firstdefence

JMOs + Doctors in Training

Summer 2009

Duty to Report to the Coroner

Healthy Doctors, Better Medicine

Am I Covered for... Volunteer Work?

Coronial Matters
the importance of good clinical notes

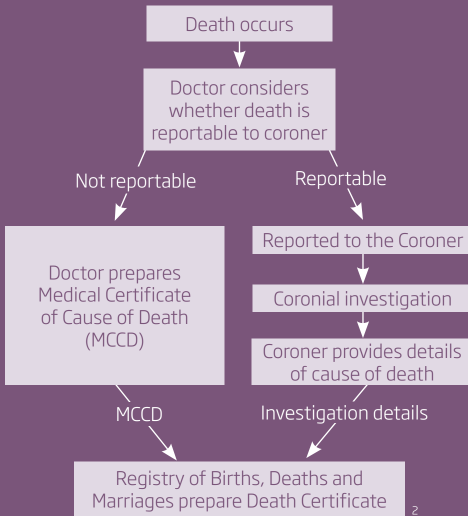
Duty to Report to the Coroner

Case Study

Dr Jayant Patel was a General Surgeon at Bundaberg Hospital from 2003 to 2005. An Inquiry into Queensland public hospitals in 2005 identified 13 deaths of patients in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome[1]. A review of these 13 deaths found that only two of the deaths had been reported to the coroner. The report noted that not only did Dr Patel have a legal duty under the *Queensland Coroners Act 2003* to report these deaths, but this duty was also imposed upon all those practitioners who became aware of a death that appeared to be reportable to the coroner. The report also noted that in the case of one patient, who died as a result of an oesophagectomy performed by Dr Patel which was complicated by a thoracic aortic bleed, the death certificate was completed by a JMO. The JMO's role in the operation was simply holding the retractor and it was the first oesophagectomy that he had been involved in. Evidence was given by JMOs at the Inquiry that Dr Patel asked them to certify patient deaths. Indeed, it was the usual practice for the most junior doctor on the team to be asked to complete the death certificate.

Medico-legal Issues

Medical practitioners are responsible for reporting a large proportion of deaths to the coroner and it is important that all medical practitioners, including JMOs, are aware of their legal obligation to report certain deaths.



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In Australia, there is a legal requirement for doctors to report 'reportable' deaths to the coroner. These may include deaths where the cause or nature of the death is:

- unknown
- unnatural or violent
- unexpected
- suspicious
- the result of an accident or injury
- during or resulting from an anaesthetic
- occurred in care, custody or as a result of a police operation
- a health-related procedure or health care related

However, each State and Territory of Australia has its own unique coronial legislation and the criteria for reportable deaths vary slightly between jurisdictions.

In particular, legislative changes to the *Queensland Coroners Act*, introduced in November 2009, now require all *'health care related'* deaths to be reported to the coroner. Similar changes to the *NSW Coroners Act* are expected to be introduced in January 2010. A death is reportable under this category if:

1. the health care caused or contributed to the death, or a failure to provide health care caused or contributed to the death AND
2. death was an unexpected outcome of the health care being provided.

Health care causes or contributes to a person's death if the person would not have died at that time if the health care had not been provided. Death is considered to be an unexpected outcome if, before the health care was provided, a professional peer (independent person) of the treating doctor would not have expected the person to die[3].

What is the Role of the Coroner?

When a death is reported, the coroner must investigate to find out:

- the identity of the deceased
- when and where they died
- how they died
- the medical cause of death.

Discussion

Research has suggested that there is significant 'under-reporting' of deaths to the coroner. A recent Victorian study reviewed 229 medical records of patients who had died in hospital to identify 'reportable deaths'. The study revealed 58 'reportable deaths', of which only 22 (37.9%) had been reported to the coroner[2]. Deaths which occurred during night shift were less likely to be reported which was thought to be the result of less clinical or administrative staff being on duty during these hours.

Conclusion

JMOs are encouraged to seek advice from MDA National or the office of the coroner if they are uncertain about their legal obligation in a particular situation to report a patient death to the coroner. MDA National's medico-legal advisers are able to provide specific advice about the coronial legislation in each state and territory of Australia. Please feel free to contact us on our medico-legal advisory line anytime, any day on 1800 011 255.

