

# firstdefence

JMOs + Doctors in Training

Spring 2009



**MDA National**  
Support Protect Promote

**Personality and Medical Practice.**

The tension between 'who we are'  
and 'how we practice'.

**A Wrong Cut is the Deepest.**

**MDA National Presents...**

**16 Hours: A Day in the life.**

**Getting Your Message Across:  
Handover Challenges.**

# Personality and Medical Practice

The tension between 'who we are' and 'how we practice'



## "I'm starting with the Man in the Mirror.."

### Michael Jackson (1987)

Borrowing these eerily self-referential words from the recently deceased Michael Jackson may seem a long bow to draw when addressing the topic of personality and medical practice. Jackson's notoriety was more than a function of his music stardom - it was the *personality* behind that *persona* which, over the past decade, filled the pages of gossip magazines and the airways with titillating scandal as commentators slowly unpicked the damaged soul that invigorated the man.

The intensity of interest may in part be explained in simple terms by the tension in Jackson between The Performer (*persona*) and The Private Citizen (*personality*).

In medical practice, junior doctors daily maintain a similar, hopefully less intense, tension between *personality* and *persona*. When we interact with patients, colleagues, allied health staff and others in the work environment, we mostly present a *persona* that we hope embodies all the qualities one might expect of a young doctor - confidence, technical knowledge and skills, resilience, decisiveness, and indefatigable enthusiasm. The truth of 'what lies beneath' is something else altogether - as the landmark work of the AMA Junior Doctor Survey 2009 reveals<sup>1</sup>. All is not quite as one might wish it to be. Stress can be generated when this tension rises, with significant impact on our sense of wellbeing, work performance and patient care<sup>2</sup>.

## How many junior doctors have seriously contemplated how their personalities are influencing their responses to the vicissitudes of modern medicine and postgraduate training?

Longitudinal cohort studies have shown that the personality factors of medical school entrants are enduring throughout training and into post-fellowship careers, and that the personality traits associated with these factors are predictive of such things as vulnerability to 'burnout' (see info box re Burnout) and dissatisfaction with work. Illustrative of this is work by Mc Manus et al in a 12 year study of British junior doctors followed up from their first year of university through to vocational training<sup>3</sup>. Initial observations found that doctors who reported high workloads and unsupportive work environments were the same doctors reporting more stress, dissatisfaction and burnout. One might conclude a causative link between these factors, but the longitudinal design allowed for a more sophisticated appreciation. These same doctors, working entirely different jobs five and six years earlier, reported similar issues with workload and support issues. Hence, characteristics of the doctor - especially aspects of their personality - which move with them from job to job have at least as significant role in the experience of stress in the workplace as impersonal factors imposed systemically.

The Five-Factor model of personality has gained significant traction across multiple domains of research in recent years. Rather than presenting a theoretical construct of personality as many older tools do, it proposes a set of domains that encompass personality traits which are measurable. Repeated studies show that of the 'Big Five' domains, three are significant in predicting vulnerability and response to stressors in doctors - Conscientiousness, Neuroticism, and Agreeableness (the other two domains being Openness to Experience and Extraversion).

But how many junior doctors have seriously contemplated how their personalities are influencing their responses to the vicissitudes of modern medicine and postgraduate training? Research into this is lacking. This is disconcerting given evidence that over the past two decades doctor satisfaction with work has declined, and rates of depression and alcoholism, irrespective of gender, are significantly greater than the broader community<sup>4,5</sup>.

In spite of such gloomy statistics the fact remains that around 90% of junior doctors in Australia would still choose medicine as a career if given their time again<sup>6</sup>.

In the past, much of the medical literature has focused on the systemic and work related factors that contribute to stress and distress in medical practice. Closer inspection of the association has demonstrated that whilst factors such as excessive work load and lack of sleep are very important, their effects are mediated through the individual practitioner to an equally important extent<sup>7</sup>.

Let's consider an example: the conscientious and somewhat obsessive young doctor, feeling an increasing loss of control in the work environment because of 'the system', begins to feel their effectiveness in clinical practice is diminishing - a classic emerging symptom of burnout. The doctor may respond with a series of *rationalisations*, to try and "explain away" the unpleasant sensation, rather than attempting to address the underlying disconnect between personality and the environment. If sustained for a long period, the rationalisations begin to lose effectiveness and other, less adaptive responses, may emerge. A state of *hypowellbeingness*, as Schattner calls it, establishes in the doctor increasing their risk of further deterioration<sup>8</sup>.

