

First Defence

JMOs + DOCTORS IN TRAINING

MDA National

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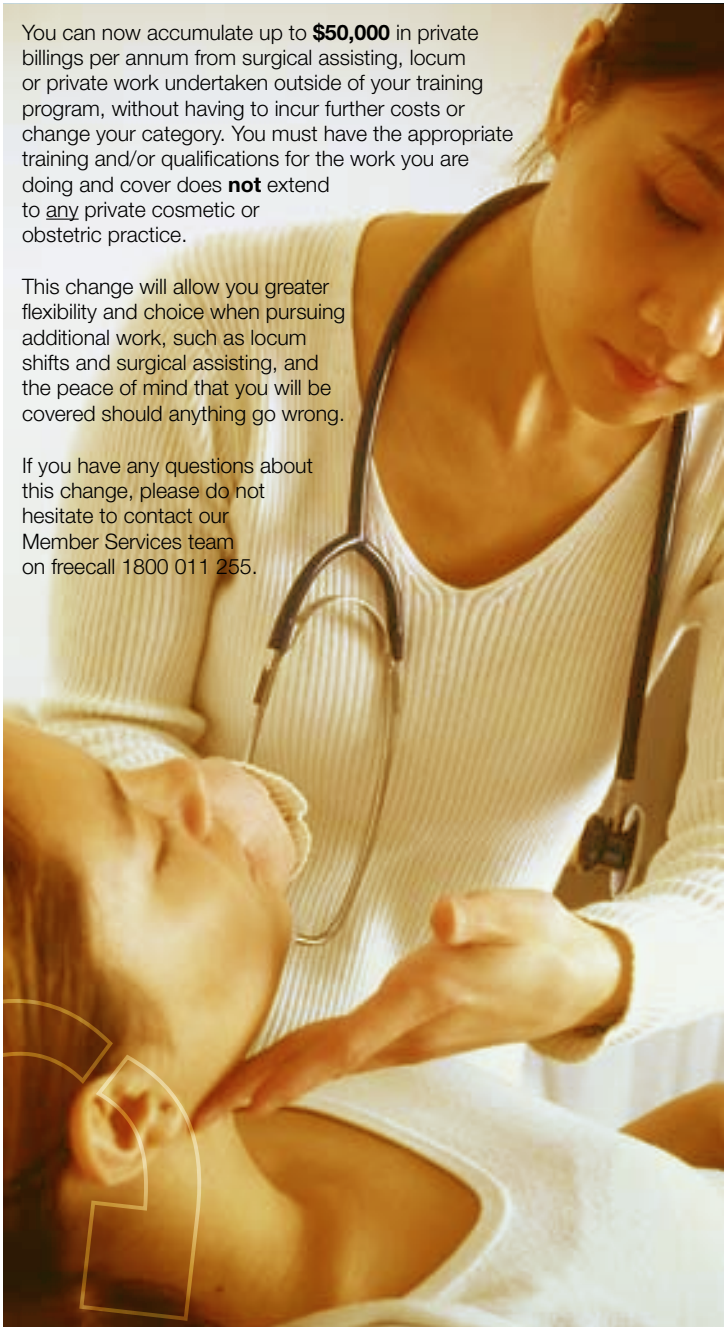

INSURANCE PTY LTD

ABN 56 058 271 417

More flexible cover for junior doctors from 1 January 2008



MDA National Insurance is pleased to announce that as of 1 January 2008 we increased the amount of private billings that can be incurred outside of your training program while still being covered under one of our junior doctor categories.



You can now accumulate up to **\$50,000** in private billings per annum from surgical assisting, locum or private work undertaken outside of your training program, without having to incur further costs or change your category. You must have the appropriate training and/or qualifications for the work you are doing and cover does **not** extend to any private cosmetic or obstetric practice.

This change will allow you greater flexibility and choice when pursuing additional work, such as locum shifts and surgical assisting, and the peace of mind that you will be covered should anything go wrong.

