery medical tool competition

Each edition of the MIPS Review features a mystery medical or dental tool that will test your knowledge. Enter for your chance to win Moët & Chandon Grand Vintage 2000 Champagne. Entries close 1 June 2009.

Entry is open to all MIPS members and will close midnight on 1st June, 2009. The first entry drawn that correctly identifies the mystery tool will win a bottle of Moët & Chandon Grand Vintage 2000 Champagne valued at \$100. If a correct answer is not received, the prize will be awarded to the most imaginative and humorous response.



If you think you know what it is, email your answer to: mysterychallenge@mips.com.au along with your full name, member number and contact phone number.

The prize will be drawn at 10.00am (EST) on 2nd June, 2009 at Level 3, 15-31 Pelham Street, Carlton Vic 3053. The winner will be notified by phone and announced in the next issue of MIPS Review.

Congratulations summer issue winner

Congratulations to Dr Chloe Stutterd of Jan Juc, Victoria for correctly guessing the mystery tool in the summer edition of MIPS Review. It was a nasal clamp



Case study

DIY wisdom tooth extraction

A 34-year-old man was to have a lower left wisdom tooth (38) extracted which resulted in him sustaining a fractured jaw. The circumstances are most unusual and worthy of further study.

The tooth was erupted and mesio-angularly impacted and needed to be removed to enable certification to be dentally fit for the Australian Army Reserve.

In this case, after explaining the treatment the patient signed a written consent advice which covered the complications possible and associated with nerve damage.

The procedure commenced with a local anaesthetic, a flap raised, buccal bone removed and the tooth luxated and initial attempts to extract it were unsuccessful. That is the end of the usual circumstances.

The dental surgeon was then temporarily called away for a few minutes to an adjacent room, leaving the patient with the dental nurse. Some time passed and the patient who became somewhat impatient wanted to try to extract the tooth himself.

The nurse who jokingly said at first "go for it", when seeing the patient grab the forceps, then strongly advised him not to do this mentioning potential complications.

Undeterred, the patient took the forceps and placed them on his tooth. The nurse offered to assist to place them but this did not work. The nurse then told him to wait until she was able to speak to the dentist.

The dentist eventually returned and the patient repeated his desire to finish the job himself, which the dentist advised him not to. The patient was determined and the dentist then decided to "assist him" by placing the forceps appropriately on the tooth. The patient then exerted a strong enough force to fracture the angle of his mandible.

Within two months, not surprisingly solicitors provided a letter of demand to the dentist.

Findings

In all the circumstances it was determined that this case was not defensible. The dentist's behaviour was quite irresponsible by effectively sanctioning the patient's actions by assisting him. Contributory negligence of the patient was argued but a significant reduction for this was not achievable. An expeditious and economic resolution to the case was planned and fortunately achieved

Case study

Dentist charged with manslaughter

A general dentist performed an in chair dental Novum implant, a procedure scheduled to take 1.5 – 3 hours. Assistance was provided by an experienced registered nurse and two dental assistants. Intravenous (IV) sedation was used and during the procedure the patient suffered a critical desaturation and died 2 days later of hypoxic (loss of blood oxygen) brain damage.



The dentist was charged with manslaughter and the criminal case was heard in the NSW District Court with judgement handed down in June 2008.

In criminal matters, the Crown must prove the accused's guilt "beyond reasonable doubt", and in the case of manslaughter, it must be "unlawful and negligent". This is different to common law civil cases where the scales simply have to be tipped slightly to the balance of probabilities.

Background

The deceased was a 67 year old, stocky male of 96kg. He had not disclosed his recent cardiac investigations and was on high daily doses of aspirin and Voltaren.

The Crown's case was principally based on allegations of: administering excessive drugs, causing the deceased to lose consciousness and his failure to respond appropriately.

The sedation regime was Midazolam (17mg in total over 55 mins) and Propofol (150mg in total). Nitrous oxide was administered through the nasal mask.

Evidence

As with any trial what is relevant is the evidence, particularly the expert medical witnesses. Specialist dentists and anaesthetists gave expert evidence and some expressed different and conflicting views about what was the appropriate medication and the adequacy of the response provided by the dentist.

