VISITING MEDICAL OFFICERS AND HONORARY MEDICAL OFFICERS
PUBLIC PATIENT INDEMNITY COVER

EXPLANATION DOCUMENT

(APRIL 2002 VERSION)
CONTENTS

1 TMF LIABILITY COVERAGE FOR VMOS.............................................................................................................. 1

1.1 WHAT IS INDEMNIFIED UNDER VMO TMF COVER? .................................................................................. 1
1.2 TMF INDEMNITY IS NOT PROVIDED FOR LEGAL AND OTHER COSTS INCURRED IN APPEARANCES BY VMOS BEFORE DISCIPLINARY PROCEEDINGS, CRIMINAL PROCEEDINGS, CORONIAL INQUESTS OR THE LIKE. ............ 1
1.3 WHAT CLAIMS ARE EXCLUDED FROM THE COVERAGE? ........................................................................... 1
1.4 WHAT IS A PHO?............................................................................................................................................... 1
1.5 WHAT IS A PUBLIC HOSPITAL? .................................................................................................................... 2
1.6 IS THIS COVER THE SAME AS THAT FOR EMPLOYEES OF PHO?.......................................................... 2
1.7 WHAT IS THE PURPOSE OF THIS EXPLANATION DOCUMENT? ................................................................. 2

2 CONTRACT OF LIABILITY COVERAGE........................................................................................................... 2

2.1 WHAT IS THE CONTRACT OF LIABILITY COVERAGE FOR VMOS?............................................................... 2
2.2 IS THE CONTRACT OF LIABILITY COVERAGE NEGOTIABLE? ................................................................... 2
2.3 HOW LONG DOES A VMO HAVE BEFORE THE INTERIM TMF PUBLIC PATIENT COVER EXPIRES? .............. 3
2.4 WHAT IS ALTERNATIVE APPROVED INDEMNITY COVER? ....................................................................... 3
2.5 DOES A VMO HAVE TO SIGN MORE THAN ONE CONTRACT OF LIABILITY COVERAGE IF THEY HAVE VMO APPOINTMENTS WITH MORE THAN ONE PHO? ............................................................................................... 3
2.6 WILL AN HMO BE REQUIRED TO SIGN A CONTRACT OF LIABILITY COVERAGE? ............................. 3
2.7 IF A DOCTOR HAS A VMO APPOINTMENT IN ONE PHO AND AN HMO APPOINTMENT IN ANOTHER PHO, WORKS IN ANOTHER PHO ARE THEY COVERED? ............................................................... 4
2.8 IF A DOCTOR HAS A VMO APPOINTMENT IN ONE PHO AND AN HMO APPOINTMENT IN ANOTHER PHO, ARE THEY REQUIRED TO HAVE 2 SEPARATE CONTRACTS OF LIABILITY COVERAGE? ........................................ 4
2.9 WHAT HAPPENS IF A DOCTOR IS NOT APPOINTED AS AN HMO OR VMO UNDER A SERVICE CONTRACT? ....... 4
2.10 WHAT HAPPENS IF THE DOCTOR IS AN EMPLOYEE OF THE PHO? ....................................................... 4
2.11 WHAT HAPPENS IF A VMO DOESN’T SIGN? ............................................................................................. 4
2.12 WHAT IS THE EFFECTIVE START DATE OF THE COVERAGE? ................................................................ 4
2.13 WHEN DOES THE COVERAGE EXPIRE? .................................................................................................... 4
2.14 DOES A VMO HAVE TO SIGN A NEW CONTRACT OF LIABILITY COVERAGE WHEN THEIR APPOINTMENT IS RENEWED? ......................................................................................................................... 5
2.15 WHAT OCCURS IF A VMO’S APPOINTMENT IS EXTENDED (AS DISTINCT FROM RE-APPOINTMENT)? ....... 5
2.16 HOW IS THE CONTRACT OF LIABILITY COVERAGE TERMINATED? ........................................................... 5
2.17 WHAT REVIEW RIGHTS DOES A VMO HAVE UNDER THE CONTRACT? ................................................ 6
2.18 WHAT DOES EXCLUSION 2 AT SECTION 1.3 OF THE EXPLANATION DOCUMENT MEAN IN RESPECT OF PRODUCTS SOLD, SUPPLIED OR DISTRIBUTED BY THE VMO? .............................................................. 7
2.19 WHAT IS MEANT BY “PRODUCT” IN EXCLUSION 2 AT SECTION 2.14 OF THE EXPLANATION DOCUMENT? .. 7

3 ELIGIBILITY FOR VMO TMF LIABILITY COVERAGE......................................................................................... 7