If you have any questions about this change, please do not hesitate to contact our Member Services team on freecall 1800 011 255.

A complex coronial inquest

The provision of legal representation at coronial inquests, if required, is one of the important components of your Professional Indemnity Insurance Policy with MDA National Insurance. Sometimes JMOs ask why it is necessary to purchase a policy from MDA National Insurance when they are indemnified by their hospital. If you have ever wondered this yourself, read on!

CASE HISTORY

A 35 year old patient was admitted under the gastroenterology team of the Regional Hospital on 28 February 2003 for management of his severe alcoholic cirrhosis, which was complicated by ascites and a large umbilical hernia. During his admission the patient had several episodes of bacterial peritonitis and acute renal failure.

On Sunday 20 April 2003, the weekend intern, Dr Barnes, was asked to review the patient who was complaining of the sudden onset of abdominal pain. By this time, the patient had been in hospital for approximately seven weeks. The intern had not seen the patient before. Dr Barnes was 14 weeks into his medical career at that time and had only been at the Regional Hospital for three weeks. He reviewed the patient's medical records briefly and then went to see the patient. Dr Barnes obtained a detailed history and performed a physical examination. Because of his inexperience and the complexity of the patient's

history and presentation, Dr Barnes advised the patient that he would ask the medical registrar to review him. The intern thought the patient's abdominal pain may have been the result of peritonitis, or possibly a UTI or pancreatitis.

He went to the computer in the doctors' room and looked up the patient's recent pathology results. He noted the results of the most recent blood tests which had been taken at 8.15 am on 19 April 2003, including white cell count 17,200, sodium 123, potassium 6.9, urea 17.1 and creatinine 133. Dr Barnes recorded his detailed findings and the results of the blood tests in the medical records [see page 4]. Having done this, Dr Barnes concluded that the complexity of the patient's medical history together with his symptoms and abnormal blood test results caused him such concern that he should contact the registrar immediately. Dr Barnes paged the registrar, Dr Halliday, and she came to the ward almost immediately.

Dr Halliday said that she had seen the patient some time earlier during his admission. Dr Barnes was in the process of outlining the patient's complaints and his findings on examination when the registrar interrupted him and asked if the patient was on antibiotics. Dr Barnes was unsure and went to obtain the patient's medication chart. On his return to the doctors' room, he observed Dr Halliday standing with the hospital records which included his very detailed notes. The registrar commented to Dr Barnes that the patient had an elevated white cell count. Dr Halliday then went and examined the patient. At the conclusion of her assessment, she told the intern to take blood cultures and then commence IV antibiotics. After Dr Barnes had done this, he made a further entry in the medical records and continued seeing other patients. He did not hear anything further about the patient.



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On Monday 21 April 2003, the gastroenterology RMO had returned to work after two weeks leave. The team had a new registrar starting that day. Therefore both doctors were unfamiliar with the team's patients. Because of the pressure of time, the RMO did not read Dr Barnes' medical record in its entirety and focused only on the recorded 'Plan'. The patient was booked to undergo an upper GIT endoscopy that morning. This was performed at about 10.00am and the patient returned to the ward around midday.

At 8.00 pm on 21 April 2003, the patient was found collapsed and, despite CPR, he was unable to be resuscitated. Blood tests which had been taken at 8.40 am that morning had revealed a potassium of 7.7.

MEDICO-LEGAL ISSUES

The patient's death was reported to the Coroner. An autopsy concluded that '*...death was probably caused by hyperkalemia in a person with acute renal failure and underlying cirrhosis of the liver with massive ascites*'.

On 24 April 2003, Dr Barnes was informed of the patient's death and he contacted MDA National for advice. The medico-legal adviser asked Dr Barnes to document his recollection of his involvement in the patient's care while the events were still fresh in his mind. He was asked to send this document to MDA National where a file would be opened to protect his interests and to enable the matter to be monitored on his behalf. The intern was informed that if he was asked to

prepare a statement for the Coroner, he should contact MDA National for advice and assistance in the preparation of the report.

