

Child Safe Environments – Time to act

Doctors in South Australia may be aware that amendments to the *Children's Protection Act 1993 (SA)* which became operational in South Australia on 1 January 2011 impose a number of obligations on health services which are being progressively phased in throughout 2011 and 2012.

By **Anthony Mennillo** Senior Claims Solicitor

Health service providers in other states have similar obligations and a summary of the applicable legislation in your state is set out in a table at the end of this article.

Child Safe Environments

Prior to 1 January 2011 government organisations and some non-government bodies were required to establish Child Safe Environments. Subject organisations were required to conduct criminal history assessments on staff and volunteers working with children in certain positions.

From 1 January 2011 amendments to the legislation extended the requirements to include additional organisations, importantly and relevantly including organisations that provide health services wholly or partly for children. That means that if a medical practice sees and treats children on a regular basis then it is required to comply with these obligations.

The requirements are being phased in. Private

hospitals (within the meaning of the *Health Care Act 2008 (SA)*) and day procedure centres attached to private hospitals were required to comply with the new requirements by 30 June 2011.

All other health services will be required to comply by **30 June 2012**.

The requirements

Health service organisations providing services to children are required to:

1. **Conduct criminal history assessments** on employees, contractors and volunteers who are working with children (see below)
2. **Lodge a Child Safe Environment Compliance Statement** with the Department for Communities and Social Inclusion (DCSI).

Criminal history assessments

The amendments to the legislation require an organisation to assess a person's criminal history prior to a person being appointed to or engaged to perform a "prescribed

function". For the purpose of health services the definition of prescribed function includes any person having regular contact with children or working in close proximity to children on a regular basis or has access to health records.

The requirement applies to persons whether they are employees, volunteers, agents, contractors or subcontractors.

We have received a number enquiries seeking clarification whether the requirement to conduct a criminal history assessment applies to medical practitioners who are not regarded as employees or subcontractors, (continued on page 2)

Seasons Greetings

Best wishes for Christmas – We hope you enjoy the festive season and wish you a safe and peaceful New Year.

Our offices will be open on the normal working days during the Christmas break.

Our 24 hour emergency medico-legal advisory service will be available for clients who need to contact us on public holidays (including Christmas Day) for urgent medico-legal advice.



• Do your colleagues have MIGA on their side?

If not, steer them in the right direction – encourage them to obtain a competitive quote and compare our services.

98% of doctor members would recommend MIGA to a colleague, read more inside.

WOW – 98% of doctor members would happily recommend MIGA to a colleague

That's the message from our ongoing member survey¹ and we would like to thank you for the vote of confidence.

For new doctors insuring for the first time, choosing an insurer can be difficult. The recommendation of a colleague can make all the difference by not only making the choice easier, but by providing a level of reassurance about the service and support that can be expected.

We value your recommendation and work hard to make sure that **when you refer a colleague to us that we don't let you down.**

We are extremely pleased with this feedback and hope that it gives you the confidence to recommend MIGA to your colleagues should the opportunity arise.

Thank you again for your ongoing support. At MIGA, we are always on your side!!!

By **Mandy Anderson**
Chief Executive Officer

1 MIGA Member Evaluations – July 2010 to March 2011

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for example, doctors who own a medical practice as a sole practitioner, in a partnership or an associateship.

Information supplied by DCSI states that the key consideration should be whether the person's role will ordinarily involve regular contact with children (or their records) rather than their job title or their job description.

The health service organisation is required to conduct a criminal history assessment. The assessment is not simply the provision of a criminal record but also includes reviewing the record to ensure that any criminal history does not preclude the person from working with children.

A criminal history assessment can be conducted by obtaining a criminal history report from South Australian Police or Crimtrac (which conducts criminal history checks) or by a Screening Unit.

The Screening Unit of DCSI provides a centralised, consistent and confidential approach to the screening and assessment of background information of people working with children. The Unit conducts the full screening service and provides a letter of recommendation to the organisation without disclosing the details of any criminal record. It does not provide a copy of the full criminal history report.

