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From the President

Health and Human Error

Thirty years ago on 28 November 1979, Air New Zealand Flight 901 (TE901) crashed into Mount Erebus, killing all 237 passengers and 20 crewmembers aboard. This crash and its aftermath was a great tragedy. However, despite the sadness and grief that no doubt still lingers for the families involved, this accident was instructive in understanding how errors occur and illustrates how far some industries have progressed, relative to health care, in the management of risk over the past 30 years.

The initial accident report of TE901 compiled by New Zealand's chief inspector of air accidents, Ron Chippindale, was released on 12 June 1980. It cited pilot error as the principal cause of the accident and attributed blame to the decision of the pilot, Jim Collins, to descend below the customary minimum altitude level, and continue at that height when the crew was unsure of the plane's position. However, in response to public demand, the New Zealand Government announced a further one-man Royal Commission of Inquiry into the accident, to be performed by the highly respected judge, Justice Peter Mahon.

Mahon's report, released on 27 April 1981, cleared the crew of blame for the disaster. On the contrary, Mahon said "the single, dominant and effective cause of the disaster was the mistake by those airline officials who programmed the aircraft to fly directly at Mt Erebus and omitted to tell the flight crew".

The need for air-accident investigators to appreciate the wider organisational and systemic issues that can lead to incidents has thus been appreciated for more than 25 years. Indeed, a less than adequate safety culture, poor design and construction of safety systems and supervisory shortcomings have been identified as the leading causes of most air and industrial accidents. Other industries have therefore looked very seriously at the cultural factors that appear to be important in preventing and minimising mistakes. They have become less inclined to attribute blame at the "pointy end": to pilots, train drivers and control room operators and more inclined to find fault with the environment in which people work.

"At times, there seems to be a reluctance to look at why or how such errors occurred, other than to simply blame the doctor(s) involved."

This year is also the tenth anniversary of the US Institute of Medicine report "*To Err is Human*". The report described a staggering number of projected deaths each year as a result of preventable medical errors. Although the scale of the projected incidents was hard to comprehend, what accompanied each of these errors were stories of countless health professionals closely involved in the event[1]. Analysis of these incidents often revealed experienced, well-intentioned staff surrounded by complex clinical conditions and by poorly designed processes and suboptimal communication patterns.

However, despite the lessons learned over the past thirty years and the need to approach human error in health care differently, there still remains a tension between the "no blame" model and a more aggressive approach for under-performing clinicians[2]. Indeed, some seem fixated with the culture of blame that was implicit in Ron Chippindale's initial report on flight TE 901 some thirty years ago while others see that creating a blame-free culture may produce safety risks of its own. Indeed several recent cases that have been commenced against our Members in two states show that there remains an inconsistent approach across Australia.

At times, there seems to be a reluctance to look at why or how such errors occurred, other than to simply blame the doctor(s) involved. Equally some commonsense patient safety practices, such as routine hand-washing or the use of the Universal protocol (pre-operative time-out, site markings etc) suffer from poor compliance because of a lack of accountability.

It has been suggested that while many other health care providers (such as Nurses and Pharmacists) are accountable to the organisations that employ them, self-employed doctors remain "subject to only weak peer reinforcement through medical staff structures" and that there is a need to find the right balance between "no-blame" and individual accountability[3].

To this end, MDA National has worked with the Medical Indemnity Insurance Association of Australia (MIIAA) during 2008 and 2009 to assist the Royal Australasian College of Surgeons implement their Competence and Performance project. It was designed to remind fellows of the personal, clinical and professional behaviours that were expected by their peers. The MIIAA is also currently exploring ways of working with other Specialist Colleges to do the same with their fellows.

MDA National hopes that this approach will improve the accountability of Members to our peers, our patients and to the regulators who investigate our conduct. We also expect that such programs will enhance professional performance, reduce errors and save lives.

Finally, as this is the last edition of *Defence Update* for 2009, I would like to extend to all of you the best wishes of your Council for a happy and peaceful festive season, a refreshing break from your clinical work, and a successful 2010 for you and your families.

From me, I would like to extend my gratitude to members of Council, our Insurance Board, various committees and to all our management, staff and advisors who have once again contributed wholeheartedly to the success of MDA National and its membership during 2009. We are fortunate to have such a fine and dedicated team supporting us all.

I would also like to thank you, our Members, for the privilege of serving you and for your ongoing support of our Association, and its mission to assist our colleagues when professional difficulties arise.

A/Prof Julian Rait
President, MDA National

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When 10% is Material

Breast Screening Case Appealed: *Sydney South West Area Health Service v Stamoulis*

“The Court of Appeal found that there was a strong possibility (62%) that if the tumour had been detected in March 2006 it would not have metastasised.”

The NSW Court of Appeal recently delivered its decision on the liability of Breastscreen NSW (“Breastscreen”) for a delay in diagnosis of breast cancer in a patient who had been part of its screening programme for 5 years. The patient could not allege Breastscreen caused her breast cancer – it did not. Her case arose from a complaint that Breastscreen, by failing to recall her for further testing in February 2006, led to a 10 month delay in the diagnosis of her cancer and an increased risk that the cancer would metastasise. The Court’s finding on the impact of this delay may not sit comfortably with a doctor’s view of the statistics.