3.1 WHO IS ELIGIBLE FOR VMO TMF LIABILITY COVERAGE? ........................................................................ 7
3.2 WHAT IS A SERVICE CONTRACT? .................................................................................................................. 8
3.3 ARE VMOS PROVIDING SERVICES THROUGH PRACTICE COMPANIES UNDER THE HEALTH SERVICES ACT 1997 COVERED? ....................................................................................................................... 8
3.4 WHAT HAPPENS IF A COMPANY WHICH IS CONDUCTED OR CONTROLLED BY A NUMBER OF DOCTORS AND/OR BY NON-MEDICAL PRACTITIONERS HAS A CONTRACT WITH A PHO TO PROVIDE CERTAIN MEDICAL SERVICES? ................................................................................................................... 8
3.5 WHAT HAPPENS IF A CONTRACT FOR MEDICAL SERVICES IS TENDERED AND A COMPANY WINS THE CONTRACT? ............................................................................................................................................. 9
3.6 ARE VISITING DENTAL OFFICERS (VDOS) COVERED? ............................................................................ 9

4 VMO LOCUMS.................................................................................................................................................. 9

4.1 WHAT IS A VMO LOCUM? ................................................................................................................................ 9
4.2 IF THE VMO LOCUM SATISFIES THE ELIGIBILITY CRITERIA FOR COVER AS SET OUT IN SECTION 3 OF THIS EXPLANATION DOCUMENT CAN THE COVER BE PROVIDED FOR TREATING PUBLIC PATIENTS IN PUBLIC HOSPITALS? ................................................................................................................... 9
4.4 WHAT HAPPENS IF AN INCENTIVE PAYMENT IS REQUIRED TO ATTRACT A LOCUM VMO? ................. 10

5 PUBLIC PATIENT/PUBLIC HOSPITAL DEFINITIONS .................................................................................. 10
5.1 What is a public patient in a public hospital?
5.2 What is an ineligible patient and can they be treated under the VMO service contract?
5.3 Is the provision of medical services to compensable or DVA patients covered by the contract of liability coverage?
5.4 What happens if a patient changes their status from public to private or private to public in a public hospital?
5.5 Can a VMO direct a person who wishes to be treated as a private patient to be treated as a public patient?

6 Consent/Failure to Warn
6.1 Is a VMO covered for “Failure to Warn” claims where the VMO has obtained consent in his or her rooms to perform a medical procedure on a patient where the patient elects to be treated as a public patient in a public hospital?
6.2 What happens where a patient is an emergency patient and treated as such in an Emergency Department?

7 Doctors' Rooms
7.1 Is the VMO covered for work (other than obtaining public patient consent as detailed in section 6.1 above) provided in his or her own rooms?
7.2 What happens if the claim involves a series of actions of the VMO both in attending a patient in their rooms and in treating the patient as a public patient in a public hospital?

8 VMO Responsibilities
8.1 What are the responsibilities of VMOS?

9 Incident Reporting
9.1 What is the difference between a claim and an incident?
9.2 Why does the VMO have to complete a TMF Incident Report?
9.3 Why must incidents be generally reported within 48 hours?
9.4 Will a VMO be covered if he or she is not aware that an incident is one that should be reported until some time after it occurs or until the claim is actually made against me?
9.5 How does the 48 hours operate during weekends and for public holidays?

10 TMF Roles/Responsibilities
10.1 What costs are met by the TMF for indemnity?
10.2 Who will conduct the claim?
10.3 Will a VMO get acknowledgment on an Incident Report?

11 Quality Assurance, Quality Improvement and Risk Management
11.1 Why are VMOS required to participate in quality assurance, quality improvement and risk management?
11.2 Will the participation be within the PHO or in Sydney?

12 Government's Announcement of 19 December 2001
12.1 What does the announcement mean in respect of proposed coverage for claims that may arise from work done in the public system on public patients in the past that have not been reported as at 31 December 2001?
12.2 Why doesn’t the Contract of Liability Coverage reflect the unreported claims in Section 12.1?
12.3 Does the 19 December 2001 announcement have any implications for cover previously provided to sessional specialist obstetricians and gynaecologists?

13 Further Enquiries
13.1 VMO Individual Enquiries
13.2 Peak Bodies
NSW Health and NSW Treasury Managed Fund (TMF) provide the following explanations in a Question and Answer format in relation to the indemnity that Public Health Organisations (PHOs) are providing through TMF to Visiting Medical Officers (VMOs) and Honorary Medical Officers (HMOs) arising from the Government’s announcement of 19 December 2001.

For the purpose of this document the expression VMO includes an HMO unless the contrary intention appears.

1 TMF LIABILITY COVERAGE FOR VMOs

1.1 What is indemnified under VMO TMF cover?

The TMF indemnity is for legal liabilities arising from health care claims made in respect of the treatment of public patients in public hospitals or through health services under the control of a PHO.

A health care claim is a claim for damages or monetary compensation, whether through legal proceedings or a verbal or written demand, against the VMO in respect of any injury or death alleged to be caused wholly or partly by the VMO in providing health care to public patients.

1.2 TMF indemnity is not provided for legal and other costs incurred in appearances by VMOs before disciplinary proceedings, criminal proceedings, coronial inquests or the like.

1.3 What claims are excluded from the coverage?

1. Any claim that does not fall within the terms of coverage in clause 2 of the contract. That coverage is for civil liability arising from health care claims for occurrences during the coverage period in relation to the provision of medical services to public patients in public hospitals or health services (including failure to warn and consent issues relating to public patients as set out at section 5 of this explanation document).

