
Medical law reporter

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SUPERVISING JUNIOR DOCTORS AND “ON-CALL” RESPONSIBILITIES: BRUS v AUSTRALIAN CAPITAL TERRITORY; GREATER SOUTHERN AREA HEALTH SERVICE v ANGUS

*The recent decisions of *Brus v Australian Capital Territory* [2007] ACTSC 83 and *Greater Southern Area Health Service v Angus* [2007] NSWSC 1211 highlight different aspects of the difficulties associated with supervision of junior doctors in the present public-funded Australian public hospital system. Their facts reveal how difficult it is for senior staff to achieve the fine balance required to assist trainees by according adequate experience and responsibility on the one hand, and to ensure patient safety, on the other. In addition, these cases highlight problems with the supervision process that are likely to be exacerbated in a privatised health care setting where senior staff may have less inclination to supervise struggling juniors unless adequately remunerated for such teaching, an issue of considerable controversy given the focus on profit of those institutions.*

INTRODUCTION

The professional relationship between a specialist trainee and supervisor is the crucible in which is produced the ethical commitment to values in health care delivery that is one of the most admirable characteristics of the Australian and New Zealand citizen-funded public health system making it an integral part of the “fair go” culture in the social framework in both Australia and New Zealand. Yet what should happen to trainees who under-perform during training? Have we got procedures in place that allow supervisors to report their judgments openly and have appropriate action taken upon them? What are the training responsibilities of a doctor while “on-call”? The cases of *Brus v Australian Capital Territory* [2007] ACTSC 83 and *Greater Southern Area Health Service v Angus* [2007] NSWSC 1211 highlight different aspects of the difficulties associated with the supervision of struggling junior doctors in the present citizen-funded Australian public hospital system.

SUPERVISING THE STRUGGLING TRAINEE: BRUS v AUSTRALIAN CAPITAL TERRITORY

The plaintiff in *Brus v Australian Capital Territory* [2007] ACTSC 83 was admitted as a public patient to the Canberra Hospital on 23 September 1998 for a vaginal hysterectomy by Dr Heaton. Dr Heaton had previously delivered her children under private health insurance cover. There were post-operative complications resulting from the plaintiff extubating herself while recovering from the anaesthetic. This delayed her discharge. Afterwards, she continued to complain of pain and discomfort, and saw various specialists for further investigation. They found her right fallopian tube had prolapsed into her vagina. The plaintiff alleged that this occurred due to the incorporation of part of the fallopian tube during the suturing to close the vaginal vault at the conclusion of the operation.

Connolly J (now sadly deceased) found that the procedure was carried out by a surgical registrar (Dr Cree) under Dr Heaton’s supervision. He found that while an experienced consultant obstetrician and gynaecologist would perform such a routine vaginal hysterectomy in less than 40 minutes, on this occasion it took an hour and that it was more likely that an inexperienced surgeon, or a surgeon with poor technique, would produce such an adverse result. The case was not pleaded as a *Rosenberg v Percival* (2001) 205 CLR 434 action of failure to warn a patient of a reasonably foreseeable

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complication. All the expert obstetricians who gave evidence said this was a very rare complication that was not previously of particular concern to this patient.

When it became apparent that the defendants would concede that the procedure had been performed by Dr Cree, the plaintiff amended the pleadings to allege negligence against the hospital and Dr Heaton, in permitting Dr Cree to perform the procedure, in failing to inform the plaintiff that the operation was to be performed by Dr Cree, and in failing to inform the plaintiff of Dr Cree's qualifications and experience.

The plaintiff gave evidence that Dr Heaton had told her that he, Dr Heaton, would personally perform the surgery. Her evidence was that, had she known that the surgery would be performed by a registrar, she would have declined the procedure. Dr Heaton gave evidence that he always told his public patients that they would be admitted as his patients and that the surgery would be performed under his list, but that he may be assisted by, or would himself assist, a registrar. The admission form signed by the plaintiff, in the normal form for a public patient, acknowledged that the hospital would make the decision as to which doctor would perform the procedure.