It is important to avoid pathologising personality. John Banja, in his book *Medical Error and Medical Narcissism*, highlights the benefits of many traits which, in different circumstances may be seen as unhelpful, but in medicine allow an individual to engage in extremely high stress, high stakes environments more effectively. Being able to depersonalise from the road accident victim whose lower limbs have been severed and are likely going to be amputated, may allow the doctor to address the more urgent life saving measures of transfusion and resuscitation. However, without adequate periods of reflection and re-engaging of emotional content, a doctor may be conditioned to the degree that such depersonalisation becomes *modus operandi*. The consequent failure to address the emotional and psychological effects at a personal level does not ameliorate them, it simply pushes them down internally where their effects become more obscure and difficult to observe. In extreme cases classical *acting out* occurs, where individuals become hostile or aggressive and demeaning towards others in the workplace believing the behaviour is justifiable because no one understands how difficult their job is, or could possibly be working as hard or effectively as they are. Instead, the behaviour is a function of anger and disillusionment that they are unable to admit to themselves either in relation to their own perceptions of themselves or, perhaps even more challenging, in relation to their patients.

**TABLE 1: Symptoms and Signs of 'Burnout'**

1. Emotional exhaustion
2. Cynicism
3. Perceived clinical ineffectiveness
4. Sense of depersonalisation in relation to patients, colleagues or both

Adapted from Spickard et al (2002)

## “As Jackson reminds us, *par excellence*, creativity and extraordinary success do not necessarily require perfected personality.”

Strategies and mechanisms do exist that can address the way doctors respond to their stress. Table 3 highlights some of these. In principle they all rely on a few key functions, Firstly, the recognition of *the self* as an autonomous entity of internally organised structures that interacts with the environment, and that a level of control can be exerted by a person as to how that interaction occurs. The AMA junior doctor survey found the majority of doctors identified using ‘coping strategies’ at least a few times a week which consisted mainly of spending time with family or friends or exercising. Such generalised methods of ‘de-stressing’ are commonly promoted and are useful, but they do not necessarily specifically address the tensions that generate the stress in the first place. Riley, Spickard and others have reported among other recommendations that much more substantial investment in doctors having a sense of control over the work environment and career path is essential, with Firth-Cozens and others advocating system wide, whole-of-training approaches that address organisational, task and human factors contributing to stress<sup>9</sup>.

For the individual doctor, recognition and awareness of the predictors of risk and symptoms of maladaptive systems of coping is another important step. ‘Mindfulness’ based training approaches are being introduced into some medical schools<sup>10</sup>, in the hope that early adoption of such systems of thinking will better assist young doctors in the first few years of practice and beyond - not forgetting that many doctors learn their responses to stress in medical school through exams and clinical placements.

As Jackson reminds us, *par excellence*, creativity and extraordinary success do not necessarily require perfected personality. In fact the tensions and discordance may be a source of intrapsychic energy which can drive individuals to extraordinary achievement. The salient lesson might be that happiness and wellbeing, emerging from a better understanding of *how we are the way we are*, makes the journey ultimately more satisfying. And our patients, family and friends will appreciate us all the more for the effort.

---

### References

- 1 AMA Survey Report <http://www.ama.com.au/node/4217>
- 2 Riley, G., *Understanding the stresses and strains of being a doctor*, MJA, 2004; 181(7): 350-353
- 3 McManus, I. *Stress, burnout and doctors’ attitudes to work are determined by personality and learning style: A twelve year longitudinal study of UK medical graduates*. BMC Medicine 2004, 2:29
- 4 Firth-Cozens, J., *Interventions to improve physicians’ well being and patient care*, 2001, 215-222
- 5 Spickard, A. *Mid-Career Burnout in Generalist and Specialist physicians*. JAMA 2002, 285:12
- 6 | bid 1
- 7 | bid 4
- 8 Shattner, P., et al, *Doctors’ health and wellbeing: taking up the challenge in Australia*, MJA, 2004; 181(7): 348-49
- 9 Firth-Cozen, J., *Doctors, their wellbeing, and their stress*. BMJ, 2003; 326: 670-671
- 10 | bid 8