2. Any claim arising from the manufacture of any products or the construction, alteration, repackaging, repair, servicing, treating of any products sold, supplied or distributed by the VMO or any claim arising out of the failure of any product to fulfil the purpose for which it was designed, specified, warranted or guaranteed to perform, other than products supplied to the VMO by the PHO.

3. Any claim that arises out of conduct on behalf of the VMO that constitutes a criminal offence or any other serious and wilful misconduct.

1.4 What is a PHO?

A PHO is an area health service, a statutory health corporation or an affiliated health organisation. (Affiliated health organisations are those organisations
whose establishments or services are recognised in the Third Schedule of the Health Services Act 1997).

1.5 What is a public hospital?

A public hospital is any hospital or associated facility controlled by an area health service, a statutory health corporation or a recognised establishment of an affiliated health organisation under the Health Services Act 1997.

1.6 Is this cover the same as that for employees of PHO?

NSW Health, on behalf of PHOs, has maintained public liability cover for its employees for many years.

The VMO public patient indemnity cover will be a separate and self-contained scheme within the TMF arrangements. It will, however, be the same in so far as it indemnifies the VMO for any legal liability for health care claims made in respect of the treatment of public patients in public hospitals. As is the case for employees, claims arising from serious and wilful misconduct are excluded from coverage.

1.7 What is the purpose of this explanation document?

The Contract of Liability Coverage will be the basis for the TMF determining whether a VMO against whom a claim is made is entitled to indemnity by the PHO. This Explanation Document is to assist VMOs and PHOs to understand their rights and obligations under the contract. It may be varied by the Department from time to time if further issues emerge requiring clarification.

2 CONTRACT OF LIABILITY COVERAGE

2.1 What is the Contract of Liability Coverage for VMOs?

This is an agreement between the VMO and the relevant PHO which entitles the VMO to indemnity under the NSW Government Treasury Managed Fund arrangements in respect of their public patient work, subject to the conditions contained in the contract.

The contract must be signed and all conditions for indemnity satisfied for the VMO to be given indemnity.

2.2 Is the Contract of Liability Coverage negotiable?

No. The Contract of Liability Coverage and the conditions are common to all VMOs who wish to have this coverage.
2.3 How long does a VMO have before the interim TMF public patient cover expires?

Those VMOs holding an appointment on 1 January 2002 have until 30 April 2002 to sign the contract before the interim cover expires. After that date, all VMOs will be required to have a signed contract of liability cover or, alternatively, approved indemnity cover from a notified insurer for their VMO practice.

2.4 What is alternative approved indemnity cover?

The Health Care Liability Act 2001 and orders made under it require all medical practitioners practising in NSW to have approved professional indemnity cover from a “notified insurer”, unless exempted by the Act or regulations.

VMOs who are covered under the TMF arrangements are exempt to the extent of that cover.

If a VMO does not wish to have public patient cover through TMF, he or she must obtain appropriate approved cover for their VMO work from a notified insurer.

A “notified insurer” is one that has notified the Director-General of the Department of Health that it will be providing approved cover as set out in the insurance approval order made by the Minister. As at 20 March 2002, 6 organisations were notified insurers:-

- United Medical Protection Ltd including Australasian Medical Insurance Limited
- Medical Indemnity Protection Society Limited
- Medical Defence Association of South Australia Limited
- The Medical Defence Association of Victoria Limited
- Medical Defence Association of Western Australia trading as Medical Defence Association National.

The VMO will require a certificate from a “notified insurer” that the VMO has professional indemnity cover for his or her entire medical practice (which would include treatment of public patients in NSW public hospitals).

2.5 Does a VMO have to sign more than one contract of liability coverage if they have VMO appointments with more than one PHO?

Yes. The VMO needs to sign a contract with each PHO with whom they have a VMO appointment and wish to have public patient liability cover.

2.6 Will an HMO be required to sign a contract of liability coverage?

Yes, to obtain coverage a contract of liability coverage must be signed by the HMO.
2.7 If a doctor has a VMO appointment in one PHO and as part of that appointment the VMO works in another PHO are they covered?

Yes, but only in respect of public patients in public hospitals or of other health services under the other PHO’s control and subject to complying with other conditions of liability coverage.

A separate contract of liability coverage is not required.

2.8 If a doctor has a VMO appointment in one PHO and an HMO appointment in another PHO, are they required to have 2 separate contracts of liability coverage?

Yes, a doctor requires a VMO contract with one PHO and an HMO contract with the other PHO.

2.9 What happens if a doctor is not appointed as an HMO or VMO under a service contract?

The doctor is not a VMO or an HMO and will not be covered. You require your own (or your employer’s) indemnification (see section 3).

2.10 What happens if the doctor is an employee of the PHO?

Doctors employed by the PHOs are covered for claims by patients who are treated in the course of their employment. Employed doctors do not need to sign the Contract of Liability Coverage. This is different to VMOs/HMOs who are engaged as independent contractors with the PHO.

