

First Defence

JMO'S + DOCTORS IN TRAINING

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01: Editorial

There are many reasons why a junior doctor should have their own professional indemnity policy but some of the most used services are assistance with medico-legal reports and giving evidence in Court. >>

Our major feature in this issue of *First Defence* addresses these important topics with Dr Sara Bird providing valuable tips on managing these events when you are faced with them.

We hope you enjoy this issue of *First Defence* and find the information useful. If you have any suggestions for articles or case studies in future issues of the magazine, please don't hesitate to contact me at cleonard@mdanational.com.au

Claire Leonard
Communications Manager



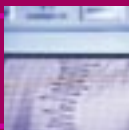
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As ever, this feature is illustrated with some relevant case studies that illustrate how easily events can occur that later lead to requests for medico-legal reports or an appearance in Court.

It's important to remember that as a member of MDA National, you can contact our Medico-Legal Advisors whenever you need them, 24 hours a day, 7 days a week.

Additionally, Dr Kieran Le Plastrier, a member of MDA National's Victorian Advisory Committee, addresses the issue of junior doctors who are considering a change in specialty but are uncertain whether they should make a move that will impact on their career going forward. Having recently changed from surgical to psychiatric training, Dr Le Plastrier is well placed to provide some thoughts on making a career change.



02: The Road Less Travelled

Medical Career Changes and Junior Doctors

Dr Kieran Le Plastrier
MDA National Victorian
Advisory Committee

Most medical students, at some stage in their training, consider their possible career paths after graduation. For most it is a process of elimination - an unforgettable term in obstetrics keeps it in the back of the mind, or a disappointing term in surgery fixes them on a career in internal medicine. Fortunately, rarely would a student feel compelled to abide by a decision about what they wish to pursue at some later date. >

The same cannot be said for many interns and residents working in the high-pressure environment of the busy general hospital. The need to define a clear set of goals is impressed upon them early and usually the first decision runs down the surgical/internal medicine divide. Consultant mentors are keen to know that their diligent resident wants to follow in their footsteps in the appropriate career and residents are loath to tell 'the boss' that given the choice, they

would prefer a toe amputation! One thing is certain, for many young doctors once a decision is made a very large commitment follows - so great that it often seems a career change, no matter how desirable, is not feasible.

Personal reflection offers some insight!

Having embarked on a determined course to become a successful plastic surgeon way back in 4th year medical

school, it is still a shock to many colleagues (and my poor mother) that next year I will be taking up the accredited Psychiatry position in my central city hospital. Most people cannot help making comment that the two careers are at opposite ends of the spectrum. But this is not the reason that the decision to change career paths was so difficult and then in the end so simple. >



03: continued

I learned a few simple lessons that made the process much less fraught than it might have been. The very first was that when I became unhappy with where I saw my life heading, I did not make any rash decisions. It was important to reflect on why I was unsatisfied. It was to take over six months to reach some clarity around the issues with which I was dealing. There were the expected culprits such as the punishing hours of surgical training and its detrimental effects on my lifestyle, which were balanced by the immense satisfaction of the work and the very good remuneration. At the heart of it was a very deep internal sense that I was not in the right job - a little voice that patiently and persistently insisted there was another option and I would have to at least consider it.

And that was the second lesson - the act of consideration is by no means a commitment. The beauty of all that grey matter in our heads is that we can wax lyrical about all sorts of outcomes but that

they remain firmly and privately within said head. Because of my steadfast determination at an early stage of training I had never seriously considered any of the other plethora of options for a medical career. I had failed to fully appreciate the exposure in internship to general medicine and many of the medical specialties, to say nothing of psychiatry. I found myself, belatedly, opening my eyes to an extraordinary sea of possibilities. These new possibilities also refocused my thoughts around my strengths and weaknesses professionally, which was important when it came to making the leap.