Connolly J did not accept that a very experienced surgeon, familiar with dealing with both public and privately insured patients, would provide a guarantee to a public patient that they would, in effect, be treated as a private patient and be guaranteed the doctor's individual services. He found that the plaintiff was mistaken in her recollection of those events (at [15]):

Such a duty, it seems to me, would be inimical to the broader public interest, in that it would undermine the future provision of health care. Most people would say, as the plaintiff has said in this case that, given the choice between an experienced consultant surgeon and a registrar, who is a qualified medical practitioner undertaking a training program to qualify as a specialist, they would choose the experienced consultant. This would have two effects if such a duty existed. The waiting list for procedures would clearly expand significantly, but more seriously, registrars would not be able to perform the procedures, under close supervision, that they need to qualify as specialists, resulting eventually in a dearth of suitably trained specialists.

Dr Heaton gave unchallenged evidence, supported by the other experts, that it was appropriate to permit a level-three registrar to undertake a vaginal hysterectomy under close supervision, but it would never be appropriate to permit a level-two registrar to undertake such a procedure. His evidence, again supported by the other experts on both sides, was that, when a consultant is working with a registrar during the training program, the consultant would, at the end of the relevant period, provide an assessment to the College of the registrar's competence. The individual consultant would, however, not be shown the assessments of other consultants.

Connolly J found that this made real practical sense, as the consultant should not be influenced in their assessment by the views of their peers. It meant, however, that Dr Heaton had no knowledge of any prior adverse assessments of this trainee. The training program extended over a calendar year. A level-one registrar is in her or his first year of training. A level-two registrar will have successfully completed her or his first year, and be in second year. A level-three registrar will have successfully completed first and second years, and be in the third year of training and so on over the six years of training. The College training manual, which was in evidence, set out in prescriptive detail exactly what skills a registrar must demonstrate in order to advance through each year of training.

Dr Cree's statement should give pause for thought to all young doctors who consider that accurate note-taking should not be for them a clinical priority:

I have perused the medical records of Lorraine Brus (formerly Houghton). I note from those medical records that I was involved in a vaginal hysterectomy performed upon Lorraine on 23 September 1998. Given the passage of time, I have no independent recollection of this procedure and rely on the medical notes for the purpose of providing this affidavit.

Having recently returned from Wagga Base Hospital in mid July and then commencing recreational leave in September 1998, I would have had only six weeks experience as an Obstetric and Gynaecological Registrar under Dr Heaton's supervision, before this particular procedure. As a relatively junior registrar, I would not have performed this task given that it is one of the more complex of the Obstetric and Gynaecological procedures ...

In normal circumstances, an Obstetric and Gynaecological Registrar might perform a vaginal hysterectomy and closure of the vaginal vault in the third or fourth year of practice, and not as in my case after six weeks with this particular consultant.

It appears from this statement that the junior doctor was blaming her supervisor for letting her perform a procedure for which she was inadequately trained. This situation where trainee and supervisor trade blame for an adverse event must be one of the most deleterious in relation to creating an institutional ethos supportive of patient safety.

Dr Cree's assessment forms relating to her period at the Wagga Base Hospital of July 1998 caused concern. Three consultants found major technical limitations or deficiencies. The records show that Dr Currie, who was her supervisor at Wagga, passed these assessment reports to Dr Peak at the Canberra Hospital. The letter added: "I had a long talk to her before she left, but she will need to make significant improvements if she is going to be able to complete her training."

A letter from Dr Peak which accompanied the assessment to the Chairperson of the College's NSW Training Committee, stated:

As you will see from the summary [Dr Cree's] scores would indicate an unsatisfactory assessment. However it became apparent to me that her assessment was not discussed with her. Nor was there any warning during the term. I do not think those who gave assessments were aware that the scores indicated an unsatisfactory assessment. I have discussed the above with Dr Currie and have decided that although the assessment scores are low the term would be passed satisfactory on the basis that: I do not believe the proper process was followed. This was the first time two registrars were at Wagga Wagga and there were some problems with the loss of specialists and registrars during the time. The main concern in the assessment was related to surgical techniques. Vanessa has been back at the Canberra Hospital for 3 months and we have not encountered any problems.

The above has been discussed with Vanessa. I have suggested she document her side of the story. If there are any surgical shortcomings we will attempt to correct these.

Although the Wagga assessments meant she was assessed as "unsatisfactory", Dr Peak decided to rate her as satisfactory. Despite this documentary material being available for some time, there was no report or affidavit from Dr Peak explaining why this course was taken.