Employee doctors are not allowed rights of private practice for treating private patients, unless they are employed as Senior Medical Practitioners. Senior Medical Practitioners may engage in private medical practice in public hospitals under relevant private practice arrangements provided they have appropriate indemnity cover (as set out in section 2.4 of the Explanation Document).

2.11 What happens if a VMO doesn’t sign?

If a VMO does not sign the Contract of Liability Coverage and has not arranged alternative approved cover through a notified insurer, the VMO will not be able to practise as a visiting practitioner. (See section 2.4 for alternative appropriate cover).

2.12 What is the effective start date of the coverage?

For all VMOs who have an appointment as at 1 January 2002 and sign the Contract of Liability Coverage by 30 April 2002 the start effective date is 1 January 2002.

Where a VMO has obtained a new appointment to a PHO sometime between 1 January 2002 and 30 April 2002, the effective start date will be the date of
appointment, providing the Contract of Liability Coverage is signed on or before 30 April 2002.

2.13 When does the coverage expire?

This is occurrence-based cover. The coverage is for health care claims in respect of the care and treatment of public patients in public hospitals or through other health services under the control of the PHO arising from occurrences during the period of liability coverage irrespective of when the claim is ultimately lodged.

For example, if a VMO is appointed as at 1 January 2002 and the contract expires on 30 June 2003 and the VMO retires or is otherwise not re-appointed, all relevant occurrences during this 18-month period will be covered in accordance with the conditions of coverage. This means that if a claim is lodged in 2010 for an incident during this 18-month period it will be covered.

Similarly, if a VMO initially has a contract of liability coverage from 1 January 2002 but, following review, it is terminated on 30 June 2003 because of a repeated failure to participate in appropriate quality and risk management activities, and the VMO then takes out appropriate alternative cover for the remainder of the term of his or her appointment, the liabilities from all relevant occurrences during this initial 18-month period will be covered. This means that if the health care claim relates to an occurrence in this 18-month period but is made after the 30 June 2003 (the date of termination of the contract of liability coverage) it is still covered under the Contract of Liability coverage.

2.14 Does a VMO have to sign a new Contract of Liability Coverage when their appointment is renewed?

Yes, each time the VMO contract is renewed a new contract of liability coverage must be signed for the period of the service contract unless the VMO wishes to exercise the option of obtaining appropriate alternative cover for the VMO's work.

It is important that the VMO sign and retain for their own records a copy of each contract of liability coverage. The PHO will also retain the contracts of liability coverage on file. When a claim is made the PHO will be asked to confirm whether or not the doctor has a contract of liability coverage for the occurrence giving rise to the claim. In the absence of a contract of liability coverage for the relevant occurrence, the VMO will need to seek indemnity from his or her own medical indemnity provider.

2.15 What occurs if a VMO's appointment is extended (as distinct from re-appointment)?

Where a VMO's or HMO's appointment is extended, the contract of liability coverage will be extended for the same period with the agreement of the VMO.

2.16 How is the Contract of Liability Coverage terminated?
2.17 What review rights does a VMO have under the contract?

Prior to being given notice, whether by the TMF or the PHO, the VMO will be asked to show cause why termination should not occur.

The “show cause” letter will outline the reasons for the proposed termination.

The VMO will be given one month to respond.

If the VMO’s response is accepted by the TMF or PHO, as the case may be, the VMO will be so advised. Otherwise, written notice of termination will be given.

If the VMO objects to the notice of termination, he or she may request a review by a review panel which has been established by the Department of Health to consider the objection. Depending upon the cause and objection, the panel will consider written or in person submissions.

The written notice of termination will advise the VMO that he or she has a month in which to decide whether to request a review of the termination decision and where to lodge his or her request.

Where the review panel concludes that termination should not proceed, the Director-General will direct the TMF Fund Manager or the PHO, as the case may be, to withdraw the termination notice.

Where the review panel supports the termination proceeding, termination will take effect on whichever is the later of the following dates:

- 3 months from the giving of the termination notice; or
- 30 days after receiving advice on the outcome of the review.

The review panel will also consider an objection by a VMO to a refusal of indemnity in relation to a particular claim.
2.18 What does exclusion 2 at section 1.3 of the Explanation Document mean in respect of products sold, supplied or distributed by the VMO?

Where the VMO sells, supplies or distributes a product in connection with the treatment of a public patient in a public hospital and that product results in a claim, TMF indemnity will not be provided for the product portion of the claim.

If the product is supplied by the PHO, the PHO will be liable through the TMF for the product portion of the claim.

Under either scenario where a claim involves both product and VMO treatment, TMF will provide indemnity for the VMO for the treatment portion of the claim.

Manufacturers of products would also be considered to have full or partial product liability in certain circumstances.

2.19 What is meant by “product” in exclusion 2 at section 2.14 of the Explanation Document?

The term “product” includes (but is not restricted to) items such as drugs, dressings, surgical supplies, prosthesis and surgical and medical equipment.