If the letter of recommendation highlights an issue that may be relevant to the organisation's decision to employ or engage a person to work with children then it would be up to the organisation to decide what, if any, further information would be required,

including a full criminal history report.

Management of criminal history assessment information

Irrespective of the type of criminal assessment that is conducted the organisation that receives the information cannot hold that information indefinitely. The organisation is required to securely dispose of that information once it is no longer required, namely when a decision has been made, and certainly within 3 months of a decision being made.

The DCSI website has a number of information sheets and detailed information regarding child safe environments in particular a publication entitled "Standards for dealing with information obtained about the criminal history of employees and volunteers who work with children". We strongly recommend that you review the website (www.dfc.sa.gov.au) and begin, if you haven't already, the process of preparation of a child safe environment compliance statement.

Other States

The table below sets out the requirements for criminal history assessments in each State and Territory. The individual legislation contains some exemptions which are not set out in this article.

This article should not be relied upon as legal advice. If you require any advice on the legislation as it may apply to you or your medical practice please contact one of our Claims Solicitors.

State	Act	Section	Requirement	Applicability	Check Type	Validity
ACT	No apparent legislative requirements		Discretionary for individual employers to conduct criminal history checks			
NSW	Commission for Children and Young People Act 1998	37 (2)	It is the duty of an employer to carry out all the relevant procedures of background checking [includes under s 34(a) criminal history checks] of the preferred applicant before employing the preferred applicant in that child-related employment.	Applies to people employed in child related employment, but does not explicitly refer to health professionals	Point in time	Required to re-perform background checks whenever employment is changed
NT	Care and Protection of Children Act 2007	187	A person involved in child related employment must hold a valid clearance notice (Ochre card)	Any person involved in child related employment including partners, body corporates, and unincorporated bodies in health services (s 185 (f) when children are ordinarily patients	Certification	2 years
QLD	Commission for Children and Young People and Child Guardian Act 2000	188(1)	A person involved in child related employment must hold a valid clearance notice (Blue card)	A person who works in a health service that provides services involving physical contact or counselling with children	Certification	2 years
TAS	No apparent legislative requirements		Discretionary for individual employers to conduct criminal history checks			
VIC	Working with Children Act 2005	33	A person cannot engage in child related work without a current assessment notice	Child related work is defined as that which usually involves, or is likely usually to involve, regular direct contact with a child in connection with that work	Certification	5 years
WA	Working with Children (Criminal Record Checking) Act 2004	22	An employer must not employ a person in child related employment if the person does not have a current assessment notice	Child related work means where the usual duties of the work involve, or are likely to involve, contact with a child in connection with a community based child health service (s 6(1)(a)(ix)) or admission to a ward of a hospital (s 6(1)(a)(xiii))	Certification	3 years

Doctors in Training

DIT Grant experience – Fred Hollows Fellowship, Vietnam

Dr Shane Durkin received a 2010 Doctors in Training Grant to undertake a Fred Hollows Fellowship in various locations including Vietnam, Nepal and Indigenous communities in the Northern Territory.

Below is an extract from Dr Durkin's first report on his experiences.

I must admit at the outset that my knowledge of Professor Fred Hollows and The Fred Hollows Foundation (FHF) was lacking. I knew Fred Hollows had been a passionate advocate for people who were blind and visually impaired in developing countries and for Indigenous Australians. I was also aware that the Foundation served to perpetuate not only Fred Hollows' memory but also to facilitate the work that he had begun in order to continue to reduce the burden of blindness in developing countries and outback Australia. My time in Vietnam taught me more about both.

Fred Hollows first visited Vietnam in the early 1990s where he was confronted by a dire situation as far as eye care was concerned. There were more than 1 million people requiring cataract surgery with more than one third of these people completely blind. The FHF, along with other organisations, has since worked tirelessly to educate more doctors, train basic eye care staff and to equip hospitals so that cataract surgery is now performed for about 160,000 people each year.

