

Winter 2010

MIPS review



If it's not recorded, it didn't happen...

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When is consent informed?

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From the MD's desk



2010–2011 Membership Renewal

At the time of writing we are still in the thick of processing membership renewal applications for 2010–2011.

Members might be interested to know that in the membership year to 30 June 2010, MIPS membership grew to over 30,000 current members including over 20,000 graduate members. Renewal is therefore a significant and growing logistical exercise – just imagine sending accounts to all your patients with the same payment due date! I therefore take this opportunity to thank members for their patience in relation to responses to queries during this time and staff for the great job they have done to date in meeting the demands of this peak load period.

2010–2011 Membership Benefits

Elsewhere in this edition of MIPS Review is an article outlining the expanded risk management program being made available to members in 2010–2011 and the additional and expanded benefits to members under the MIPS Members' Personal Accident Policy.

New twist to old risk

The decision by government to allow patients to choose their pathology or radiology provider rather than attending the provider selected by the referring practitioner, has the potential to expose patients, and therefore members, to additional risk especially in relation to abnormal results and follow-up. A real life example of an inadvertent lapse following the introduction of this initiative triggered a member to write to MIPS. (See page 5).

Dr Troy Browning
Managing Director, MIPS

Things you should know about MIPS

– where Members matter

Did you know...

As a not for profit mutual membership association, all the assets of the Medical Indemnity Protection Society (MIPS) ultimately belong to you – the Members. MIPS members' assets are also applied only to the benefit of MIPS members – and only MIPS members can access the services or protections that MIPS offers – all of which means that MIPS does not expose members' assets to non-members.

In addition, MIPS does not pay a dividend to shareholders and all surplus funds and investment returns are reinvested directly back to benefit the Membership. This in turn allows MIPS to keep your membership subscriptions lower than would otherwise be the case, and helps ensure that additional or expanded benefits can be introduced.

MIPS goes to great lengths to ensure that fairness and member equity is maintained. For example MIPS blending approach to membership subscription pricing ensures that if members move to a different membership category, their membership subscription fee

reflects, over time, the likelihood of claims relating to that new membership category. MIPS' approach in this respect is not only prudent and technically sound but fair and equitable for all members reflecting as it does the individual risk and changing circumstances of each member.

MIPS does not discount. That is because as an efficiently run not for profit organisation, any discounts would have to be paid for by a price loading on other members. In general terms, an efficient not for profit organisation can only really offer discounts in a prudent manner if it has included an additional loading in its original pricing to fund them. Such an approach is not in keeping with MIPS view of treating all members in a fair, equitable and transparent manner.

Members will note that for this 2010–2011 membership year MIPS has again introduced additional benefits for members. However be assured – MIPS consideration of how to better meet members needs never stops.

So that's what we believe is so special about being a MIPS member – membership in a unique organisation that clearly and continually focuses upon flexible, portable and comprehensive benefits for its members.

Disengaging with a patient

Most practitioners will at some time in their professional lives, reach a stage where there is no point continuing the professional relationship with a particular patient. That may be because the patient does not wish to continue to see that practitioner (and rather than just going elsewhere wishes to formally sever the relationship), but more frequently MIPS is contacted when it is the practitioner who seeks to terminate the relationship.

It should be noted that as a health care professional, you have the right to disengage from the care of a patient and refuse to provide further treatment (except in emergency situations). It is

important, however, that the patient be given some indication as to the reasons why, and those should be stated clearly in a professional and objective manner. In most cases the principle reason is because it is the practitioner's opinion that the professional or therapeutic relationship has broken down.

MIPS recommends that when disengaging from a patient, the patient be advised in writing that:

- you are no longer able to care for them and the decision has been taken in their best interests
- they should advise you of the details of their new provider

- you will, at no charge, arrange for the transfer of their records and care together with a summary of any current health issues to that provider (remember to retain copy for your records).