Dr Heaton's evidence was that as a result of the information provided to him by Dr Peak, he was of the view that Dr Cree was a "Level 3 Registrar in Training. Level 3 out of 6 levels" (T 436/ 34). Dr Heaton said that, from his present recollection, he was satisfied with the level of Dr Cree's textbook knowledge as a level-three registrar as at September 1998 (T 439/45). His recollection as to her surgical skills was that she was competent, in that he meant (T 441/30):

She basically can hold a scalpel correctly, that she can control bleeding which occurs, that she can tie knots, very important and that she can stitch appropriately.

Where he was supervising a level-three registrar, Dr Heaton described again each step in the procedure and how he would be in a position to closely observe the steps. He said (T 449/45):

If I perceive that they're not competent or technically there's a difficulty beyond their level of expertise then I'll relieve them of that duty and I will take over the surgery.

Conolly J was very concerned that Dr Cree was not made available for cross-examination in these proceedings. He found she did, in fact, perform this procedure under the close supervision of Dr Heaton (at [25]):

For a Judge in one court to be told that Dr Cree is not available and has not answered a subpoena, while the Master in the court next door is being told that the Australian Capital Territory Government Solicitor was in active contact with her, is disturbing, and it certainly invites me to draw a most adverse inference. I am entitled to draw the adverse inference that her evidence would not have assisted the first defendant's case (*Jones v Dunkel* (1959) 101 CLR 298).

Conolly J found that the negligence that occurred was when Dr Cree caught the fallopian tube within the suture line as she was closing the incision in the vaginal vault. This occurred on the internal side, and could not have been observed by Dr Heaton. Conolly J was satisfied from Dr Heaton's evidence and the evidence of other experienced surgeons that it was entirely appropriate for him to allow a level-three registrar to perform this procedure under his close supervision.

Connolly J found negligence on the part of the hospital in holding Dr Cree out as a level-three registrar, capable of performing this procedure. Being in possession of adverse assessment reports which showed that Dr Cree had been rated as unsatisfactory for surgical skills as a level-two registrar, the hospital, through Dr Peak, made a decision to rate her as satisfactory, and held her out to Dr Heaton as a level-three registrar in good standing.

On the facts of this case, had Dr Heaton been informed of the true situation, he would have simply taken over and performed the procedure himself. Connolly J held (at [63]):

A consultant is entitled to assume that a trainee who is allowed to continue in the program has passed the earlier parts of the program at a satisfactory level, and is entitled to assume that a registrar at a given level holds the appropriate skills for that level.

Connolly J stated (at [62]) that he did

not accept that there is a general duty of care on a public hospital to in effect provide public patients with a choice of doctor, or to appraise a patient as to the academic standing of a registrar. However, there is a duty on a hospital to ensure that it provides patients with suitably qualified staff. The rigorous College training program ensures that, at each stage of their training, a registrar in good standing is suitably qualified to perform the range of procedures commensurate with their level of training. In this case, a registrar known to the hospital to have major deficiencies in surgical techniques for a level 2 Registrar was held out to Dr Heaton as a level 3 Registrar, and he allowed her to perform a procedure that he would not have permitted a level 2 Registrar to perform.

Connolly J gave judgment for the plaintiff against the first defendant in the sum of \$82,019.77 with costs and judgment for the second defendant.

RESPONSIBILITIES OF BEING ON CALL: GREATER SOUTHERN AREA HEALTH SERVICE V ANGUS

Greater Southern Area Health Service v Angus [2007] NSWSC 1211 concerned an action by the next friend of a baby (Jack Tori) for damages alleging negligence against the Service in the management of a labour and delivery at Wagga Wagga Base Hospital in 1995 that resulted in brain damage and disabilities, including cerebral palsy, epilepsy and moderate intellectual disability. Those proceedings were ultimately settled in 2003 for \$7.5 million plus costs. The Service then commenced proceedings against Dr Angus pursuant to s 5(1)(a) of the *Law Reform (Miscellaneous Provisions) Act 1946* (NSW) as a joint tortfeasor liable to contribute to the judgment approved by Levine J. Dr Angus was a visiting medical officer at the hospital and the specialist “on call” obstetrician on the day of Jack’s birth.

