

First Defence

JMOs + Doctors in Training Spring 2008 Issue

MDA National



Is There a Doctor on Board?

A few years ago, I was travelling back from China. As I turned on the in-flight entertainment, I heard crackles over the loudspeaker. "If there is a doctor on board, please make yourself known to cabin staff." I paused. I had just finished my intern year. I surveyed the aisles, waiting for another medico to answer the call. Time was anxiously ticking by.

As the stewardess rushed past me, I stood up. "I'm a doctor. Can I help?"

"Yes, come this way".

I grabbed my boyfriend (who was a medical student at the time) for moral support.

My stomach churned with every step. I remembered the story of a Professor who decompressed a tension pneumothorax with a coathanger and an Evian bottle. Other awful scenarios reared their ugly head.

I could hear him gasping. He was grey, sweaty and limp. Thick secretions coated his lips. But he was responsive. I wriggled my fingers in to find a bounding pulse.

"Pass me an oxygen mask and a blood sugar machine."

I secured the oxygen mask. There was no glucometer. His colour began to improve. He was confused. There were no eyewitness reports as he had collapsed while leaving the washroom. We searched his belongings for clues. Was this a vasovagal? Myocardial infarct? Hypoglycaemia? Or perhaps a seizure? His wet pants confirmed my suspicions about the latter.

I spent the next 7 hours wedged in between my patient and an oxygen cylinder. He improved dramatically and was advised to see a doctor on arrival in Sydney. I was farewelled with a bottle of champagne.

Thinking back to this experience, I realise how little I knew about the legalities of treating someone away from the hospital environment.

So, what should a doctor do in this situation? Are we covered legally for an act of medical goodwill? And how common are these incidents anyway?

According to a 1999 British Airways review of in-flight medical emergencies, there is one event per 11,000 passengers.¹ Of these, 70% are managed by cabin crew and the remainder by medical professionals.

A 2000 UK government study estimated that medical help is required for every 1 in 14,000 passengers.²

The arrival of the new Qantas A380 this month means more passengers per flight. This, combined with an older population with more medical comorbidities, could mean the chances of carefree flights for doctors will be less.

So, should we be worried about this?

Firstly, most doctors will be comfortable with treating complaints that typically arise in-flight. The common calls are for vasovagal syncope, vomiting, diarrhoea, dehydration, anxiety and asthma.^{1,2} Generally, oxygen, adrenaline, bronchodilators, antihistamines, antiemetics, anti-diarrhoeal agents, glucagon and diazepam will be available. Some airlines will have emergency cardiac drugs, and defibrillators.¹ Therefore, the main issue in providing patient care for common conditions will be space limitations, rather than pressure and altitude challenges.

Secondly, Good Samaritan acts are usually covered by the airline, or your medical indemnity organisation. Legal action arising from such acts is extremely rare.

A Good Samaritan is defined as a person (including a health professional) who comes to the aid of another person, acting without payment or other considerations.³

As doctors, we have an ethical and professional obligation to act as Good Samaritans. In Australia, the Good Samaritan doctrine has recently been incorporated into State and Territory legislation. This provides better legal protection for the Good Samaritan. In New South Wales and the Australian Capital Territory, doctors have a legislative duty to provide assistance on request. In the Northern Territory, this duty extends to legislate any passer-by, regardless of training, to provide assistance.⁴