It is relevant to know Ms O’Gorman attended Breastscreen for a screening mammogram of her breasts in 2002, 2004 and February 2006. Following the 2006 mammogram, two Radiologists independently reviewed the mammogram and entered a finding in the computer system that the mammogram was ‘normal’.

In January 2007 Ms O’Gorman detected a lump in her left breast. A mammogram and ultrasound revealed that she had breast cancer. Ms O’Gorman underwent chemotherapy to shrink the tumour, followed by a mastectomy in August 2007 and radiation therapy. In May 2008 metastatic tumours were found in both her lungs and brain.

Ms O’Gorman successfully brought proceedings against the operators of Breastscreen for the increased risk of her cancer metastasising. Breastscreen appealed the decision.

Ms O’Gorman died shortly after the decision, at first instance, was handed down.

Causation

Recent NSW Court of Appeal case law has determined that where it is alleged that a patient/plaintiff’s risk of injury has been increased, the patient/plaintiff must prove, on the balance of probabilities that the increase in the particular risk materially contributed to their injury.

In Ms O’Gorman’s case the trial judge found that the delay in diagnosis of her breast cancer had increased the risk of the cancer metastasising by approximately 10% (from 38% to 42%). There was argument on appeal as to whether this 10% increase in risk was sufficiently significant as to have materially contributed to the metastases.

The Court of Appeal found that there was a strong possibility (62%) that if the tumour had been detected in March 2006 it would not have metastasised. The 10% increase in risk caused by the delay in diagnosis when added to the strong possibility that the cancer would not have metastasised, was sufficient for a finding that, on the balance of probabilities, the delay in diagnosis caused the metastases. The estate of Mrs O’Gorman was successful on appeal.

Expert Evidence

During the first instance proceedings, in addition to the evidence of independent experts, Breastscreen sought to rely upon written statements of the two Radiologists who had examined Ms O’Gorman’s 2006 mammogram and determined that it was ‘normal.’

These statements covered the Radiologists’ interpretation of the 2006 films and the basis for their findings that the mammogram was ‘normal’ and did not warrant recall for further investigation. Their opinions had in a large part been dismissed by the trial judge because it was felt, as employees of Breastscreen they had an interest in the proceedings.

The Court of Appeal held that such evidence constituted expert evidence and was not inadmissible merely because the expert, in this case the Radiologists, had an interest in the proceedings. The Court held that such evidence was admissible and that any issues regarding the reliability of the evidence, given the expert’s material interest in the proceedings, should go to the weight given to the evidence by the Court.

Significance

The decision raises two interesting matters. Lawyers will be interested in the acceptance by the Court of Appeal that the opinion of an interested but otherwise qualified practitioner is no less a valid opinion.

Doctors may find it difficult to understand how a 10% increase in the risk of the cancer metastasising was sufficient, on the balance of probabilities, to show that the delay in diagnosis had caused the metastases. Notably, the decision stands in stark contrast to the Court’s decision in *Gett v Tabet* [2009] NSWCA 76, where it was found that the loss of a 15% chance of a better outcome was not, on the balance of probabilities, material.

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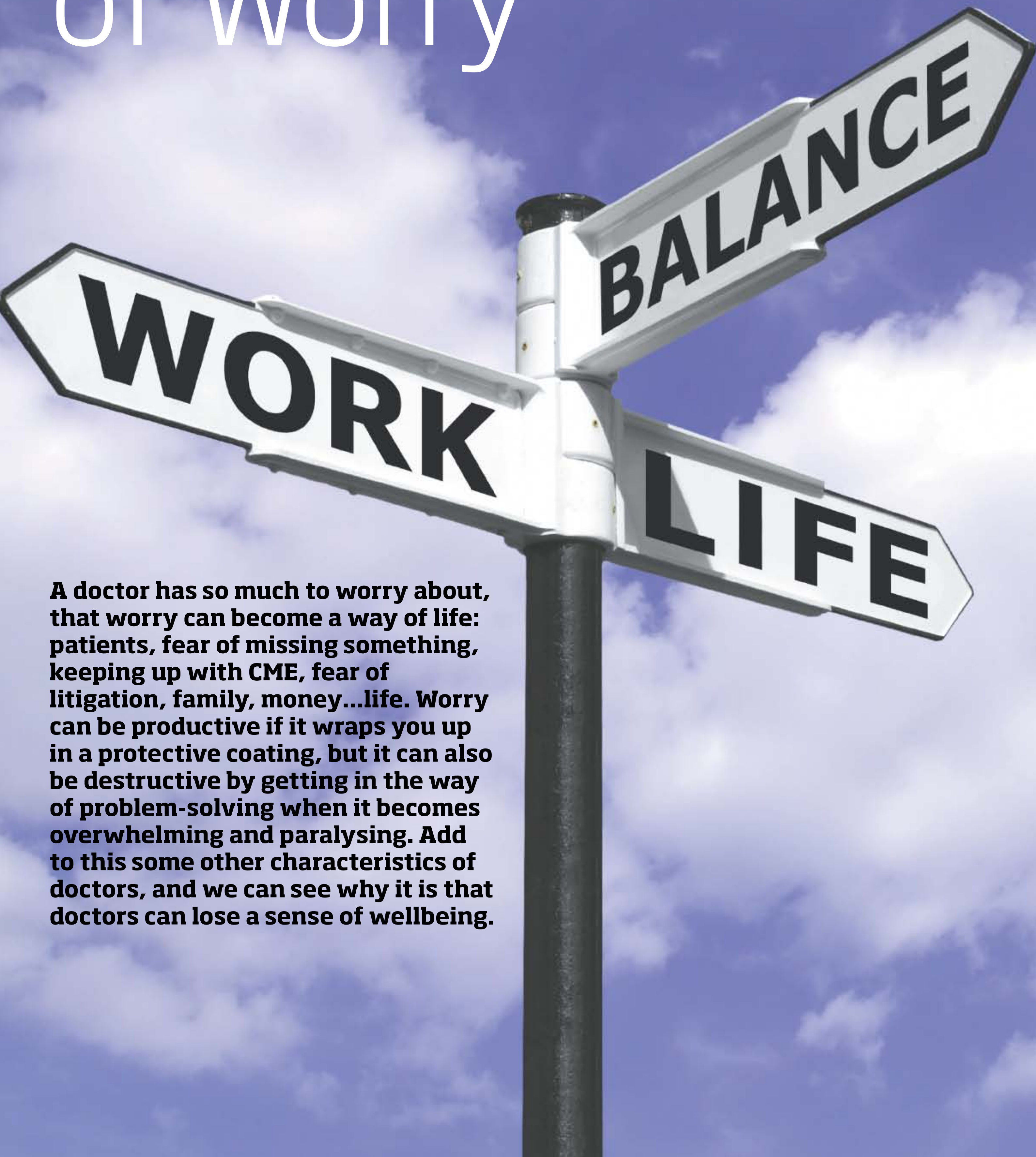
The Magic of Worry