**TABLE 2: The Doctor's Rationalisation 'Tool Kit' and Questions to Challenge Them**

Rationalisation	Challenge
<ul style="list-style-type: none"> <li>• Euphemistic language</li> <li>• Advantageous comparison</li> <li>• Distorting the consequences of an action</li> <li>• Displacement of responsibility</li> <li>• Diffusion of responsibility</li> <li>• Attributions of blame</li> <li>• Fragmentation</li> </ul>	<ul style="list-style-type: none"> <li>• What was the nature of my mistake?</li> <li>• What are my beliefs about the mistake?</li> <li>• What emotions did I experience after the mistake?</li> <li>• How did I cope with the mistake?</li> <li>• What changes have I made as a result of the mistake?</li> </ul>

Adapted from Banja (2005)

**TABLE 3: Strategies for Individuals Responding to Stress**

Recognition of psychological and emotional impact of work, the interaction between the self and the environment, and appreciate signs and symptoms of distress and maladaptation
Adoption of 'Mindfulness' style of practice <ul style="list-style-type: none"> <li>• heightened sense of awareness of one's thought processes and emotions developed through specific routines and disciplines (see Hassed, 2002)</li> </ul>
Regular 'de-stressing' activities such as socialising with family and friends, physical exercise
Share difficult and upsetting experiences with colleagues and peers
Regular conscious challenge to patterns of thinking like rationalisations, diagnoses and treatment, resource utilisation, and clinical effectiveness <ul style="list-style-type: none"> <li>• Formal cognitive restructuring programs in individual and group settings</li> <li>• What else could this be? Am I up to date on therapeutic options?</li> <li>• How do I really feel about this outcome for my patient? Why am I so angry there is no discharge destination for this patient?</li> </ul>
Reclaim a sense of control of working environments through dialogue with colleagues, administrators and co-workers and use of limit setting
Identify and regularly remind oneself of rewarding aspects of work whether perceived or 'real'
Identify and develop mentors
Establish a relationship with a GP
Access formal referral arrangements for professional support services when evidence of sustained distress and performance issues

**Dr Kieran Le Plastrier MBBS MPsych  
Psychiatry Registrar**

# A Wrong Cut is the Deepest



## Case History 1

John Smith was scheduled to undergo a total hip replacement and Jon Smyth was booked to undergo an inguinal hernia repair at a large metropolitan teaching hospital. Due to the similarity of the patients' names, they were inadvertently taken to the wrong theatres, but the mix-up was not discovered prior to the commencement of each operation. When upon exploration, the surgeon could not find an inguinal hernia, Mr Smith's clinical notes were checked, and it was discovered that he was consented to undergo a hip replacement. After reviewing the theatre list and noting that there was a "John Smith" and a "Jon Smyth" on the morning list, the scout nurse telephoned the other theatre and asked them to check the identity and consent of their patient. In the other theatre, as Mr Smyth's femoral head had been removed and acetabular reaming commenced, surgeons had no choice but to continue to replace the hip.

## Case History 2

At another hospital, a 42-year-old patient was scheduled to undergo an abdominal hysterectomy, with conservation of her ovaries. The consent form stated "TAH - retention of ovaries". Prior to scrubbing, the registrar reviewed the consent form, which he thought said "resection of ovaries". The patient's ovaries were removed as part of the procedure. The error was not noted until a post-operative discussion was held with the patient about the commencement of hormone replacement therapy. During a Root Cause Analysis investigation, it was ascertained that prior to being anaesthetised, the patient had asked the anaesthetic nurse to ensure that her ovaries were not removed during the procedure.