3 ELIGIBILITY FOR VMO TMF LIABILITY COVERAGE

3.1 Who is eligible for VMO TMF liability coverage?

To be eligible to sign a Contract of Liability Coverage, the doctor must be a VMO or HMO whose appointment satisfies the requirements of the Health Services Act 1997.

“A visiting medical officer” is a medical practitioner appointed under a service contract (whether the practitioner or his or her practice company is a party to the contract) to provide services as a visiting practitioner for monetary remuneration for or on behalf of the public health organisation concerned.

An “honorary medical officer” is a medical practitioner appointed under an honorary contract (whether the practitioner or his or her practice company is a party to the contract) to provide services as a visiting practitioner for or on behalf of the public health organisation concerned.

A “practice company” is defined as “a corporation (however incorporated) that is controlled or conducted by a medical practitioner and by means of which the medical practitioner conducts his or her medical practice”.

Section 86 of the Health Services Act provides that a VMO/HMO must not be appointed “unless the terms and conditions to which the officer is to be subject are in the form of a written service contract.” An appointment that does not satisfy this section is void.
Non-standard remuneration arrangements are not covered

In the absence of specific approval from the Director-General of the Department, a PHO is not authorised to enter into a VMO contract of liability coverage if the VMO is not remunerated in accordance with the rates and conditions specified by the Department, relevant determinations under Chapter 8 of the Health Services Act 1997 or in the standard service contract as approved by the NSW Minister for Health. (VMOs who are paid an incentive may be covered for public patient work where the PHO can demonstrate in advance to the Director-General of the Department of Health that coverage is appropriate notwithstanding that the VMO locum will be receiving an additional benefit of an incentive payment).

3.2 What is a service contract?

Section 80(1) of the Health Services Act 1997 defines this as:-

“80 What is a service contract?

(1) A service contract is an agreement between:-

(a) a public health organisation and a medical practitioner under which the practitioner is appointed as a visiting practitioner to provide to or on behalf of the public health organisation the medical services that are specified in the agreement, or

(b) a public health organisation and a practice company under which:-

(i) the medical practitioner who conducts his or her practice by means of the company is appointed as a visiting practitioner, and

(ii) the company agrees to provide to or on behalf of the public health organisation the medical services, to be performed by the medical practitioner (as a visiting practitioner), that are specified in the agreement.

3.3 Are VMOs providing services through practice companies under the Health Services Act 1997 covered?

Yes. The Contract of Liability Coverage specifically recognises coverage for services provided through practice company arrangements.

A practice company must fall within the definition set out in section 3.1 above: it must be for the conduct of the individual VMO’s practice and controlled or conducted by the VMO).

3.4 What happens if a company which is conducted or controlled by a number of doctors and/or by non-medical practitioners has a contract with a PHO to provide certain medical services?
Coverage through the TMF will not be available. Coverage is only available for the single doctor practice company arrangements for VMOs.

Contracts for services provided by other companies will require such companies to ensure their medical practitioners are properly covered through their insurance policies or through the doctors taking out their own approved cover.

3.5 What happens if a contract for medical services is tendered and a company wins the contract?

Coverage through the TMF will not be available. This is not a service contract within the meaning of section 80(1) of the Health Services Act 1997. In fact, section 80(2) of this Act specifically excludes such arrangements: -

"Any contract, agreement or other arrangement for the supply of medical services that is entered into as a result of a tendering process is not a service contract."

Successful tenderers will therefore need to ensure their medical practitioners have appropriate professional indemnity cover in providing services to NSW public hospitals for treating public patients.

3.6 Are Visiting Dental Officers (VDOs) covered?

Cover is available for VDOs to the extent that they provide maxillofacial services to public patients in public hospitals or through health services under the control of the PHO.

Cover is not available for other dental services.

4 VM O LOCUMS

4.1 What is a VMO Locum?

A VMO Locum must be appointed as a VMO satisfying the requirements of the Health Services Act 1997 (see Section 3 above). Such appointments are short term and are for:-

- a period for which a standard VMO appointment is not possible;
- a period when the appointed VMO is on approved leave.

4.2 If the VMO Locum satisfies the eligibility criteria for cover as set out in Section 3 of this Explanation Document can the cover be provided for treating public patients in public hospitals?

Yes, providing a Contract of Liability Coverage is signed in advance of the period of appointment.

4.3 If the VMO Locum is engaged by the appointed VMO under terms and conditions negotiated between the VMO and the locum, but will fulfil the
obligation of the VMO’s service contract, is cover available for the locum’s treatment of public patients in public hospitals?

Yes, providing the locum signs both a Contact of Liability Coverage in advance of treating public patients and a service contract within the meaning of the Health Services Act 1997.

4.4 What happens if an incentive payment is required to attract a Locum VMO?

The PHO will need to demonstrate to the Director-General of the Department of Health that coverage is appropriate notwithstanding the VMO locum will be receiving the additional benefit of an incentive payment.

