

defenceupdate

Quarterly Magazine for MDA National Members

Autumn 2013



 **MDA National**
Support Protect Promote

Managing Boundaries

**Medico-legal Feature:
Supervision**

Genetic Testing

Leaving a Practice

MDA National CaseBook



Editor's Note

In our first issue of *Defence Update* for 2013, I am delighted to have Professor Geoff Riley contribute a comprehensive and thoughtful feature article on Managing Boundaries. Professor Riley is the Winthrop Professor of Rural and Remote Medicine and Head of the Rural Clinical School of WA. As a psychiatrist, he cared almost exclusively for doctors.

The topic of boundary violations in clinical practice is complex and serious. An analysis of cases adjudicated by medical disciplinary tribunals in Australia and New Zealand between 2000 and 2009 found that 24% of the cases involved sexual misconduct towards a patient.¹ Two thirds of these cases involved sexual relationships with patients, as opposed to other inappropriate sexual contact. The penalties for the tribunal cases were severe, with 81% of cases leading to either deregistration or restrictions on clinical practice. While general practice had the highest number of cases resulting in disciplinary action, obstetrics and gynaecology and psychiatry were the specialties with the highest rates of disciplinary tribunal action. Professor Riley's article provides an important discussion of the underlying nature of the doctor-patient relationship and the factors that increase the risk of boundary violations.

Other articles in this issue include the New Year's resolution inspired The Balanced Doctor, an examination of the emerging medico-legal challenges posed by direct-to-consumer genetic testing, a pull-out feature on supervision and patient safety, and our regular CaseBook series.

I hope you enjoy this issue.

Dr Sara Bird
Manager, Medico-legal
and Advisory Services

¹ Elkin KJ, Spittal MJ, Elkin DJ, Studdert DM. *Doctors disciplined for professional misconduct in Australia and New Zealand, 2000-2009*. Med J Aust 2011; 194:452-456.

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From the President

Is patient experience the early warning system for patient safety?

Nowadays, greater choice makes good decision making even more challenging. But fortunately, emerging technologies offer us ways to choose more wisely from the many options available. Hoteliers, restaurateurs and recording artists now unveil their work and then stand back to await an avalanche of either praise or derision from the public, critics or bloggers through an array of websites and applications.

Improved disclosure of information and customer satisfaction ratings have made everything from travel planning to purchasing a car easier while allowing vendors to compete more effectively via higher quality products and/or better prices.

Likewise, modern day health care is becoming more patient driven. While disconcerting to some doctors, patient feedback is increasingly being recognised as an integral part of cultivating a more positive experience of health care and ensuring patient safety.¹

As reported elsewhere in this edition of *Defence Update*, patient experience was the key theme at the MPS International Conference in London last November, entitled "Quality and Safety in Healthcare: Making a Difference".

One of the most fascinating speakers at the conference was Dr Neil Bacon.

Neil trained as a nephrologist, but stepped out of clinical practice in 1998 to found his first company - Doctors.net.uk - which became the UK's largest and most active professional network for British clinicians. In July 2008 Neil also established the iWantGreatCare website which was designed to actively seek feedback from patients about their clinical experiences, in order to improve care in the UK's National Health System.²

During the conference Neil argued that traditional methods of feedback such as patient surveys are flawed: "If you examine the existing systems of monitoring and regulation including traditional surveys of patients, well they don't work. We've had the Bristol Heart Scandal, the Mid Staffordshire Trust failings, the Mayday Hospital problems; all of which have happened when the existing guard has been on-duty".

Neil continued: "What we have to do is to look outside the traditional methods of feedback. Other sectors have shown that if you can harness the wisdom of the crowd - and in our case the wisdom of patients - you can create a highly sensitive system to detect problems long before they lead to deaths; sort of like a 'smoke detector' for patient safety".

Of interest, is that a paper published in a peer reviewed journal last year also suggests that superior patient experience at a hospital (as rated via commercial websites in the USA), was strongly correlated with a lower mortality and re-admission rate for both myocardial infarction and pneumonia.³

This followed an earlier study, which found that the characteristics of providers or organisations that offered more "personal" care were associated with higher levels of satisfaction. More "personal" care was felt to result in better communication and more patient involvement, and hence superior quality and greater safety of care.⁴

And in recent years, leading practices and hospitals in Australia have begun to focus more on providing an outstanding patient experience and on embedding this ethos into their organisational culture. So being polite, helpful, courteous and kind are now seen as the minimum level expected, and I expect that soon patients will also be encouraged to speak up about their care - both good and bad - via Facebook or Twitter.

So rather than creating more distrust and anxiety through greater regulation, hopefully this approach will create an environment that's more open and honest, where patients can get all the information they need to make informed decisions, and where doctors, patients and carers can feel valued as full participants in care, and who can all contribute to higher quality and greater safety.

Another speaker at the MPS conference, Dr Michael J Von Bertele, Chief Executive at the Picker Institute, summarised this scenario well: "Used to its fullest potential, data on patient experiences can be used as part of process reviews to find out what needs to change to improve safety. However, data is merely a collection of numbers until you do something tangible with it. Making changes to policy in relation to negative feedback is only the tip of the iceberg - the real challenge is changing culture".⁵

A/Prof. Julian Rait MDA National President

MDA National would like to congratulate A/Prof. Rait on his recent appointment as Chair of Anglican Overseas Aid. For more information visit anglicanoverseasaid.org.au.

For a full list of references, visit defenceupdate.mdanational.com.au/From-The-President.

Notice Board

New MDA National Office Now Open in Tasmania

Growing from strength-to-strength, we opened our inaugural Tasmanian office on 4 February in response to our Tasmanian Members' preference for a local, reputable and trusted Medical Defence Organisation in their state. Our new office is located in Hobart at 206-208 New Town Road, New Town, Tasmania 7008.

Our Tasmanian office is serviced by Jo Edwards, State Relationship Manager for Tasmania.



Jo Edwards, State Relationship Manager, Tasmania.

Medico-legal Minefield 2013

Using technology to deliver health care at a distance and communicating online with your colleagues, friends and the public can bring enormous benefits. Yet security, medico-legal requirements, and maintaining the highest level of professionalism can be challenging.

This year's forum explores communication technologies, particularly telehealth and social media. Events will be held around Australia from April to June. The forum provides an opportunity to share ideas with your peers alongside technological and medico-legal experts and to optimise your outcomes of modern communications for both doctors and patients.