A doctor has so much to worry about, that worry can become a way of life: patients, fear of missing something, keeping up with CME, fear of litigation, family, money…life. Worry can be productive if it wraps you up in a protective coating, but it can also be destructive by getting in the way of problem-solving when it becomes overwhelming and paralysing. Add to this some other characteristics of doctors, and we can see why it is that doctors can lose a sense of wellbeing.

“get more out of medicine and more out of life”

(Dr Caroline West Warne)

Having said this, doctors are a healthy lot. Of the general population, doctors rate well above the average in terms of health and healthy lifestyle. They smoke less, drink less, exercise more and eat better quality food. Of course they do, they are more familiar with the consequences of not taking care of themselves, and are better educated as to how to take better care of themselves. However, the indicators are that actually, while doctors may eat better food, smoke less, drink more responsibly, they are worse than many at taking care of themselves. They put off going to the doctor when ill, they treat themselves, they keep working when sick, they put off regular health checks, and delay investigations when something is amiss. Is this because they are in denial, or don’t have time?

Readers may well identify with the reasons. Some of the reasons were the subject of papers presented at the Healthy Doctors Better Medicine Conference in September. Dr Margaret Kay, a GP and PhD student at the University of Queensland, is looking more closely into the barriers to accessing health care experienced by doctors. She considered the vulnerabilities that may affect behaviours about seeking care and says that by identifying these, doctors may better understand their own behaviours when it comes to keeping themselves well.

She challenged the beliefs that doctors are in denial and that they self treat or consider corridor consultations to be “health care”. She noted that actually:

- It is normal to observe one’s own symptoms, and to check with a colleague: how sick does one have to be to be “sick”?
- It is normal to delay care: when is the right time to access health care?
- Doctors are especially aware of the nature of investigations: they are not benign

She also asked if doctors really are bad patients:

- Doctors have vicarious experience: they know what can happen to others
- Doctors, like everyone, feel fear, but expect not to
- It may be difficult to be a patient: knowing so much about what is happening and what it means, but not always recognising one’s own response to illness
- And importantly, there is a negative public image of an impaired doctor, so it is natural to not wish to be one of them

Healthiness is more than physical health. It is also about maintaining your own resilience, health and sense of wellbeing that will sustain you through a long and challenging career, and will help keep you as committed to your craft as the day you started. Your patients will benefit too. Professor Erica Frank confirmed in her keynote speech 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 other key message about doctors’ health and wellbeing is that we know that doctors are overworked, anxious, have high expectations of themselves and by others. All of these add up to a pressured lifestyle, and worry is a natural feature of this lifestyle. But does it really cause stress?

For some, worry and pressure can be invigorating, gives you meaning and drive. For others, it can lead to stress that becomes debilitating, and this is when doctors need to look seriously at their own situation: what can be changed, what support or help is needed. Dr Geoff Riley, a WA Psychiatrist who has worked for many years with doctors suffering from distress, argues that it is the lack of autonomy and sense of control over one’s working life that is largely responsible for the stress that many doctors feel. Demands that cannot be met, appointment schedules that do not allow for sufficient breaks during the day, too many patients to see, not taking holidays or spending time with friends and family, bureaucratic demands and paperwork, may all add up to this sense of powerlessness.