The crucial questions were, first, whether Dr Angus was consulted by his junior registrar on the crucial day in connection with the question whether Mrs Tori’s labour should be augmented with intravenous Syntocinon (also known as Oxytocin); and second, if so, whether Dr Angus should have ensured that certain procedures were put in place as precautions against the risks associated with such augmentation.

The plaintiff submitted that, had that monitoring been undertaken, intervention in the delivery would have occurred which, in all probability, would have resulted in Jack being born uninjured. It was also argued that Mrs Tori should have been moved out of the birthing suite into a labour ward bed since, once her labour was augmented by Syntocinon, she was no longer a low-risk patient and being in a labour ward bed made certain delivery procedures easier to undertake. It was conceded on behalf of the Service that, if Dr Angus was not informed of the proposal to administer Syntocinon, then there was no basis for claiming a contribution from him. It was not suggested that administration of Syntocinon was professionally inappropriate or negligent.

Dr Angus was at the relevant time a visiting medical officer (VMO) in obstetrics and gynaecology at the hospital, his appointment having commenced in 1994. It is not disputed that he was responsible for the proper clinical management of all patients admitted to the hospital under his care and he took full clinical responsibility for diagnostic and treatment services provided to those patients, including Mrs Tori. On 20 September 1995 he was the “on call” obstetrician. At that time he was “on call” every one week in five and the “on call” period was for one week, Monday morning to Monday morning.

At the relevant time Dr Richard Draper was working as a junior registrar in obstetrics at the hospital. He was under the supervision of the senior registrar in obstetrics and, of course, of the VMOs who specialised in obstetrics and practised at that hospital, including Dr Angus. A description of Dr Draper's position as "junior obstetric registrar" was a local classification to distinguish between someone in his position on the one hand and, on the other, the registrar undergoing specialist obstetric and gynaecological training, who was designated the senior registrar. At the time of Jack's birth, Dr Draper had 15 months' experience as an obstetric registrar and had been working in New South Wales hospitals since 1991.

Dr Draper's belief was that, because of his relative inexperience and the possible complications that might arise from the use of Syntocinon to augment labour, he would at all events have consulted Dr Angus about it. He frankly admitted that he has no actual recollection of speaking to Dr Angus about it. His belief that he did so was a reconstruction of likely events resting essentially upon his belief that he was not sufficiently experienced at the time to make the decision without doing so and the strong likelihood that Dr Angus was in the labour ward at the time on his rounds, in which he would usually be accompanied by Dr Draper.

Dr Angus confirmed that he did ward rounds between 8.30am and 9.30am and that this included visits to the labour, maternity, gynaecology and antenatal/postnatal wards. He said that, unless he had been asked to visit patients on a particular ward for a specific reason, it was likely that he commenced his round on the labour ward and then went down to the maternity ward and then to the other wards. Dr Angus agreed that, in the normal course, he would have expected the senior registrar to have performed a check of the patients before he (Dr Angus) arrived in order to assess who needed to be seen. Where the registrar had not undertaken the check, Dr Angus assumed that a member of the nursing staff or a midwife would alert him to any issues that might have required his attention.

In the end, Adams J found that Dr Draper did not consult Dr Angus about whether Syntocinon should be administered. He also found that the omission to monitor by CTG or, if it did not occur, to monitor by auscultation with sufficient frequency, made no material contribution to the injury suffered by Jack Tori. Adams J gave judgment for the defendant with costs.

This case raises particular issues about the responsibilities of on-call VMOs. It seems to have been Dr Angus's practice to rely on registrars and nursing staff to alert him to problems with any of the patients. Had his specialist college or that hospital produced a guideline about on-call responsibilities and had he consulted it?

THE PROBLEM OF SUPERVISION IN A PRIVATISED SYSTEM

In the United States, the *Emergency Medical Treatment and Active Labor 1986* (US), its regulations and similar State laws, are designed to ensure that all patients who come to the emergency department receive appropriate care, regardless of their insurance or ability to pay. The legislation became necessary because many United States emergency departments were turning away patients who lacked private insurance. Hospitals under this legislation are required to provide all presenting patients with a medical screening examination to determine if they have an emergency medical condition and, if so, to stabilise that condition. The laws prevent hospitals from transferring patients until they are stable, unless the expected benefits of transfer outweigh the risks, or the patient has made a request to be transferred. Violations can involve penalties of up to US\$50,000 per incident and possible exclusion from Medicare and Medicaid.¹ These laws, however, appear to disadvantage the apparent economic efficiency of hospitals in poorer regions of the United States (where more people lack insurance or are under-insured).