Practitioners do not have the right to refuse or decline treatment of an individual or a group based on religious, racial, socio-economic or other similar grounds and to do so would expose a practitioner to virtually indefensible complaints and/or claims against them. So before embarking on this process, be sure your reasons for disengaging are clear, concise and above all – legal.

Social and cultural differences

In the autumn edition of MIPS Review, we began a series of risk management articles primarily to assist MIPS international medical graduate (IMG) members, by focusing on communication issues – a very important issue for all medical practitioners.

This article reflects on the social and cultural differences that members may face when practicing in Australia.

Australia has a remarkably diverse community with a range of values, ethics and beliefs. Migrants have come to Australia from many different regions of the world. This is reflected in the variety of backgrounds of health practitioners now practicing in Australia. This rich mix of cultures inevitably raises issues of different codes of conduct, different customs and different taboos. The Australian culture can be described generally as being concerned about equality, where men and women of all ancestry are considered equal. Most Australian patients have a low tolerance of a superior or insensitive approach whether real or perceived, to them or their health care. Indeed, this same principle applies to the work place, staff and colleagues.

Patients are individuals (not a class or group) and expect explanations, information and sensitivity, privacy and confidentiality from a medical practitioner. Members should be prepared for this and as always consider and document their treatment and advice.

Practitioners should ensure that ethical standards are espoused which:

- encourage the health and well being of all patients, and
- prohibit doctors from behaving in their own self interest and reinforce the observance of strict physical doctor/patient boundaries.

The Australian Medical Council, *Good Medical Practice: A code of conduct for Doctors in Australia* is an excellent resource material in this regard.

www.goodmedicalpractice.org.au

From 1 July 2010 the Medical Board of Australia National Law obliges registered health practitioners and employers to report a registered colleague or employee who is impaired or practicing incompetently or unethically, to the Board. All members need to be aware of the potential consequences of a divergence from the expected ethical and legislative standards which apply to health professionals.

Summary

- Remember equality – do not be perceived as superior or insensitive. This applies equally to your patients, staff and colleagues
- Explanations, information, consent, sensitivity, privacy and confidentiality is always required and should be documented
- Warn, explain and seek permission for examinations and tests
- Caution a patient when you propose to carry out a test or examination that is of a personal nature and where the patient may feel vulnerable
- Always respect the patient and their privacy
- The promotion of health and well being of your patient is paramount.

Patients are individuals (not a class or group) and expect explanations, information and sensitivity, privacy and confidentiality from a medical practitioner.

Dental record keeping

by Dr Gerry Clausen

When decisions are made concerning the management of a claim, the adequacy of the records continues to be of paramount importance. Unfortunately, in a significant number of cases the written records do not reflect the version of events that the practitioner relayed to the claims manager during the initial telephone notification. A couple of recent cases reflect this and are worthy of mention.

Case study one

After routine restorative dental treatment the patient reported TMJ (temporomandibular joint) pain and subsequently, restricted mouth opening. Management by an oral surgeon involved admission to hospital, manipulation under general anaesthetic and subsequent review appointments with associated costs.

The patient made a claim against the dentist for initiating the TMJ problem. Initial discussion with the dentist indicated that upon presentation, there was audible joint clicking, a history of discomfort over the joint/ear area when chewing tough foods and intermittent locking had

occurred in the past. This had made routine dental treatment difficult. The practitioner, quite correctly asserted that this predisposed the patient to problems. However, whilst the practitioner maintained that the findings had been observed and the potential effect of joint symptoms had been discussed with the patient at the initial consultation, the dental record simply stated which teeth had been restored with composite resin and that a local anaesthetic solution had been administered. Restorative procedures including the type and dosage of local anaesthetic and proprietary brand of composite resin were not recorded.

Defence in such circumstances can be quite compromised without well maintained records. This is because without good records the recollection of a patient will often be preferred. Such oversight or laxity in record keeping could result in a payment being made to the patient and the possibility of a further claim to the registration board in the future on the basis of inadequate record keeping.