A sense of mastery is what gives us a sense of well being – having the confidence to make decisions and to say no, to get on top of the demands, to arrange for breaks, to offload with colleagues, and seek help when needed. Medicine may be a vocation, but practitioners are also human and are not indestructible. As Dr Hugh Kearns elucidated, doctors are not clever at everything, they can maintain their reputation and stop feeling guilty by taking a holiday, they are not indispensable and the world (or hospital or clinic) will not fall apart if they work reasonable hours and take occasional breaks, and this busy time will still be a busy time regardless. When things go wrong, it does not mean a doctor is a failure and not everything is the doctors’ fault.

Above all, worry as a way of life can actually be productive (if it doesn’t strangle you). But worry does not solve problems, so to regain and maintain one’s sense of wellbeing, the challenge for doctors is to reflect on how one’s own personality traits, behaviours and beliefs either hinder or promote health, wellbeing and happiness in one’s profession. Building balance and caring for oneself helps one “get more out of medicine and more out of life” (Dr Caroline West Warne).

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

Elizabeth van Ekert, Risk Manager

MDA National Vice President Receives RACGP Award

MDA National's Vice President, Dr Beres Wenck, has been recognised by the Royal Australian College of General Practitioners (RACGP) with Honorary Fellowship of the College.

The RACGP is the professional body that focuses on the safety and quality of general practice and maintains standards for quality clinical practice, education, training and research. Each year the college recognises excellence in general practice with awards such as Honorary Fellowship.

The award of Honorary Fellowship is given in recognition of the years of service to general practice and to the RACGP, for service to medicine in the fields of education, research or administration and general service to the community.

Dr Wenck's association with general practice and the RACGP is long standing. A General Practitioner in Queensland for over 30 years, Dr Wenck has been involved with RACGP in numerous capacities including her current position as Chair of the National Standing Committee for GP Advocacy and Support.

Dr Wenck is proud of her award that recognises her continuing commitment to general practice and the RACGP.

"As a GP keenly involved in health system reform, patient safety and quality and chronic disease management, I am honored and privileged to receive this award. Serendipitous opportunities such as Medical Director, Cardiac Rehabilitation Program and two coordinated care trials have been useful grounding for my role at the College".

MDA National congratulates its Vice President Dr Beres Wenck on her Honorary Fellowship of the Australian College of General Practitioners.

Announcement

President's Medical Liaison Council

Over the last two months, as advertised in the Spring issue of *Defence Update*, the President's Medical Liaison Council (PMLC) has been seeking expressions of interest from Members who would like to join this newly formed group.

MDA National is pleased to announce that the following representatives have been appointed to the PMLC. Our congratulations go to the following Members:

WA	SA	VIC	NSW	QLD
Dr James Anderson	Dr Christopher Baughman	Dr Travis Brown	Dr Elizabeth Feeney	Dr Nick Brown
Dr Michael Gannon	Dr Marcus Dreosti	Dr Michael Galvin	A/Prof Andrew Keegan (Chair)	Dr David Gilpin (Chair)
Dr Lachlan Henderson (Chair)	Dr Anna Galanopoulos (Chair)	Dr Kieran Le Plastrier	Dr Maria Li	Dr Mellissa Naidoo
Mr Christopher Heyes	Dr Michael Hayes	Dr Patrick Lockie	Dr David Malouf	Dr Alex Ritchie
Dr Dror Maor	Dr Anuja Kulatunga	Dr Phoebe-Anne Mainland (Chair)	Dr Brian Morton	Dr Anne Spooner
Dr Moira Sim	Dr Min-Qi Lee	Dr Joe Rotella	Dr Saxon Smith	Dr Josie Sundin

There was an overwhelming response of highly qualified applicants to our request for expressions of interest which made the process of selecting only 6 representatives from each state a very difficult undertaking.

We would like to take this opportunity to thank everyone who registered their expressions of interest and we encourage you to stay tuned as there may be other opportunities to be involved in the future.

Doctors Support Doctors through the PMLC

Now that the PMLC is officially formed it will shortly commence its functionality within the organisation. Some expected areas of involvement include:

- Advising of early warning changes in medical practice and/or surgical procedures which will assist in providing service to our Members.
- Providing the claims and advisory services, risk management and other departments with clinical knowledge to create resources for Members.
- Contributing to workshops, presentations and publications arranged by MDA National.
- Participating in national medical conferences.
- Engaging with colleagues informally when the opportunity arises.

National Registration and Accreditation Scheme for the Health Professions:

What Do You Need to Know?

Background

On 26 March 2008, the Council of Australian Governments signed an Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions ("the Scheme"). The new Scheme is scheduled to be introduced on 1 July 2010. The ten health professions to be covered by the Scheme are:

- Chiropractors
- Dental care practitioners
- Medical practitioners
- Nurses and midwives
- Optometrists
- Osteopaths
- Pharmacists
- Physiotherapists
- Podiatrists
- Psychologists.

The protection of the public is the key objective of the Scheme. The Scheme is intended to:

- Provide greater safeguards for the public;
- Allow health professionals to move around the country more easily;
- Reduce the regulatory burden on health professionals;
- Promote a more flexible, responsive and sustainable health workforce; and
- Establish a national register for each health profession to ensure that a professional who has been banned from practising in one jurisdiction would be unable to practise in other Australian jurisdictions.