Visit mdanational.com.au for more information and to register. **Hurry! Places are limited.**

MDA National's Response to the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) Bill was introduced into Parliament on 29 November 2012. This legislation sets up the framework for the introduction of the NDIS and will enable the NDIS to be launched from July 2013 in five trial sites in ACT, NSW, SA, TAS and VIC. MDA National is concerned about the

Supporting Doctors' Mental Health with *beyondblue*

As part of our Corporate Social Responsibility Program, we've joined forces with Australian charity *beyondblue* to raise awareness about mental illness in the medical profession and break down the stigma associated with it. In particular, we are supporting *beyondblue's* world first National Mental Health Survey of Doctors and Medical Students. This will:

- help us better understand the issues associated with mental health in the medical sector
- assist in the development and delivery of improved mental health services and support for doctors and medical students.

The results of the survey will be available in July. For more information about *beyondblue* and the survey visit beyondblue.org.au/dmhpsurvey.

Think Pink Masquerade Ball 2013

This year's annual Think Pink Masquerade Ball will be held on Saturday, 18 May 2013 at the stunning Crown Casino Palladium Ballroom, Melbourne. The Think Pink Foundation is an independent, volunteer-based charity whose focus is to raise funds to provide support to breast cancer patients.

As part of our Corporate Social Responsibility Program, MDA National is proud to support the Ball and The Think Pink Foundation. For more information on how to donate, assist or attend the Ball visit thinkpink.org.au.

Dr Rod Moore - #1 Eagles Ticket Holder

Dr Rod Moore, MDA National Board member and team doctor for the West Coast Eagles, has been announced as the West Coast Eagles' number one ticket holder for the next two years.

Dr Moore is a founding principal of two multi-disciplinary sports medicine clinics in Perth. He has had a long involvement with Australian Rules Football and has been team doctor for the West Coast Eagles since 1987. This is a well-deserved honor for the lengthy service Dr Moore has provided to the Eagles.



Genetic Testing

MDA National Medico-legal Adviser, Dannielle Stokeld, reviews the medico-legal issues surrounding genetic testing.

Genetic testing presents a unique challenge for medical practitioners as the information resulting from assessment of an individual may be relevant not only to that person but also to relatives who share the same genetic heritage. Despite the potential benefits of providing this information to genetic relatives, the results of genetic testing are considered to be confidential health information pertaining to the patient. While some patients will either notify family members themselves or give consent to their doctor to do so, there may be circumstances where the patient does not give consent. In this situation, the results cannot be disclosed without the patient's consent in accordance with the provisions of the *Privacy Act 1988* (Cth).

However, there is an exception for medical practitioners working in the private sector if they reasonably believe that there is a serious threat to the life, health or safety of a genetic relative of the patient and the use or disclosure to the genetic relative is necessary to lessen or prevent that threat.¹ This is a high threshold and the medical practitioner must consider in each case whether this threshold is met to justify breaching their obligation of confidentiality to the patient. Importantly, disclosure without consent is generally recommended to relatives no further removed than third-degree relatives.²

Patient confidentiality and privacy

Medical practitioners can readily make the incorrect assumption that there has been a free flow of information about the results of a genetic test within the family. This can result in inadvertent breaches of privacy/confidentiality and caution must be exercised when medical practitioners are involved in the care of other family members.

Medical practitioners should ensure that they appropriately document their discussion with the patient in the medical records. The National Health and Medical Research Council's (NHMRC's) *Medical Genetic Testing; Information for health professionals*³ provides useful guidance in this regard. The guidelines recommend that when disclosing genetic test results, medical practitioners should include a discussion of whether the results are definitive or suggestive, the clinical significance of the results, whether further investigations are necessary, the confidential nature of the results and the impact of the results on the future health of genetic relatives.

Disclosure without patient consent

Where the patient indicates that they do not want genetic relatives informed of the results and the medical practitioner considers that disclosure without consent may be necessary, the NHMRC's *Use and disclosure of genetic information to a patient's genetic relatives under section 95AA of the Privacy Act 1988* (Cth)² recommends that a medical practitioner should:

- Allow time for the patient to review their decision and consider arranging genetic counselling.
- Hold further discussions with the patient and ask that they reconsider the refusal of consent if there is reasonable belief that there exists a serious threat to the life, health or safety of a genetic relative.
- Discuss the basis of their decision and the process of disclosure with the patient if use or disclosure without consent is considered necessary, unless the nature of the condition requires an urgent response.

While medical practitioners may act to facilitate the process of family communication by providing written information or agreeing to phone contact from the patient's genetic relatives, they must ensure that legal and ethical requirements regarding privacy and confidentiality are maintained.

The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*⁴ recognises that there are complex issues related to genetic information, stating:

3.4 Confidentiality and privacy

Patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations. Good medical practice involves:

3.4.3 Being aware that there are complex issues related to genetic information and seeking appropriate advice about disclosure of such information.

New and emerging issues:

The introduction of direct-to-consumer (DTC) genetic testing presents a complex medical and medico-legal area, where the potential risks are still evolving. The results of DTC genetic testing are often difficult to interpret, and medical practitioners are advised to exercise caution when approached by patients who are seeking advice as to their results.

The NHMRC's recently released draft guide for general practitioners, *Assessing the Direct-to-Consumer (DTC) Genetic Testing Results of your Patient*⁵, recommends medical practitioners ensure that they act within their clinical expertise, and if necessary, refer the patient to a specialist/s for further discussion, investigation and/or interpretation of the results.

For a full list of references, visit defenceupdate.mdanational.com.au/genetic-testing.

Managing Boundaries

Professor Geoff Riley explores the complexities of managing boundaries.



Moral authority and the social contract

The medical profession's moral authority is in the first instance formally conferred by society through the process of licensing or registration. This is the social contract through which doctors are accorded special status in return for a particularly stringent set of behavioural expectations. Doctors will use the best of their ability, knowledge, skills and judgement in the service of the patient. The social contract establishes an *a priori* assumption of trustworthiness of the profession which enables patients to reveal intimacies of mind and body. The reality of that assumption is tested in each encounter between a patient and practitioner.

In an operational sense the social contract also establishes the rules of engagement for the consultation. Doctors are obliged to: be competent, behave ethically and professionally, have good interpersonal and communication skills, demonstrate common decency, and offer compassionate and empathic care. Patients will also deal fairly by respecting doctors' positive and negative rights, and adopting the normal expectations of the sick role: patients should know that they are ill, want to get well, seek help appropriately, and follow reasonable advice.

The doctor-patient relationship

The doctor-patient relationship is unique among professional relationships precisely because of the nature and degree of intimacies shared. The patient's anxiety, need, dependence, and loss of control and autonomy equate to a substantial power imbalance in the doctor-patient relationship. There is potential for exploitation of the patient by the doctor. This imbalance of power imposes a great responsibility on the doctor to behave according to the highest ethical standards. Any breach of this responsibility will diminish the moral authority of the individual doctor and of the profession as a whole. Furthermore, tribunals tend to reject the idea that patient consent for, or collusion in, boundary transgression should have any bearing on judgements of the appropriateness or reasonableness of a doctor's actions.