It was generally accepted that the dose of Midazolam was too high and that the Propofol (usually for sedation purposes) was inappropriate in dental surgery. It was stated that even small doses lead to unconsciousness.

For dental procedures the spectrum of sedation ranges from conscious sedation (continuous rational communication), deeper sedation (respond to extreme stimulate) to unconscious sedation. Going beyond conscious sedation runs the risk of hypoxia or oxygen saturation. Where patient's oxygen saturation decreases to a level under 90% "the alarm bells should start ringing.

According to the expert evidence provided at the trial, in this type of treatment, it is important that the dentist maintain patient consciousness. There is a need to maintain rational communication with the patient and there is unlikely to be any unintended loss of consciousness. This is referred to in the Guidelines on Sedation in Dental Procedures from the ANZ College of Anaesthetists/Royal Australian College of Dental Surgeons.

The dentist had undertaken more than 680 previous sedations and employed an oximeter, which was quite rightly set to alarm at or below 90%. It sounded, he stopped the procedure, extended the head to open the airway (a chin lift) and recommenced when the sats had risen to 90% - in accordance with the above guidelines.

There were several registrations of sats below 90%- one at 63% at 9.45, which was 5 mins after the previous reading of 90%. Surgery was terminated and emergency treatment commenced, however hypoxic brain damage was sustained from which the patient later died.

Findings

In summarising the judgement, the judge found that there were errors in judgement in the sedation management but having regard to the dentist's training and what he was taught, he found that the drugs were not administered negligently. He also found that the procedure should have been terminated earlier but in the absence of specific medical training, he could not find that this was negligent. He did however reason that the dentist's response was negligent; however it was not to the degree necessary to be found guilty of manslaughter. The accused negligent conduct fell well short of that which would "amount to a crime against the State and conduct deserving of punishment"

Members should note that this is not a MIPS case study. The full judgement can be found at: www.lawlink.nsw.gov.au/d judgments/2008nswdc.nsf/849ff245542dce81ca257...26/06/2008

Proposed extension to ROCS

MIPS has put forward a proposal for enhancement of the Medical Indemnity Run-off Cover Scheme or an expansion of the Premium Support Scheme benefits. Our aim is to assist with affordability of medical indemnity insurance for practitioners forced to cease practice due to unexpected, serious but non-permanent impairment.



Background

Several years ago the Federal Government introduced a raft of initiatives to stabilise the medical indemnity industry subsequent to the distress of United Medical Protection/ AMIL Group.

Those initiatives included the Run-off Cover Scheme (ROCS) and Premium Support Scheme (PSS) for medical practitioners.

The ROCS provides eligible medical practitioners with no-cost medical indemnity insurance cover when they have ceased practice.

The PSS is designed to assist medical practitioners cover the cost of their medical indemnity premiums.

The ROCS is funded through a levy on Medical Indemnity Insurers' medical practitioner policyholders' premium (currently 5%).

The PSS is funded by the Federal Government. In general terms, the PSS funds 80% of the total medical indemnity costs exceeding 7.5% of an eligible practitioners total actual annual income from medical services during the policy period.

The following are current ROCS eligibility categories:

- A doctor 65 years or older who has permanently retired from paid medical practice
- A doctor who has not engaged in paid medical practice during the preceding three years (Note: unlike other categories, eligibility does not occur immediately upon ceasing practice)
- A legal representative of a deceased medical practitioner (provided that a claim can be made against the deceased's estate)
- A doctor who has ceased paid medical practice due to permanent disability
- A doctor who has ceased paid medical practice because of maternity
- An overseas trained doctor, who worked under a 422 or 457 visa, has permanently ceased medical practice in Australia and does not reside in Australia

Existing ROCS scheme

Currently doctors who are forced to cease practice, perhaps for extended periods up to the ROCS qualifying 3 years, due to unanticipated, significant, non-permanent accident, injury or illness, do not qualify for the ROCS.

Since the introduction of the Medical Indemnity (Prudential Supervision and Products Standard) Act 2003 the only type of medical indemnity cover available to Australian medical practitioners is "claims-made" insurance where a current policy of insurance must be in place at the time the policyholder reports a claim to the insurer.