"The protection of the public is the key objective of the Scheme."

Current Status of the Scheme

A staged approach is being taken to establishing the legislative basis for the Scheme.

The Health Practitioner Regulation National Law 2009 ("Bill B") was introduced into the Queensland Parliament on 6 October 2009. This legislation includes the Scheme's arrangements for:

- o Registration;
- o Accreditation;
- o Complaints, conduct, health and performance; and
- o Privacy and information-sharing.

The other States and Territories will then introduce adopting or corresponding legislation (known as "Bills C") into their parliaments to implement the Scheme so that it is fully operational by 1 July 2010.

New Features of the Scheme

- Mandatory reporting of colleagues will be introduced across all of the health professions included in the Scheme. The Scheme imposes on all registered health practitioners, and employers of health practitioners, a legal obligation to report to the relevant National Board any registered health practitioner who has behaved in a way that constitutes 'notifiable conduct'.

  'Notifiable conduct' means the practitioner has:

  (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or

  (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or

  (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or

  (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

  Exemptions to the requirement to report colleagues are provided to practitioners who are:

  - employed or otherwise engaged by a professional indemnity insurer; or
  - a member of a quality assurance committee, council or other body approved or authorised under an Act, and unable to disclose the information because the Act prohibits disclosure.

- Registration arrangements will include:
  - o Compulsory professional indemnity insurance
  - o Criminal history and identity checks; and
  - o Compulsory continuing professional development.
- Complaints arrangements
  - o Bill B contains provisions for disciplinary, health and performance pathways. However, some states and territories, such as NSW, will retain their existing complaints management provisions.
- The annual renewal date for all Australian medical practitioners will be 30 September.
- The new Medical Board of Australia will be based in Melbourne. The State and Territory Medical Boards will be retained as committees of the National Board.

Next Steps

Through the Medical Indemnity Industry Association of Australia and other avenues, MDA National has been involved in the consultation process and has provided a number of submissions, in particular in relation to the complaints handling functions and the mandatory reporting provisions of the Scheme. Importantly, all medical practitioners employed or engaged by professional indemnity insurers are exempted from the mandatory reporting requirements of the Scheme.

MDA National will continue to monitor and have input into the development of the Scheme to ensure that the interests of the medical profession, and our Members, are protected.

More information about the Scheme is available on www.nhwt.gov.au/natreg.asp

Dr Sara Bird, Medico-legal Manager/ Advisory Services Manager

CaseBook

The following cases have been prepared by the Claims and Advisory Services Department. They are based on actual medical negligence claims or medico-legal referrals. Certain facts in the case, Duty to Report to the Coroner, have been omitted or changed and all names changed by the author to ensure the anonymity of the parties involved.

“Members are encouraged to seek advice from MDA National in situations involving a patient who refuses to consent to recommended medical treatment.”

Treatment Refusal

Case History

On 4 November 2008, Mr Christian Rossiter was admitted to Brightwater, a residential care facility in Perth. Mr Rossiter was a quadriplegic. Over a period of 20 years, he had suffered three serious injuries which led to the development of quadriplegia. The third injury, involving a fall on 3 March 2008, resulted in an emergency admission to Joondalup Health Campus. He was then transferred to Sir Charles Gairdner Hospital on 8 March 2008 where he underwent treatment and rehabilitation before being transferred to Brightwater for ongoing care in November 2008. At this time, the patient’s capacity to move was limited to some movement in one finger and some foot movement. He had a tracheostomy and a percutaneous endoscopic gastrostomy (PEG) tube. During his stay in Brightwater, the patient informed his GP and the nursing staff that he wanted to die. He asked his GP and the staff at Brightwater to discontinue the provision of nutrition and hydration through the PEG tube.

On 14 August 2009, the patient and Brightwater sought a declaration from the Supreme Court of Western Australia with regard to their respective rights and obligations. Specifically, the staff at Brightwater and the GP were concerned that compliance with Mr Rossiter’s directions might result in their criminal prosecution.

Medico-legal Issues

The key issue to be determined by the Court concerned the legal obligations of a medical service provider, which had responsibility for the care of a mentally competent patient, when that patient stipulated that he did not wish to continue to receive medical treatment which, if discontinued, would lead to his death[1].

Evidence was heard from the patient’s GP that he had described to the patient, as best he could, the physiological consequences which would ensue during the process of starvation. The GP gave evidence that the patient had the capacity to comprehend and retain information given to him in relation to his treatment, and he had the capacity to weigh up that information and bring other factors and considerations into account in order to arrive at an informed decision.

A neuropsychology report was also served which concluded that Mr Rossiter was capable of making reasoned decisions concerning his own health and safety. In particular, he was capable of making decisions with respect to his future medical treatment after weighing up alternative options and was capable of expressing reasons for the decisions which he made in that respect. The report also noted that Mr Rossiter unequivocally demonstrated that he understood the consequences of withholding the provision of nutrition and hydration through the PEG tube, and displayed insight into the consequences of that decision.