I spent some time talking with my partner, colleagues and friends, but I soon found that apart from a few, most were very supportive, at least in principle, of my considering a career move. I was very grateful to a number of my friends who had already taken time away or who had made significant changes - it is always reassuring to know one is not alone. They were also helpful for asking

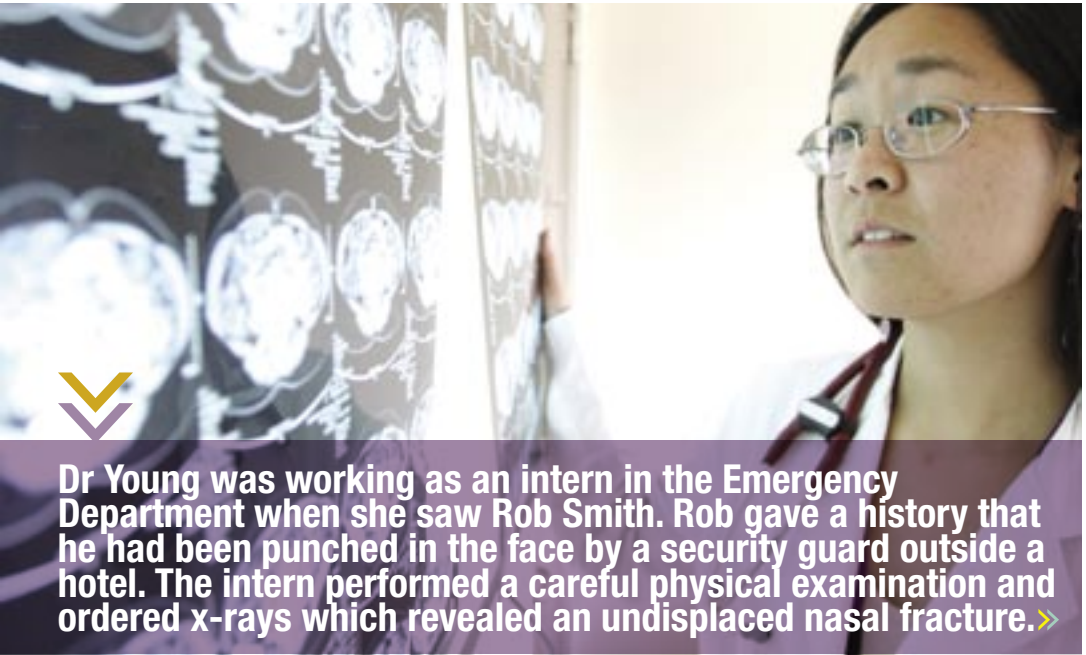
some blunt questions that one is sometimes fearful to ask one's self.

I discovered that a decision needed to be made one way or the other, or I was going to find myself in a vicious and damaging cycle of doubt. I had to apply for jobs for the following year and the College was asking for its annual fees. But the pressure that such deadlines might previously have created was mitigated by the final revelation that no decision is necessarily final - one is always free to change one's mind! When I deferred my surgical place for the year I thought initially I would apply for basic physician training with a view to Endocrinology, but a serendipitous term in psychiatry sealed my fate (*at least for now!*).

So my simple rules are:

- Reflect carefully on the motivations for change
- Consider all your options
- Talk to colleagues and friends
- Think about the future (but not too much)
- Take as long as you need - deadlines have a natural flow
- Remember NO decision is final
- Balance work with the rest of life
- Never forget the joy and privilege of your work

04: Subpoena Strategy



Dr Young was working as an intern in the Emergency Department when she saw Rob Smith. Rob gave a history that he had been punched in the face by a security guard outside a hotel. The intern performed a careful physical examination and ordered x-rays which revealed an undisplaced nasal fracture. >>

Some months later, the intern received a request from medical administration for a statement regarding her management of the patient. The police had requested the report because the alleged assailant had been charged with assault. Dr Young was provided with the relevant medical records and a signed authority from the patient. She prepared a brief, factual report as follows:

“On 1 June 2004, I was working as an intern (first year medical graduate) in the Emergency Department, Royal Perth Hospital. I saw Mr Robert Smith at approximately 8.30pm. Mr Smith stated that he had been punched in the face by a security guard earlier that evening. On examination, Mr Smith was alert and orientated. A 4cm diameter purple, tender bruise was noted under the right eye (infra-orbital

margin). Diffuse tenderness and bruising was also noted over the bridge (top) of the patient’s nose. There were no other abnormal findings on physical examination. Facial x-rays were performed which revealed a fractured nose and no other abnormalities. Mr Smith was provided with a referral to the Ear, Nose and Throat Clinic for management of his fracture and he was discharged from hospital at 11pm. I have not seen Mr Smith since the consultation on 1 June 2004.”

Twelve months later, Dr Young received a subpoena requiring her attendance at Court in Perth in relation to this matter. At this time, she was working in Melbourne. Dr Young contacted MDA National for assistance. She was advised to contact the solicitor who had issued the

subpoena and inform the solicitor of her current place of work and provide the solicitor with her contact details. Arrangements were made for Dr Young to give evidence by telephone, if required. Dr Young sent a fax to the solicitor confirming the arrangements that had been made. She also sought further advice from MDA National about giving evidence in Court. On the scheduled day of the hearing Dr Young was contacted by the solicitor and advised that she would not be required to give evidence.

[NOTE: If you are required to attend Court and give evidence the party that has subpoenaed you to give evidence is required to pay your reasonable travel expenses and loss of income for attendance at Court.]



05: Writing Medico-Legal Reports and Giving Evidence in Court - A Guide for JMOs

From time to time, you will be asked to prepare medico-legal reports and give evidence in Court. The most common context for a request for a medico-legal report is a patient seen in the Emergency Department who was the victim of an assault. The request for the report will usually be received directly from the police or via your hospital administration. >>

Dr Sara Bird
Medico-Legal Manager



The aim of this article is to provide guidance on:

- > writing a medico-legal report, and
- > giving evidence in Court.

As always, if you have any questions or concerns about a particular situation, you should contact MDA National for advice and assistance.

Writing medico-legal reports

The focus of the article is on 'treating doctor' reports, not independent expert reports. The majority of the reports you will be asked to prepare are treating doctor

reports; that is, factual reports outlining your involvement in the management of a patient. However, you may also be asked to provide your medical opinion eg the prognosis of a soft tissue injury. In writing a medico-legal report, it is essential that you clearly differentiate between the facts and your opinions.

Before preparing your medico-legal report

What is the purpose of the medico-legal report? - You should know the purpose of the report that you have been asked to prepare. For example, if you receive a request from your hospital

administration for a report about a patient you have managed, you should ensure that the reason for the request is clear.

Do you have the patient's authority to prepare the report? - Do not breach your patient's confidentiality. You must have a signed authority from your patient (if the patient has died the authority should be obtained from the executor of the patient's estate). The authority should be recent and specific for the purpose of the report. Note: The exception to this requirement is a report for the Coroner. If you are asked to prepare a report for the Coroner, you do not need an

authority. However, you should obtain written confirmation from the police or the requesting party that the report is being obtained on behalf of the Coroner. JMOs are advised to contact MDA National for assistance before sending reports to the Coroner and any patient's advocate authority eg HCCC, Health Rights Commission or the Office of Health Review.

Your medico-legal report

Always use the medical records to prepare your report. Do not rely on your memory or the instructions from the requesting party.

The report should be:

- Factual
- Relevant to the request
- Understandable to the audience - a medico-legal report is not a communication with a colleague. If necessary, provide definitions and explanations of medical abbreviations or terminology eg 'the patient had tachycardia (rapid heart rate)', 'PR (rectal examination)'. Do not use legal terminology such as 'grievous bodily harm'. Do not use personal abbreviations that will not be understood by others. The provision of a clear

explanation and avoidance of medical jargon may prevent an unnecessary trip to Court to give evidence.