Boundaries in the doctor-patient relationship

Another characteristic of this special relationship is that the doctor commits to use the encounter solely in the service of the patient. The doctor in return receives only remuneration and the personal satisfaction of doing meaningful work. Specifically the doctor will not exploit the professional relationship for any other personal or self-serving purpose. This, for example, might include:

- improper influence, persuasion or manipulation
- improper gain, whether financial or informational
- receiving favours or gifts, including sexual favours
- selling something, literally (drugs or investment schemes) or metaphorically (religion, politics)
- role reversal, in which the doctor improperly seeks care, succour or "therapy".

In short, whatever transpires between the doctor and the patient in this professional relationship should address the patient's concerns and should not be about the doctor. Unlike a social relationship, it is a one-way arrangement; everything that goes on in the medical consultation is in the service of the patient and the doctor must never impose his or her needs on the patient.

An important example is that doctors should be particularly aware that self-revelation is fraught. Judicious self-revelation may occasionally be acceptable if it is genuinely in the service of the patient. It is often benignly misunderstood by doctors as good empathic sharing - the "I've been there" idea - when it is in fact often gratuitous, and indeed sometimes a product of blatant neediness on the part of the doctor.

Boundary transgression

Boundary transgressions can be divided into boundary crossings and boundary violations.

- **Boundary crossings** are departures from usual practice that are not exploitative and can sometimes be helpful to the patient.
- **Boundary violations** are transgressions which are harmful to patients.

An example of a benign boundary crossing might be giving a young mother a lift home at the end of the day when it is raining, it is late and it is on your way home. But what if you have always found the person to whom you are giving a lift especially attractive? This may already be a boundary violation. Ask yourself why you are really doing this. And what if it starts to become routine, because you have decided to see this patient regularly in the last appointment of the day? And what if you decide after a while to stop and have a coffee or a drink on the way home? Are you telling your partner about this? Because this is not just a boundary violation; it could be about to ruin your life and the lives of many others around you.



Factors that increase the risk of boundary violation

We know that certain factors increase the risk of boundary violation. Doctors who are under stress, particularly relationship stress, are at increased risk of boundary violation. Those who are in solo practice, who are professionally isolated and/or emotionally unsupported, are also at greater risk. Finally, certain psychiatric states tend to increase the risk. These include dependent and narcissistic personality disorders, depression, and alcohol and substance abuse.

Patients who are more likely to violate boundaries include those with vulnerabilities of various types such as borderline and dependent personality disorders. Notably, female patients who have been sexually abused in the past are especially at risk of being abused again in professional relationships. Borderline patients in particular may initiate inappropriate relationships and may test boundaries with active flirtation. Other demanding patients may push doctors in ways that violate professional and ethical norms, some of which may result in the doctor violating professional boundaries.

Dual relationships

The term “dual relationships” describes situations where a professional relationship is used to establish a parallel personal relationship.

Classic examples of dual relationships are treatment of intimates including close friends, staff and associates. These situations are fraught because of the loss of objectivity. They have the potential to permanently damage personal relationships and consequent entanglements can have legal and administrative ramifications. When treating one’s own family the price is potentially higher.

Treating oneself has always been recognised as stupid, but at least the main victim is you! As Osler is quoted as saying in Aphorisms, “A physician who treats himself has a fool for a patient”.

The ultimate improper “dual relationship” is the sexual relationship with a patient. This topic has been well rehearsed elsewhere but it needs to be said unequivocally that it is forbidden. Such conduct ruins lives and further degrades the perception of the profession.

Professor Geoff Riley AM is the Winthrop Professor of Rural and Remote Medicine and Head of the Rural Clinical School of WA.

Table 1. Identifying risky boundary behaviour - the checklist

Always be prepared to check your behaviour against this list.

- Is what I’m doing part of accepted medical practice?
- Does what I’m doing fit into any of the recognised high-risk situations that I have learnt about?
- Is what I’m doing solely in the interest of the patient?
- Is what I’m doing self-serving?
- Is what I’m doing exploiting the patient for my benefit?
- Is what I’m doing gratuitous (not what the patient has asked for)?
- Is what I’m doing secretive or covert? Would I be happy to share it with my spouse, partners or colleagues?
- Am I revealing too much about myself or my family?
- Is what I’m doing causing me stress, worry or guilt?
- Has someone already commented on my behaviour, or suggested I stop?

Table 2. Additional self-test questions for dual relationships - treating family, friends or colleagues

- Am I doing this to raise my own status or in some other way gratify myself?
- Am I too close to be objective in my management of “Tom”?
- Can I perform intimate examinations of “Mary” or ask her intimate or sensitive questions?
- Can our personal relationship survive a professional error or disagreement?

The Balanced Doctor

There is no perfect work-life balance. Everyone is different and needs change over time as personal and work commitments evolve. MDA National Education Developer, Gemma Brudenell, outlines strategies that may help you overcome challenges to attaining balance.

Demand among the Australian medical workforce for improved work-life balance is high and often unmet.¹ Maintaining personal and professional balance is a challenge that doctors continually face and must constantly endeavour to achieve – medical practitioners are unlikely to be effective and productive if they neglect their own health and wellbeing.² Being proactive about managing work-life balance will assist you to provide excellent patient care, maintain patient safety and improve patient satisfaction.

Strategies for attaining balance

Suggestions regarding how to attain balance may not always be achievable but serve as ideals to consider and strive towards. Be confident to prioritise your own wellbeing when the opportunity arises and focus your time and attention on aspects that you can control.

Personal approaches:

- Prioritise developing your personal relationships whenever possible.³ When you plan your week, schedule time with your family and friends, or plan a regular social activity.
- Delegate time-consuming tasks², e.g. hire someone to clean your house, wash your car, do your gardening or mow your lawn. Groceries may be ordered online and delivered, or have your dry cleaning or ironing picked up and dropped off at your home or office.
- Multi-task. For instance, combine exercise with walking the dog to the shops to pick up small grocery items. Or discover activities you and your friends or family all enjoy and can do together such as exercise, gardening, or cooking.