Dr Sara Bird, Manager,
Medico-Legal and Advisory Services

References

1. Queensland Public Hospitals Commission of Inquiry Report. Honourable Geoffrey Davies, 30 November, 2005. Accessed at http://www.qphci.qld.gov.au/final_report/Final_Report.pdf
2. Charles A, Ranson D, Bohensky M, Ibrahim J. *Under-reporting of deaths to the coroner by doctors: a retrospective review of deaths in two hospitals in Melbourne, Australia.* Int J Qual Health Care 2007; 19(4): 232-236.
3. Information for Health Professionals. Office of the State Coroner Queensland, 2009. Accessed at http://www.courts.qld.gov.au/Coroners_Court/OSC-fs-InfoForHealthProfessionals.pdf

Healthy Doctors, Better Medicine

In our Winter edition of *First Defence,* we spoke about Tired Doctors: tired doctors who feel they can't cope, and tired doctors who can lose their good judgement and make mistakes or injure themselves. Many readers asked for a back copy of *Surviving Night Duty* and others asked for advice on managing in their own workplaces.

In our Spring edition, Dr Kieran Le Plastrier looked at how personality can influence how one responds to stressors at work and in training, with the consequent impact on patient care, sense of wellbeing and performance. We are well aware of the effects of lack of sleep, broken sleep and heavy workloads, but wellbeing can also be affected by the personality traits of the individual that make them more, or less, vulnerable to burn-out.

First, the 'not-so-good' picture of junior doctors: surviving on cafeteria and take-away food, late nights studying or partying, long shifts and terrible sleeping habits, their health and lifestyle reflects the parlous state of their non-medical peers. But of course being younger and more robust, they get away with it. Or do they? Junior doctors are tired and have so much to get through they put off looking after themselves. The worst time for burn-out, it seems, is at the mid intern year.[1] The AMA Junior Doctors survey study found that most junior doctors agree it is commendable and necessary to take care of oneself properly and to seek professional help in times of stress, nevertheless, few junior doctors actually do so. Those who do, remark on the benefits.

Staying on top of the demands on your lifestyle is not only about feeling better and being resilient.

Professor Erica Frank, keynote speaker at the Healthy Doctors Better Medicine Conference in Adelaide, confirmed that if doctors have healthy habits, they are more likely to counsel patients in healthy lifestyle, and they are more believable to their patients. The program made no difference to alcohol consumption, as we might guess from the complex position it holds in the social milieu.

What actually causes the stress of a pressured lifestyle? Dr Geoff Riley, a Psychiatrist from WA who has worked for many years with doctors suffering from distress, argues that a lack of autonomy and sense of control over one's working life are largely responsible for the stress that many junior doctors feel. Rostering that is unreasonable, a remote yet highly demanding supervisor, nurses who give you a hard time, all contribute to a feeling of powerlessness.

A sense of mastery is what gives us a sense of wellbeing – having the confidence to make decisions, know your stuff, be able to speak up, ask questions, check with others if uncertain. How does one gain this confidence when feeling run down, stretched, and at the bottom of the pecking order? Doctors experiencing and witnessing these barriers offered their suggestions:

- Don't just *think* it's a good idea to have regular check-ups and get help when you are feeling ill, tired, stressed or anxious: actually go and do it. There are self-assessments available online, that are a good start
- Talk to others, as you are not alone
- Find a mentor, or several, with whom you feel comfortable and trust. A mentor can be anyone, but someone who can give sage advice and model the way of coping and behaviour that you admire not only for their technical skills but for their survival skills
- Learn to speak up if you think you, your patients or colleagues are at risk. Practise in a safe way how you will do so
- Feel brave enough to challenge yourself: are you in the right stream, the right specialty, do you like your patients, do you still feel passionate about medicine?
- Be aware that the personality traits and talent that got you into medicine can be your most essential asset, or can hinder you by placing too high an expectation on yourself to be perfect, at all times, even while you are in training.

Learning to be a good doctor is more than learning the skills and knowledge of medicine; it includes maintaining your own resilience, health and sense of wellbeing to sustain you through a long and challenging career. This will help keep you as committed to your craft as the day you started. Junior doctors who have accessed support services have benefited, and drop-out rates from college have decreased. Ultimately, your patients will benefit too.