Case study two

A patient raised a complaint with the State Dental Board regarding endodontic treatment of the upper right lateral incisor tooth. Although treatment had been conducted some months previously, the patient was dissatisfied as the tooth was still tender to percussion and now exhibited signs of discoloration.

As part of the review process to determine the reason for treatment, the Board requested the treating practitioner's records. Review of the records indicated that working length was not noted, radiographs, whilst taken, had not been noted and there was no mention of rubber dam application. What commenced

as a relatively simple complaint about the quality of treatment received turned into a censure of the practitioner with regard to record keeping along with application of a penalty and further education requirements.

The message in these cases is that numerous bodies can request and acquire access to your records. Failure to record clinical findings or treatment can imply a lack of care and thus treatment that is not up to the expected standard. Dental registration boards have very specific guidelines regarding what must be recorded and ignorance is no

excuse. There is never a better time to review your own record keeping and notation process and to institute change if critical self-assessment reveals deficiencies. Remember... to avoid complications in the review process keep your records thorough and updated. If it's not recorded, it did not happen!

Patients selecting pathology and diagnostic imaging providers

On the basis of increased competition and improving patient choice the Federal Government introduced initiatives so that patients can choose their own pathology or diagnostic imaging provider for Medicare services. Request forms inform patients that they (rather than the doctor) can choose the provider and still participate in Medicare.

A member has contacted MIPS to express his concern about this change and his story is well worth sharing. The member in question conducted an executive health check in which further tests were requested. As the member was not going to see the patient again he indicated on the request 'copy to patients GP'.

The patient chose to go to a local pathology provider for the routine test. The provider was unknown to the member requesting the test and the member was therefore unfamiliar with the way in which results were reported by this particular provider. This unfortunately led to the member inadvertently missing an abnormal result on the report.

Most members would prefer to choose to send their patients to a provider they know well and have confidence in. That is, confidence in the way they conduct the tests, the time-frame for such testing and reporting and the way they report results – particularly abnormal results. Over time most members will have developed an 'efficient' method of scanning reports for abnormal results based on the format of a provider's reporting. In the case of our member he overlooked the abnormal result, which was later picked up by the patient's GP who fortunately was familiar with the format of results of the pathology provider's reports.

This experience alerted the member to some other potential medico legal risks around these changes:

- patients not knowing when providers are/are not available
- patients not knowing how to facilitate urgent testing
- patients attending a different provider to the one recommended
- lack of seamless interaction between parties – electronic systems
- not understanding the need for having a follow up procedure in place and the tests simply not being done or acted upon (remember *Tai v Hatizistaurou & Kite v Malycha*). Lack of consistency of testing of an illness over time with all available data at the one provider which can assist with diagnosis (cumulative reporting)
- delays may occur should the provider not know the doctor and the doctor cannot pursue them as they do not know which practice the patient chose to attend
- there may be valid clinical or practical reasons for a certain provider to complete a test e.g. same equipment for comparing radiological results.

Currently there is no standard format for reporting abnormal results. As this appears to be the major ongoing risk associated with this consumer choice initiative, members will need to pay heightened attention to ensure abnormal results aren't missed.

Should an issue arise please contact your Medical Indemnity Protection Society medico legal advisers on **1800 021 223**.

If you have a story to share or wisdom to impart, please contact MIPS at info@mips.com.au and mark your story c/o the editor, *MIPSReview*.



Mt Everest viewed from the air



Could this be why uterine prolapse is so common?



Recovery nurse Bianca Orszagh with patient

For two weeks before Easter this year, I had the privilege of joining the Nepal Reconstructive Surgical team on their annual pilgrimage to this beautiful country. Organised by the Sydney Adventist Hospital Health Outreach Program, the team comprised some twenty five health professionals, all of whom gave freely of their time, skills and means to improve the quality of life of more than fifty Nepali people suffering the effects of burn scars, and the pain and embarrassment of uterine prolapse.