	Legislation	Protection	Exclusion from protection
ACT	Civil Law (Wrongs) Act, 2002	Honesty and without recklessness	Liability falls within ambit of a scheme of compulsory third party motor vehicle insurance Capacity to exercise appropriate care and skill was significantly impaired by a recreational drug
NSW	Civil Liability Act, 2002	In good faith	If the Good Samaritan's intentional or negligent act or omission caused the injury or risk of injury. Ability to exercise reasonable care and skill was significantly impaired by being under the influence of alcohol or a drug voluntarily consumed Failed to exercise reasonable care and skill
NT	Personal Injuries (Liabilities and Damages) Act, 2003	In good faith and without recklessness	Intoxicated while giving the assistance or advice
QLD	Law Reform Act, 1995	In good faith and without gross negligence	
SA	Civil Liability Act, 1936	In good faith and without recklessness	Liability falls within ambit of a scheme of compulsory third party motor vehicle insurance Capacity to exercise due care and skill was significantly impaired by alcohol or another recreational drug
TAS	No legislation	N/A	N/A
VIC	Wrongs Act, 1958	In good faith even if emergency or accident was caused by a act or omission of the Good Samaritan	
WA	Civil Liability Act, 2002	In good faith and without recklessness	Ability to exercise reasonable care and skill was significantly impaired by being intoxicated by alcohol or a drug or other substance and intoxication was self induced

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Legal proceedings mostly relate to failure of the plane to be diverted despite medical advice, leading to an adverse patient outcome.² The airline will usually cover the Good Samaritan, if assistance is at their request and if there is no question of gross negligence or wilful misconduct. If there is no airline cover, medical indemnity organisations will generally cover the Good Samaritan – The Professional Indemnity Insurance Policy issued by MDA National Insurance includes cover for Good Samaritan Acts. Claims which arise out of treatment provided by the insured doctor while intoxicated or otherwise impaired by the use of an intoxicant or drug are excluded (except where the claims relate to a reasonable refusal to provide treatment because of the influence of such intoxicant or drug).

As doctors-in-training, we need to recognise and inform crew and passengers of our limitations and seek senior help (in particular ground medical assistance)

when indicated. We should clarify that the airline has requested our help, document events and remember the *primum non nocere* (do no harm) principle of medicine.

In retrospect, it would have been nice to know that I was legally covered. In essence, if we act reasonably, as expected from a medical professional with our skills and undertaking our particular role, we can respond to calls for medical help without repercussions.² As outlined in the table above, protection from civil liability is not available if assistance is provided when significantly impaired by alcohol or drugs.

Dr Marion Mateos

Paediatric Registrar - Sydney Children's Hospital
Member – MDA National NSW Advisory Committee

References:

1. Dowdall, N. "Is there a doctor on the aircraft?" Top 10 in-flight medical emergencies. *BMJ* 2000; 321 (7272): 1336-1337
2. Shepherd B, Macpherson D, Edwards CMB. *In flight emergencies: Playing the Good Samaritan*. *J R Soc Med* 2005; 99: 628-631
3. Gulam H, Devereux J. *A brief primer on Good Samaritan law for health care professionals*. *Aust Health Rev* 2007; 31(3): 478-482
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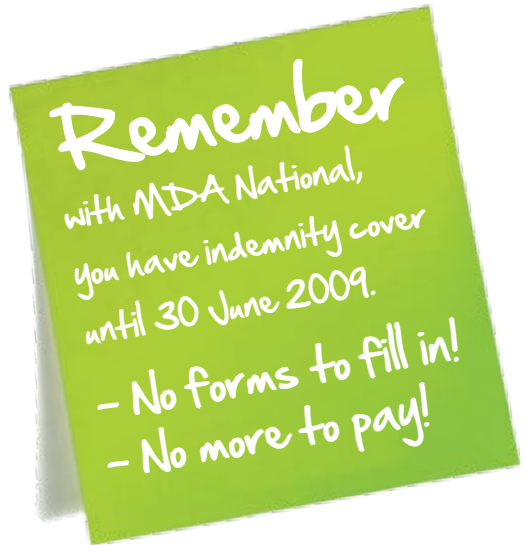
Was 2008 Your Intern Year?