For further information about the conference and the messages delivered by those presenting papers, including details and findings of research, please contact riskmanagement@mdanational.com.au

Elizabeth van Ekert, Risk Manager

References

1 A/Prof Jill Gordon, delivering stats from the Doctors Health Advisory Service, at the conference

Am I Covered for... Volunteer Work?

MDA National often receive queries from doctors asking whether they are covered under their Professional Indemnity Insurance Policy for volunteer work, such as acting as a team doctor for their friend's/child's sporting team or volunteering their services at a fun run or another community event.

While the short answer to this question is yes, there are some important factors you should be aware of when deciding whether or not to agree to provide health care services in a voluntary capacity.

Cover for First Aid and Preliminary Assessment

All doctors who hold a Professional Indemnity Insurance Policy with us are covered – subject to the Policy terms and conditions – for the provision of healthcare services on a voluntary basis where the services are provided in Australia and the extent of the activity is first aid and preliminary assessment only.

For instance, if you volunteered to provide health care services at a school fun run and an entrant collapsed with dehydration, you would be covered for claims/inquiries arising from the provision of first aid to the runner until the ambulance arrived. Similarly, if you volunteered to provide health care services at the local church fete and a child fell off a swing and sustained a suspected fractured arm, you would be covered for claims/inquiries arising from assessing the child and applying a sling.

Cover for Services Beyond First Aid and Preliminary Assessment

If you are expected to provide services beyond first aid and preliminary assessment, you will need to ensure that the category under which you are indemnified is appropriate for the work you will be doing.

In most cases, for junior doctors and doctors in specialist training the appropriateness of the services provided is assessed by taking into consideration the qualifications, training and experience of the insured, the equipment and environment in which the services are provided and the availability of or proximity to alternative healthcare providers, such as a general practice, ambulance or hospital. Where there is sufficient access to an alternative health care provider, we recommend that the extent of the services provided at the scene is limited to those required to stabilise the patient and prepare them for transport.

You should contact us to seek confirmation of indemnity under your Policy if you are engaging in volunteer work that goes beyond first aid and preliminary assessment, particularly if it involves high risk sports or situations such as boxing, horse riding or car/motorcycle racing.

Cover for Volunteer and Aid Work Outside Australia

If you are planning to provide healthcare services outside Australia in a voluntary capacity, we can in certain circumstances extend cover under your Policy to indemnify you for this practice (subject to Underwriting approval). Please contact us for more information.

It is worth remembering that in certain circumstances, the Ministry of Health of the country in which you will be providing voluntary health care services may indemnify you. For instance, if you go overseas as part of a surgical team (Operation Open Heart team or a Plastic Surgery team), you should ask the Team Co-ordinator to let you know if the recipient country will be indemnifying the team members.

Fenella Barnes, Underwriter
MDA National Insurance

In the next issue:
Am I covered for… Practising Overseas?

Risk Management Tips

The risk to you is minimal if your role is confined to being a volunteer on stand-by in the event that something goes wrong and you are only required to stabilise the patient and provide appropriate care (e.g. basic first aid) and make decisions about care (e.g. transfer to hospital, monitoring for neurological symptoms, shock, fractures, bleeding, etc.) however there are some additional precautions that require consideration.

1. Be clear on the nature of your relationship with the organisers – does being a "volunteer" also attract special non-monetary rewards such as tickets to the grand final in lieu of payment? If so, this may be viewed as a fiduciary arrangement with the organisers.
2. Volunteering for the kids' Saturday afternoon footie game, a fun run or other community event is one thing, but some sporting activities are not as "clean". Is this boxing match at Jim's "gym" a legitimate one, and if not are you indirectly condoning an illegal activity such as assault or battery? Are you being asked to assess competitors for fitness? If so, the level of risk rapidly escalates.
3. Do you have the skills to undertake what is expected? Doctors have attracted complaints of unsatisfactory professional conduct stemming from a lack of relevant skill and knowledge required to carry out the procedures undertaken.
4. As a medical practitioner, you have obligations to your patients even if they are transient ones. You must ensure that you protect the patient's privacy (while there will no doubt be curious onlookers, announcing the diagnosis and the name of the patient over the loud-speaker is a clear breach of their privacy), inform them of what you propose to do and why and seek their agreement (or that of a parent) and always keep accurate and contemporaneous notes of each incident. For patients who you believe have suffered a more significant injury, ensure you make adequate arrangements, provide clear instructions and follow up if you feel it is warranted, e.g. for a patient who may have a head injury but seems to be ok for now, inform them of what symptoms to look for and what to do and document all of the details. If you think a patient should go to hospital, tell them and if they refuse *("I'll be right, I just want to get back to the game")* provide clear warnings and document your recommendations and any refusal on the patient's behalf to follow your advice.