Professional tactics:

- Maintain professional boundaries such as overtime limits and avoiding discussing medical issues away from the workplace.²
- Try to leave your work at work. If you have to bring work home, set aside time when you are not participating in activities that are important in your personal life. Similarly, take time to talk with colleagues about work issues instead of taking this stress home with you.⁴
- Plan ahead to allow regular breaks throughout the day and year.² It may be useful to block out times and dates in your diary in advance for your own and others' reference so appointments are not made. This could include scheduling routine lunch breaks, doctor and dentist appointments, exercise, and family "appointments".
- Strive to stay on task and on time as meetings, telephone calls and emails can get off-topic and waste time.
- Take part in flexible work arrangements including job share, shared care/call and flex time where appropriate.

Organisational suggestions to consider if the opportunity arises:

- Improve administrative systems.⁵ This can involve receiving more support from administrative staff and nurses which may require team building, improved communication and negotiation skills, and delegating tasks.
- Examine your daily agenda and consider whether there are inefficiencies that can be eliminated to reduce your workload.
- Develop your handover system to enable continuity of care rather than continuity of the carer.¹

Do not feel overwhelmed by assuming that you need to make big changes to bring more balance to your life. In reality, imbalance simply happens. Set realistic and achievable goals by starting small and then building on the strategies that are important and that work for you at your particular stage in life. Remember that your wellbeing is critical for you and your patients' safety.

For a full list of references, visit defenceupdate.mdanational.com.au/the-balanced-doctor.





Supervision

"Effective supervisory relationships are grounded in a mutual understanding of the responsibilities of a supervisor and supervised doctor, and these responsibilities need to be explicitly identified by both parties at the start of supervision."

Supervision and Patient Safety

Quality supervision is essential for learning, competent delivery of care and patient safety. MDA National's Education Services team review what constitutes effective supervision and propose suggestions for enhancement.

The supervisor's immediate responsibility for patient safety has a central role in vocational training, particularly in helping the supervised doctor learn personal accountability for quality of care. Patient safety can be enhanced through a positive supervisory relationship that encourages the supervised doctor to approach their supervisor for support. Supervised doctors may not ask for help for various reasons including fear of recrimination, embarrassment at demonstrating a lack of competence, or fear regarding a loss of trust, autonomy or respect.

Supervision is an important part of medical education, allowing experiences to be processed through guided learning. Effective supervision develops medical professionalism and attainment of skills for the supervised doctor thus producing better health outcomes and safe care for patients.

Roles and responsibilities

Effective supervisory relationships are grounded in a mutual understanding of the responsibilities of a supervisor and supervised doctor, and these responsibilities need to be explicitly identified by both parties at the start of supervision. One area for discussion is the medico-legal issues associated with each role. It is a requirement that the supervised doctor does not perform any duties outside of the medical indemnity insurance scope of their supervisor. It is also important that the supervised doctor knows what to do if the supervisor is unavailable and assistance is required and when to refer patients to their supervisor for review.

Supervisors' responsibilities

1. Communicating responsibilities at the initial supervision stage:

- Explain how the supervision will be conducted in line with the requirements of the medical college and training provider/organisation.
- Establish guidelines and triggers where the supervised doctor must seek advice.
- Establish a feedback system to support the supervised doctor's self-regulation.

- Explain arrangements if the supervisor is sick or unable to be contacted.
- Explain medico-legal insurance and its impact on scope of practice.
- Review where common mistakes in the workplace occur and develop strategies to minimise risk.
- Establish an approachable and supportive demeanor.
- Provide an orientation to the people, policies and systems of the workplace.

2. Supervisors' responsibilities during supervision:

- Establish the supervised doctor's skills, abilities and learning needs, and assist them in developing a learning plan.
- Ensure clinical skills are taught.
- Offer feedback and promote communication, including a review of the feedback system established at the start of the supervision stage.
- Identify and address the supervised doctor's blind spots (see opposite).
- Handle errors with a "no blame" approach, exploring contributing factors and discussing how to prevent a similar problem in the future.
- Support work-life balance and monitor the supervised doctor's stress levels.
- Tailor supervision style to the individual needs of the supervised doctor.
- Recognise and manage conflict and other problems early.

Responsibilities of the supervised doctor include:

- Establishing what to do if your supervisor is busy and you need assistance.
- Confirming the triggers and rules for when you need to contact your supervisor.
- Preparing adequately for task duties.
- Seeking assistance and advice early if you are unsure of patient treatment.

- Avoiding situations which may risk the safety of the patient, practice or treating doctors.
- Reflecting on experiences to acquire meaningful knowledge, skills and attributes.
- Recording self-reflection notes which prompt questions and establishing times to discuss these.
- Building a communication channel which supports being able to raise concerns and discuss issues with your supervisor.
- Seeking training opportunities and assistance on procedures and systems from a range of staff members where possible.
- Identifying learning gaps and possible training solutions.
- Finding, observing and working with mentors who have high professional standards.
- Being open to challenges.
- Responding to feedback from the supervisor in a structured and professional manner.

The supervised doctor must accept responsibility for clinical decisions they make; however, they should always remember that they are part of a “shared responsibility” with the supervisor and other medical staff. Patient safety must always be the priority.

For summaries of the responsibilities of a supervisor and supervised doctor visit defenceupdate.mdanational.com.au/supervision.

Blind spots

All doctors have areas in which skill or knowledge is lacking. Supervised doctors who are unaware of their incompetence are unlikely to ask for help and may therefore compromise patient safety. The aim of identifying supervised doctors’ blind spots is to ensure that they seek support about patient management from their supervisor when it is required. Supervisors’ blind spots in relation to teaching should be investigated to check that they are supervising in a manner that does not risk patient safety.

Strategies for senior doctors to identify their own weaknesses regarding supervision include:

- Arranging supervision support with a mentor.
- Seeking feedback from the supervised doctor.
- Participating in supervision training.

Supervisors can also develop strategies to assist in identifying the blind spots of the doctor they are supervising. These include:

- Selecting random patients to review and discuss diagnosis and management with the supervised doctor.
- Organising occasional sit-in sessions or other observational techniques.
- Requesting the supervised doctor to record daily self-reflection notes where possible to prompt discussion and evaluation of decisions.
- Providing regular feedback including feedback that supports self-regulation.

Self-regulation and feedback

Self-regulation is the ability to evaluate your skills and recognise when to seek support. It is recommended that a feedback system be designed and agreed upon at the start of the supervisory relationship to improve the doctor’s self-regulation. The purpose is to improve the supervised doctor’s ability to know when to make decisions on their own and when to seek the supervisor’s advice. This should be in conjunction with established criteria of when to contact the supervisor.