Ultimately, the question that was required to be determined by the Court was whether Brightwater was legally obliged to comply with Mr Rossiter’s direction or, alternatively, legally obliged to continue the provision of the services to maintain his life. If the Court determined that Brightwater was legally obliged to comply with Mr Rossiter’s direction, the Court was also asked to determine a subsidiary question: Mr Rossiter had asked his GP to prescribe analgesics for the purpose of sedation and pain relief as he approached death by starvation. The GP was concerned that he might face criminal prosecution in the event that he prescribed medication for these purposes.

The Court noted the common law position that an adult is assumed to be capable of having the mental capacity to consent to, or refuse, medical treatment. A medical practitioner or service provider who provides treatment contrary to the wishes of a mentally competent patient breaks the law by committing a trespass against that person. Another well established common law principle is the right of autonomy or self-determination. This right was described in 1914 in the United States by Justice Cardozo:

‘Every human being of adult years and sound mind has a right to determine what shall be done with his (or her) own body; and a surgeon who performs an operation without the patient’s consent commits an assault for which he (or she) is liable in damages’[2].

Therefore, at common law, the Court determined that Mr Rossiter had the right to determine whether or not he would continue to receive the services and treatment provided by Brightwater, and the staff at Brightwater would be acting unlawfully by continuing to provide treatment contrary to the patient’s wishes.

The Court then went on to consider whether the Western Australian statutory provisions imposed a duty upon Brightwater to provide the necessaries of life to Mr Rossiter against his wishes. This included an analysis of Sections 259 and 262 of the WA *Criminal Code*.

Section 259 of the *Criminal Code* states:

‘(1) A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) –

(a) to another person for that other person’s benefit; or

(b) to an unborn child for the preservation of the mother’s life, if the administration of the treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.

(2) A person is not criminally responsible for not administering or ceasing to administer, in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care) if not administering or ceasing to administer the treatment is reasonable, having regard to the patient’s state at the time and to all the circumstances of the case’.

Treatment Refusal continued...

Section 262, Duty to provide necessaries of life, states that 'It is the duty of every person having charge of another who is unable by reason of age, sickness, mental impairment, detention, or any other cause, to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and he is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty'.

The Court held that the nutrition and hydration provided to Mr Rossiter through the PEG tube was '*surgical or medical treatment*' within the meaning of s 259. With regard to s 262, the Court found that this did not impose upon Brightwater a duty to provide the necessaries of life against the patient's wishes. Having regard to the common law principle of self-determination, the Court felt it was '*reasonable*' under s 259 to act in accordance with the informed decision of a mentally competent patient who refuses to consent to medical treatment. Therefore, the Court concluded that the legislation in WA did not in any way alter the clear position established pursuant to common law principles.

The Court then considered the provision of palliative care to Mr Rossiter following his withdrawal of consent to the provision of nutrition and hydration. The Court noted that the GP's obligations with respect to the provision of palliative care to Mr Rossiter, if and when he directed Brightwater to discontinue the provision of nutrition and hydration, were no different to the obligations which attend the treatment of any other patient who may be approaching death.

The Court made the following declarations:

(1) If after Mr Rossiter has been given advice by an appropriately qualified medical practitioner as to the consequences which would flow from the cessation of the administration of nutrition and hydration, other than hydration associated with the provision of medication, Mr Rossiter requests that Brightwater cease administering such nutrition and hydration, then Brightwater may not lawfully continue administering nutrition and hydration unless Mr Rossiter revokes that direction, and Brightwater would not be criminally responsible for any consequences to the life or health of Mr Rossiter caused by ceasing to administer such nutrition and hydration to him.

(2) Any person providing palliative care to Mr Rossiter on the terms specified in s 259(1) of the *Criminal Code* would not be criminally responsible for providing that care notwithstanding that the occasion for its provision arises from Mr Rossiter's informed decision to discontinue the treatment necessary to sustain his life.

Discussion and Risk Management Strategies

The role of the courts is to adjudicate particular cases on their facts, and not to discuss broader ethical issues. In this case, the Court made it quite clear that the judgment was not about euthanasia, nor was it about medical practitioners providing lethal treatments to patients who wished to die. The case was really about whether or not a competent adult patient had the right to refuse medical treatment, even if that refusal led to the patient's death. The Court confirmed that competent adults do have the right to refuse to consent to medical treatment. However, as with any rights, there are limits to the right to refuse medical treatment. Most obviously relevant is the competence of the patient.

Decisions to refuse treatment often occur in cases where the patient's capacity to make such a decision may be impaired and medical practitioners have to be careful to properly assess any possible incapacity on the part of the patient[3]. In general terms, capacity is present if the patient can fulfil the following criteria:

- an ability to comprehend and retain information, and
- weigh that information to reach a choice[4].

It should also be noted that there are other exceptions to the right to refuse medical treatment which are primarily based on protection of the public or third parties, such as those involving pregnant women who refuse medical treatment and put their unborn child at risk.

Members are encouraged to seek advice from MDA National in situations involving a patient who refuses to consent to recommended medical treatment.

Dr Sara Bird, Medico-legal Manager/ Advisory Services Manager

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Duty to Report to the Coroner:
Legislative Changes in Queensland and New South Wales

Do you need to report the following deaths to the coroner?

Case History 1

The 57 year old patient presented to her GP with a severe headache. The GP diagnosed a migraine and prescribed analgesia. The patient returned to see a locum in the practice a few days later with ongoing headache. Her BP was noted to be mildly elevated and the GP recommended the patient return to see her usual GP a few days later for review. He prescribed additional analgesia for the headache.

