



# FIRST DEFENCE

JMOs + DOCTORS IN TRAINING

## welcome...

Welcome to the first edition of MDA National's newsletter *First Defence*, specifically written for JMOs and Doctors in Training. The medico-legal issues confronting the junior doctor can be very different to those affecting consultants in private practice. For this reason, we have initiated this addition to your usual *Defence Update*.



We hope to address the questions commonly asked by junior doctors, and examine areas of concern in more detail. As you will see from this edition, we have used case studies of recent cases reported to MDA National's Legal Team as illustrations of these issues. We hope that this assists you in understanding the medico-legal aspects of the issues, and allows you to gauge how you would respond to a given situation.

This is your newsletter—and your forum for information. Please provide us with your feedback on this edition, or topics you would like covered in future editions. Dr Sara Bird, one of our Medical Advisers, is keen to answer any medicolegal questions that you have, and we will endeavour to keep the content relevant.

My email address for feedback is [scarroll@mdanational.com.au](mailto:scarroll@mdanational.com.au), or call 1800 011 255.

**Siobhán Carroll**  
Liaison Officer

- VICARIOUS LIABILITY
- PATIENT COMPLAINTS
- CONFIDENTIALITY



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## ‘vicarious liability’

Recently, we have been receiving questions from members regarding their level of cover while in training positions. Each Medical Indemnity Insurer has its own rules regarding junior doctor cover, and members have requested clarification of our position. At MDA National, Registrars pay lower premiums in part to reflect the limited liability in respect of their properly supervised training and in part as a concession because incomes are generally lower in the earlier stages of your career. In most training positions, you are a public hospital employee, and would therefore expect to be covered by the hospital’s indemnity.

However, there are some cases, like General Practice training, where you are in private practice, and these lower premium rates still apply. Although you may not be directly supervised at all times, you are in a ‘supervised’ position, and therefore your ‘supervisor’ may be considered vicariously liable for some of your actions.

However MDA National members who are in training and who have a *Professional Indemnity Insurance Policy* need not worry about the complexities of whether vicarious liability applies or not. The policy provides coverage\* for medical negligence and investigations arising from the delivery of medical services, and in the event of a claim you should notify us immediately. We will decide how apportionment of liability, if any, should be handled.

It follows that a GP Registrar’s indemnity follows that of his/her appointed supervisor. Where the appointed supervisor has ‘procedural’ cover, the GP Registrar is covered for procedural matters. Where the appointed supervisor has ‘non-procedural’ cover, the GP Registrar is only covered for non-procedural matters. Like all Doctors in Training, GP Registrars must act under the supervision and at the direction of the supervisor.

This information often leads to the question, "what constitutes ‘supervision’?" We acknowledge that your supervisor may not be physically present at all times, but she/he must be accessible to you. MDA National does not define ‘adequate supervision’ because it is not possible, nor appropriate, to set a benchmark for all fields of medical endeavour and prescribe adequate supervision for every eventuality. What is clear is that there must be a level of supervision and that it must be appropriate to your own experience, the procedures undertaken and the context of your training. Colleges often have their own guidelines for supervision, and we take those into account.

While you are a junior doctor, your supervisor’s indemnity is just as important as your own—it is an essential part of the responsibility of training.

*\* in accordance with the terms and conditions of your policy*

## PATIENT COMPLAINTS

Nobody likes to be the subject of a complaint, but, unfortunately, they are a fact of life for the medical practitioner, and a common reason for Junior Doctors contacting MDA National. Whether it is a verbal, or written complaint to you, or a formal complaint to the Hospital Administration, Medical Board, or Complaints Commission, it can be an upsetting experience, so here are a few tips on how to deal with a complaint against you.