Feedback principles to improve a supervised doctor’s self-regulation:

- Develop self-assessment tasks which are completed and discussed together between the supervisor and supervised doctor.
- Offer timely feedback which not only covers strengths and weaknesses but is corrective, i.e. commenting on specific and observed behaviours, rather than on general performance, at the time of the event or shortly afterwards.
- Encourage dialogue. Reflection and discussion highlight learning gaps and reinforce understandings.
- Encourage a positive feedback environment focusing on improving learning and patient safety.
- Provide opportunities for the supervised doctor to re-complete tasks they need to improve on after feedback has been given.
- Allow the supervised doctor to explain how feedback could be presented more effectively to suit them.

For a summary of the feedback principles promoting self-regulation visit defenceupdate.mdanational.com.au/supervision.

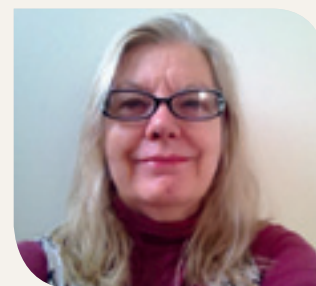
Conclusion

It is critical for patient safety that the supervisor and supervised doctor understand and explicitly define their role and responsibilities at the start of the supervisory relationship. During the supervision period it is vital that blind spots are identified and minimised, and feedback is provided that encourages self-regulation. Patients deserve the most experienced care possible, which means that experienced doctors are required to be available to both the patients and the doctors they are supervising.

It is MDA National’s position that, to enhance patient safety, patients should be informed if they are to be treated by a supervised doctor. More safeguards will likely be in place for both the patient and the doctors if the patient is aware that their doctor is being supervised.

For a full list of references, visit defenceupdate.mdanational.com.au/supervision.

A Medical Educator's Perspective



I started my journey in medical education around the same time I started my career as a GP. I was working as a GP in a small rural town, became a GP supervisor and ignited a desire to become more involved in medical education and a lifelong respect for the importance of clinical supervision.

Sadly as time has gone on and with a deepening involvement in medical education, my involvement in clinical practice has reduced and my direct involvement in supervising trainees has also diminished. What has not changed is my belief that clinical supervision is integral in developing the skills and expertise of our junior colleagues. Clinician supervisors commit their time and expertise into mentoring, teaching, coaching and assessing their junior colleagues while keeping patients safe, supported and in receipt of high quality care. We need to ensure that our supervisors are trained, supported and acknowledged for the role they play in developing and maintaining a skilled clinical workforce.

I have considered myself privileged to have had the opportunity to be involved in the supervision of junior doctors. It has taught me to be a better doctor. In turn I have focused on maintaining the integrity of clinical supervision in my work in medical education.

I have also had the privilege of working alongside colleagues who are now lifelong friends. Our friendships were forged as part of the supervisor-trainee relationship and I have watched these trainees go on to become exemplary clinicians, and GP supervisors themselves.

The most important element of supervision is the quality of the relationship between supervisor and trainee. Like any relationship, it requires effective communication, trust and mutual respect. It requires an understanding and acceptance of what each other brings to the relationship, including prior experiences and expectations of the supervision process. Like any relationship, there may, at times, be misunderstandings, differences of opinion and in the worst instance, communication breakdown. However provided there is trust, honesty and respect for the importance of the supervisory relationship, the integrity of supervision will remain intact.

There are multiple elements of supervision. Skills such as teaching, assessing, mentoring, coaching, evaluating and providing feedback are all integral

to effective supervision. This requires supervisor training and ongoing maintenance of clinical as well as supervising skills.

Supervision is not the responsibility of only one person within the supervision relationship. The trainee is also accountable for ensuring effective supervision is taking place. Patients themselves often play an important role in the provision of feedback about the care that is being provided and in turn the quality of the supervision. Depending on the clinical setting, context and type of clinical training there are often multiple members of the team contributing to the supervision. Clinical supervision is multifaceted in nature and the roles and responsibilities of all parties involved in the supervision need to be acknowledged.

Why is clinical supervision so important? Because it ensures that patients can receive safe and quality care while the new clinician is learning their craft, and the novice clinician can receive safe and quality training while delivering patient care.

There will always be increased demands on clinicians to see more patients, deliver more clinical services and at the same time teach more students and supervise increasing numbers of trainees. At times the delivery of teaching services will seem to be a competing priority with the delivery of clinical services but in fact the two should be seen as synergistic. Supervising trainees is directly related to being a clinician and should always remain fixed in the heart of the clinical setting. There will always be the need for someone experienced and trained to be available to the trainee to provide clinical assistance, to debrief over clinical cases, to mentor and teach the learner. Exposure to experienced clinicians is essential for trainees to learn how to become experienced clinicians themselves. A positive supervision experience will encourage these trainees to become supervisors themselves for the next generation of clinicians.

Dr Kaye Atkinson is a GP, medical educator and MDA National Member.

Achieving Quality and Safety in Healthcare

Medical Protection Society (MPS) convened a conference on “Quality and Safety in Healthcare: Making a Difference” on 15 and 16 November 2012.

The conference, of which MDA National was a key partner, tackled a wide range of topics with the collective aim of trying to make medical practice safer. The conference sessions addressed:

- the patient experience and the importance of listening to patient feedback
- achieving a culture of safety
- disclosure and apology after adverse events
- quality, professionalism and cost in healthcare.

The conference was truly international with more than 250 delegates from around the world, including the UK, Australia, USA, Canada, New Zealand, Singapore, Malaysia, Hong Kong, the Caribbean and Bermuda.

MDA National participated in a panel debate - “The Rising Cost of Clinical Negligence - Is it Sustainable?” - which explored the rise in negligence costs in a global context. Tony Mason, former Chief Executive Officer of MPS, reported that clinical negligence costs in the UK are now the highest anywhere in the world, except in the USA. He outlined the ways in which governments could tackle the cost of rising medical negligence claims:

- introducing Tort Law reform which restricts the number and/or cost of claims
- providing subsidies to doctors in private practice e.g. by taking over the claims against them
- introducing a no-fault scheme to cover all or some medical treatment injuries (e.g. cerebral palsy)
- having such good healthcare and welfare systems that patients feel no need to claim against their doctor.

The debate reinforced the fact that the Tort Law reforms which were introduced in Australia in 2002/2003 have brought stability to our medical indemnity industry.

Other conference sessions

eRating of Doctors

Dr Neil Bacon, the founder of the UK healthcare rating website, iWantGreatCare, described the vision of the site to collect patient experience and feedback to enable doctors, other healthcare professionals and hospitals to monitor and compare their performance. According to Dr Bacon, patient feedback is “the smoke detector of patient safety”. Doctors who use iWantGreatCare can upload a personal profile to the website, including their photo, a biography and professional description.

Dr Bacon suggested that doctors should encourage all their patients to leave feedback about their care on the doctor’s personal profile page. An email alert is sent to the doctor when a new review is added to their page. Doctors are also encouraged to respond to postings on the website, while ensuring that patient confidentiality is not breached.