- Indicate the name of the requesting party (eg police officer), the date of the request and the purpose of the report.

At the beginning of the report outline your credentials, including your qualifications and position at the time of the events/incident - eg "I obtained my medical degree, MBBS, in 2003. At the time I saw Ms Smith in the Emergency Department on 15 January 2005, I was a second year resident medical officer..." >

Remember you may be cross examined on your report - only write what you would be prepared to say under oath in Court.

If you have any questions or concerns, contact MDA National.



Common Pitfalls

Do

- Know the purpose of the report
- Always use the medical records to assist in the preparation of the report
- Ensure the report is well organised, in chronological order and clear
- Provide the report within a reasonable timeframe
- Personally check and sign your report

Don't

- Provide an opinion beyond your expertise
- Act as an advocate for one side or the other
- Alter your report at the request of your patient or a third party - if you have received further information or you have made a mistake, provide a supplementary report
- Use emotive or derogatory language



07: continued

The body of the report should be organised and, if the report is long, headings should be used.

There are many ways of formatting a medico-legal report. A suggested format for a report is as follows:

- Patient's name and date of birth
- Requesting party and date of request
- Your credentials
- Facts in chronological order, including history and symptoms eg "When asked what happened, Ms Smith stated that..."
 - examination findings
 - investigations
 - provisional diagnosis
 - treatment/management
- Opinion (if any)
- Response to specific questions (if any)
- Your signature and date the report was written/signed by you.

Giving evidence in Court

An understanding of the Court process is useful for any potential witness. Generally, a case involving an assault will be heard in the Criminal Courts. The presumption of innocence is very real in the Criminal Courts and the burden of proof in criminal matters is 'beyond reasonable doubt'.

The Court layout includes the presiding Court officer who sits at the 'bench' at the front of the Court. There is a witness box and perhaps a separate jury box.

The parties' legal representatives, comprising barristers/counsel and solicitors, sit at the 'bar table' facing the Judge or Magistrate (referred to as 'Your Honour'). Court proceedings are usually open to the public and there is seating at the back of the Court to accommodate members of the public. A trial proceeds in a set manner: following an opening address first by the prosecution's barrister and then possibly by the defence, the factual witnesses are called to give evidence. Independent expert witnesses may also be called for the prosecution and defence. Finally, there are addresses by the prosecution and defence barristers and then the jury (where applicable) receives direction from the Judge.

Do I have to go to Court?

If you are required to attend Court, you will usually receive a subpoena or summons to attend Court as a witness. A subpoena or a summons is a Court order and you are required to comply or the court may order a bench warrant for you to attend court. This will require a police officer attending and escorting you to Court. On receipt of a subpoena or summons, contact the party who issued the document. The name of the person who issued the subpoena or summons is usually listed at the end of the document. Do not simply turn up at Court at 10am on the first day of the trial or you could have a long and frustrating wait! Once you have contacted the person who issued the subpoena, try to ascertain the likelihood that you will be required to give

evidence and, if possible, the date and time that you will be required to attend Court. Provide your contact details (eg mobile phone number). You may be able to put yourself on 'stand by'; for example, agree to attend Court within one hour of being contacted. Confirm in writing any arrangements you make with respect to your attendance at Court. If necessary, MDA National can assist you in making these arrangements.

How should I prepare for Court?

Before attending Court

There is no substitute for good preparation before going to Court. You should review your medico-legal report and the relevant medical records. Normally, you will be attending the Court as a factual witness. That is, you will be asked to give evidence about when and where the patient was examined, your findings and any treatment given. The line between a factual and expert medical witness can occasionally become blurred. The major pitfall to avoid is giving an opinion beyond or outside your expertise eg a JMO providing evidence about the long term care requirements of a patient with a severe brain injury.