Dr Barnes then heard nothing further about the matter until March 2005 when he was contacted by a solicitor acting for the Regional Hospital. The solicitor informed Dr Barnes that a coronial inquest had been set down for hearing and he would be required to give evidence at the inquest which was scheduled to commence in two weeks. Dr Barnes immediately contacted MDA National for further assistance. MDA National's medico-legal adviser contacted the hospital's solicitor. The solicitor said the Coroner had obtained expert reports from an intensive care specialist and a gastroenterologist who were both critical of the failure of the medical staff to treat the patient's hyperkalemia. The solicitor informed the medico-legal adviser that she did not have statements from Dr Barnes or Dr Halliday. The medico-legal adviser was concerned that the evidence of Dr Barnes and Dr Halliday was likely to be in conflict, making it impossible for the one solicitor to represent the interests of all of the medical staff at the hospital. The medico-legal adviser told the solicitor that if there was any conflict evident in the statements provided to the Coroner by Dr Barnes and Dr Halliday, then MDA National should be informed immediately.

On 28 March 2005, Dr Barnes met with MDA National's

medico-legal adviser who assisted him in preparing his report to the Coroner. The medico-legal adviser also reviewed the Coronial Brief of Evidence and determined that there was likely to be a conflict of interest.

On 4 April 2005, the hospital's solicitor informed MDA National that there was a conflict between the statements of Dr Barnes and Dr Halliday. The solicitor said that the counsel (barrister) assisting the Coroner had informed her that there was 'clearly an omission on the part of Dr Barnes in not telling Dr Halliday about the elevated potassium level'. It appeared that Dr Barnes' conduct would unfairly be a focus of significant criticism at the inquest. Indeed, it appeared that the intern was going to be the 'scapegoat' and inappropriately held responsible for the death of the patient. In order to best protect Dr Barnes' interests, it was determined that separate legal representation was required for him at the inquest. Accordingly, MDA National instructed a barrister to appear on behalf of Dr Barnes at the inquest.

At the commencement of the inquest, Dr Barnes' barrister made an application for an adjournment on the basis that he had had insufficient time to prepare for the inquest. The Coroner refused to grant an adjournment. There was also an issue about a perception of bias on the part of the Coroner. The patient's treating gastroenterologist, who was also due to give evidence at the inquest, had recently performed a procedure on the Coroner.



20/4/03 F BARNES (WEEKEND INTERN PAGER # 3651)
ATSP re: abdominal pain

- Hx # sudden onset AP > 1000 today
 - across abdomen (epigastric + hypochondrial region)
 - radiating around to back
 - sharp in nature
 - 5/10 intensity
 - constant
 - °Δ in severity \bar{c} time
 - \uparrow \bar{c} movement
 - \downarrow \bar{c} analgesia (? some relief \bar{c} sitting forward)
 - assoc \bar{c} \rightarrow nausea, dry retching and LOA
 - \rightarrow feeling "hot + sweaty"
 - \rightarrow "my body shook so much I thought I was having a fit" (? rigors)
 - \rightarrow dysuria

Bowels opened today (diarrhoea): passing flatus: denies \uparrow in abdominal distension (NB pt has ascites)

- # °HA / °photophobia / °neck stiffness / °rash
- # °pl cr / °cough / °haemoptysis
- # has had similar pain before (when pt developed

? bacterial peritonitis after an ascitic tap - as per notes)

O/E # T 36° BP 106/62 PR 100 reg RR 16 SaO2 98% on RA


- # wincing in pain
- # cachectic
- # °diaphoresis
- # Hands - warm
 - well perfused (cap return < 3 sec)
 - ? early Dupuytren's contracture
 - °other peripheral stigmata of liver disease
- # Arms - both radials palpable
 - °RR delay
 - °echymoses / °petechiae


continued...