If in doubt, even if you are already on the field, please do not hesitate to seek advice by contacting our medico-legal advisory line, anytime, any day on 1800 011 255.

Coronial Matters

the importance of good clinical notes

"The patient ran out of olanzapine over the weekend. On the Monday the patient told the CNC that over the weekend her mood had deteriorated during the afternoons and she queried if this could be related to stopping olanzapine."

Case Study

The patient saw her GP and appeared withdrawn, expressed suicidal thoughts and was convinced she had a serious illness. The patient's family told the GP they believed the patient was suicidal and that they were caring for her 24 hours per day. The patient's GP initially sought to have the patient cared for privately, but when an early psychiatric appointment could not be obtained, the GP referred her to Sunshine Coast District Mental Health Services Network ("the MHS").

At the time of the patient's first interaction with the MHS in mid-December 2006, she had been taking Lexapro for 16 days and Stillnox for two months. A clinical nurse initially assessed the patient over the phone. The patient was willing to be involved with the Community Assessment and Treatment Team ("CATT") and was referred for further assessment. The following day, the patient was seen by the Principal House Office ("PHO") and a Clinical Nurse Consultant ("CNC"), and assessed as having a major depression, possibly with psychotic features. Although "frank discussions" were held about the potential risks associated with her condition, the patient and her family were keen to pursue community-based treatment and were opposed to the possibility of hospitalisation. It was considered that the patient did not meet the criteria for involuntary assessment or treatment under the *Mental Health Act*. The following treatment plan was devised: cease Lexapro, allow one day for washout, commence mirtazapine (an anti-depressant) daily, and daily home visits with the patient to watch for any emerging psychotic symptoms.

The patient was seen at home each day by a variety of health professionals, including the PHO and a Psychiatrist. The psychiatrist changed the patient's medication to olanzapine (an anti-psychotic) and considered she needed twice daily home visits. The Psychiatrist also sought a second Psychiatric opinion. The second Psychiatrist agreed with the assessment and considered that the dose of olanzapine should be increased as on balance, he felt the patient may have very low grade evolving psychotic features.

Over the ensuing days, the patient's condition was recorded as gradually improving. When the patient was reviewed by the PHO in early January 2007, there seemed to have been a significant improvement in her condition. Due to concerns the patient had about her weight, the PHO (in consultation with the second psychiatrist) reduced the dose of olanzapine.

That weekend, the patient went away with her family and no home visits were scheduled until the following Monday. The patient ran out of olanzapine over the weekend. On the Monday the patient told the CNC that over the weekend her mood had deteriorated during the afternoons and she queried if this could be related to stopping olanzapine. The medication was recommenced. Two days later, the PHO was unable to attend a home visit and instead had a telephone discussion with the patient, who felt she had not improved since the olanzapine had been reintroduced. The PHO increased the dose of olanzapine until the patient was medically reviewed.

The daily home visits continued. In mid-January 2007, a social worker visited the patient, recorded that she was having a bad day, and discussed organising another medical review. Although the social worker thought the patient's suicide risk was moderate, she did not believe there was an immediate risk because the patient discussed plans for the next day. When the patient told the social worker she wanted some space, the social worker suggested that the patient and her husband go for a walk on the beach the next day. The next day, the patient committed suicide.