Nepal is dominated by the grandeur of the Himalayas, which draw many an intrepid traveller to their snow-capped peaks. The view of Mount Everest that we saw on the flight into Kathmandu will remain etched in my memory forever. However the ever-present smoky haze at street level in downtown Kathmandu, the noise, pollution, traffic and poverty are more prominent in my mind. I would not see the mountains again until the flight home.

The Nepalese are a poor people, and their health needs are great.

Our base was the Scheer Memorial Hospital in Banepa, a small town some 25 kms (and 1–2 hours drive, depending on the condition of the road) outside of Kathmandu.

The patients were sourced from near and far by a Scheer employee, and were all brought to the hospital on the first day of our trip to be seen by the surgical teams and planned for surgery. Thereafter ensued 10 full days of operating during which over 50 patients received life-changing reconstructive surgery.

The surgery is at times quite ‘retro’ – the lack of microsurgical instrumentation necessitates the judicious use of such antiquated procedures as cross-leg flaps

and groin flaps. This was an amazing experience for the two plastic surgical assistants in the team, both of whom had never seen a cross-leg flap or a groin flap performed back home. To this end, the team was reliant on the services of the local plastic surgeon, Dr Basant Mathema, who followed up each patient and performed the necessary flap division surgery after our team had left. Without him, many of the procedures would not be possible.

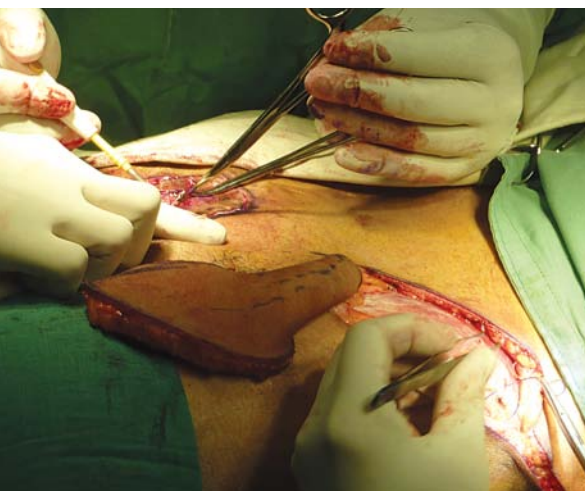
For the first time this year, two gynaecologists joined the team to operate on women with uterine prolapse. This is not an uncommon condition, with many women carrying heavy baskets soon after childbirth. This life-changing surgery was particularly fulfilling, with patients’ gratitude written all over their faces.

At the end of the two weeks, apart from the fulfilling work and countless new friends made, it is the smiles of patients and their families that linger longest in the memory. This has been the birth of a passion for me, and I intend to make many return trips to the country of Nepal. Maybe next time I will get a closer look at those mountains!

Dr Tom Pennington



The plastic surgical team



Raised groin flap



Dr Pennington at work

This was an amazing experience for the two plastic surgical assistants in the team, both of whom had never seen a cross leg flap or a groin flap performed back home.



Severe burn scar contractures on feet of a young boy



... and after the operation, crossleg flap in plaster cast



Severe hand deformity from burn scar contracture

In mid June 2010 I was fortunate enough to be part of a trip to East Timor, sponsored by AusAid, and organised by the Royal Australian College of Surgeons. The travelling party included Malcolm Baxter (ENT Surgeon), Lana Tutin (Theatre Nursing) and Lorraine Baxter (Nursing).

We went to the town of Maliana, a district town about 4 hours drive from Dili and just a few kilometres from the Indonesian border. Maliana has a population of 22,000 and sits on a beautiful tableland in the mountains.