## References

- 1 NSW Health Policy Directive "Correct Patient, Correct Procedure, Correct Site" (PD2007\_079) at [www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007\\_079.pdf](http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_079.pdf).
- 2 RACS & NSW Health, "An important safety message for all surgeons" (2009).
- 3 For instance, see Haynes, et al, *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population*, New England Journal of Medicine, 360(5) pp 491-499.
- 4 Australian Commission on Safety and Quality in Health Care - see <http://www.health.gov.au>.
- 5 [www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007\\_079.pdf](http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_079.pdf); [www.health.qld.gov.au/patientsafety/eis/webpages/eishome.asp](http://www.health.qld.gov.au/patientsafety/eis/webpages/eishome.asp); [www.health.vic.gov.au/vscc/downloads/correct\\_side.pdf](http://www.health.vic.gov.au/vscc/downloads/correct_side.pdf); [www.health.act.gov.au/c/health?a=dpubpoldoc&idocument=85](http://www.health.act.gov.au/c/health?a=dpubpoldoc&idocument=85); <http://www.safetyandquality.sa.gov.au/SAFETYANDQUALITY/Portals/0/3cPolicy.pdf>; <http://www.health.wa.gov.au/circularsnew/pdfs/12204.pdf>; <http://www.health.nt.gov.au>; See the table on page 7 at [http://safetyandquality.gov.au/internet/safety/publishing.nsf/Content/336A2258BA0A4602CA2574E400202C33/\\$File/19793-ReviewCPCSCP.PDF](http://safetyandquality.gov.au/internet/safety/publishing.nsf/Content/336A2258BA0A4602CA2574E400202C33/$File/19793-ReviewCPCSCP.PDF).

## Discussion

All members of the surgical team owe the patient a duty to ensure that the correct operation is performed on the correct site of the correct patient. The errors described above could have been prevented if the various operative teams had performed a "Time Out" prior to commencing each operation. Junior doctors are an integral part of this process.

Incorrect patient, incorrect procedure, incorrect site incidents are preventable occurrences and largely the result of miscommunication and unavailable or incorrect information.<sup>1</sup>

A "Time Out" is a "vital and final 'fail safe' patient safety check"<sup>2</sup> that protects both the patient and the operative team (including the surgeon, surgical assistant and theatre nurses). A "Time Out" is a surgical checklist that the operative team runs through prior to the commencement of each operation. Research supports the implementation of a surgical checklist, as its use is associated with reduced mortality and morbidity.<sup>3</sup>

A "Time Out" must be performed in the operating theatre when the patient is present (ideally prior to the initiation of regional or general anaesthesia) and prior to the commencement of the procedure. During the "Time Out", when all other activity in the operating theatre has stopped, the operative team must verbally confirm:

- The presence of the correct patient;
- The procedure to be performed;
- That the correct site has been marked;
- That the correct implant is available (if applicable).<sup>4</sup>

The Health Departments of most states and territories have introduced policies that seek to minimise - and ideally prevent - surgical errors of the type referred to above.<sup>5</sup>

To further maximise patient safety, when a "Time Out" is being performed, it is also a perfect opportunity for the theatre team to check other things about the patient - such as allergies and whether thromboprophylaxis is required.

**Yvonne Baldwin**  
Claims Manager (Solicitor)

MDA National Presents...

16 HRS:

## A day in the life

**16 Hours: A Day in the Life** explores the all too common and complex medico-legal issues faced by junior doctors against the backdrop of the realities of a stressful workplace.

You may have already seen one of the DVD session topics however there is still more topics to see!

DVD sessions topics include:

- **Stress, the Workplace, Myself and I**
- **Medication Errors**
- **Consent**
- **Breaking Bad News**

**“Very good and informative”**

**Cairns Base Hospital**

Have your MEO organise a DVD session at your hospital or contact your State Liaison Manager for more details on 1800 011 255 or [peaceofmind@mdanational.com.au](mailto:peaceofmind@mdanational.com.au)

Find out why over 98% of your colleagues enjoyed the presentation and content – arrange a session at your hospital today!

**“Excellent presentation”**

**Royal Hobart Hospital**

**“Excellent, very useful and practical”**

**Dandenong Hospital**



**Meet Michelle Buchanan, 27. Michelle aspires to a career in general medicine and has been rostered on for 3 months in the Neurological Department. Normally a calm person, today Michelle will be pushed to her limits...**



**MDA National**  
Support Protect Promote

# Getting Your Message Across

## Handover Challenges



### Case History

The patient underwent an elective thyroidectomy at a large metropolitan teaching hospital. The patient had a significant past history of thrombosis, including multiple DVTs and a CVA from which she had made a good recovery. The patient was on long term Warfarin therapy. The patient's Warfarin had been ceased pre-operatively and she had been commenced on Clexane. In the immediate post-operative period, a therapeutic dose of Clexane was recommended.

On the first post-operative day, at about 5:00pm, the patient started to complain of tightness in her neck and severe wound pain. Because of the patient's complex medical history, she had remained admitted under the medical team. The nursing staff paged the medical RMO who promptly attended the ward to review the patient.