Two days later, the patient was taken by ambulance to the local hospital with an increasingly severe headache. She was seen by a resident medical officer who thought the patient was exhibiting 'drug seeking' behaviour. She was discharged a few hours after her initial assessment.

The following day, the patient was taken back to the same hospital by ambulance. About 15 minutes after arriving in Emergency Department (ED), the patient's Glasgow Coma Scale went from 15 to 3. Her left pupil was noted to be fixed and dilated. The patient was transferred to the intensive care unit of a tertiary hospital where an urgent CT scan revealed a significant subarachnoid haemorrhage, secondary to a ruptured aneurysm in the Circle of Willis. Neurosurgical opinion was sought but, in view of the patient's poor neurological condition, it was felt that operative intervention would be futile and the patient died a couple of hours later.

Case History 2

A 67 year old man was brought to the ED by the police. Some hours earlier he had been charged with a number of serious sexual offences and taken into police custody. However, soon after his arrest, he had complained of the onset of central, crushing chest pain, which prompted the police to bring him to the ED.

On arrival in ED, the patient was hypotensive and tachycardic. He had a long history of ischaemic heart disease, including coronary stenting two years earlier. His ECG revealed ST elevation consistent with acute myocardial infarction. The ED physician proceeded to insert an intravenous line and take bloods. However, a few minutes later the patient had a cardiac arrest. Despite intensive medical intervention, the patient was unable to be resuscitated.

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 are aware of their legal obligation to report certain deaths.

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. 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.

Duty to Report to the Coroner: Legislative Changes in Queensland and New South Wales continued...

To assist medical practitioners in determining whether health care caused or contributed to the death, the Office of the State Coroner Queensland has provided the following guidance:

- Would the person have died at about the same time without the health care?
- Did the death result directly from an underlying disease or injury?
- Was the health care carried out with all reasonable care and skill?

If the answer is 'no' to any of the above, the death is reportable. If the answer is 'yes' to all the above, the death is not reportable.

With regard to the death being an unexpected outcome, the professional peer should be qualified in the relevant area of health care and be aware of relevant matters including:

- The person's known state of health before the health care was provided; for example, whether they had any underlying disease, condition or injury
- The clinically accepted range of risk associated with the health care.

To determine whether the death was the unexpected outcome of the health care, the medical practitioner should ask the following questions:

- Before the health care was provided, was the person's condition such that death was foreseen as more likely than not to occur?
- Was the person told that death was foreseen as more likely than not to occur?
- Was the decision to provide the health care reasonable given the person's condition including their quality of life if the health care wasn't provided?

If the answer is 'no' to any of the above, the death is reportable. If the answer is 'yes' to all the above, the death is not reportable[1].

The NSW *Coroners Act* is expected to be amended in early 2010 and will now require reporting of a person's death when it was not the reasonably expected outcome of a health-related procedure. A health-related procedure means a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug). A death is also reportable if the deceased person was not attended by a medical practitioner in the six months preceding death (rather than three months, as previously).

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.

Will There be a Coronial Hearing?

An inquest is a public court hearing which is conducted by a coroner to gather more information about the cause and circumstances of a death. Only a very small number of coronial investigations proceed to an inquest. It should be noted that an inquest is not a trial and there is no jury. An inquest is not about deciding whether a person is guilty of a criminal or civil offence, an inquest does not assess or determine negligence.

An inquest must be held in certain circumstances, such as when a death occurs in custody. In other cases, the coroner may decide to hold an inquest if it is in the public interest, or if the family of the deceased requests an inquest. For example, an inquest may be held if:

- there is significant doubt about the cause and circumstances of the death
- holding an inquest may help prevent future deaths or uncover systemic issues which affect public health and safety.

Discussion

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 Jayant Patel, at Bundaberg Hospital between 2003 and 2005, contributed to the adverse outcome[2]. 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 *Coroners Act* 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.

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[3]. The cases not reported to the coroner had a higher mean age than those reported and were more likely to have a 'not for resuscitation' order in place. Other factors, such as family concerns regarding a coronial autopsy, may also play a part in 'under-reporting'. Deaths which occurred during night shift were also less likely to be reported which was thought to be the result of less clinical or administrative staff being on duty during these hours.

Risk Management Strategies

Medical practitioners in Queensland and NSW should familiarise themselves with the amendments to the Coroners Acts in these states, and revise relevant policies and procedures to ensure that all reportable deaths are properly reported in accordance with the legislative requirements.

Members 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. As always, please feel free to contact us on our 24 hour medico-legal advisory line 1800 011 255.

Note

The patient's death in Case History 1 would be reportable in Queensland on the basis that failure to provide health care contributed to the death (failure to take adequate history, or investigate or refer during the first three presentations), but not reportable in other states and territories.

The patient's death in Case History 2 would be reportable in all states and territories because the patient was in police custody at the time of death, although the cause of death was known.

**Dr Sara Bird, Medico-legal Manager/
Advisory Services Manager**

References

1 *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

2 *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

3 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.

"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."