Disclosure and Apology - It’s not about the money

Dr Lucian Leape, Adjunct Professor of Health Policy, Harvard School of Public Health, described how a serious preventable injury was doubly devastating for the patient. Not only does the patient suffer a physical wound (the adverse event) but they also suffer an emotional wound, involving a sense of betrayal and loss of trust in the healthcare professional. He stated that a serious preventable injury to a patient is a “medical emergency” and the treatment is honest, open, full communication and, when indicated, an apology.



Dr Sara Bird, Manager, Medico-legal and Advisory Services, discussed Australia’s Tort Law reform at the MPS International Conference in November 2012.



A summary report of the “Quality and Safety in Healthcare: Making a Difference” conference and copies of the keynote presentations can be accessed at:

mpsinternationalconference.org

Leaving a Practice?

Do you have a legal obligation not to disclose or use confidential information obtained from your former practice?

In order to consider your obligations to your former practice it will be necessary to determine if you were engaged as an employee or an independent contractor.

While many arrangements purport to be principal/independent contractor relationships, the Courts will look at the facts behind any such agreement to determine the true nature of the relationship. The Courts will consider aspects such as control and expectation of work, how it is performed, hours of work, the payment method and equipment use.¹

In *Boyar v House of Life*², Fair Work Australia determined that a locum alternative medicine practitioner was an employee of the Traditional Chinese Medical Practice. In reaching this decision, the Commissioner stated the "single most important factor" in determining the type of relationship was that at all times the patients remained patients of the practice.

It is therefore likely that a large number of arrangements entered into by medical practitioners would be viewed as employment relationships.

In Australia employees owe certain fiduciary duties (a fiduciary duty is an obligation to act in the best interest of another party) to their employer, including an obligation of good faith. This includes not disclosing or misusing confidential information which was obtained during the course of employment. This applies even when there is no expressed confidentiality or restraint clause in the contract.

The information generally, however, should be truly confidential as opposed to knowledge, skill and experience that a medical practitioner has acquired. In a recent case³, the Federal Court of Australia stated:

The entitlement of an employee to use information obtained in the course of employment after leaving that employment will depend upon the nature of the information, and the manner in which it is obtained by the employee. The general rule is that, after the employment relationship has ended, a former employee may use know-how obtained in the course of the prior employment. He may not, however, use information of a confidential nature. The situation is different if the information in question, even though it is not strictly speaking confidential information of the employer, is deliberately taken or copied by the employee while the employment relationship persists for use after the employment relationship ceased: Faccenda Chicken Ltd v Fowler [1987] Ch 117 at 136. In that case, a former employee was prevented from using the employer's know-how or non-confidential information that might otherwise have been available for use after termination of the employment relationship, because the information and the advantage that flowed from it was obtained through dishonesty.

In the context of a medical practitioner, this could include taking patients' details with the intention of contacting them either during or after leaving the practice and encouraging them to see the practitioner at their new practice.

It is important to bear in mind that the scope of what constitutes confidential information can be broadened by the terms of an employment contract.

That said, medical practitioners must also consider their professional and ethical obligations to patients when leaving a practice. This would include ensuring appropriate arrangements have been made for a patient's ongoing care. It would therefore be reasonable to inform patients that the practitioner is leaving the practice and to assist in facilitating arrangements for ongoing care, as opposed to actively soliciting patients and encouraging them to see the practitioner at their new practice.

In contrast, independent contractors do not owe a fiduciary duty to their principals, so the obligations owed to a former principal, in the absence of a written agreement, are less onerous. However, the Courts still may provide remedies to prevent unauthorised use of information, if it is found that the information was confidential, it was disclosed in circumstances indicating an obligation of confidence and damage or loss was suffered as a result of the information being disclosed or used.

MDA National recommends that Members exercise extreme caution if you consider that there is a possibility that you might use confidential information obtained from your former practice. If an issue arises, please contact MDA National for advice.

By Sharon Russell, Claims Manager, MDA National.

1 *Independent Contractors and Employees - Fact Sheet*, Australian Government, Fair Work Ombudsman Website - fairwork.gov.au.

2 [2011] FWA 7953

3 *Spotless Group Ltd v Blanco Catering Pty Ltd* (2011) 93 IPR 235

What do you think?

Share your comments with us at *Defence Update* online defenceupdate.mdanational.com.au/leaving-a-practice.



The Evolution of Failure to Warn

Dr Patrick Mahar discusses a recent complex claim which considered the issues of consent and causation.

When considering cases of medical negligence, it must first be established that a doctor owes a duty of care to a patient, and it must be possible for a patient to show that duty of care was breached. A medical practitioner has a duty to warn a patient of all the material risks inherent in the proposed treatment. Further, in order to establish negligence the Court must be satisfied that the failure to warn was the cause of the harm. An action in negligence will not be successful, however, if the breach of duty cannot be shown to have caused a harm befalling the patient.

Case history

The recent NSW Court of Appeal case, *Wallace v Kam*¹, visited this issue of establishing causation, whereby a patient suffered a particular harm, and held that the clinician was in breach of his duty of care by not disclosing specific relevant material risks that did not in fact eventuate.

In this case, the patient sought the opinion of a neurosurgeon with regard to management of his back pain, which was caused by a lumbar disc prolapse. The pain had become progressively worse and was limiting the patient's mobility. Conservative measures were initially advised. However, following failure of these, the patient attended a subsequent consultation where the neurosurgeon recommended immediate surgery.

Both the patient and the neurosurgeon agreed that the patient was advised of an approximate 75% chance of improvement of symptoms. The neurosurgeon contended that the patient was consented with respect to an approximately 5% risk of catastrophic paralysis as a result of injury to the spinal cord, however the patient contended he was not. Further, the patient contended that he was not warned about the risk of bilateral femoral neuropraxia.

Following a lengthy operation, the patient awoke with significant pain and paralysis in both legs. Following investigation of these symptoms, the patient was diagnosed with bilateral femoral nerve neuropraxia as a result of patient positioning, exacerbated by the patient's weight, which was approximately 124 kilograms.

Medico-legal issues

At the initial trial in the NSW Supreme Court, the patient sought damages with respect to the surgeon's failure to warn him of the risk of neuropraxia and 5% risk of paralysis.² The judge held that the surgeon had breached his duty of care in failing to warn the patient adequately with respect to the risk of developing bilateral femoral

neuropraxia; however, it was held that the patient did not establish that he would have declined surgery if warned of that risk. The judge did not consider the 5% risk of paralysis relevant, as this had not actually eventuated.