It was a great opportunity for me to be a part of this work and to visit several centres within Vietnam to get a feel for and experience first hand how the present-day FHF is continuing to work to reduce blindness. My first 6 weeks were spent within the Vietnam National Institute of Ophthalmology (VNIO) in Hanoi. The VNIO is a large tertiary referral hospital with more than 300 beds, just for eye patients! It is also staffed by more than 70 ophthalmologists.

There are five main departments: trauma, retina and uveitis, cornea, paediatric ophthalmology and glaucoma. Each of these departments then provide support to the Community Eye Program, which is instrumental in screening for, preventing and treating blindness at the village level. The majority of my time was spent within the Trauma Department where I dealt mostly with lid lacerations, penetrating trauma and blunt injuries. There were an unfortunately disproportionate number of children needing surgery and it often involved multiple operations.

My attachment within the Trauma Department made me realise that there is a real need for a public health campaign



surrounding safe eye practices and more broadly improved occupational health and safety standards. Many injuries were the result of unsafe work practices, unsafe play or road traffic accidents. The provision of simple protective eye wear at work places would have prevented many of the injuries that were seen within the department.

My time at the VNIO was demonstrative of the great task it is to provide tertiary level eye care to millions of people with limited resources. This is compounded by difficult access through mountainous areas and many educational and cultural barriers.

My experiences in Vietnam have been both enjoyable and rewarding. **I have learnt new surgical skills, operated in difficult circumstances with challenging cases and also discovered more about conditions that we rarely encounter in Australia.** It was a great opportunity to see the Fred Hollows Foundation in action 'on the ground' and it was also invaluable to have the support of MIGA.

Read Dr Durkin's full report at the DIT Grants Program page of the MIGA website.

Key Dates

Doctors in Training Grants Program

Applications closed : 5.00pm (CDT) Friday, 28 October 2011
Recipients notified : After Friday, 9 December 2011

Group News

Medical Advisory Panels – Representing your views

As the year draws to a close we would like to acknowledge the efforts of those doctors who give up their time to represent the membership on our Medical Advisory Panels.

The Panels were expanded this year to incorporate local representation from both NSW and Victoria.

The Panels provide us with a fantastic forum to gain feedback on our performance, views on proposed changes to our operations and insurance cover and are a source of ideas, motivation and innovation.

The Medical Advisory Panels provide input to our business in the following areas:

- Insurance coverage
- Development of the Risk Management Program
- Website and our use of technology

- Brand and marketing communication
- Member engagement

We always encourage and welcome feedback from our members and you can do this directly or via your local Panel member. We firmly believe that the effort and participation of the members of the Medical Advisory Panels keeps our decision making grounded to ensure our products and services meet the expectation of our membership.

On behalf of all our members we would like to thank those doctors who are part of our Panels for their commitment of time and energy to MIGA. Their contribution has and continues to shape our organisation.

More information about the Panel members can be found on our website.

Case study – Actions of staff

By **Neil Rankine**
Business Development Manager (Corporate)



This Case Study highlights the need for practices and companies to review their medical indemnity insurance arrangements to ensure they are adequately insured.

Background

An orthoptist who was employed by a medical practice had a claim made against him by a patient alleging they were injured in the course of an examination by the orthoptist.

Although the ophthalmologists who worked in the practice had their own insurance they were not involved in the examination of the patient. The allegations in the statement of claim were not directed at any of the doctors. Instead **the claim was made against the orthoptist and the practice company that employed him.**

The doctors were part owners or associates in the practice but did not “own and control” the practice.

What happened with the claim?

The practice was vicariously liable for the actions of the orthoptist in the conduct of his duties. The practice did not have its own insurance.

The doctors’ individual medical indemnity insurance policies did not cover the practice entity as it was not owned and controlled by them.

If the practice had arranged its own insurance (Business Medical Indemnity (BMI) Insurance) with MIGA it would have been covered for this incident.