Our work was carried out in the Maliana Referral Hospital. The hospital is Australian built and new. The operating room is equipped with second hand equipment from many sources. While serving the purpose, an operating table that goes up and down, but doesn't lock or tilt is a surgical challenge at times. The anaesthetic machine and ventilator work well; the anaesthetic monitoring is a small portable monitor, which functions adequately. Good, old fashioned alcohol sterilization made up for a lack of other functioning equipment, although limiting the type of equipment we could use, and hence the extent of the surgery that could be performed. The sign above the scrub sink (no smoking; no littering) is a reminder that even some of our simple rules are not routine.

The hospital staff are from a variety of backgrounds (mainly local or Cuban) and the degree of training is variable. The theatre averages less than one case per day in its routine operation. To get local staff to focus on a list that goes a large part of the day is a bit of a challenge.

The patients are seen in clinic, and via local interpreters have the proposed operation explained to them and are booked for surgery, usually the following day. Elective surgery is still a novelty in Maliana (except for cataract surgery according to local staff). The reliability of patients appearing for surgery the

next day depends heavily on the second opinion – if Mum doesn't agree, the patient just doesn't return! The children were all delightful and tolerated many procedures in the Outpatient clinic that may require much more intervention at home.

Working with the local "anaesthetists" in Maliana is interesting. Hospital staff selected for training are taught the relevant recipes for the likely surgery (rapid sequence induction for general anaesthesia for most things, and spinals for caesarean sections). These staff are taught to work in a team of at least 2 and continually check on each other. They function well and provide a good service for the incumbent general surgeon (on contract from Cuba), and their patients.

Remembering that East Timor is one of the poorest nations on earth, and is still very much a developing nation, I am pleased to report that the hotels in town are reasonable – the lodgings secure – and even better, more or less secure against mosquitos! There was also always plenty of cold water. The two local restaurants provided reasonable food – although I must confess that I could not bring myself to tackle the broiled intestines!. The market is active, with plenty of fresh local produce.

I am still very much a novice at health delivery in developing areas, however, I am pleased to report that the experience was both educational and enjoyable.

Dr John Monagle
Director, Anaesthesia and Perioperative Medicine
Southern Health



A typical home in the region



Administering anaesthetic to child patient



Scrub sink Maliana style



Our operating theatre

2010–2011 Membership Benefits

New Improved Workshop Program

For several years now MIPS has provided members with the opportunity to attend risk management workshops throughout Australia which have been conducted on our behalf by the clinically trained and skilled presenters of the Cognitive Institute.

To date almost 300 of these workshops have been conducted, over seven topics presented and attended by approximately 7500 members. These workshops have proven to be well regarded by members and provide a valuable membership benefit and educational resource to members.

To ensure MIPS members continue to receive the very best in risk management programs a new and improved risk management workshop program is being developed.

Not only will there be 2 new workshop topics on offer through the Cognitive Institute workshop program, members will also have the opportunity to attend other workshops that are closely aligned with the nature of their practice or to their circumstances.

In summary, the new workshop program will comprise:

- **Cognitive Institute Workshops**

Our traditional workshops are open to members and cover all the essential risk management issues surrounding appropriate communications. Two of the new workshop topics are:

- Mastering work/life balance – for all members
- Healing at the end of life – for general practitioner members

- **MIPS Risk Management Workshops**

A new workshop is being made available to all members which will provide the latest advice on risk management, medico legal and medical indemnity industry hot topics. These will be conducted by local MIPS medico legal advisers in association with external solicitors.

- **GP Risk Management Workshops**

These workshops are specifically for general practitioner members and focus on the more challenging issues faced in contemporary general practice. These are conducted by local MIPS medico legal advisers and external solicitors.

- **IMG Risk Management Workshops**

These workshops have been especially designed for our international medical graduate members and canvass the potential additional challenges that they may be faced with in practicing in Australia. These workshops are conducted by local MIPS medico legal advisers and external solicitors.

The next risk management workshop program will take place through September to November 2010.