The patient complained that she had severe pain in her neck and she thought her neck was very swollen. The patient also stated that her voice sounded 'different' after the surgery. The RMO performed a brief physical examination of the patient but decided not to take down the patient's surgical dressing. She noted that the patient had a normal respiratory rate and her chest examination was normal. The RMO checked the patient's medication chart and noted that she had only been prescribed Panadeine Forte on a PRN basis for post-operative pain relief.

The RMO paged her Registrar to inform him of the patient's increasing pain and voice changes. The Medical Registrar said that it was a surgical issue and asked the RMO to contact the Surgical Registrar. By this time it was about 5:30pm. The RMO did not know who the Surgical Registrar was. She decided to chart the patient for some Endone. She also paged the evening RMO. She asked him to review the patient and to call the Surgical Registrar, if necessary. She informed the evening RMO that the patient had post-operative pain and she had charted the patient for some additional analgesia.

At approximately 9:00pm the same evening the patient developed stridor. The nursing staff paged the evening RMO and asked him to review the patient urgently.

On review, the evening RMO noted that the patient was distressed, and her neck was quite tense and swollen. He immediately contacted the Surgical Registrar. He informed the Registrar that the patient was day 1 post-op thyroidectomy. The RMO said his call was urgent because the patient had now developed significant stridor. The Surgical Registrar said it was most likely that the patient had developed a haematoma in the surgical site.

The patient was immediately transferred to theatre where the neck wound was opened and a large haematoma was evacuated. Fortunately, the patient made a full recovery from this complication of her thyroidectomy.

### References

- 1 Safe Handover: Safe Patients. *Guidance on Clinical Handover for Clinicians and Managers*. Australian Medical Association, 2006.
- 2 Jorm C, White S, Kaneen T. *Clinical handover: critical communication*. Med J Aust 2009; 190 (11 Suppl):S108-109.
- 3 Marshall S, Harrison J, Flanagan B. *The teaching of a structured tool improves the clarity and content of interprofessional communication*. Qual Saf Health Care 2009; 18:137-140.

## Discussion

In this case, the medical RMO was not attuned to the possible post-operative complications following thyroidectomy, particularly in an anti-coagulated patient. The medical registrar refused to take responsibility for the care and review of the patient. The handover from the medical RMO to the evening RMO was poor. Handover to the surgical registrar did not initially occur. Fortunately, when the patient's condition deteriorated, the evening RMO clearly communicated the urgency of the situation to the surgical registrar, enabling prompt emergency treatment to be provided to the patient.

Clinical handover is defined as “the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis”<sup>1</sup>. The primary objective of any patient handover is the accurate transfer of information about a patient's condition and care plan. Handover is a ubiquitous feature of health care and it has been estimated that at least 7 million handovers occur annually within Australian hospitals<sup>2</sup>. Limits on junior doctor hours have led to an increased need for clinical handover. However, as illustrated above, handovers are high risk scenarios for patient safety.

## Risk Management Strategies

Poor communication between health professionals is a significant underlying cause of adverse patient events. Indeed, communication failures are estimated to be a major factor in up to 60–70% of serious patient incidents. A lack of structure and standardisation for communications, uncertainty about who is responsible for the patient's management, hierarchy, sex and ethnic background may all be contributing factors to communication difficulties between health professionals. It has been suggested that a structured method of communication between health professionals may improve the quality of information exchange during handover.

One example of a standardised communication method is the ISBAR tool (see Figure 1). This tool was initially developed by the US Navy for standardising important and urgent communications in nuclear submarines. Recent research has explored its adaptation in a health care setting. A recent Australian study involving 160 final year medical students examined the use of the ISBAR tool as part of communication skills with another clinician<sup>3</sup>. One half of the students had training in the ISBAR tool, while the other group had no formal training in the ISBAR tool, acting as a control group. In the intervention group, the communication content and the clarity of delivery of information, was significantly higher.

Handovers should be viewed as part of the provision of safe patient care and are a critical component of a JMO's work life. The need to improve clinical handover has been recognised as important for reducing errors and improving patient safety.