Here are some important points about your indemnity insurance policy:

- Your policy is not due for renewal until 30 June 2009. A notice will be sent to you before that date.
- You have access to medico-legal advice 24 hours a day, 7 days a week.
- Your policy provides you with \$20 million protection for medical negligence claims with a \$500,000 sub-limit for defence costs for investigations, inquiries, allegations of sexual or criminal conduct and costs in seeking an Apprehended Violence Order.
- If you choose to work or volunteer overseas, your policy will cover you for up to 12 months (subject to underwriting approval).

Once you have finished your Intern year, your MDA National Insurance policy will cover you for:

- All private work undertaken as part of an accredited training program.
- Doctors in the Post Graduate and Doctors in Specialist Training categories can generate up to \$50,000 in billings per annum from surgical assisting, locum or private work undertaken outside of a training program providing you have the appropriate training and/or qualifications for this work (excludes private cosmetic and obstetric practice).



All for no additional premium.

If you have any questions about the MDA National Group or your policy coverage, or you would like to update your contact details, please don't hesitate to contact Member Services on 1800 011 255 or visit our website at www.mdanational.com.au

Have you seen 16hrs: A day in the life?

16 Hours: A day in the life is an interactive DVD developed as an educational tool to help junior doctors explore the complex interplay of factors contributing to stress in medical practice. It was written by Dr Kieran Le Plastrier, a Doctor in Training who is a member of MDA National's Victorian Advisory Committee.

The story is centred on a single day in the life of a fictional character, Dr Michelle Buchanan, a senior resident at a teaching hospital in Australia. The essential elements at play in the story cover four main areas that can impact on events during a working day:

- Personal life.
- Hierarchy of medicine.
- Hospital environment.
- Socio-political factors.

It does not represent a comprehensive teaching tool providing specific answers to the various risk management topics presented in the story and was not designed for this purpose. However, it does raise awareness and encourage consideration of how to better deal with certain circumstances that you may come across.

What benefits can it provide to junior doctors?

There are many benefits that this DVD can provide to junior doctors. Some of these include:

- Stimulates reflection about personal experiences among peers.
- Learn from peer's personal experiences.
- Assist junior doctors identify and manage some common medico-legal issues from everyday practice.

What topics are presented?

Currently the DVD has three modules. However more topics are in development for future sessions. This means that you can see the material or attend sessions more than once and still benefit from new information.

The three current modules include:

- Medication Errors.
- Consent.
- Stress, the Workplace, Myself and I.

What is the session format?

Depending on the time available, the sessions will generally run in the following format:

- Introductory comments.
- Viewing of DVD Main Program.
- General discussion in relation to the broad themes of the story.
- Viewing of the DVD Module Program.
- Specific discussion in relation to the selected topic.
- Summary of thoughts & learnings.

The facilitation of the session is provided by a qualified MDA National staff or committee member, all of whom have clinical experience.

There is also the opportunity for relevant hospital staff to join in on the discussion and provide a local perspective in relation to the topic being presented, for example a member of the hospital pharmacy staff can provide specific insight into the instances of medication error in your hospital or Area Health Service.

Is there a cost involved?

No, all DVD sessions are free of charge. Also, all participants receive an information pack on completion of the session. This contains a summary of the learning objectives, information presented in the session and a selection of relevant journal articles on the presented topic.

How can I get the chance to view 16hrs: A Day in the Life?

If you are interested in MDA National holding a DVD session in your hospital, please contact your State Liaison Manager who can provide you with information to pass on to your Medical Education Officer (MEO) or they can contact your MEO on your behalf.



Case Study

Root Cause Analysis: What is it? What should I do?

The JMO was working as the night medical intern during her release term. On 8 February 2008 at 03:00 hrs, there was a medical emergency team (MET) call for a 75 year old patient who had hypotension. The patient had been admitted that day from the emergency department (ED) with excessive diarrhoea, one day after an annual colonoscopy. In the ED, the patient had been assessed as moderately dehydrated. Intravenous re-hydration had been commenced and the patient had been transferred to the ward in the early evening under the care of the Medical Team. During the MET call, which the JMO attended, the patient was given an IV fluid bolus and his IV fluids were continued at an increased rate. A decision was made to keep the patient on the ward and to repeat his investigations in one hour.