Therefore, to be covered for claims that may emerge from the period of practice prior to their period of cessation of practice, doctors must maintain ongoing medical indemnity insurance. For some doctors in higher risk practice categories or where there are no alternate income sources, ongoing cover may be a very significant expense during their period of non-practice until they return to work or qualify for ROCS. That cost, in turn, may lead them to a decision not to hold insurance and/or to allow medical indemnity insurance cover to lapse through non-payment.

Why you may be asked for further information from the Claims Division

When notifying incidents members will be regularly asked to provide further information to the Claims Department.

Whilst this may be frustrating, members may not be aware that when certain incidents are notified to MIPS, a financial "reserve" is put against the matter, which is our best estimate of the likely costs of a claim.

In the case of a matter reserved as an "Incident Likely", this reserve is the likely estimated costs to finalisation should a claim arise.

This reserve contributes to the claims liability of MIPS Insurance Pty Ltd and is ultimately reflected in insurance premiums charged to members. It is therefore in everyone's interests to ensure those reserves that are assigned to notifications are based on complete information and are thus as accurate as can be realistically estimated.

The timely provision of information sought from you by the Claims Division is essential and forms part of your insurance policy. As a reminder the section is reproduced below.

A decision not to continue to buy cover during such a non-income earning period exposes a practitioner to significant financial risk and patients, potentially, to non-recovery of damages to which they would be otherwise entitled.

The cost of cover for extended periods of unplanned cessation of practice due to unanticipated, significant but non-permanent accident, injury or illness where no income could be or is generated during the policy period, was in the past significantly mitigated through the PSS. Practitioners who had to cease practice in such circumstances could previously be included as part of a subset of a PSS eligibility group called "Special Category Members" and received 80% subsidy of their total medical indemnity costs in years where there was no practice income.

The PSS "safety net" for doctors in such a position was removed last year following the introduction of a requirement that for PSS eligibility purposes, annual income during a policy period could not be zero.

Members will be aware of a number of situations that can suddenly force doctors to cease practice that cannot be classified as permanently incapacitating. They include psychiatric illness including depression and substance abuse, vascular events such as acute myocardial infarction, diagnosis of malignancies and other severe illnesses, motor vehicle and other accidents.

MIPS has approached Government with the suggestion that the ROCS be modified to allow for eligibility of doctors who have to cease practice for significant periods of time due to serious health events/accidents.

To help mitigate the financial outcome following some types of accidents, MIPS provides its members with automatic cover under a MIPS Group Personal Accident policy. That cover is not exhaustive due to overall cost and associated difficulty in underwriting/managing health related benefit triggers.

Members will also be aware that cessation of practice may be linked to intervention by medical boards concerned about the risk to patients due to health issues of a practitioner. With the proposals to extend requirements for mandatory reporting (see national registration and accreditation comments, refer to page 2) it is likely that more doctors will be required to cease practice for varying periods of time due to health issues.

It is expected that the loss of PSS eligibility last year may also act as an additional financial impediment to doctors self-reporting impairment. Such an outcome is not in the best interests of stakeholders.

MIPS Proposal

MIPS has approached Government with the suggestion that the ROCS be modified to allow for eligibility of doctors who have to cease practice for significant periods of time due to serious health events/accidents; i.e. events that fall short of the permanent incapacity or other current requirements for qualifying for ROCS.

In its current form ROCS permits temporary cessation of practice due to non-permanent triggers, albeit currently limited to reasons of maternity.

There are however technical issues associated with such an initiative so MIPS has also proposed a simpler fast-track interim proposal.

Alternative fast-track proposal

An alternative and technically easier approach to mitigating the problem is for reintroduction of PSS eligibility for practitioners who have zero annual income and hold appropriate medical certification stating that they are medically unfit to practice.

Although not providing "free" cover to affected practitioners (unlike the outcome if the ROCS eligibility was extended to such a group), such a change to PSS eligibility would significantly improve the affordability of cover for those unable to practice due to health/accident events.

The matter has been discussed in a meeting between The Department of Treasury and The Department of Health and Ageing and members of the Insurance Council (of Australia) Medical Indemnity Working Party. The AMA has also been advised and approached for comment.