If coverage is not deemed appropriate, the VMO locum will need to have approved cover from a notified insurer for their entire medical practice, including any VMO work they undertake.

5 PUBLIC PATIENT/PUBLIC HOSPITAL DEFINITIONS

5.1 What is a public patient in a public hospital?

A public patient is any Medicare eligible patient who upon admission to a public hospital or upon presentation to an Emergency Department of a public hospital, or in being treated as a non-inpatient, elects to be treated as a public patient and thus forego the right to a doctor of choice.

Treatment of the Medicare eligible patient will be by either a VMO as part of the public hospital contract or a senior or junior salaried medical officer of the hospital.

Treatment of such a patient does not involve any financial consideration between the patient and VMO, but rather between the PHO and VMO.

A public patient does not include a person who is a compensable patient (i.e., workers compensation, third party etc), a Department of Veterans Affairs patient, an ineligible patient or an eligible patient who elects to be treated as a private patient.

5.2 What is an ineligible patient and can they be treated under the VMO service contract?

An ineligible patient is any non-Australian resident (a broader category than citizen) who does not hold travel insurance or whose country is not part of a reciprocal health care agreement.

In the normal course an ineligible patient is to be treated as a private patient by the VMO/HMO who is able to charge the patient for services provided, in which case TMF cover will not be provided.
However, where the PHO requires a VMO or HMO to treat an ineligible patient under the service contract (including call backs) as a public patient in a public hospital, TMF cover will be provided.

Where the PHO requires the VMO or HMO to treat the ineligible patient under their service contract, the PHO will still raise the gazetted fees for the ineligible patient's period in hospital.

5.3 Is the provision of medical services to compensable or DVA patients covered by the contract of liability coverage?

No. These persons through their funder (e.g., insurer) are subject to separate financial arrangements with the medical practitioner. NSW Health is only paid for accommodation by their funder. Services provided to these patients by a VMO must be as a private patient with the VMO to have appropriate cover by a notified insurer.

5.4 What happens if a patient changes their status from public to private or private to public in a public hospital?

If the incident that caused the claim was whilst a public patient, TMF cover will be provided. However, if the incident was whilst a private patient, it will be the responsibility of the VMO's indemnity provider.

Where the incident is related to treatment as both a public and private patient, legal advisers for the TMF and the VMO's indemnity provider (for the private patient portion) will determine on apportionment of liability.

5.5 Can a VMO direct a person who wishes to be treated as a private patient to be treated as a public patient?

No. NSW as a signatory to the Australian Health Care Agreement is required to allow any Australian resident to be treated as a private patient in NSW Health facilities if they so elect. Hospital admission and patient election policies reflect this. Providing the service that the patient requires is consistent with the VMO appointment and the kind and level of services is available at the particular facility, he or she is entitled to be treated as a private patient. In this case the VMO will be covered by his or her own indemnity provider.

6 CONSENT/FAILURE TO WARN

6.1 Is a VMO covered for “Failure to Warn” claims where the VMO has obtained consent in his or her rooms to perform a medical procedure on a patient where the patient elects to be treated as a public patient in a public hospital?

Yes. The TMF will provide indemnity coverage for failure to warn claims where a VMO admits a patient as a public patient to a public hospital for the purpose of performing surgery or other medical procedures. This coverage will apply irrespective of where the consent was obtained, including doctors' rooms.
For the cover to be provided, the provision of advice about the benefits and risks of the proposed procedure and the obtaining of consent must be in a manner consistent with the Department of Health policy at that time. Departmental Circular 99/16 details policy and the standard form of consent to be obtained to enable patient admission to a PHO. Generally, the written consent form must be provided by the patient to enable admission to a public hospital.

The Department of Health and AMA are having discussions concerning variations to the consent forms contained in Circular 99/16 as a consequence of the decision to provide TMF cover from 1 January 2002. Until varied, Circular 99/16 is to be observed.

6.2 What happens where a patient is an emergency patient and treated as such in an Emergency Department?

Unless a patient's status is properly identified and confirmed as private or compensable, they are assumed to be public and therefore TMF will accept liability. Where a patient elects to be private or their status is deemed not to be that of a public patient any liability would be the responsibility of the VMO’s indemnity provider.

7 DOCTORS’ ROOMS

7.1 Is the VMO covered for work (other than obtaining public patient consent as detailed in section 6.1 above) provided in his or her own rooms?

No. Services including treatment, pre-operative consultations or advice (other than as part of obtaining public patient consent) given by a VMO or HMO in their own rooms are not covered.

The TMF cover is for claims arising from the treatment of public patients in public hospitals. Patients who are attended to by the doctor in their private rooms by direct arrangement with the patient or the patient’s referring doctor are private patients. The practitioner raises an account for this work, which is rebatable under Medicare.

The only indemnity coverage for activity in doctors’ rooms is for failure to warn claims as part of obtaining written informed consent, which is consistent with Department of Health policy, as set out at section 6.

7.2 What happens if the claim involves a series of actions of the VMO both in attending a patient in their rooms and in treating the patient as a public patient in a public hospital?