One hour later, the junior ward nurse recorded the patient's blood pressure as 70 systolic. Instead of initiating a second MET call, the nursing staff paged the JMO. The JMO assessed the patient, and found that he was still dehydrated. She paged the evening registrar, who advised her to give another 250ml of Gelofusion and to keep the patient's blood pressure greater than 90 systolic. The JMO did not document this call or the advice given by the registrar in the medical records. A manual check of the patient's blood pressure immediately post IV bolus revealed a systolic of 100. The JMO reviewed the blood test results and thought the arterial blood gas results were consistent with an improving metabolic acidosis. She decided to keep the patient under close review during her shift.

Unfortunately, it was a very busy night on the wards and the JMO finally returned to review the patient again at 06:30 hrs. The patient's blood pressure was 80/50. The JMO tried to page the medical registrar on two occasions, without success. She decided that she would discuss the case with the registrar at handover at 08:00 hrs. During handover, there was another MET call. The patient had suffered a cardiac arrest from which he could not be resuscitated.

Two weeks later, on 22 February 2008, the JMO was asked to attend a meeting as part of a root cause analysis (RCA) of the events leading to the patient's death. The JMO was not sure what to do and she sought advice from MDA National. Following discussion and assistance from the medico-legal adviser, the JMO participated in the interview.

In April 2008, the JMO was provided with a copy of the final RCA report. The report documented the “root causes” or contributing factors to the patient’s death. These included:

- At the conclusion of the first MET call at 03:00, contact was not made with the primary consultant or on-call surgical registrar or intensive care consultant, who would have prompted a comprehensive review of the patient and provided more timely resources to manage the patient’s metabolic acidosis, dehydration and haemodynamic status.
- Following the first MET call, there was an inadequate management plan, including a lack of observation orders, comprehensive assessment or resource allocation to provide an increased level of care for the patient. Pathology results which were scheduled to be reviewed and repeated in one hour, did not occur in a timely manner.
- The urinary output of the patient was not known. No strategies were put in place to accurately measure the urine output. A lack of recording of input or output, following transfer to the ward from the ED, prevented daily fluid balance total to be assessed.
- Medical handover did not provide for timely follow-up of tests ordered or adequate supervision of junior staff.

The RCA team made the following recommendations:

- To review the MET policy to include after hours nomination of medical or surgical registrars to speak directly with the primary consultant and/or on-call consultant immediately post MET call.
- Following a second MET call for a patient within a 24 hour period, ICU consultant to be contacted immediately.
- A post MET call plan for patients remaining on the ward should be developed, including:
 - medical review by treating team to be attended one hour after MET is completed
 - review of after hours registrar coverage.
- Escalation plan to be developed for delayed medical response to calls for urgent/essential ward review of patients.
- Reinforcement of existing policy on clinical documentation. Registrars to confirm JMOs’ documentation of consultant and other orders, including phone orders.

Discussion

Root cause analysis (RCA) is a process analysis method, which can be used to identify the factors which cause adverse patient events. RCA is used in hospitals to investigate serious patient incidents to identify the underlying causes and to guide solutions to address safety systems failure. RCA is normally only performed on high-risk, high-impact events, such as sentinel or reportable events, including unexpected patient deaths. Most Australian States and Territories have in place legislation to facilitate the performance of RCAs in a hospital setting. The main principles of an RCA investigation are to:

- focus on systems and processes, not individual performance;
- be fair, thorough and efficient;
- focus on problem-solving;
- use recognised analytical methods;
- use a scale of effectiveness to develop recommendations.

The RCA team must focus on system change, and is not permitted to investigate the competence of an individual doctor or other staff member. At the end of the process, the RCA team must provide a written report describing the incident, the reasons they think it occurred and any recommendations for change to practice or procedures.