MDA National Risk Management Workshops

Cognitive Institute Workshops Calendar

Feb 2010

Mastering Shared Decision Making
Wednesday 24th
6.00pm - 9.00pm
Perth

March 2010

Mastering Shared Decision Making
Wednesday 3rd
6.00pm - 9.00pm
Sydney*

Mastering Adverse Outcomes
Wednesday 3rd
6.00pm - 9.00pm
Brisbane

Mastering Adverse Outcomes
Wednesday 3rd
6.00pm - 9.00pm
Perth

Mastering Difficult Patient Interactions
Wednesday 10th
6.00pm - 9.30pm
Sydney*

Mastering Adverse Outcomes
Wednesday 10th
6.00pm - 9.00pm
Melbourne

Mastering Difficult Patient Interactions
Saturday 13th
9.00am - 12.30pm
Perth

Mastering Shared Decision Making
Saturday 13th
1.30pm - 4.30pm
Perth

April 2010

Mastering Shared Decision Making
Wednesday 21st
6.00pm - 9.00pm
Melbourne

Mastering Shared Decision Making
Wednesday 21st
6.00pm - 9.00pm
Brisbane

May 2010

Mastering Shared Decision Making
Saturday 15th
9.00am - 12.00pm
Sydney

Mastering Difficult Patient Interactions
Saturday 15th
1.00pm - 4.30pm
Sydney

Mastering Shared Decision Making
Saturday 22nd
9.00am - 12.00pm
Perth

Mastering Adverse Outcomes
Saturday 22nd
1.00pm - 4.00pm
Perth

Mastering Difficult Patient Interactions
Wednesday 26th
6.00pm - 9.30pm
Perth

* We are trialling a new venue for Wednesday night workshops in Sydney. These workshops will be held at the Eastern Suburbs Leagues Club in Bondi Junction, which we hope will be more convenient for our Members. We welcome your feedback about the location and venue.

Registration can be completed online through the Member Online Services section of the MDA National website or by contacting Risk Management at riskmanagement@mdanational.com.au or 1800 011 255.

Full descriptions of the workshop topics can be found in the Risk Management section of the MDA National website.

All workshops attract CME/CPD points and are free of charge to doctors who hold a current Professional Indemnity Insurance Policy. Please check the online calendar regularly as more workshops will be added throughout the year.

Numbers are limited for these sessions so make sure that you register early to ensure your place.

Please note that registration is not available until 3 months before the date of the workshop.

Freecall: 1800 011 255
Risk Management Fax: 1300 011 240
Email: riskmanagement@mdanational.com.au

www.mdanational.com.au

Please notify us now...

Do not forget to let us know, as quickly as possible, of any incidents that may give rise to a claim. In some cases a claim can be minimised or even avoided altogether where we have immediate notification.

It is also a condition of your MDA National Insurance Professional Indemnity Insurance Policy that claims or circumstances are notified in writing as soon as practicable.

Don't wait for a complaint or adverse outcome to become a claim before you notify us of the incident concerned.

Please use this form to notify us of any incidents. It is a good rule of thumb that if you are worried about an outcome, you should report it.

To quickly notify us of an incident you can also log-in to our secure Member Online Services at www.mdanational.com.au to complete and submit the form online. If you require assistance logging into the secure section of the website, please contact Member Services on 1800 011 255 during business hours.

Remember - the sooner we know about an incident, the quicker we can help.

Notification of Incident Form

MDA National
Support Protect Promote

Member Details

Full name

Membership number

Preferred contact number/email address

Patient Details

Name				
Date of birth / /	☐ Male	☐ Female	Marital status	No. of dependents
Employment				
Treatment given				
Outcome				
Patient type	☐ Private	☐ Public	☐ Public with private consultation	☐ Not yet known

Other Practitioners Involved

Name	
Address	Postcode
Name	
Address	Postcode

Incident Details

Location of incident	State of occurrence
Date of incident / /	Date you became aware of incident / /
Your medical specialty at time of incident	

Brief Summary of Incident

Include details of patient presentation, diagnosis, treatment and outcome. **Please send a copy of the relevant patient's medical records. Do not send the originals. Please ensure your original records are preserved and kept separate from any correspondence with MDA National Insurance. If this matter develops into a claim, the medical records will become critical to your defence.**

Attach any correspondence relevant to the notification. Attach additional comments on separate pages if necessary.

Please Sign and Date Here

Signed **Date / /**

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Please post or fax the completed form and related documents to:
Claims Division, MDA National Insurance
PO Box 1557, Subiaco WA 6904
Fax: 1300 011 235

Policy holders based in all other states
Please post or fax the completed form and related documents to:
Claims Division, MDA National Insurance
Ground Floor, 69 Christie St, St Leonards NSW 2065
Fax: 1300 011 235

Freecall: 1800 011 255 Member Services Fax: 1300 011 244
Email: peaceofmind@mdanational.com.au www.mdanational.com.au

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Have you moved? Have your practice details changed?

If so, please take a moment to notify us of your new information. To update your details, please call Member Services on 1800 011 255 or log on to the Member Online Services section of our website **www.mdanational.com.au**

It is important that you notify us of your updated information to ensure you maintain continuous cover and to make sure that we can continue to contact you with important information about your medical indemnity.

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