Figure 1 - ISBAR tool<sup>3</sup>

<b>I</b>	<b>Identify</b> Identify self: name, position, location and who you are talking to Identify patient: name, age, sex, location	
	<b>S</b>	
<b>S</b>	<b>Situation</b> State purpose “The reason I am calling is .....”	
	If urgent - say so	eg “This is urgent because the patient is unstable with a BP of 90”.
<b>B</b>	<b>Background</b> Tell the story Current problem	
	Relevant history Relevant examination Relevant test results Management	If urgent: Relevant vital signs Current management
<b>A</b>	<b>Assessment</b> State what you think is going on	
	eg “So the patient is febrile and I can't find a source of infection”.	Urgent eg “The patient seems to be deteriorating, I think they may be bleeding”.
<b>R</b>	<b>Request</b> State request	
	eg “I'd like your opinion on the most appropriate test”.	eg “I need help urgently, are you able to come?”

The World Health Organisation has listed “Communication during Patient Care Handovers” as one of the High 5 Patient Safety initiatives. Transfer of responsibility for patient care and accountability is not well practised. Handovers are rarely taught to JMOs in a systematic way. There is little standardisation and great variation across disciplines and health care organisations in the way in which handovers are performed.

JMOs are encouraged to examine their skills in this area of medical practice and to consider the use of one of the standardised tools of information exchange during handover, such as the ISBAR tool.

**Dr Sara Bird**  
**Medico-Legal Manager /**  
**Advisory Services Co-ordinator**

# Risk Management Workshops

Registration can be completed online through the Member Online Services section of the MDA National website or by contacting Risk Management at [riskmanagement@mdanational.com.au](mailto:riskmanagement@mdanational.com.au) or 1800 011 255.

Numbers are limited for these sessions so make sure that you register early to ensure your place.

Please note that registration is not available until 3 months before the date of the workshop.

Full descriptions of the workshop topics can be found in the Risk Management section of the MDA National website.

All workshops attract CME/CPD points and are free of charge to doctors who hold a current Professional Indemnity Insurance Policy. Please check the online calendar regularly as more workshops will be added throughout the year.

## Cognitive Institute Workshops Calendar

### Sept 09

Mastering Difficult Patient Interactions

**Saturday 26th**  
9.00am - 12.30pm **FULL**  
**Sydney**

Mastering Adverse Outcomes

**Saturday 26th**  
1.30pm - 4.30pm **FULL**  
**Sydney**

### Oct 09

Mastering Adverse Outcomes

**Wednesday 7th**  
6.00pm - 9.00pm **FULL**  
**Perth**

Mastering Difficult Patient Interactions

**Wednesday 21st**  
6.00pm - 9.30pm **FULL**  
**Perth**

### Nov 09

Mastering Difficult Patient Interactions

**Saturday 14th**  
9.00am - 12.30pm  
**Perth**

Mastering Adverse Outcomes

**Saturday 14th**  
1.30pm - 4.30pm  
**Perth**

### Feb 10

Mastering Shared Decision Making

**Wednesday 24th**  
6.00pm - 9.00pm  
**Perth**

### March 10

Mastering Shared Decision Making

**Wednesday 3rd**  
6.00pm - 9.00pm  
**Sydney**

Mastering Adverse Outcomes

**Wednesday 3rd**  
6.00pm - 9.00pm  
**Brisbane**

Mastering Adverse Outcomes

**Wednesday 3rd**  
6.00pm - 9.00pm  
**Perth**

Mastering Adverse Outcomes

**Wednesday 10th**  
6.00pm - 9.00pm  
**Melbourne**

Mastering Difficult Patient Interactions

**Saturday 13th**  
9.00am - 12.30pm  
**Perth**

Mastering Shared Decision Making

**Saturday 13th**  
1.30pm - 4.30pm  
**Perth**

# Contact your State Liaison Manager

MDA National's team of State Liaison Managers are available to provide support to Members through provision of educational and risk management activities and sponsorship of both educational and social activities.

You should contact your State Liaison Manager if you have any suggestions for events at your hospital or within your Area Health Service that MDA National could be involved with.