- # Face - ° anaemia
 - ° jaundice (NB poor lighting)
 - coated tongue

- # Neck - JVPNE
 - both carotids palpable (° bruits)
 - trachea midline (° tug)

- # Percussion - ° signs of liver dx
 - APND, ° thrills, ° PS heaves
 - H₁-H₂, \bar{c} Gallop rhythm

- #  - ↓ AE bilaterally
 ° creps ° wheezes
 ° Sacral oedema

- #  - Gross ascites
 - ° Grey Turners / ° Cullen sign
 - soft (° guarding ° rigidity)
 - epigastric tenderness on deep palpation

- ulcerated
 umbilical hernia (oedematous) - (R) Flank pain on ballotting
 - PN resonant periumbilically (dull towards flow)
 - BS present (° tinkling)
 - PR not done

- # legs - ° calf tenderness
 - ° SOA

Ix - FBE 168 / 17.2 / 452
 UEC 123 / 6.9 / 17.1 / 133
 LFT BR 11 / ALT 22 / ALP 218 / GGT 109 / Ab 28

- Blood film - toxic changes (mild)
 - anisocytosis (moderate)
 - elliptocytosis (some noted)
 - target cells (some noted)

- PDX # ? UTI (± pyelonephritis)
 # ? peritonitis
 # ? pancreatitis

(P) # med reg Dr Kimble aware
 - has kindly agreed to R/v pt

Addition

Dr Kimble has kindly R/v'd pt
 - ? spent bacterial peritonitis

[Signature]
 F. BARNES

- (P) # iv access # iv fluids (24/24) as charted pls
- # 1g ceftriaxone daily (start dose tonight pls)
- # msu - m/c/s
- # Ascitic fluid - m/c/s
- # Bloods for Monday
 - slip v
- # Blood cultures
 → pt has left ward for cigarette
 → will attempt iv access → blood cultures upon his return

20/4/03 Addit 1940

- # 22G iv cannula inserted
 under sterile conditions (R) FA
 - flushed i 10ml (R) saline (patent)
 - secured i steri strips and Tegaderm
- # Blood cultures taken (not v much but
 sent anyway)

[Signature]
 F. BARNES
 # 3651

continued...

In his statement to the Coroner, the gastroenterologist had expressed criticism of the junior doctors, including Dr Barnes, for not informing him of the results of the patient's blood tests. On this basis, Dr Barnes' barrister sought an order that the Coroner be prohibited from further hearing the proceedings. This order was ultimately granted in the Supreme Court in August 2005.

A few months later, another Coroner was given carriage of the inquest and the matter proceeded to a delayed hearing in March 2006. Evidence was heard from a number of medical witnesses over a period of four days and Dr Barnes gave evidence on the second day of the inquest. He was again represented by a solicitor and barrister who had been instructed on his behalf by MDA National. Indeed, all of Dr Barnes' legal costs (in excess of \$70,000) were covered under his MDA National Insurance Professional Indemnity Insurance Policy.

OUTCOME

The Coroner handed down his findings on 9 October 2006, some three and a half years after the death of the patient. With regard to Dr Barnes, the Coroner concluded that *'the overwhelming impression from his statement, his oral evidence and that of the other witnesses is that he is a methodical and conscientious person. Of those who were asked to comment on the hospital notes he recorded in relation to the patient, all acknowledged that they were thorough and detailed particularly considering how inexperienced he was as at 20 April 2003'*.

Dr Barnes subsequently wrote to MDA National:

"I just wanted to let you know that everything went really well with regards to my day in court. It was all very nerve-wracking, despite the solicitor's best attempts to calm me down, but I was fine once I got up there and started answering questions. The barrister for Dr Halliday was rather scary in cross examination, but I suppose he's not paid to be nice to me, is he?!"

Thank you so much for everything MDA National has done for me. From my first petrified phone call to MDA National in 2003 to this day, you have been absolutely wonderful. Your advice, encouragement, and unwavering support during this whole ordeal has meant a lot to me'.