If your practice employs staff we recommend you speak to us to ensure your business has adequate insurance protection.

By **Timothy Bowen**
Senior Associate
DibbsBarker

Advanced Care Directives – Determining validity

Health service providers who become aware of an Advanced Care Directive in the course of treating a patient should take steps to familiarise themselves with the requirements where they practice and take the Directive seriously.

Importantly, Advance Care Directives are not restricted to the elderly or terminally ill and can come into play at any point in a patient’s life.

Advanced Care Directives, where a patient gives instructions about their future medical care, are becoming more common. The most common and potentially controversial instructions include ceasing certain treatments and continuing only palliative care at a certain point, or refusing certain modes of treatment (such as blood transfusion). Normally, this should make things clearer for the treating team when a patient can no longer give instructions about their care. **However, one can be left trying to work out exactly what the patient meant and whether the Directive is valid,** perhaps amongst conflicting voices from the patient’s family and friends about what they **think** the patient wanted.

A competent patient can refuse treatment, even if it seems irrational and would lead to their death. However, who is ‘competent’? What is ‘treatment’? How can you be sure it is the patient’s decision and continuing wish? Did they need to receive advice beforehand?

There is no entirely consistent approach throughout Australia. Directives are governed by statutory schemes in some areas, and the common law only in others. There are differences over the form of the Directive, how it is verified, need for pre-Directive advice, when it operates and what it can include.

The relative lack of cases on Directives perhaps indicates that there are difficulties with Directives only in relatively limited circumstances. However, a few examples provide some clues on the approaches to take.

The NSW case of *Hunter and New England Area Health Service v A*¹ involved a Directive refusing dialysis. No pre-Directive advice was given and it was unsigned. A Court found the Directive valid where it was made when the patient was competent; it was free and voluntary and was applicable in the circumstances. There was no requirement for pre Directive advice on all possible consequences of the patient’s decision.

When in doubt about the validity of a Directive, similar considerations to those for emergency treatment apply, namely whether the Directive is reasonable, in the patient’s

best interests and not contrary to their known wishes.

A similar approach was adopted in the SA case of *H Ltd v J*,² where an insulin-dependent diabetic, suffering from chronic pain and confined to a wheelchair, gave a Directive refusing treatment (including both insulin and sustenance) beyond palliative care for pain and discomfort. The Court found the patient’s carers could follow it where it appeared to be made freely and like the NSW case found no need to ensure that the patient was informed of all potential consequences.

A slightly different approach was adopted in the WA case of *Brightwater Care Group (Inc) v Rossiter*,³ where a quadriplegic instructed his nursing home to cease providing sustenance as the patient wished to die. The Court found the instruction valid but, unlike the NSW and SA cases, placed greater emphasis on ensuring the patient was aware of the implications of their decision.

In the ACT case of *ACT v JT*,⁴ a patient with significant psychiatric problems refused food (including via nasogastric tube). The Court declined to endorse any provision of palliative care only where the patient was incompetent to give the Directive. It was not a case involving no reasonable prospect of a meaningful recovery.

Doctors who become aware of a relevant Directive during the course of treating a patient should take it very seriously and take steps to satisfy themselves that it is clear and unambiguous, and remains current (including through discussions with family and friends). **Any doubt about validity** (including disputes by family or friends) **necessitates involving health facility administration** (as these cases usually occur in a hospital or nursing home context) **and legal advice on what the doctor should do.**

The claims solicitors at MIGA are available to advise you on these issues. Doctors who see Directives on a regular basis should familiarise themselves with particular requirements where they practise. Information is available through MIGA, health facilities and health department websites.

1 (2009) 74 NSWLR 88; [2009] NSWSC 761

2 [2010] 107 SASR 352; [2010] SASC 176

3 [2009] 40 war 84; [2009] WASC 229

4 (2009) 232 FLR 322; [2009] ACTSC 105



By **Maurie Corsini**
Underwriting Manager

Who is covered by your medical indemnity insurance with MIGA?