All State Liaison Managers can be contacted on

## Freecall 1800 011 255



**Olivia Watson**  
State Liaison Manager - WA  
E: [owatson@mdanational.com.au](mailto:owatson@mdanational.com.au)



**Nina Soldatovic**  
State Liaison Manager - VIC/TAS  
E: [nsoldatovic@mdanational.com.au](mailto:nsoldatovic@mdanational.com.au)



**Judi Pickett**  
State Liaison Manager - VIC  
E: [jpickett@mdanational.com.au](mailto:jpickett@mdanational.com.au)



**Dinethra Nandakoban**  
State Liaison Manager - NSW/ACT  
E: [dnandakoban@mdanational.com.au](mailto:dnandakoban@mdanational.com.au)



**Angela Barker**  
State Liaison Manager - QLD  
E: [abarker@mdanational.com.au](mailto:abarker@mdanational.com.au)



**Helena Manis**  
State Liaison Manager - SA  
E: [hmanis@mdanational.com.au](mailto:hmanis@mdanational.com.au)



**Megan Sheldon**  
State Liaison Manager - SA  
E: [msheldon@mdanational.com.au](mailto:msheldon@mdanational.com.au)



**Don't miss your mail!**  
Update your details, so we can keep you up-to-date

## Would You Like to Receive *First Defence* via Email?

We offer all readers the opportunity to receive an electronic copy of *First Defence* instead of a hard copy.

If you would prefer to receive your *First Defence* magazine by email, please let us know by sending an email to [firstdefence@mdanational.com.au](mailto:firstdefence@mdanational.com.au) putting the word 'Subscribe' in the subject line and including your name and Member number in the body of the email.

You will be able to change the way you receive *First Defence* at any time, simply by sending an email to the address above.

It is also possible to change the way you receive publications from MDA National by logging into the Member Online Services and noting your preference on your Membership record.

If you require assistance logging into the secure section of the website, please contact Member Services on 1800 011 255 during business hours.

Have your postal, email or practice details changed? As a Member of MDA National you receive Member benefits, policy notices, documents and other relevant communication via your postal and email addresses.

Don't miss this important information. Keep your details updated, so we can keep you up-to-date!

Updating your details is easy.

1. Go online to [www.mdanational.com.au](http://www.mdanational.com.au)
2. Enter our Member Online Services using your login and password (you can register for these online today)
3. Click on the 'view and update your details' link and follow the prompts to update your details.

Alternatively, you can call Member Services on freecall: 1800 011 255.

**Freecall: 1800 011 255 Member Services Fax: 1300 011 244**

**Email: [peaceofmind@mdanational.com.au](mailto:peaceofmind@mdanational.com.au) Web: [www.mdanational.com.au](http://www.mdanational.com.au)**

Perth	Melbourne	Sydney	Brisbane	Adelaide
Level 3	Level 1	Ground Floor, AMA House	Level 8	Level 1
516 Hay Street	101 Dundas Place	69 Christie Street	87 Wickham Terrace	63 Waymouth Street
Subiaco WA 6008	Albert Park VIC 3206	St Leonards NSW 2065	Spring Hill QLD 4000	Adelaide SA 5000
Phone: (08) 6461 3400	Phone: (03) 9915 1700	Phone: (02) 9023 3300	Phone: (07) 3120 1800	Phone: (08) 7129 4500
Claims Fax: 1300 011 235	Fax: (03) 9690 6272	Fax: (02) 9460 8344	Fax: (07) 3839 7822	Fax: (08) 7129 4520

The information in *First Defence* is intended as a guide only and should not be taken as legal or clinical advice. We recommend you always contact your indemnity provider when advice in relation to your liability for matters covered under your insurance policy is required. The case histories used are based on actual medical negligence claims or medico-legal referrals; however, certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved. The MDA National Group is made up of MDA National and MDA National Insurance Pty Ltd. Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073. With limited exceptions they are available only to Members of MDA National. MDA National Insurance is a wholly owned subsidiary of The Medical Defence Association of Western Australia (Incorporated) ARBN 055 801 771, trading as MDA National incorporated in Western Australia. The liability of Members is limited. Before you make any decision whether to buy or hold any products issued by MDA National Insurance, please consider the relevant Product Disclosure Statement and Policy Wording. Contact us if you require a copy. Privacy: The MDA National Group collects personal information to provide and market our services or to meet legal obligations. We may share personal information with other organisations that assist us in doing this. You may access personal information we hold about you, subject to the Federal Privacy Act. The MDA National Group's Privacy Policy is available by calling us on 1800 011 255 or by visiting our website at [www.mdanational.com.au](http://www.mdanational.com.au) If you wish to change your contact details or to be removed from our mailing list please contact us on 1800 011 255. 304.12 Sep 09