

Part 7: Defamation issues

Another risk is that the patient might argue that the disclosure of information about their violent/abusive behaviour has unlawfully defamed them.

Here I am dealing specifically with the risks arising from disclosure to fellow healthcare professionals. The issues are different when it comes to notification to the police: in the latter situation, a crime is being reported to the relevant and responsible authorities (though it does raise privacy and confidentiality issues, discussed elsewhere in this advice). In the former situation, the member is not notifying authorities but is simply seeking to give colleagues, either internally or externally, a “heads-up” about the risk of similar behaviour occurring in their possible future interactions with the patient.

Before going any further, your members will need to understand that an absolute defence to defamation is truth (other defences are available as well, which I discuss below). In other words, if your member tells a colleague that the patient is vicious and dangerous; the patient cannot sue for defamation if that patient is in fact vicious and dangerous.

I have no doubt that your members will be able to capably and responsibly identify when there has been an episode of violence/abuse perpetrated by a patient.

That, however, is not the key legal risk from a defamation perspective.

Rather, the risk arises where the disclosure of the episode to a third person (called "publication" under defamation law) does more than simply recite the facts but conveys further certain additional imputations and inferences which, so the patient would argue, were wrong and unjustifiable.

For example, the patient may argue (and may well argue correctly) that the violence/aggression was an isolated episode or was prompted by acts or omissions of the member or by certain personality difficulties between the member and the patient. They could argue that the member's decision to notify others, either the authorities or other health care professionals, carried with it an imputation that the violence/aggression was in fact not an isolated incident but was just as likely to occur with others and in other circumstances... and indeed, justified notification to other persons to put them on notice. In these circumstances, the imputation is that the patient, far from being involved in an isolated incident, has or might have a propensity towards violence/aggression, particularly towards healthcare professionals.

And given the very broad definition of "violence/aggression" adopted in the College toolkit, it is clear that we are dealing here with a very wide spectrum of behaviours. In that situation, a "one size fits all" approach to disclosure is clearly inappropriate but instead needs to be circumstance-specific.

Your members need to understand that before they notify other healthcare professionals, they need to have satisfied themselves that the episode may well not simply constitute an isolated, one-off event.

Once again, they need to exercise caution and commonsense, and to do so with at least a basic understanding of the legal framework within which the laws of defamation now function.

For that reason, I set out below a brief description of the way the laws operate and the defences that might be available to members where the patient alleges that the disclosed information about their alleged violence/aggression was defamatory of them.

New defamation laws

Defamation law is now uniform throughout each State and Territory in Australia. Material (both written and oral) is defamatory if it is likely to –

- injure a person's reputation, or
- Injure a person in their profession or trade

Whether material is defamatory involves determining what is meant by the material. Another way of putting this is to ask what "imputation" the material conveys. Having identified those imputations, the next task is to assess whether the meaning satisfies the definition of what is defamatory. In determining these issues, a court examines the natural and ordinary meaning of the words – how an ordinary person would interpret the material unaided by special knowledge.

Possible defences to defamation

The laws recognise that the need to protect reputation may sometimes be overridden by the public interest in freedom of speech and the availability of accurate information regarding public affairs. For these reasons, several defences are available to your members even if they do publish defamatory material about a patient.

For current purposes, the most relevant statutory defences are:

- a. Justification (truth),
- b. Contextual truth,
- c. Qualified privilege,
- d. Honest opinion,

These are in addition to any other defence or exclusion of liability available at common law (unless modified by the Acts) or under statute (unless repealed by the Acts).

Let me address briefly some of the most relevant defences to this particular matter.

a. Truth

One defence is that the defamatory imputations carried by a statement are substantially true. 'Substantially true' means true in substance or not materially different from the truth. A mere inaccuracy in detail which does not go to the substance of the imputation will not stop it from being substantially true.

b. Contextual truth

Contextual truth is now available to defendants both for contextual imputations that are separate and distinct, as well as those which are substantially similar to, the defamatory imputations the plaintiff complains about. The new defence is wider than was previously available. There is no public interest requirement.

c. Defence of honest opinion

These new laws do **not** prevent people from expressing honestly held (but wrong) opinions, **so long as** they can demonstrate that it was in the public interest for them to express that opinion. In order to rely on this defence, the member must prove that:

- The published matter was an expression of opinion rather than a statement of fact; and
- The opinion relates to a matter of public interest; and
- The opinion is based on proper material.

The Act does not define what ‘public interest’ means, so this defence will rely on the court’s interpretation of what is a matter of public interest. The common law has previously interpreted this as requiring a matter to relate to people in public office or within the public arena, performing public duties. In my view, this will probably:

- extend to discussions with the police, but
- not extend to discussions with other healthcare professionals

However, for this particular defence to apply, the member's statement must be an honest statement of opinion or comment, **not** a statement of fact. The test is: would an ordinary reader consider the statement to be one of opinion or of fact. This can be a surprisingly complex analytical area, involving the making of the most subtle and tortured intellectual distinctions.

Under the new laws, an opinion is based on “proper material” if the material in question:

- is substantially true; or
- was published on an occasion of absolute or qualified privilege (either under the Act or at common law);

d. Qualified privilege

For current purposes, this privilege protects the publication of material in the performance of a duty or to protect an interest. However, it only exists where there is a reciprocity of duty and interest between the publisher and those to whom the material is published. In my view, that reciprocity exists in member dealings with police, but not necessarily with respect to discussions between healthcare professionals in private practice.

Summary, recommendations and next steps

In this advice, I have sought to highlight and address the medicolegal issues and risks associated with the various risk management strategies explored in the toolkit.

If there is one unifying theme here, it is that your members absolutely should take steps to avoid and minimise the risk of violence/aggression from patients, but need to do so by exercising a proportionate, commonsense approach

which continues to respect privacy and confidentiality and which recognizes relevant member duties and relevant patient rights.

More often than not, through the implementation of commonsense risk management initiatives your members should be able to protect themselves and their staff without breaching any laws. But some risk management strategies can be more problematic than others. And when they arise, your members should seek help and advice from their medical defence insurer. As with any medical legal (and, I suspect, clinical) issues, it all comes down to a circumstance-specific solution.

With thanks,

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