Who is "You"?
That may depend on
the circumstances.



We are often asked "who is covered under my policy", or more specifically "is a certain individual, type of individual or legal entity covered under my medical indemnity insurance policy".

MIGA's medical indemnity insurance policy for doctors is mainly designed for their sole benefit and there is a very good reason for this. The Federal Government's medical indemnity framework, under which the insurance is provided, was principally established to provide security for individual doctors.

Under MIGA's 2011/2012 Medical Indemnity Insurance Policy "You" is defined to mean:

- (a) **the Doctor** (the medical practitioner identified in the Schedule of the Policy, including their estate, heirs and legal representatives or assigns of the Doctor in the event of their death or permanent disablement)
- (b) **any Practice Entity** (i.e. a company or trust owned and controlled by the Doctor and which provides services for the purpose of Practice by the Doctor)
- (c) **an Employee** (i.e. any person employed by the Doctor or a Practice Entity who is not a registered medical practitioner and who is not a person who bills in their own name)

(d) **any Medical Student** (provided they are assigned to You by their medical school or university).

Doctors are specifically identified and recorded as an insured party under their policy. Other persons or parties may only be insured if they meet the relevant definition, as above, at the time a claim is made.

Any claim against a **Practice Entity** will be only covered if the entity was, at the time of the claim:

- a) owned **and** controlled by the doctor; and
- b) providing services for the doctor.

In addition, a claim against an **Employee** will only be covered if they are **employed by the doctor or his/her Practice Entity** and they are not a medical practitioner or a person billing in their own right.

If you are in doubt about whether your practice company or employees are covered by your individual doctor policy with MIGA, then please call us. MIGA can help you with clarifying this and determine if additional cover is needed.

We encourage you to review our Policy to ensure you are clear on who is covered by it. It can be accessed from our website at www.miga.com.au.

Should you have any queries, please do not hesitate to contact our Client Services Department for assistance.

Do you need to change your Category of insurance or contact details?



You can do this quickly and easily on-line using the Change of Details Form in the Client Area of our website at www.miga.com.au.

Affordable insurance for employer indemnified and junior doctors

MIGA has fantastic pricing for employer indemnified and junior doctors. We offer an easy and convenient way of insuring with us on-line.

If you have colleagues who are practising without their own insurance – let them know about MIGA and the benefits of cover with us. Look at these competitive insurance offers:

Junior doctors

Doctors in their 2nd, 3rd, 4th or 5th post graduate year can insure with MIGA for just \$55p.a.¹

Other employer indemnified doctors

Can arrange cover for Medical Tribunal legal expenses only from just \$77p.a.²

Is it worth it? – Protecting our members for over 110 years tells us that it is.

Full details and brochures about both offers are available from our website.

Apply on-line today at www.miga.com.au

It's quick and convenient and you will receive immediate confirmation of your cover emailed direct to your inbox.

¹ Based on the Category of cover – "Salaried Medical Officer in Training", working in South Australia (as at November 2011). Total cost will be lower for doctors working in other States. Please note that the cover from MIGA is only available to the extent you are not otherwise indemnified by your employer.

² Based on the Category of cover – "Employer Indemnified – Medical Board, Tribunal cover only", working in New South Wales or Queensland, price includes all statutory charges (as at November 2011) (category of cover specifically excludes cover for private practice work). Please note that the cover from MIGA is only available to the extent you are not otherwise indemnified by your employer.



Snapshot – Dealing with requests for reimbursement

We occasionally receive calls asking for advice in relation to a request by a woman for:

- Waiver of gap fees
- Reimbursement of fees already paid.

These requests usually arise in circumstances where there is a:

- Perception that care has been below standard
- Misunderstanding about the care that has been provided.

The importance of seeking advice

It is critical that these circumstances are well managed, so we recommend that you discuss any requests with one of our claims solicitors before contact with the woman and a decision is made.