From time to time, JMOs may be asked to attend an interview with an RCA team. If you are asked to participate in an RCA process, please do not hesitate to contact MDA National’s medico-legal advisory service for advice and support.

Dr Sara Bird
Medico Legal Claims Manager

Employer Indemnity and Your Professional Indemnity Insurance Policy

We get a number of enquiries from junior doctors employed in the public health system about employer indemnity and the indemnity provided under the Professional Indemnity Insurance Policy issued by MDA National Insurance.

Unless you have a specific contractual requirement to carry your own professional indemnity insurance, employees of the public health system would be indemnified by their employer for any civil liability arising from actual or alleged medical negligence. In each state and territory, schemes are in place to provide civil liability cover for all public hospital employees in respect of their treatment of public patients.

The Professional Indemnity Insurance Policy issued by MDA National Insurance excludes claims where you are indemnified under a government scheme or by your employer and claims which arise out of the provision of healthcare services to a public patient in a public hospital.

I've checked with my hospital and I do not have access to employer indemnity. What do I do?

If you are practicing as a locum (or other contractor) rather than an employee, you may be excluded from the state or territory government indemnity scheme. GP Registrars should also pay careful attention to their indemnity requirements where they are treating public patients in a public hospital but are not hospital employees. You may also be excluded from the state or territory

indemnity scheme if you are employed by a corporate entity that holds a contract to provide services to a public hospital.

If you are not covered for claims arising from the treatment of public patients in public hospitals, you should apply to have your Professional Indemnity Insurance Policy endorsed. In these circumstances, MDA National Insurance can extend cover to include this work, subject to underwriting approval. An additional premium may be required if this cover is issued.

Members in this situation should obtain written confirmation from the hospital confirming that they do not have access to indemnity and forward this confirmation to us with a completed Treatment of Public Patients Proposal, available from the Download Centre on our website or by calling Member Services on 1800 011 255.

Please note that indemnity from MDA National Insurance for claims relating to the treatment of public patients in public hospitals will only be considered if you do not have access to any government indemnity scheme or employer indemnity for this work.



I have employer indemnity. If you don't cover claims from my treatment of public patients in public hospitals, then why do I need my own policy?

The various state and territory indemnity arrangements do not generally extend to provide assistance for investigations and inquiries such as Medical Board and Coronial Inquiries, disciplinary proceedings and hospital inquiries. Cover for the legal costs associated with these sorts of matters is provided by your Professional Indemnity Insurance Policy with MDA National Insurance.

There may be significant legal costs associated with these types of inquiries and investigations. Costs for major inquiries and investigations can run to almost \$100,000. If you ever become involved in an investigation or inquiry, having your own medical indemnity insurance gives you the security of knowing that you will have your own team providing you with assistance, support and legal advice.

In addition, Members in the Post Graduate and Doctor in Specialist Training categories will have civil liability cover for claims arising from private

practice performed outside of a training program (subject to conditions¹) at no extra cost. This allows you the flexibility to make the most of a variety of employment opportunities without having to worry about your indemnity entitlements.

More information?

If you have any questions in relation to the cover provided under your Professional indemnity Insurance Policy, please do not hesitate to contact your local state Liaison Manager or call Member Services on 1800 011 255.

Fenella Barnes

Underwriter

- 1 Doctors in the Post Graduate and Doctor in Specialist Training categories can generate up to \$50,000 in billings per annum from surgical assisting, locum or private work undertaken outside of your training program providing you have the appropriate training and/or qualifications for this work (excluding private cosmetic and obstetric practice).

Dr Kyla Bremner Intern and Australian Olympian!

At this year's Beijing Olympics, Dr Kyla Bremner had the exciting honour of being the first female wrestler to represent Australia in an Olympic Games. Not only is she an Australian Olympian she also is a medical intern at Bankstown Hospital in NSW, and a Member of MDA National.