At the NSW Court of Appeal, the patient claimed that the surgeon's duty was to warn the patient of all material risks of the operation as a single duty.¹ This single duty in this case included being warned of the risk of bilateral femoral neuropraxia, which the patient suffered, as well as the 5% risk of a catastrophic outcome and thus the issue of causation should be determined with respect to a breach of this one "single comprehensive duty". The patient also contended that, was he warned of the risk of catastrophic outcome, he would not have proceeded with the operation at that time and thus would not have developed bilateral femoral neuropraxia.

Causation was not considered to be established in this case by the majority judgment; hence the action in negligence on behalf of the patient was not successful. The Court held that the failure to warn of a particular risk that would have prevented the patient from undergoing surgery but did not occur, does not necessarily result in a finding of negligence in relation to another harm where the risk does occur.

Discussion

In no way should this judgment reduce the legal obligation of Members to warn patients of relevant material risks prior to undertaking an operation or a procedure. It does, however, suggest that patients cannot, if they suffer a particular adverse outcome, claim in retrospect that they would not have proceeded with a procedure because they were never warned of a risk that did not actually occur. Otherwise a patient would be able to claim compensation for *any* harm that eventuated if they were able to establish that there was a material risk that was not disclosed which, if disclosed, would have resulted in them not undergoing the procedure.

The High Court has recently granted special leave to the patient's solicitors to appeal the decision of the Court of Appeal.

Dr Patrick Mahar MBBS (Hons), LLB (Hons) is a member of the President's Medical Liaison Council and a MDA National Member.

¹ *Wallace v Kam* [2012] NSWCA 82

² *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518



Duty to Follow Up Revisited by the Courts

In October 2012, the case of *Grinham v Tabro Meats Pty Ltd & Anor; Victorian WorkCover Authority v Murray* [2012] VSC 491 was heard in the Victorian Supreme Court. The decision provides some clarification on the legal duty of medical practitioners to follow up patients.

Case history

Between 2002 and 2006, Stephen Grinham was employed in an abattoir owned by Tabro Meats Pty Ltd. In 2002, he presented to Dr Murray, a GP, for testing and immunisation for Q fever, which can occur in people who work in close contact with animal faeces, urine, blood, pregnancy fluids or inhalation of dust particles from abattoirs. The results of the tests were inconclusive in that blood testing indicated Mr Grinham was low positive for Q fever, even though skin testing indicated he was negative. Following review of these results, Dr Murray provided Mr Grinham with a pathology request form, advised him he could not be vaccinated at that time and requested he return to the practice after having the Q fever blood test repeated in one month's time. Mr Grinham did not re-present to the practice and he subsequently contracted Q fever in 2006.

Medico-legal issues

Mr Grinham sought damages from his employer (this was settled part way through the trial) and Dr Murray, alleging that she was negligent in failing to provide adequate and appropriate advice on the seriousness of his situation and had failed to recall him when he did not re-present the following month or have further testing done as requested. The Victorian Workcover Authority and the employer sought reimbursement from Dr Murray of money paid to Mr Grinham alleging she had breached her duty of care to the patient.

The Court held that Dr Murray's actions were reasonable and that her failure to follow up was not negligent, nor did she breach her duty of care to him. The Court considered that Dr Murray could have implemented a follow up system, however found her actions in this case to be reasonable on the basis that:

- (a) The patient was cognisant of the advice given to him by the GP.
- (b) There was nothing to suggest that the patient would not attend for the recommended blood test and present for a further doctor's appointment.

(c) There was nothing to suggest that the patient was suffering from a life threatening illness at the consultation.

(d) The patient knew that he was still at risk of contracting Q fever, and that "it was his (not Dr Murray's) decision not to undergo further testing and to not make an appointment to return for further advice and treatment".

The Court accepted evidence from other general practitioners that Dr Murray's actions were consistent with practice at the time and that each one would most likely have acted accordingly.

In determining whether follow up is required, a medical practitioner may need to consider and evaluate the specific factors for each patient. For example, if there are possible life threatening implications or consequences of not attending the test, and whether there are any cognitive or language impairments of the patient which can prevent their understanding of the possible risks.

Discussion

Were Dr Murray's actions appropriate?

It was alleged that Dr Murray had failed to provide appropriate information to Mr Grinham so that he was fully cognisant of the risks of contracting Q fever and that she had a duty to recall Mr Grinham given the seriousness of the situation when he failed to re-attend.

As initial testing was inconclusive, further testing was indicated and immunisation could have placed Mr Grinham at risk of a severe vaccine reaction. Expert evidence presented at trial indicated that Dr Murray had acted appropriately in ordering re-testing in one month after the initial test in May 2002.

One GP expert stated that given Mr Grinham's type of employment and the risk posed to him, a recall system would have been prudent. Further, the expert also stated that the doctor was entitled to make an assessment of the reliability of the patient to attend for follow up. Dr Murray gave evidence that she considered Mr Grinham would have further testing done and attend for follow up.

In determining whether follow up is required, a medical practitioner may need to consider and evaluate the specific factors for each patient.

It is widely accepted at common law and in legislation that the duty owed by a medical practitioner to the patient is assessed on the basis of reasonable skill and care, but also the standards as practised by the practitioner's peers at the time the service was provided. Critically in this case, most experts agreed that it was very unlikely in 2002 that any medical practice had a consistent system for recalling patients.

Risk management

The benefit of good clinical notes

Dr Murray's medical records included notes on her discussions with the patient, with her supervisor at the practice, with the Health Department about vaccination in view of the inconclusive tests, information given to Mr Grinham about Q fever and a further pathology request.

Mr Grinham however stated he could not accurately recall the consultations and denied having received the pathology request form. He gave evidence at the hearing that he would definitely have attended for re-testing had he been given a request form.

Given the consistency between both Dr Murray and her supervisor's evidence and the detailed medical records, their evidence was accepted by the Court where Mr Grinham's was not.

An effective recall system

In 2011-2012, 41% of risk management recommendations made to MDA National Members were concerned with systems issues.¹ This category includes recall and patient follow up.

The recommendations made are generally designed to assist medical practitioners to set up and maintain a recall system.

In essence, any medical practice should:

- Have a simple yet effective system that allows tracking of test results for patients of concern, which includes routine review to alert practitioners of any test results which have not been received over a period of time.

- Have clear understanding of the roles each practice staff member takes in the test tracking and recall system (for example, once the doctor reviews the test result and marks the patient for recall, who is to contact the patient to book a follow up appointment).
- Expand the test tracking and recall system to include factors reflective of an individual patient's condition, the reason for the investigation or referral, the patient's history of compliance/non-compliance and their level of understanding.