On the day

Know where the Court is located and how long it will take to get there. Bring to the Court a copy of your medico-legal report and the relevant medical records (if available). Dress in a formal and conservative manner.

What will happen when I give evidence?

Normally you will not be allowed into the Court before giving evidence. Identify the correct courtroom and wait outside at the time you have been asked to attend. When it is your turn to give evidence, a Court officer will show you into the Court and take you to the witness box. The Court officer will ask you to either swear an oath or affirm to the Court that the evidence you give will be truthful. If swearing an oath, the Court officer will ask you to hold a Bible and repeat the oath. If you have no religious beliefs, you may choose to 'affirm'; that is, take the oath without associated religious words or actions. You will then be asked to take a seat in the witness box.

Examination-in-chief

The barrister acting for the party who called you to give evidence will ask you a series of questions to take you through the information contained in your report and/or the medical records. Before doing this, the barrister will usually ask you to provide your name, qualifications, position and experience. The purpose of examination-in-chief is for you to provide your evidence to the Judge and/or jury. On occasions, the Judge may also ask you some questions to clarify certain issues.

Cross examination and re-examination

When the examination-in-chief has concluded, the barrister acting for the other party will

then question you. In some situations, there may be no cross examination and the barrister will indicate that he/she has no questions to put to you. Otherwise, the barrister will ask you questions to probe particular issues in your report and evidence. Your role is to inform the Court and you should remember that you are not there to represent one side or the other. In particular, it is not your role to 'defend your side'. When the cross examination has concluded, the first barrister has the opportunity to re-examine and clarify any issues raised during the cross examination. No new matter can be raised at this time, only further questions about those issues already examined. It is then usual for the party that has called you to ask the Judge to excuse you from Court and you are then free to leave.

Giving evidence

Remember you are impartial. Your role is to inform the Court and to help the Judge and/or jury to better understand the evidence before it, not to assist one side or the other.

Listen carefully to each question. Pause and decide if you are able to answer the question.

Look at the person who is asking the question but provide your answer to the Judge or jury. You may need to turn your head or swivel in your chair in order to do this.

Answer the question as succinctly as possible. Do not over elaborate. If the question is

not clear, ask for an explanation. If you are unable to answer the question, say so. Do not try and guess an answer to a question. For example, you should feel comfortable saying 'I am sorry, I have had no experience in that area of medical practice and so any answer would be speculation on my part'.

In cross examination, answer with a 'Yes' or 'No' providing such a reply would not be misleading. However, do not get lulled into saying 'Yes' or 'No' when that is not an accurate answer. You are entitled to be assertive and firm about any propositions with which you do not agree.

If you hear the word 'Objection' from either barrister, simply stop what you are saying, even if it is mid sentence. Wait until the matter is dealt with by the Judge. If you are in doubt, ask the Judge to indicate to you when you can resume your response. If you have lost your train of thought, ask for the question to be repeated by the barrister.

Conclusion

Giving evidence does not have to be an anxiety provoking or stressful experience. Good preparation before going to Court will ensure that you appropriately and professionally fulfil your role as a medical witness.