Some of the concerns that we will discuss with you include:

- The circumstances that led to the request
- The range of outcomes if the request is denied
- The nature of the problem from the woman's perspective
- Your thoughts and wishes.

Generally what we are looking to do is determine the fairest and most reasonable way of resolving the issue for the midwife and the woman.

A midwife may decide to meet a request as an acknowledgement of the woman's dissatisfaction and as an expression of good faith. In such cases, the midwife should take care not to admit liability. What may be intended as a simple apology may in some States amount to an admission.

It is not to say that fees should be waived or expenses reimbursed every time there is a disgruntled patient. Each case must be

considered on an individual basis and care must be exercised in how you respond.

We understand that midwives will want to deal with these requests quickly but good management and careful consideration is the key to resolving any issues. **Reimbursement does not necessarily mean the end of a matter** and it is important to talk through with us how to best achieve closure.

Risk management tips

1. There is **no substitute for good ongoing communication**
2. **Demonstrate concern and empathy** during any interaction with the client
3. If possible, and where appropriate, **meet with the client face to face**
4. **Always document** your discussions.
5. **Call MIGA** if you are considering making an expression of regret to your client.



IRM CONFERENCE & HYPOTHETICAL "Conduct under the microscope"

Have you booked your place? Time is running out!

Only 3 IRM Conferences remain for 2011/2012

- Brisbane** Saturday 11 February 2012
- Adelaide** Saturday 18 February 2012
- Sydney** Saturday 3 March 2012

"The Hypothetical is an excellent, informative and entertaining/engaging way to cover multiple issues of great importance. I hope that there is another Hypothetical next year"

"The moderator was entertaining and I liked the panel's practise tips"

Hurry – Limited places available at the remaining conferences

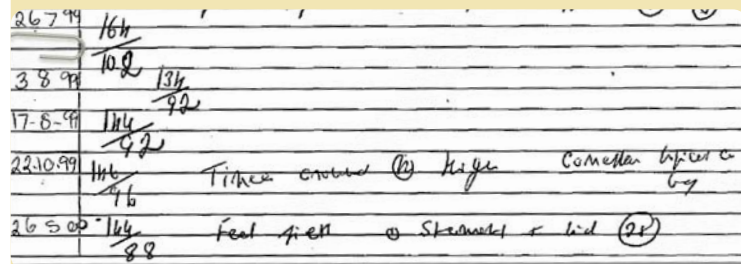
Earn IRM and CPD Points

Book today via the Client Area of our website or call the Risk Management Department on **1800 777 156**

Risk Management

Medical records – What's missing?

There are 3 critical things missing from this medical record. Do you know what they are?



Further resources: Risk Resource Library and MBS Search App for iPhone

Report to the Professions 2008/2009 Case Study 5, page 44.
MBS item billed is justified by the record. "Professional Services Review practitioner taking over the care of the patient, and that the particular medical record is such that it would not disadvantage another history recorded "feel sick" is also inadequate. The expected quality of a reading is an inadequate record of any consultation. Similarly the only an appropriate management plan. Only recording a blood pressure positives and negatives of history and examination. It should also detail "it is expected that a medical record should include the relevant

3. Appropriate management plan

2. Examination

1. Patient history

elements are:

A medical record should include the doctor's clinical input. The missing

Answer:

AMA survey raises issues of concern

Sourced by: **Anthony Mennillo**
Senior Claims Solicitor

Written by: **Mr Hugh Rischbieth**
Acting Chair, Accident Compensation Committee,
Law Society of South Australia

Mr Hugh Rischbieth, acting chair of the Accident Compensation Committee, a sub committee of the Law Society of South Australia, recently published an article in the South Australian Law Society Bulletin regarding an AMA survey of doctors. The survey followed concerns raised by the Law Society of difficulties for compensable patients accessing medical treatment and provision of medico-legal reports.