The Coroner identified three areas where the hospital system had failed the patient:

- > There was no pathology 'critical alert' system. The laboratory staff had failed to alert the appropriate medical staff in a timely manner of critical pathology results, namely the potassium levels of 6.9 and 7.7.
- > The most junior doctors were rostered on to cover wards where they were unfamiliar with patients and rostered on weekends when there was minimal staff cover. There were only three doctors per shift in the medical wards,

which involved looking after 300 or more patients.

- > There was a failure of the hospital doctors to ensure that information was shared between shifts of doctors and between levels of doctors within the same shift.

The Coroner concluded *'I make it clear that I am of the view that blame cannot be attributed to any one individual who testified before me'*. The intern was extremely relieved that the Coroner had not expressed any specific criticism of his management of the patient.

JMO errors

A recent study examined the characteristics of, and factors contributing to, JMO errors¹. The study confirmed the relationship of poor teamwork to preventable errors and quality of care. Adverse outcomes in the study were serious: one-third resulted in significant physical injury, one-fifth in major physical injury and one-third resulted in death.

Cognitive factors contributed to nearly all of the trainee errors, with 72% of cases involving judgement errors and 57% involving failures of vigilance or memory. A lack of technical competence or knowledge was involved in 58% of cases. Diagnostic decision making was the primary task at hand in half of the cases in which technical competence or knowledge problems occurred. Good diagnostic decision making depends on a mix of system factors, including communication of information between JMO, other medical practitioners, nurses, laboratory staff and other allied health professionals.

Teamwork related factors were involved in 70% of the errors, especially failures of supervision and handover. Handover problems most commonly occurred between JMOs. In 34% of cases where a handover error occurred, an incomplete or inaccurate transfer of information took place between two trainees (as in the preceding case study). In general, the chains of communication within which handover breakdowns occurred were complex. Twenty per cent of handover problems involved more than two entities and 25% of the chains extended to interactions with nurses, pharmacy and laboratory staff, and entities external to the JMO's hospital.

Communication failures involving JMOs may stem from several tensions in teamwork, such as medical hierarchies, role ambiguity and interpersonal dynamics. Skills which enable JMOs to be comfortable to confirm and clarify directions are important. Problems of excessive workload, including tiredness, hunger and distraction, were also a feature of the JMO errors.

Reference

- [1] Singh H, Thomas E, Petersen L et al. *Medical Errors Involving Trainees. A Study of Closed Malpractice Claims from 5 Insurers*. Arch Int Med 2007; 167(19): 2030-2036.



New state liaison managers

MDA National are proud to introduce the latest additions to our expansive Business Development Team.

OLIVIA



OLIVIA WATSON – STATE LIAISON MANAGER WA

Olivia has taken on the role of State Liaison Manager for Western Australia. She has an extensive background in Business Development and is the main point of contact for education sessions and sponsorship requests in WA.
E: owatson@mdanational.com.au

ANNE



ANNE POWELL – STATE LIAISON MANAGER SA (DIP/DIT)

Anne has joined MDA National as the State Liaison Manager for South Australia. More specifically, she looks after junior doctors and doctors in practice. Anne has a long history within the healthcare industry, including over 10 years in medical indemnity.
E: apowell@mdanational.com.au

JUDI



JUDI PICKETT – STATE LIAISON MANAGER VIC (DIP/DIT)

Judi has taken on the role of State Liaison Manager for Victoria and will be looking after junior doctors and doctors in practice. Judi also has extensive experience within the medical indemnity industry, particularly in Victoria.
E: jpickett@mdanational.com.au

ANNA



ANNA MCQUEEN – STATE LIAISON MANAGER VIC (STUDENTS/INTERNS)

Anna is our other State Liaison Manager for Victoria and will be looking after medical students and interns throughout the state. She has a great deal of expertise in working with health care professionals.
E: amcqueen@mdanational.com.au

NINA SOLDATOVIC – STATE LIAISON MANAGER TAS

Nina has taken on the role of State Liaison Manager for Tasmania. She has been working for MDA National for almost 2 years within Business Development and has recently moved into this newly created position.
E: nsoldatovic@mdanational.com.au

All State Liaison Managers can be contacted on freecall 1800 011 255.