Summary Points

From a risk management perspective, this Court decision highlights a number of key points:

- Good medical records are essential.
- All medical practices should have an effective recall system in place.
- The system needs to take into consideration individual patient circumstances.

By Allyson Alker, Risk Adviser, MDA National.

¹ MDA National, *Annual Report 2012* June 2012; 28.

What do you think?

Share your comments with us at *Defence Update* online defenceupdate.mdanational.com.au/duty-to-follow-up.



Medical Manslaughter

MDA National Medico-legal Advisers, Dr Jane Deacon and Ms Janet Harry, examine the Australian experience of manslaughter charges arising from medical practice.

Case history

A psychiatrist Member sought our advice after a recent case was reported in the press where a French psychiatrist was found guilty of manslaughter after one of her patients hacked an elderly man to death.¹ Our Member asked if such a case could occur in Australia.

Medico-legal issues

It is evident that decisions such as this can cause considerable concern among psychiatrists. However, there were a number of aspects of the French case that should be taken into consideration:

- The decision was reportedly the first of its kind in France, and likely to be appealed.
- The French legal system has some important differences from the Australian legal system.
- The Court itself expressed that this was a decision which turned on the facts of the particular case:

The Court said [the psychiatrist] should have requested [the patient] be placed in a specialised medical unit or referred him to another medical team, as one of her colleagues had suggested. Her refusal had amounted to a form of "blindness", the Court president, Fabrice Castoldi, said. He stressed that "we are not judging psychiatrists or the psychiatric profession, but a particular case".¹

Discussion

In Australia, criminal prosecutions for medical negligence are rare events. In 1843 Dr Valentine was charged and found guilty of manslaughter. Since then a handful of doctors in Australia have faced charges of manslaughter:

- A GP was found guilty in 2000 after administering an adult dose of morphine to a young child, resulting in the child's death.
- An anaesthetist was charged and acquitted of manslaughter in 2001 when he allegedly failed to notice his patient was not breathing after an operation.
- A GP pleaded guilty to negligent manslaughter in 2006 after inadvertently prescribing 5 ampoules of morphine tartrate 120mg for unsupervised use to a patient with lower back pain. The patient died of a morphine overdose.
- A surgeon was charged, but charges were dropped mid-trial in 2009 in relation to the death of a patient from punctured iliac vessels during a hysterectomy.

More recently Dr Jayant Patel was convicted of three counts of manslaughter and one case of grievous bodily harm.

In August 2012, the conviction was rescinded by the High Court and a retrial was ordered due to "highly emotive and prejudicial evidence that was irrelevant to the case" led before the jury.

The threshold for a prosecution for medical manslaughter is high. In order for a successful prosecution, it must be shown not only that the negligent act caused the death, but more importantly, it must be shown that the degree of negligence was so gross or culpable as to warrant criminal conviction and punishment.

It is also worth noting that the cases mentioned above involve the situation between a doctor and their patient, and we are not aware of any case in Australia which has extended to a third party, such as in the French case.

Risk management strategies

Where you are concerned about the potential risk a particular patient may pose, either to a specific individual, the general public, or to themselves, then you could consider:

- Reviewing the patient's clinical history with an experienced colleague to determine what, if any, action is required to protect the public, or to protect the patient from self-harm.
- Contacting the Chief Psychiatrist and/or MDA National for advice.

There are certain exceptions to your duty of confidentiality and privacy, so that if you are of the view that there is a serious and imminent threat to the safety of an individual, or an overriding duty in the "public interest" to disclose information regarding a patient, then you can breach confidentiality and take appropriate steps. Again, we would suggest that this be considered after review with your peers, and discussion with MDA National.

Summary Points

- Criminal prosecutions for medical negligence are extremely rare.
- The duty of confidentiality is not absolute. Exceptions include circumstances where there is a serious and imminent threat to the safety of an individual, or an overriding duty in the "public interest" to disclose information regarding a patient.

¹ Dyer C. *French psychiatrist is convicted of manslaughter after her patient kills an elderly man*. BMJ 2012; 345:e8693. Available at bmj.com/content/345/bmj.e8693

What's On?

MDA National is promoting your professionalism and wellbeing in 2013 with our Medico-legal Minefield Forum, Practical Solutions to Patient Boundaries and Keys to a Healthy Practice workshops.

We are also supporting Members by sponsoring a number of state and local conferences and events in collaboration with colleges and associations. We welcome you to visit us at any of the events below.

April 2013

Medico-legal Minefield Forum
Various locations and dates
Visit mdanational.com.au

May 2013

Medico-legal Minefield Forum
Various locations and dates
Visit mdanational.com.au

4-8 ANZCA Annual Scientific Meeting
(sponsored event)
Melbourne, VIC

5 RACGP 56th Clinical Weekend
(sponsored event)
Brisbane, QLD

6-9 RACS Annual Scientific Congress
(sponsored event)
Auckland, NZ

18 Think Pink Masquerade Ball
(sponsored event)
Melbourne, VIC

19-22 ACD Annual Scientific Meeting
(sponsored event)
Sydney, NSW

26-29 RACP Future Directions in Health
Congress 2013 (sponsored event)
Perth, WA

June 2013

Medico-legal Minefield Forum
Various locations and dates
Visit mdanational.com.au

1 SAPMEA GP Clinical Update
(sponsored event)
Adelaide, SA

3-7 RANZCR 9th Breast Interest
Group Meeting (sponsored event)
Darwin, NT

Find out more

To find out more or to register for any of the MDA National events:
visit mdanational.com.au
email events@mdanational.com.au
or contact 1800 011 255.

Medico-legal Minefield 2013

Communication Technologies – Risks, Responsibilities and Rewards

Using technology to deliver health care at a distance and communicating online with your colleagues, friends and the public can bring enormous benefits. Yet security, medico-legal requirements, and maintaining the highest level of professionalism can be challenging.

Join us at the 2013 forums to explore communication technologies, particularly telehealth and social media. Share ideas with your peers alongside technological and medico-legal experts to optimise your outcomes of modern communications for both doctors and patients.



Visit mdanational.com.au
for more information and to register.

Hurry! Places are limited.



Facilitators

Professor Stephen Trumble

Chair, Clinical Education and Training Development,
University of Melbourne.
Education Services Advisory Group, MDA National.

Dr Patrick Mahar

Doctor in Specialist Training.
President's Medical Liaison Council, MDA National.

How much does it cost?

Complimentary for MDA National Members.
Places are limited so register today.

CPD accreditation

CPD accreditation is currently pending.

Dates and locations

Various locations around Australia from April to June 2013.
For more information visit mdanational.com.au.



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