8 Your duty to co-operate

8.1 You agree to:

- 8.1.1 Give MIPS Insurance, its investigators and legal representatives all information and assistance they reasonably require; and**
- 8.1.2 Co-operate fully with MIPS Insurance, its investigators and legal representatives.**

Contemporaneous notes

There have been several cases (luckily not involving MIPS members) that have reinforced the need to remind members of the importance of contemporaneous notes.

The defence of any claim will largely, if not wholly, be based on what your notes contain.

In one case, the entire defence was based on what was in the practitioner's notes. He was adamant that his records were contemporaneous and had not been amended or altered. They were completely at loggerheads with the patient's allegations. Clearly, the Medical Defence Organisation thought they had an extremely good case on causation and liability and had made no offers.

The patient's lawyers obtained the notes and subjected them to a forensic document analysis which concluded that they had been altered and more than one pen had been used.

When confronted with this, the practitioner conceded the notes were not contemporaneous and his defence was in tatters.

In another case, MIPS and a non MIPS member were co-defendants to an action. The co-defendant swore that her notes were contemporaneous and accurate. This undermined our case substantially.

Just prior to being sworn in to give evidence to this effect, she capitulated and admitted to re-writing her notes after the writ had been served. Her case collapsed around her and her insurer nearly walked away from her for a material breach of the duty of good faith.

Findings

- Do not amend, edit, revise or alter records – ever!
- You can add a post script – but identify it as such and date/sign it
- If your notes are not contemporaneous, for any reason, say so

Tips for making your renewal simpler

In preparation for the 2009/10 renewal cycle, please ensure you notify MIPS Member Services on 1800 061 113 if your details have changed since your last renewal.

These details include changes to your:

- Address, residential and primary practice
- Telephone
- Email address
- Practice category for 2009/10
- Practice State
- Estimated earnings for 2009/10

Renewal options

A renewal invitation will be mailed to all members prior to June 2009. Members can respond by mail or alternatively choose to renew their policies for 2009/10 online. If you elect to renew online we will require your current email address.

If you renewed online last year

MIPS will send out an email to confirm your renewal option preference and also to verify the email address held on file. If you wish to change the address to which the renewal email will be sent in June, please contact Member Services as soon as possible.

For further information regarding renewing online and/or to update your details please contact Member Services on 1800 061 113, info@mips.com.au or complete our online form found at www.mips.com.au



News in brief

Risk Management Workshop Series

During March and April MIPS will be conducting 22 risk management workshops across Australia. These workshops are delivered by the Cognitive Institute on behalf of MIPS and aim to develop members' skills in identifying and implementing risk mitigation strategies. The workshops are accredited for CPD points.

For more information and to register for a workshop, please go to our website www.mips.com.au. The workshops book out quickly, so if you are unable to attend this series we can place you on a priority waiting list for our next series in September 2009. Please contact Member Services on (03) 8620 8853 to book a workshop.

Dentechno Victoria 2009

MIPS recently sponsored and exhibited at the Oral Health Professionals Association Dentechno Victoria Exhibition in February.

Held at the Melbourne Park Function Centre, Dentechno attracted over 200 registrations and gave the dental industry an opportunity to network with colleagues while also investigating products and services in the market.

MIPS has been providing medical professional indemnity insurance in the dental market since 2003.

Dentechno was a good opportunity for MIPS to raise its presence in the industry, while also supporting the Oral Health Professionals Association in providing a quality event for their members.

New Medico Legal Seminar Series VIC & NSW

Resulting from the highly successful seminar series launched in Queensland with TressCox Lawyers, a similar series has been confirmed in NSW with Deacons and in Victoria with Perry Maddocks Trollope. The seminars will be held in May/June 2009 and details will be distributed to members in due course.

Online risk modules

If you are unable to attend one of our risk management workshops or prefer to complete an education module online you can complete one of our three online risk management modules. These are available to all members on our website www.mips.com.au

Three topics are available:

1. Key Risk Management Principles
2. Health Records
3. Open Disclosure

The modules attract CPD points and take an hour to fully complete.

If you have any questions regarding our Risk Education programs, please contact MIPS on 1800 061 113 or email workshops@mips.com.au

Freecall **1800 061 113** www.mips.com.au