The Inquest

An Inquest was held to "establish whether or not the treatment given to the patient was appropriate and whether alternate treatment should be recommended in similar circumstances."[1]

Dr Varghese, Consultant Psychiatrist, prepared an expert report for the coroner[2] and concluded that the patient had suffered from an episode of psychotic depression with somatic and self-deprecatory delusions. Dr Varghese considered that the risk of suicide with this illness was very high, and that it was unwise to attempt to treat such a serious condition in an outpatient setting, unless around the clock monitoring could be provided. Once the decision was made to manage the patient in the community however, Dr Varghese considered the level of care provided was appropriate. He noted that except for the weekend the patient went away, she was seen at least once daily – and was sometimes seen twice a day and telephone reviewed – by a combination of Psychiatrists, the PHO, a Psychiatric Registrar, a Social Worker, a Psychologist and Nurses.

Coronial Matters
the importance of good clinical notes

Dr Lawrence, Psychiatrist, gave expert evidence at the Inquest.[3] She considered the patient's treatment was appropriate in the circumstances. Dr Lawrence assessed the medical records and noted that the various doctors were not convinced of the extent of severity or extent of the patient's psychotic features.

Of relevance are the coroner's comments in relation to the clinical notes. The coroner said it was "*made very clear in the clinical notes*" that neither the patient nor her family wished for her to be admitted to hospital.[4] The coroner noted that the PHO and first Psychiatrist had made contemporaneous notes of what discussions were held with the patient and her family, and that the notes indicated that hospitalisation had been discussed. In her findings, the Coroner said "*I accept the evidence of the notes*."[5]

One of the issues for consideration was whether the support and information given to the family was adequate. The coroner noted that the level of treatment was *"well itemised in the clinical notes."*[6] Although the family's legal representative was critical that the patient was visited by different healthcare professionals at different times of day and that this would result in different moods being displayed, the coroner did not see how this would differ from what would have occurred if the patient had been in hospital. The coroner said that what was important, *"… was that after each visit detailed notes were taken – so detailed in fact that we are able to get a clear picture of what was occurring with Ms Blake and how she was responding to treatment. These notes were of a very high standard."*[7]

Although the coroner mostly praised the quality of the clinical notes and commented that they included the plan of action and medication to be given, she suggested that the plan and medications be listed separately with an indication of who would be responsible for each part of the plan. The coroner considered that this would have ensured that the plan was properly followed. The coroner also opined that the family carers should also have been given a copy of the plan, as this would have enabled them to be fully aware of what needed to be done and to then ensure that it was done. The coroner considers that this would have had the added benefit of ensuring that the family remained focussed on the seriousness of the patient's illness and of their role in her treatment. Had this been performed, the coroner believes it would have prevented the situation occurring in which the patient ran out of medication on the weekend she went away.

At the conclusion of the Inquest, the coroner found that the patient committed suicide at her home by drowning. The coroner recommended that the plan for treating a person in the community (including medication to be administered) be *"itemised in the clinical notes separately with an indication as to who is to be responsible for carrying out the plan."*[8]

Discussion

It is clear from the coroner's comments that good, contemporaneous medical records should be kept, regardless of the clinical setting. In this case, although the coroner was critical of some aspects of the clinical notes, they nevertheless enabled the expert witnesses and coroner to reconstruct the MHS's interactions with the patient and her family. If each member of the treating team had not made thorough entries in the clinical notes, it is likely that they would not have been able to prove the level of care they provided to the patient.

Conclusion

JMOs are encouraged to write contemporaneous, clear, thorough clinical notes. JMOs are also encouraged to seek advice from MDA National if they are asked to provide a report or statement to the coroner. Please feel free to telephone our medico-legal advisory line anytime, any day on on 1800 011 255 or e-mail peaceofmind@mdanational.com.au.

Yvonne Baldwin, Claims Manager (Solicitor)

References

1 *Inquest into the death of Melissa Maree BLAKE*, findings of coroner Callaghan delivered on 16 March 2009; accessible at http://www.courts.qld.gov.au/BlakeMM20090316.pdf.
2 Summarised at pages 4 – 6 of the coroner's findings.
3 Summarised at page 6 of the coroner's findings.
4 Findings at page 7.
5 Ibid.
6 Ibid at page 8.
7 Ibid at page 9.
8 Ibid at page 14.

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.

All State Liaison Managers can be contacted on

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