Such laws, however, are indicative of wider problems with respect to junior staff who are likely to have considerable responsibility in "stabilising" such patients and weighing the benefits and risks of transfer. Would an on-call specialist, eg, be required to have a call-back to the hospital every time such

¹ Lord J, Moorhead J and Porto G, *On-Call Responsibilities for Hospitals and Physicians*, American College of Emergency Physicians, <http://www.acep.org/practres.aspx?id=30122> viewed 28 November 2007.

a patient was transferred? If not, what should be the criteria that allow such a specialist to rely in such a setting on the skills and judgment of the trainee?

Another important consideration in the supervision of the struggling trainee is the stress associated with long working hours and the excess numbers of patients.² Many junior doctors find it difficult or not worthwhile to admit to or discuss with their supervisor stress from work and exam pressures or sleep deprivation, as well as balance between work and home life believing this could prejudice their references.³ Senior doctors often underestimate the impact they have on the working lives of their juniors.⁴ For example, the more time that consultants dedicate to supervision and training, including feedback and appraisal, the more satisfied junior doctors are with their posts.⁵

Some institutions and services in Australia have started to develop guidelines concerning senior doctors' on-call responsibilities. These can state, eg, that doctors on call should be available (as rostered) when not in attendance at the hospital. During on-call periods, he or she should attend both urgent outpatients and patients who need admission and review inpatients who require it.⁶ Such guidelines need to give more attention to constructing a handover system that identifies the patients most in need of review and assists junior and senior doctors in setting priorities.⁷ Weekends, holidays and the early hours of the morning are times worthy of particular consideration.⁸

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RECENT DEVELOPMENTS

HEALTH POLICY

The election of the Rudd Labor Government on 24 November 2007 means that interest in health policy will now focus on the new Health and Hospitals Policy Commission being established by the new Health Minister Nicola Roxon. It is to be hoped that the senior academics and professionals appointed to this body possess a broad range of skills, experience and viewpoints. Of particular concern for maintaining the Labor commitment to a "fair go" would be any preference given to

² Deanu B, Schachte M, Vincent C and Barber N, "Causes of Prescribing Errors in Hospital Inpatients: A Prospective Study" (2002) 359 *The Lancet* 1373 at 1378, <http://www.thelancet.com/journals/lancet/article/PIIS0140673602083502/fulltext> viewed 28 November 2007.

³ Luck C, "Reducing Stress Among Junior Doctors" (2000) *British Medical Journal*, Career Focus, <http://www.careerfocus.bmj.com/cgi/content/full/321/7268/S2-7268> viewed 28 November 2007.

⁴ Firth-Cozens J and Greenhalgh J, "Doctors' Perceptions of the Links Between Stress and Lowered Clinical Care" (1997) 44(4) *Social Science & Medicine*, http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-3SWV5WT-9&_user=554534&_coverDate=04%2F30%2F1997&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000028338&_version=1&_urlVersion=0&_userid=554534&md5=ccd4ac6700191cab60b83a92fd922a43 viewed 28 November 2007.

⁵ Firth-Cozens J and Moss F, "Hours, Sleep, Teamwork, and Stress: Sleep and Teamwork Matter as Much as Hours in Reducing Doctors' Stress" (1998) 317(7169) *British Medical Journal* 1335, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1114246> viewed 28 November 2007.

⁶ Queensland Health Department, *Roles and Responsibilities for QCRP Program Participants*, http://www.health.qld.gov.au/orh/qcrd/docs/roles_respons.doc viewed 28 November 2007.

⁷ Cheah L-P, Amott DH, Pollard J and Watters D, "Electronic Medical Handover: Towards Safer Medical Care" (2005) 183(7) *Medical Journal of Australia* 369 at 369, http://www.mja.com.au/public/issues/183_07_031005/che10928_fm.html viewed 28 November 2007.

⁸ Cheah, Amott, Pollard and Watters, n 7.

industry representatives or those ideologically allied with them, in seeking federal control over Australian public hospitals merely as a prelude to the diminution of State powers or promotion of a wider agenda on health care privatisation.

TAF