- 1.** Call MDA National. Not only are we there for medico-legal advice, we can provide the peer support which is essential at the time.
- 2.** Respond as soon as possible. If the patient receives a quick, rational response, it may reduce their bad feelings toward the event, and calm them down. Making them wait for a response may add to their perception that their complaint has merit.
- 3.** Do not let yourself respond in an aggressive, or inflammatory manner. Even if you believe that the patient has been unreasonable, maintain a professional and informative tone in your correspondence, so that they are not given further reason to take the complaint further.
- 4.** If you respond to a complaint verbally, make detailed notes about the conversation.
- 5.** Review the details of the complaint, medical records and any other relevant documentation before answering a complaint. Given how many patients you may have seen in the intervening time, you will want to ensure that you have the facts straight.
- 6.** You must not admit liability in your response (‘it was my fault’), but it is important to exhibit empathy and understanding. Although the patient’s concerns may seem irrational to you, remember that your understanding of the processes of medicine is far greater than theirs, and a considered explanation of your version of events can do much to prevent an escalation of tensions.

# PATIENT COMPLAINTS

Complaints against medical practitioners are not uncommon. In NSW it has been estimated that 1 in 20 medical practitioners receive a written complaint each year

## A bit green behind the gills...

Dr Leonard was a first year surgical registrar working with two general surgeons in a large teaching hospital. On 20 December Dr Leonard received a written complaint from one of the patients he had looked after a few months earlier. The letter of complaint had been left in his 'pigeon hole' with a covering letter from the Director of Surgery, Professor Blade. Professor Blade asked Dr Leonard to provide a written response to the complaint by 24 December. The patient's letter, which was addressed to the hospital's CEO, read as follows:

*"Dear Sir/Madam*

*I write to you about a distressing incident that occurred on 21 September. The morning after my surgery two young men came in to see me. I was not given any names - only that one of them was the surgical registrar. I think this young man needs to be taught some courtesy and manners. He insisted on taking down my surgical dressings. I informed the registrar in a polite manner that I did not want him to touch the dressings without the permission of my surgeon. This was simply brushed aside. If there are any problems as a result of this, I expect compensation for my pain and suffering. The registrar behaved like an upstart coming along and doing as he saw fit and taking no notice of anything that I said. This registrar is still 'green behind the gills' and I strongly believe that he is pursuing the wrong career.*

*Yours sincerely  
Mr Rob Heap"*

Dr Leonard was surprised and dismayed to receive the letter of complaint. He could barely remember the particular patient and had no

sense that the patient was distressed at the time he saw him. The registrar was quite upset about the personal nature of the patient's letter. He was also concerned about the effect the letter may have on his future career and, in particular, his application for an accredited registrar's position the next year.

Dr Leonard phoned his MDO for advice. The medico-legal adviser provided some general advice about responding to complaints and asked Dr Leonard to fax a copy of the complaint and a draft response to the MDO for review. The medico-legal adviser reassured Dr Leonard that complaints against medical practitioners are not uncommon (in NSW it has been estimated that 1 in 20 medical practitioners receive a written complaint each year) and that his emotional response to the receipt of the complaint was quite normal. After further discussion with his MDO, Dr Leonard made some minor amendments to the draft response and forwarded his reply to Professor Blade on 23 December. A few weeks later, Professor Blade told Dr Leonard that the patient was satisfied with his response and the matter was now closed. Professor Blade also mentioned that complaints against surgeons were not uncommon (indeed he had received several himself!) and that he should not be too concerned about the matter.

## Neck and neck, a lucky escape

A 15 year old school boy was injured during a Saturday rugby match. He felt something "give" in his neck and experienced pins and needles in his arms and legs over a period of several minutes. The school boy was transferred to the local emergency department (ED) by ambulance. The ED intern quickly examined the patient and organised cervical spine x-rays. The orthopaedic registrar was then asked to review the patient. Physical

examination was normal and no abnormality was noted on the cervical spine x-rays by either of the doctors. The patient was subsequently discharged home with a soft cervical collar in place.

Some days later the patient saw his GP who ordered further cervical spine x-rays. These x-rays revealed a fracture of C6. The patient was admitted to hospital and following appropriate treatment made a full recovery.

The patient's mother wrote a letter to the ED complaining about the management provided to her son by the intern and orthopaedic registrar. Review of the cervical spine x-rays taken at the hospital revealed that they were of very poor quality and the C6 and C7 vertebrae were not adequately visualised on the films. Additionally, reporting of the cervical spine x-rays by the radiologist on the following Monday morning indicated a possible abnormality of C6. The radiologist recommended that further x-rays should be performed. However, this information was not followed up.