In a mixed system of health care it is to be expected that one episode of care may involve a number of steps to which different indemnity arrangements apply.
In these circumstances, legal representatives of the TMF (for public patients in public hospitals) and the VMO (for the patients in the doctor’s room) reach agreement on an apportionment of liability.

This arrangement already exists where VMOs and public hospitals are co-defendants.

8 VMO RESPONSIBILITIES

8.1 What are the responsibilities of VMOs?

1. The VMO or their practice company must have a written service contract and the VMO must also have a contract of liability coverage with the PHO.

2. VMOs must report in writing any incident using a standard form that may trigger the liability coverage to the Fund Manager through the PHO as soon as the VMO becomes aware of such an incident. (The relevant TMF Incident Report proforma is attached to the Contract of Liability Coverage).

3. VMOs must co-operate with and participate in clinical quality assurance, quality improvement and risk management processes, projects and activities as required by the PHO.

4. VMOs must, within 10 days of being requested by a PHO, provide a record of their claims history for the last 6 years.

5. VMOs must fully co-operate with the PHO, Fund Manager and legal service providers appointed for the purpose of managing and conducting the claim. (The Contract of Liability Coverage provides that the management and conduct of any claim passes to the PHO and TMF).
9 INCIDENT REPORTING

9.1 What is the difference between a claim and an incident?

A claim is where a person has made a demand for compensation or commenced legal action against a VMO.

An incident is something which occurs during the patient’s course of treatment which the doctor believes could give rise to a possible health care claim. It includes matters such as incorrect surgical procedure, incorrect drug treatment program, inadequate warnings of risk, alternative treatments or inadequate post surgical regimes. VMOs are required to comply with incident reporting requirements as outlined in the Contract of Liability Coverage.

9.2 Why does the VMO have to complete a TMF Incident Report?

It is a condition of the Contract of Liability Coverage that the VMO must promptly report incidents using the form provided.

It is expected that where practicable the form will be completed and referred to the PHO Liaison Officer within 48 hours of a VMO becoming aware of an incident.

The PHO will forward the form to the Department/TMF. This will be used primarily to assist in the future management and conduct of any subsequent claim, including obtaining legal advice and representation.

Aggregated information from Incident Reports may also be used to assess opportunities for clinical improvement within the health system.

9.3 Why must incidents be generally reported within 48 hours?

Early reporting of incidents is an effective risk management technique as it allows an incident to be investigated, reports to be gathered and relevant facts obtained to enable an early assessment of the legal position and ensure that any future claim can be conducted effectively.

Forty eight hours, in ordinary circumstances, should be regarded as prompt incident reporting under the contract of liability coverage.

Circumstances sometime place a VMO in a position where the earliest he or she can practically report an incident is more than 48 hours after its occurrence. The prompt reporting requirement in clause 3 of the contract will be satisfied provided that the VMO acts in good faith, is able to demonstrate that it was not practicable to report within 48 hours and reports the incident as soon as practicable after becoming aware of it.

9.4 Will a VMO be covered if he or she is not aware that an incident is one that should be reported until some time after it occurs or until the claim is actually made against me?
The contract of liability cover requires a VMO to promptly report incidents that can reasonably be expected to trigger liability cover as soon the VMO becomes aware of them.

In rare circumstances a VMO may not be aware of an occurrence which may trigger the liability cover until much later on or until a claim is actually made. Provided the VMO acts in good faith and has genuinely been unaware that an incident might give rise to a claim the VMO will be covered.

The following three examples are given:-

1. During a surgical operation, an accident occurs with a scalpel which causes serious damage to the patient in a part of their body for which no surgical intervention was anticipated or expected by the patient. Long term and/or short term physical impairment is highly probable. The lodgement of an incident report within 48 hours of completing the operation is expected.

2. A public inpatient is prescribed a particular drug regime prior to discharge and is required to have a consultation in 7 days. After 3 days the patient makes contact concerning adverse and unexpected complications. Further investigations reveal the patient was allergic to some of medication and recovery will now be significantly longer and more difficult. The lodgement of an incident report within 48 hours of the results of the investigation being made available is expected as the original incident occurred whilst the patient was a public inpatient.

3. Several years after treating a public patient in a public hospital a VMO becomes aware that the patient may be seeking information as they appear less than satisfied with their treatment. It would be expected that upon the VMO becoming aware that the patient is seeking information an incident form will be completed within 48 hours as the original incident involved a public patient in a public hospital.

The VMO should also notify using the Incident Form if they receive a letter of complaint or demand from a patient or through a third party such as a solicitor, the Health Care Complaints Commission, PHO or Medical Board.

9.5 How does the 48 hours operate during weekends and for public holidays?

Early reporting of incidents has many advantages and, where possible, immediate submission is preferred.

It is recognised that at weekends and on public holidays, notifying within 48 hours in some circumstances may be problematic and allowances will be made for this as appropriate.