09: ECG Error

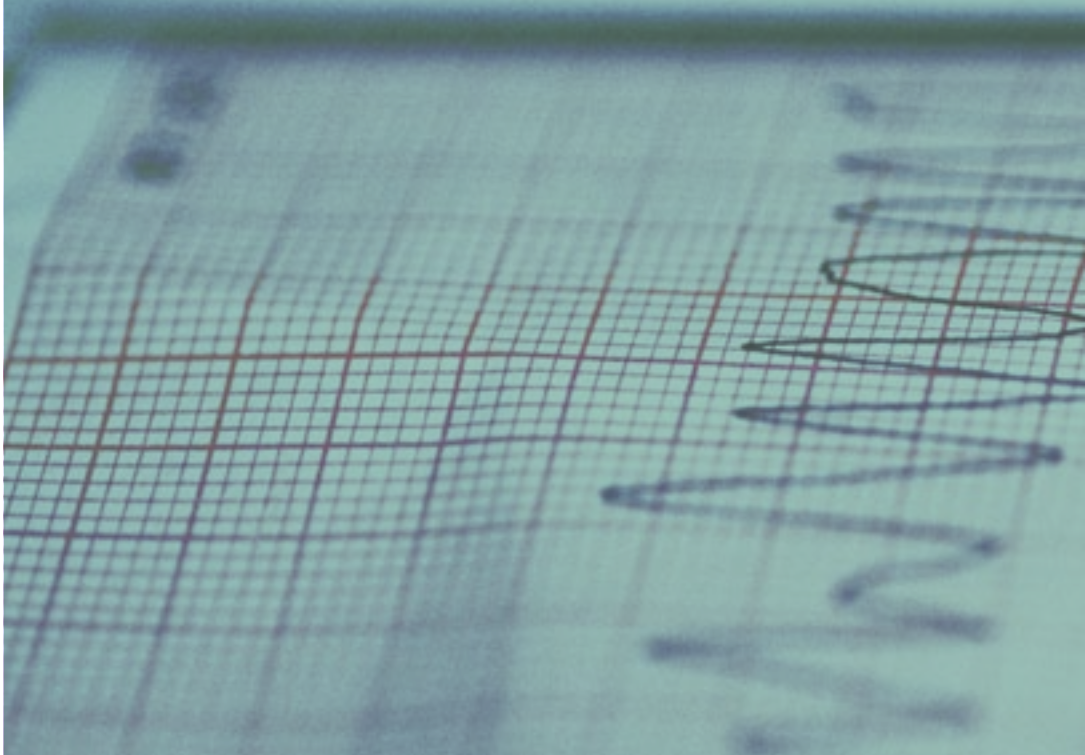


The 52 year old patient presented to the Emergency Department (ED) complaining of epigastric pain. >

He was seen by the JMO. The patient gave a history of several hours of burning epigastric pain which radiated to his chest and throat. The patient reported that the pain was like his usual 'reflux' but more prolonged. The patient was a smoker and had recently been diagnosed with NIDDM. There was no past history of ischaemic heart disease. He was on Lipitor for elevated cholesterol and Somac for gastro-oesophageal reflux disease (GORD). On physical examination, the JMO noted that the patient looked anxious. There was no abnormality on physical examination apart from mild epigastric tenderness.

By the time the JMO assessed the patient, his pain had almost resolved...

The JMO made a provisional diagnosis of an exacerbation of GORD. He reviewed the ECG that had been performed on admission and thought it appeared normal. As per the ED protocol, the JMO discussed the case with the registrar on duty. He told the registrar that the patient had experienced an episode of pain similar to his usual GORD pain and that physical examination and investigations were normal.