Members will receive invitations and full details of the courses from MIPS in the coming weeks. Such information will also be available on line at

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

Premium Support Scheme (PSS)

For those medical practitioner members participating in the PSS, attendance at any one of these workshops will meet Medicare's mandatory requirement to undertake risk management education.

Additional Membership Benefits – MIPS Members' Personal Accident Policy

The standard benefit levels under the MIPS Members' Personal Accident Policy are unchanged however dental and medical members who have been members of MIPS for 5 or more continuous years qualify for a 50% increase in benefit levels. In addition there is now a \$100,000 sum payable if, in accordance with the policy terms and conditions, a member permanently loses their health practitioner board registration due to Accident or Sickness.

Protecting our members in all sorts of ways

MIPS were a proud sponsor of the Jetty 2 Jetty Fun Run organised by the Moreton Bay Road Runners and held in Redcliffe, Queensland in July. Around 75 doctors ran and walked the course ...all well protected with MIPS water bottles, caps and sunscreen!



Jetty to Jetty Fun Run 2010

How to respond to a complaint

A letter of complaint – whether from a statutory body or directly from a patient – can be a difficult matter to manage through to a positive outcome. By positive outcome we mean that ideally the outcome should be positive for both the patient and for you!

One thing is for certain. If you do not invest time and effort dealing with the complaint up front, you will spend far more time managing the situation further down the track and usually with less success.

In some cases there is an ‘ostrich’ like approach of denial and avoidance of the issue, with some member’s placing correspondence in the bottom draw in the hope the problem will go away by itself. However in most cases, the first reaction to a complaint is disbelief and anger. This is definitely not the time to send a response. Unless it is incredibly urgent, the strong recommendation from MIPS is to put the complaint aside and look at it again 24 hours later preferably when there are no competing pressures for your time and when the immediate visceral response has dulled.

In the cold hard light of day, whether the complaint has any real basis or not is somewhat immaterial. The patient (or their representative) has a perceived level of dissatisfaction, and this is what now needs to be addressed by you to ensure the matter is resolved as efficiently and satisfactorily as possible.

MIPS suggests that your response be formulated in stages, and a helpful process is to:

- take some time out to read the complaint again. At this stage it is helpful to go through the letter highlighting the key issues that constitute the actual complaint being raised
- match those highlighted issues to your notes. This is another reason why good note-taking is so important and can save the day. Attempt to formulate a response to each issue based on your notes, any other records in the patient’s file and your recollection of the consultation(s)
- re-read your draft response and eliminate anything that is not absolutely clinically relevant and factual. The response should be objective, benign, passive and written in an empathic style. Do not respond angrily or defensively as antagonizing the complainant may just add fuel to the fire.

Now you have your draft – but do not send it to the patient yet.

Here’s where MIPS can provide invaluable assistance to you

If you haven’t already contacted MIPS, then this is the time to do so. You should send a copy of the letter of complaint, a copy of your notes and

a copy of your draft response to MIPS for perusal. Our medico-legal experts will be able to provide a constructive critique with possible suggestions on how to maximise the chances of resolution of the matter.

An independent review by one of MIPS experienced clinician medico-legal advisers can often make the difference between satisfying the complainant and merely exacerbating the matter.

The aim of your response should ideally be to satisfy any request for information, clarify the facts, objectively state your position, show some empathy to the patients perception of the situation and hopefully from there the matter will go no further.

A poor response will often, however, result in the patient leaving your practice (sometimes with considerable malice and ill will), along with the possible loss of other patients, and very often, notification of further either related or additional unrelated complaints (e.g. to registration board).

There is never any guarantee that an appropriate response will ensure the issues are managed to the patient’s complete satisfaction. However, it is almost certain that a poorly researched and constructed response will see the patient continue to be dissatisfied.

Help us to help you

To ensure MIPS can provide timely, comprehensive, advice and assistance it is important that when contacting MIPS, members are able to provide necessary information.