The article is informative and of general interest to the profession and is reprinted in its entirety with the kind permission of the Law Society of SA:

The Medico-Legal Advisory Group (MLAG) is a committee established by the South Australian Branch of the Australian Medical Association (AMA) and the Law Society of South Australia (the Society).

MLAG aims to:

- (a) promote harmonious relations between the members of both professions;
- (b) promote one source, clear guidelines and information on medico-legal matters in the Medico-Legal Joint Statement available on the Law Society website at: http://www.lawsocietysa.asn.au/pdf/Medico_Legal_Joint_Statement_May_2005.pdf
- (c) "ensure that the efforts of both doctors and solicitors are co-ordinated and directed towards the rapid and efficient settlement of the patients' claims for their injuries; and
- (d) deal with complaints."

The AMA Survey

Recently, the AMA surveyed its members due to concerns raised by the Society of difficulties for compensable patients accessing medical treatment and the provision of reports.

The survey results clearly indicated that some doctors no longer offer nor provide treatment for motor accident claims, WorkCover or public liability claims, nor reports. The primary reasons cited included:

- (i) excessive paperwork associated with the treatment of compensable patients;
- (ii) the prescribed or gazetted fee for provision of treatment and reports is too low;
- (iii) doctors have had a negative experience involving a patient or a patient's legal representative in providing treatment;
- (iv) the treatment of compensable patients adds a greater degree of complexity.

Seventy-four per cent (74%) of survey respondents believed that access to medical treatment for compensable patients was becoming more difficult for the patients. Doctors recognised difficulties in referring patients to other fields of specialty practice particularly neurosurgery, orthopaedics and spinal surgery whilst many other specialties were also identified.

Doctors' concerns

Doctors were also asked to cite examples of issues that concerned them in providing treatment and reports and what previous negative experiences they had experienced. Unfortunately, it is fair to say that some of those surveyed reported they felt strongly about the role of the legal profession and have had negative experiences as a consequence. Some doctors identified the following:

- (a) a lack of courtesy towards them;
- (b) unprofessional conduct by lawyers towards doctors;
- (c) lawyers able to charge **photocopying rates far in excess** of the rate that doctors themselves can charge. Doctors are compelled to charge both in motor vehicle accident claims and WorkCover claims for copying of notes at 20 cents per page being the WorkCover gazetted rate unless a subpoena is issued;
- (d) **late payment of fees, medical report fees and late notice of cancellations** for appointments and court attendances.

The joint Medico-Legal Statement

The joint Medico-Legal Statement needs also be read with Practice Direction 5.4 and Rule 160 as to the role of an expert in the provision of a report. Whilst an expert witness as a medical practitioner has an overriding duty to assist the Court, **the importance of a strong relationship between the legal and medical professions is crucial** to enable ongoing provision of medical services and reports relating to the compensable patients.

Both the AMA and the Society are seeking to foster improved relationships but the survey responses indicate that some legal practitioners and practices need to improve their dealings

with doctors so as to improve relationships overall.

Issues for the legal profession

If as lawyers we fail to treat others with the same respect that we ask for ourselves in our professional life, we will not engender ongoing relationships nor build on those relationships. Compensable patients deserve to have the same access to medical treatment as non-compensable patients. However, responses indicated that **the scale of fees** both for treatment and medical report fees **does not adequately reward doctors** for the added complexity of treating compensable patients.

All lawyers in their dealings with doctors are reminded of the Medico-Legal Joint Statement and complaints by medical practitioners towards lawyers which remain unresolved are referred to the MLAG and in some instances to Professional Standards of the Society.

Lawyers are reminded that the responsibility for the payment of fees for medical reports is the responsibility of the lawyer engaging the report. Similarly, the solicitor ought to make payment for the report within one month of receiving it in the absence of prior agreement. The lawyer should not arrange to schedule medical appointments unless that medical practitioner is willing to provide treatment for that patient's condition and has the necessary expertise to provide treatment for that patient.