As a result of this incident, a protocol was put in place in the Radiology Department to ensure the quality of radiographs taken on the weekend were of an adequate standard. Additionally, a system was put in place for the follow up of abnormal test results in the ED.

The intern and registrar sought advice from their MDO regarding an appropriate response to the complaint. The patient and his mother were provided with a full explanation, including a discussion of the steps that had been taken by the hospital to prevent another similar incident. In the letter of response, the intern and registrar also apologised for their failure to diagnose the cervical spine fracture. This response was accepted and the matter was concluded to the satisfaction of everyone involved.



# ISSUES OF PATIENT CONFIDENTIALITY

## Is there a burglar in the house?

At 2am the (ever alert) medico-legal adviser received a phone call from a JMO working in the Emergency Department (ED) of a small metropolitan hospital. The police had arrived in the ED and wanted to know the names of any injured patients who had attended the hospital earlier in the evening. The police said there had been a break and enter at the local shopping mall. A large glass window had been smashed during the break-in and there was a lot of blood around the scene of the crime.

Earlier that evening, the JMO treated a young man, Mr John Smith, who had lacerations to both his forearms. When the JMO had asked the patient how he had injured himself, Mr Smith said he had fallen through a window. The JMO cleaned, sutured and dressed the wounds and discharged the patient for follow up with his GP.

The JMO was not sure whether he should inform the police about Mr Smith's attendance and injuries. He rang his MDO to seek advice about what to do.

The JMO was advised that he owed the patient a duty of confidentiality. Exceptions to this duty of confidentiality included:

1. mandatory disclosure required by law eg a search warrant
2. an overriding duty in the 'public interest' to disclose information – this generally only applied if there was a direct threat of harm to another person.

Neither of these situations applied in this case. The JMO was advised to politely decline the police request for information.

All doctors are aware of the sanctity of the doctor-patient relationship. However, there are some cases where questions arise as to the benefit to others of a doctor revealing information which was provided by a patient in a consultation. Here are several case studies which illustrate different situations in which the question has arisen, and contrast the responses of different junior doctors, and the repercussions of their decisions. **What would you have done?**

## Emergency Department Confession

A young man attended the Emergency Department of a large teaching hospital, and was seen by Dr Phil, a RMO. During the course of the examination the patient confessed to Dr Phil that he had been shooting semi automatic weapons at the local police station for the last two nights. Dr Phil shared this information with the registrar on duty, and sought his advice as to what he should do. The registrar then relayed this information to the VMO and Medical Superintendent, who decided that the police should be advised. In making this decision, no consideration was given to maintaining patient confidentiality.

Dr Phil was required to give the police a statement. He then had to give evidence at a pre-trial court hearing, as the patient's defence lawyers were asserting that the information obtained by him was unlawfully obtained and therefore inadmissible at trial. The RMO gave evidence for about one and a half hours, in what was an extremely stressful experience.

It could be argued that the public interest in breaching the patient's confidentiality was justified in this situation on the basis of risk to the public. The RMO in this case however, had followed the advice of his senior colleagues without any professional input about his legal obligations. This eventually put Dr Phil in a difficult position as he had to personally justify his disclosure and argue that he had not acted unlawfully.

## Making the jailbird sing...

An intern was doing her psychiatry rotation when a prisoner was transferred to the unit following a drug overdose. Whilst on duty late one evening, the intern received a telephone call from the manager of the local prison asking if the results of the prisoner's drug screen were available. The manager wanted to ensure the supply of the particular drug was tracked down and further access prevented. The intern was not sure whether she should provide this information to the prison manager. She contacted her MDO for advice. The medicolegal adviser informed the intern that the prisoner was entitled to confidentiality – just like any other patient. Having received this advice, the intern contacted the manager and politely declined the request for information about the patient/prisoner.

These stories document typical Public Hospital encounters—such situations can happen to anyone. The number one lesson here, is the importance of gaining expert advice before taking action—call MDA National. Don't be too busy looking out for everyone else, to look out for your own best interests.

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