Incidents

Adequate details relating to the incident being reported are essential. An incident as defined in the MIPS Members' Medical Indemnity Policy is "...any act, omission or circumstance that occurs in the course of, or in connection with the provision of health care...and includes an incident that is claimed to have occurred."

Incidents include:

- complaints – whether to you directly or through a statutory body
- claims for damages – e.g. on a court document or a letter of demand
- an adverse outcome in a patient's management or care
- an investigation or proceedings before an administrative or disciplinary tribunal etc.

Because of the obligations relating to the duty of disclosure and claims-made nature of insurance cover, MIPS must be advised of incidents that might give rise to a claim, even if you believe that the patient is unlikely to ever take this step.

Other details to have ready

MIPS always requires the following information:

- your name and (ideally) your membership number
- the patient's full name and (ideally) their date of birth
- the date on which the incident occurred.

It will also be of great assistance if you can have on hand:

- copies of all documents in relation to the patient's treatment
- copies of any originating documentation.

Timeliness

In order to protect your professional interests, it is vital that you contact MIPS and forward any relevant documentation to MIPS immediately. If asked by MIPS for further information it is a requirement that you provide this to us or alternatively advise us that you don't have it in your possession.

Confidentiality

MIPS recognizes that there is a reluctance to provide patient names and details, however, this is essential information in terms of assessing incidents and we assure members of absolute confidentiality and of compliance with Privacy requirements in their dealings with us.

MIPS medico-legal 24 hour, seven days a week phone **1800 021 223**.

INFORMED CONSENT

There is a huge difference between consent and informed consent. Many years ago consent was pretty straight forward. The patient was advised that they need a procedure – and they agreed! That's a form of consent. But is it informed? No its not – and if something goes wrong there can be significant adverse consequences. Take the following de-identified case study for example.

A 40 year old patient consents to a hysterectomy. The surgeon who will perform the operation always removes the uterus with both ovaries and fallopian tubes (bilateral salpingo-ooporectomy) as a matter of course, believing this is good practice as it eliminates any risk of the future development of ovarian Ca. He assumes the patient understands that the hysterectomy involves these

additional steps. The patient signs a consent marked "TAH and BSO" but unfortunately doesn't have any insight into what this really means and doesn't want to appear ignorant by asking. The patient is later told that all went well – including the removal of her ovaries and fallopian tubes. She doesn't believe that she had consented to that and on reflection confirms that she did not want her ovaries removed, is concerned about early masculinisation and the need for HRT and attendant risks associated with that therapy.

For consent to be truly informed, you must satisfy yourself that the patient understands; what the condition is; what you believe needs to be done about it (and alternatives if there are any); the risks (i.e. frequent and/or severe as well as those of importance

to that particular patient's decision) and the benefits associated with the proposed procedure or doing nothing at all; and the potential costs if there are likely to be any 'gaps'.

When you are explaining something complex, it is important to stop often and make sure that the patient, and where necessary their support person, really understands what you are telling them. Use diagrams or patient information sheets where possible and check that you are understood. Remember, we all talk in medical terms and use language that is often unfamiliar to our patients.

Finally – and vitally – make sure that your notes fully and accurately reflect the discussion and explanations offered.

Thank you for
renewing your
MIPS membership

Protection!

Support!

Advice!



MIPS

MIPS – where members matter!

Medical Indemnity Protection Society Ltd.

Call 1800 061 113 www.mips.com.au

MELBOURNE

Level 3,
15–31 Pelham Street,
CARLTON VIC 3053

SYDNEY

Level 5,
140 Arthur Street,
NTH SYDNEY NSW 2060

BRISBANE

Lobby 2, Level 4,
153 Campbell Street,
BOWEN HILLS QLD 4006

TASMANIA

Level 3,
2–4 Kirksway Place,
HOBART TAS 7000

PERTH

Suite 5,
531 Hay Street,
SUBIACO WA 6008