The addition of these highly experienced individuals to the MDA National team will improve the level of service available to Members right across Australia.

NINA





Are you a locum doctor?

During your post graduate years, many of you will undertake some form of locum work outside your training program or hospital rotations. Depending on the nature of your locum work, this may affect your indemnity requirements.

If your locum work is in a private hospital and you do not have access to hospital indemnity, you will need to notify us of the billings you expect to generate for which you require our indemnity. Generally, this will be at no additional cost, however you should notify us to ensure that your level of cover is adequate.

If your locum work is in a public hospital, you will need to ascertain whether you are entitled to indemnity from that hospital for any claims that may arise as a result of your locum work. As you may or may not know, MDA National Insurance's Professional Indemnity Insurance Policy specifically excludes indemnity for civil claims that arise from the treatment of a public patient in a public hospital. Please refer to clause 9.5 of the policy wording which states:

We will not indemnify you under this policy when the claim arises in any way from the provision of medical services to a public patient in a public hospital.

This exclusion is included in the policy because public patients in public hospitals, and the healthcare provided to those patients, are typically considered to be the State or Federal Government's responsibility. Therefore, if a public patient in a public hospital experiences an adverse outcome, the responsibility of indemnity should also lie with the State or Federal Government.



continued...

- > However, you may or may not have access to the hospital's indemnity scheme. Important factors include which hospital you will be locuming for and the hospital's payment method and/or employment policy. If you have a PAYE locum job and you are recognised by the hospital as an employee, you will generally have access to the hospital's indemnity scheme for civil claims. However, if the locum job requires you to invoice the hospital for the services you provide, for example through an ABN, then you may be seen by the hospital as an independent contractor rather than a direct employee and therefore lose your entitlements to hospital indemnity.

It is always advisable to confirm your individual entitlements with the hospital(s) in which you work as a locum, as eligibility can vary vastly from hospital to hospital and from state to state. You may wish to ask your locum agency to direct you to the appropriate person or department within the hospital. If you are advised that you are not eligible for the hospital's indemnity scheme, you should contact us as a matter of urgency. If you are not able to elect to be indemnified by the hospital, MDA National Insurance can agree to provide you with cover in some instances.


Even if you are entitled to cover for your locum work under the hospital indemnity scheme, it is recommended that you maintain your own indemnity cover. In most cases, the hospital scheme will only cover you in the event that there is a finding or judgement against you and an amount of compensation has been awarded

to the patient. MDA National Insurance's Professional Indemnity Insurance Policy provides you with cover for investigations and inquiries arising from the treatment of patients, including public patients in public hospitals. This may include cover for legal costs relating to Coronial Inquiries, Medical Board Inquiries, Hospital Inquiries, Disciplinary Tribunals and Royal Commissions. Furthermore, as a member of MDA National you also have access to our 24/7 medico-legal advice line should you require assistance while working as a locum.

If you have any questions or concerns about your entitlement to indemnity cover for your locum work, please do not hesitate to contact one of our Member Services Advisers on freecall 1800 011 255.



Take A Break competition winners




In line with MDA National promoting good health and consequently best practice for junior (and senior) doctors nationally, we ran the Take A Break On Us competition for medical school graduates and interns starting their internship in 2008. Eligible entrants were given the chance to win a slice of paradise to get away from it all - a \$1,000 Travel Voucher from Flight Centre.

We are pleased to announce that our 5 Take A Break Competition winners are:

Dr Claire Armanasco (WA)
Dr Vineet Kwatra (SA/NT)
Dr Yuni Ongso (VIC/TAS)
Dr James Shine (NSW/ACT)
Dr Darina Vuong (QLD)

MDA National would like to thank all of our entrants for their participation.