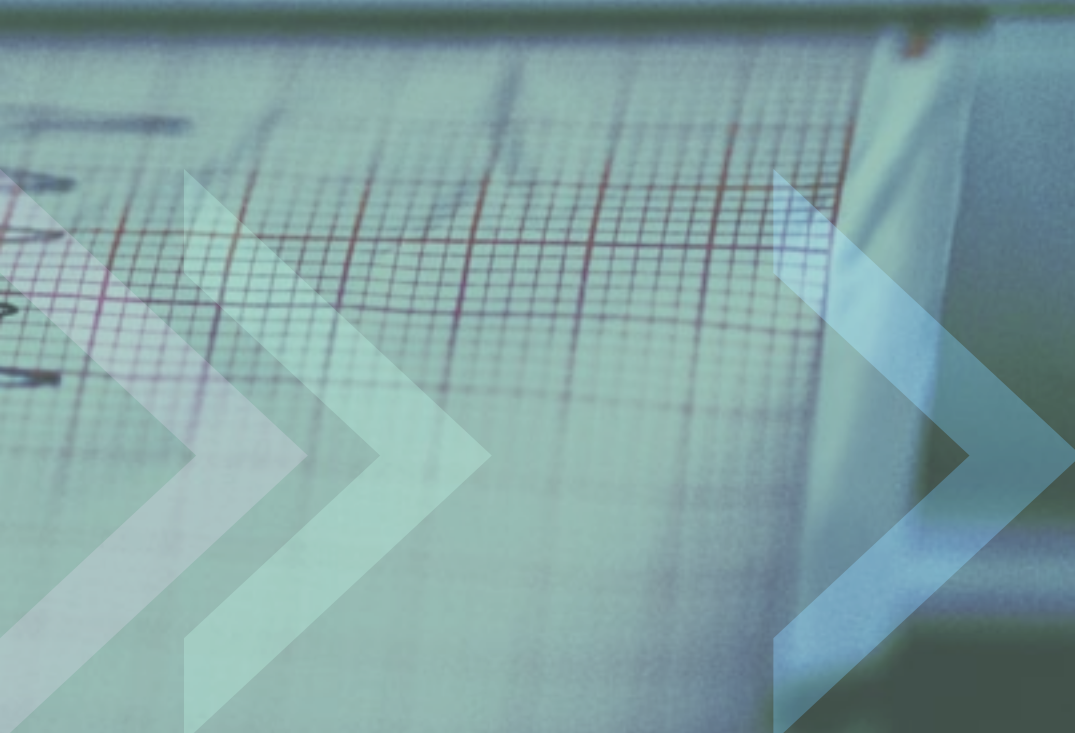
The JMO thought it was appropriate to discharge the patient on an increased dose of Somac and to ask him to return if the pain recurred...

The registrar briefly looked at the admission notes and agreed with the JMO's plan.

A few hours later, the patient was brought in by ambulance after suffering a cardiac arrest. Resuscitation attempts were unsuccessful...

In view of the nature of the patient's death, the matter was reported to the Coroner. Subsequent autopsy confirmed the presence of recent myocardial infarction. Review of the ECG performed on admission revealed an inferior myocardial infarct. The JMO had incorrectly interpreted the ECG and the registrar's review of the case was only cursory, resulting in the patient's inappropriate discharge from hospital.

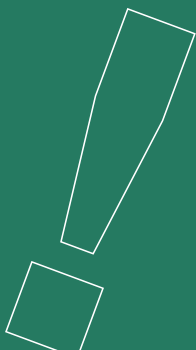
CODE
MARKER





11: Death Certification Drama

The JMO was working on night shift when he was called to certify the death of a patient and complete the Medical Certificate of Cause of Death. The patient had been receiving palliative care for metastatic breast cancer... >>



The death was expected and was not reportable to the Coroner. The JMO had never completed a death certificate before. He was in a hurry and was uncertain what to include under the various headings on the certificate. In his haste, he simply recorded "Metastatic cancer 2 years" under the heading "Disease or condition directly leading to the death". He did not make any notation under the other headings: "Antecedent causes" and "Other significant causes".

Several days later, the JMO received an angry phone call from the patient's husband. The husband had received a copy of his wife's death certificate. He was extremely upset that the certificate was not accurate. The husband told the JMO that his wife had been diagnosed with breast cancer 2 years earlier and she had developed liver metastases 6 months prior to her death. She also had insulin dependent diabetes mellitus which had not been recorded on the certificate. To make matters worse, the patient's name had been spelled incorrectly.

Accurate death certification is important to family members.

It allows them to understand what caused the death and to be aware of conditions that may occur in other family members, now and in the future. The information is also coded by the Australian Bureau of Statistics (ABS) for use by the public health sector and medical researchers for evaluating and developing measures to improve the health of Australians generally.

The ABS has published a booklet which provides guidance on completing Medical Certificates of Cause of Death. If you would like a copy of this booklet, please contact MDA National.



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