Dr Bremner kindly agreed to share some of her thoughts and experiences with fellow MDA National Members.

1. How does it feel being the first female wrestler to represent Australia at the Olympics?

Representing Australia at the Olympics was the most amazing experience of my life. It feels fantastic to wear the green and gold and it's just an added bonus that I was the first female in my sport. Hopefully I can raise the profile of wrestling and women's wrestling in Australia.



2. What was the highlight of the Beijing Olympic experience?

There were so many highlights! I didn't do so well in the competition but still, stepping out onto an Olympic mat was something I'll never forget. Meeting the other team members and watching them compete was definitely a highlight. I also got some last minute tickets for myself and my brother to watch the men's 100m final, which was unreal!

3. How do you balance being a doctor and an Olympian?

It's tough to work full-time and also train at an elite level. I struggled a bit last year when I was doing my internship and trying to qualify for Beijing. Luckily my work colleagues were supportive and traded shifts with me so I could get to training most days. I took this year off full-time work and have just been doing a bit of locuming around NSW, which I've quite enjoyed. It does give me a lot more flexibility with a good income to pay for a lot of my wrestling trips!

4. How important is it to you to have other interests than your work life?

It's absolutely essential. I think that having something to focus on and enjoy outside of the hospital is crucial to having a happy and well-balanced life.

5. What advice would you give other junior doctors juggling to have a healthy work life balance?

Don't give up your other interests and goals. We all have something (other than medicine) that makes us tick. Why give it up! Life is about fun and enjoying yourself!

Also, it seems to me that a lot of my colleagues put a huge amount of pressure on themselves to always progress along their chosen career path. Medicine will always be there. If you need to, take a break. Most people still seem to get the jobs they want, and the career will inevitably come. No one ever reaches the end of their life and says they wish they'd worked more!

Contact Your State Liaison Manager

MDA National's team of State Liaison Managers are available to provide support to Members through provision of educational and risk management activities and sponsorship of both educational and social activities.

You should contact your State Liaison Manager if you have any suggestions for events at your hospital or within your Area Health Service that MDA National could be involved with.



Olivia Watson

State Liaison Manager - WA
E: owatson@mdanational.com.au



Megan Sheldon

State Liaison Manager – SA
(Students/Interns)
E: msheldon@mdanational.com.au



Anne Powell

State Liaison Manager – SA (DIP/DIT)
E: apowell@mdanational.com.au



Monica Corso

State Liaison Manager – NSW (North)
E: mcorso@mdanational.com.au



Dinethra Nandokoban

State Liaison Manager
– NSW (South)/ACT
E: dnandokoban@mdanational.com.au



Nina Soldatovic

State Liaison Manager – TAS
E: nsoldatovic@mdanational.com.au



Melissa Kruger

State Liaison Manager – QLD (South)
E: mkruger@mdanational.com.au



Angela Barker

State Liaison Manager – QLD (North)
E: abarker@mdanational.com.au



Judi Pickett

State Liaison Manager – VIC
E: jpickett@mdanational.com.au

All State Liaison Managers can be contacted on

Freecall 1800 011 255

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Perth	Melbourne	Sydney	Brisbane	Adelaide
Level 3	Level 1	Level 5, AMA House	Level 8	Level 1
516 Hay Street	101 Dundas Place	69 Christie Street	87 Wickham Terrace	63 Waymouth Street
Subiaco WA 6008	Albert Park VIC 3206	St Leonards NSW 2065	Spring Hill QLD 4000	Adelaide SA 5000
Phone: (08) 6461 3400	Phone: (03) 9915 1700	Phone: (02) 9023 3300	Phone: (07) 3120 1800	Phone: (08) 7129 4500
Claims Fax: (08) 9415 1492	Fax: (03) 9690 6272	Fax: (02) 9460 8344	Fax: (07) 3839 7822	Fax: (08) 7129 4520

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