Solicitors should ensure in all of their dealings with doctors that those dealings are at all times maintained as courteous and cordial dealings so as to foster and engender continuing relationships without compromising the relationship between the doctor and the patient and the lawyer. It remains clearly a matter of lobbying for the AMA and other medical practice groups to ensure that appropriate fees are paid for medical services and reports, including the rate of photocopying. As a profession, lawyers ought to lobby to ensure that doctors continue to provide services and that there is no further deterioration in compensable patients seeking the same access to medical treatment as non-compensable patients.

Student Elective Grants – 2011 recipients announced

Each year medical students from around Australia show strong interest in MIGA's Elective Grants Program. **This year we received a record number of proposals** from students actively seeking to share their skills with developing communities.

MIGA has a long-term commitment to the Elective Grants Program and it forms an integral part of our strategy to support both the medical profession and the broader community.

This year **MIGA is excited to award five Grants**, each consisting of \$2,000 to fund the travel and accommodation costs of the recipient and a \$1,500 Medical Support Grant to provide medical or other aid to the community they visit.

Our congratulations go to the following students who have been awarded 2011 MIGA Elective Grants.

Lucy Francis,
Griffith University

Western Province, Papua New Guinea Rumingae Rural Hospital
Grant use: Various medical equipment including resuscitation equipment, oxygen concentrators and intraosseous drill.



Louise Greenup,
University of Sydney

Phnom Penh & Siem Reap, Cambodia Children's Surgical Centre & New Hope
Grant use: Provision of much needed antibiotics to enable the treatment of patients with malaria and dengue fever.



Nicholas Smith,
University of Adelaide

Yantaló, Peru The Yantaló Foundation
Grant use: Various medical equipment including sphygmomanometers, otoscopes, blood glucose monitors and a microscope.



Kary Suen,
Monash University

Bomet, Kenya Tenwek Mission Hospital
Grant use: Donation to the 'Tenwek Needy Patient Fund' to enable major surgery and sight-restoring cataract surgery for patients unable to fund their own treatment.



Tia Ozarczuk,
University of Western Australia

Nuku'alofa, Kingdom of Tonga Vaiola Hospital
Grant use: Much needed medical equipment including stethoscopes, blood glucose meters, cholesterol meters and electronic scales.



We wish each of the Elective Grant recipients well on their elective placements and look forward to bringing you their stories in future Bulletins.

Graduating students – You could win an iPad 2!



Completing your medical studies this year? Don't forget to enter our competition for graduating students. Simply by providing us with your updated contact details by 30 December 2011 you could win 1 of 2 64GB iPad 2s, each with Wi-Fi and 3G and worth an amazing \$949!* To enter, visit our website and follow the links.

With MIGA you can be assured of ongoing protection as we automatically provide existing student members with FREE Intern insurance upon graduation. In January 2012 you will receive correspondence from MIGA confirming this change and outlining the details of your Intern cover.

Your fellow graduating medical students can also access this free upgrade by joining MIGA prior to graduation. Plus they'll go in the draw to win one of the iPad 2s! Joining MIGA is easy – just complete the online Application Form available from www.miga.com.au.

* Competition terms and conditions available from www.miga.com.au. Authorised under NSW Permit No. LTPM 11/00492, ACT Permit No. TP 11/02561.1.

Watch your inbox

In the spirit of 'Movember', our regular competition asked students to vote for their favourite moustache from a number of featured celebrities – Yosemite Sam proved to be the winner with over 30% of votes.

Participating students were entered in a draw to win two \$250 Sunglass Hut gift vouchers. We congratulate the lucky winners – **Dianna Luong** from the University of Queensland and **Patrick Chen** from the University of Melbourne.

- **Watch your inbox early next year** for our next issue of Medical Student News
- and **another chance to win an awesome prize!**

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Always on your side

Letters to the Editor : We encourage clients to contact us with their views (By email to mandy.anderson@miga.com.au or follow the links in our website at www.miga.com.au)