10 TMF ROLES/RESPONSIBILITIES

10.1 What costs are met by the TMF for indemnity?
TMF will pay the total sum arising from any claim for which the VMO is liable, including any settlement amount or verdict, costs order and defence legal and other costs and expenses (for example, barrister’s fees, expert witness fees) incurred by the Fund Manager or PHO in connection therewith.

10.2 Who will conduct the claim?

It is a condition of coverage that the conduct of a claim rests entirely with the Fund Manager and this includes decisions on legal representation, expenses, settlements and the like.

In order to be indemnified for a claim a VMO must co-operate fully with the Fund Manager from the time an incident is reported through to the time a claim is settled or determined, including any recovery action from third parties. In accepting indemnity the rights of the VMO in respect of the claim are subrogated to the PHO. This may involve the VMO executing legal documents to enable settlement, recovery action or other legal action arising from the management/conduct of a claim by the TMF and PHO or their legal representatives.

10.3 Will a VMO get acknowledgment on an Incident Report?

Yes, all Incident Reports will result in an acknowledgment by the Fund Manager. A request for more information may be made where further advice or action is required.

11 QUALITY ASSURANCE, QUALITY IMPROVEMENT AND RISK MANAGEMENT

11.1 Why are VMOs required to participate in quality assurance, quality improvement and risk management?

There is support for active participation by medical practitioners in initiatives that will reduce the occurrence of adverse patient outcomes and therefore patient claims for damages. Clinical governance, as set out in A Framework for Managing the Quality of Health Services in New South Wales, provides the framework for how best practice in patient care should be provided and the occurrence of adverse outcomes minimised.

The tools to achieve this are outlined in the Quality Framework and described in more detail in The Clinician’s Toolkit for Improving Patient Care. The use of these tools, including facilitated incident monitoring, sentinel event management and clinical indicators, will assist the VMO to identify problems in his/her clinical performance. Utilising the data and information arising out of the use of these tools with strategies to improve the VMO’s performance, such as clinical practice improvement, can lead to improved delivery of patient care and the reduced occurrence of adverse events.

This approach is endorsed by the NSW Council for Quality in Health Care. The Quality and Clinical Policy Branch of the Department of Health and the
Institute for Clinical Excellence will provide leadership to support VMO participation in these initiatives.

11.2 Will the participation be within the PHO or in Sydney?

It is expected that for the majority non-Sydney VMOs, participation will be within their PHO.

Within the greater Sydney area, participation may vary depending upon the VMO’s speciality, project and/or activity.

12 GOVERNMENT’S ANNOUNCEMENT OF 19 DECEMBER 2001

12.1 What does the announcement mean in respect of proposed coverage for claims that may arise from work done in the public system on public patients in the past that have not been reported as at 31 December 2001?

This aspect of the Government’s decision was to provide further assistance in supporting and stabilising the level of NSW medical indemnity premiums in the current difficult insurance and reinsurance environment. It effectively involves a transfer of responsibility for these claims from the relevant medical indemnity provider which, through the subscriptions gathered from its members, would otherwise have to meet these claims. Indeed, a number of these claims will relate to individuals that have long ceased to be VMOs or are deceased. For these reasons it is not a matter for appropriate inclusion in contracts of liability coverage with individual VMOs.

This transfer of claims responsibility is necessarily contingent upon full management and conduct of the claim passing to the TMF and the relevant indemnity provider agreeing, under comprehensive Department of Health oversight, to:

- undertake a process, including retrospective case file review, to review current subscription rates for NSW members in order to assess and provide rebates where appropriate; and

- co-operate in a transparent, accountable and auditable process to clearly verify claims that remain the responsibility of the indemnity provider and claims that will be covered by the NSW Government.
12.2 Why doesn’t the Contract of Liability Coverage reflect the unreported claims in section 12.1?

The Contract of Liability Coverage is prospective occurrence-based cover available to VMOs from 1 January 2002 in treating public patients in public hospitals.

Acceptance of responsibility by the TMF for those claims relating to pre 1 January 2002 occurrences under section 12.1 above is by agreement between the TMF and individual medical indemnity providers.

The TMF in accepting such claims will need to be satisfied that not only was the claim unreported to the indemnity provider as at 1 January 2002 but also that the claim involved a public patient in a public hospital or other health service.

The TMF will need to seek further information from the indemnity provider and/or the relevant practitioner in managing and conducting these claims.

12.3 Does the 19 December 2001 announcement have any implications for cover previously provided to Sessional Specialist Obstetricians and Gynaecologists?

That cover is now subsumed by the broader post 1 January 2002 cover.

All Sessional Specialist Obstetricians and Gynaecologists previously covered are required to sign the Contract of Liability Coverage consistent with other VMOs in order to continue to have TMF cover for their public patient work.

13 FURTHER ENQUIRIES

13.1 VMO individual enquiries

All PHOs are required to nominate a VMO Risk Management Liaison Officer and an Incident Reports Officer. (This may be the VMO Risk Management Liaison Officer).

VMOs should contact these officers in the first instance

13.2 Peak Bodies

Peak bodies such as the AMA, RDA or Colleges should contact the Department directly.