Medication errors

Medication errors are unfortunately very common and comprise approximately 25% of all hospital reported adverse incidents, making it the second most common type of adverse incident reported¹.



Medication errors are often found to be the result of weaknesses or latent failures in hospital systems, rather than negligence on any one person's behalf. If there is a breakdown in the system, it increases the risk of something going wrong.

Consequently hospitals go to great lengths to put systems in place which aim to prevent medication errors, in particular the 'human error' element, so it is often the case that medication errors are the result of a failure to follow appropriate practices and procedures.

Medication errors can be classified into 4 main categories:

1. *Prescribing errors* – whereby the medication order is erroneously or inadequately documented, such that an inappropriate dispensation or administration occurs;
2. *Dispensing errors* – where medication is erroneously dispensed (by pharmacy) notwithstanding a correct medication order;
3. *Administration errors* – when medication is incorrectly administered to a patient (for example wrong medication, patient, route, dose or time); and
4. *Documentation errors* – when crucial information is not documented appropriately or at all (for example a failure to note adverse drug reactions or allergies).

Not all medication errors result in harm to patients. Some of the factors which raise the likelihood of an adverse outcome are:

- the involvement of high risk medications, where the therapeutic dose for one patient is close to the dangerous dose for another patient; and
- the age of the patient, for example those who are young (with low tolerance) or elderly (with low tolerance, and possibly complex medication regimes).

Practitioners need to remember that prescribing medication constitutes the recommendation and implementation of a treatment option, and as such the usual procedures for obtaining a patient's consent applies. This necessitates a discussion with the patient of the clinical need for the medication, alternatives to the drug prescribed (if any) and the relative benefits of the recommended drug, including an outline of material risks and side effects.

SOME SIMPLE STRATEGIES FOR AVOIDING MEDICATION ERRORS

1. While the policies and procedures governing the practice of prescribing and dispensing medication may be seen to be unduly time consuming and tedious, they are designed to prevent medication errors. Accordingly the best protection against medication errors is to know and apply the policies and procedures that exist in your workplace.
2. Ensure you are in possession of all necessary information regarding the patient before you prescribe medication. In particular, be satisfied that the patient does not suffer from any known adverse drug reactions or allergies.


3. Utilise available resources such as Pharmacist support, electronic prescribing programs, and protocols and checklists that apply to high risk medications.
 4. Illegible prescriptions and vague, misleading or incomplete documentation is often responsible for medication errors, so ensure that your prescription is unambiguous and contains all of the necessary information to enable accurate dispensing and administration.
 5. Avoid unapproved abbreviations.
 6. Involve patients and educate them regarding their medication regime.
 7. Be particularly vigilant about prescribing medication under pressure, such as emergency situations, or where phone orders are sought while you are busy.
 8. Participate in medication error reviews and learn from previous errors.
- These tips will assist you in reducing your risk of being involved in a medication error. However, if a medication error should occur, remember to contact MDA National on our freecall number 1800 011 255 for support and advice.

Notes

- [1] Runciman W, Roughhead E, Semple S, et al. *Adverse drug events and medications errors in Australia*. International Journal for Quality in Health Care 2003; 15: 149 - i59.



Have you changed your contact details?



After graduation and internship, it is common for junior doctors to move or change other contact details such as their mobile number and email address.

To ensure that you maintain continuity of medical indemnity cover for your practice, it is very important that you notify MDA National Insurance of any changes to your contact details.

You can update your details by:

- > logging on to the Member Only section of our website www.mdanational.com.au**
- > emailing us at peaceofmind@mdanational.com.au**
- > contacting our Member Services Team on freecall 1800 011 255**
- > faxing your new details to us on 1300 011 244**

If you have any questions in relation to your contact details or your medical indemnity cover with MDA National Insurance, please do not hesitate to contact Member Services on freecall 1800 011 255.

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

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