First Defence

JMOs + DOCTORS IN TRAINING

MDA National

6 »

SUMMER 06

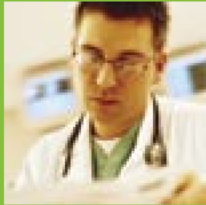
» what's inside... surviving night duty > an unfortunate analogy > risk management: receiving gifts

MDA NATIONAL

MDA NATIONAL INSURANCE PTY LTD

ABN 56 058 271 417

01: In This Issue


02:
beware AAA

03:
surviving night duty

07:
an unfortunate analogy

09:
risk management:
receiving gifts

10:
ugly email

02: Beware AAA

Dr Gold was working the night shift (2200hrs to 0830hrs) at a regional hospital as the resident medical officer. His duties included covering the Emergency Department and the eight surgical and medical wards.

Between 0200 and 0700, Dr Gold was the sole medical officer covering these duties. A registrar was on call and available for advice or assistance, if needed. In the three days prior to Dr Gold's night shift, he had worked 32 hours.

At 0400, he was asked to assess a 58 year old man who had presented to the ED with back and abdominal pain. The patient had been triaged category 3. On review, Dr Gold obtained a history of sudden onset of pain in the back, radiating to the right side of the abdomen.

The pain had started about six hours prior to presentation. The patient had called his GP who referred him to the hospital. The pain was now a constant dull pain in the right iliac fossa. The patient described the pain as 6/10 in intensity. Apart from a couple of loose bowel motions and some associated nausea, there were no other symptoms. The patient had a past history of hypertension and an acute myocardial infarct three years previously. He was on an ACE inhibitor for his blood pressure. The patient was a smoker but he denied any alcohol consumption.

On examination, the patient did not look unwell. His pulse was 100/min, blood pressure 115/78 and he was afebrile. His oxygen saturation was 98% on room air. On abdominal examination, the abdomen was noted to be soft. There was some localised tenderness in the right iliac fossa. There was no organomegaly, normal bowel sounds and a PR examination was normal. There was no loin tenderness. The patient was unable to produce a urine specimen for testing.

Dr Gold made a provisional diagnosis of renal colic. He prescribed 10mg morphine ivi and ordered screening blood tests, MSU and a CXR and AXR. The x-rays did not reveal any free air under the diaphragm or any evidence of a bowel obstruction or renal calculi. Some calcification of the aorta was noted on the AXR. The patient was handed over to the daytime ED staff at 0800 for follow up of pathology results and possible specialist review.

At approximately 1130, the patient suffered a cardiac arrest and was unable to be resuscitated. Because the cause of the patient's death was not known, the matter was referred to the Coroner. An autopsy revealed a ruptured abdominal aortic aneurysm with haematoma in the right abdomen. Dr Gold was asked to prepare a report to the Coroner and he was assisted by MDA National in preparing his report. Following submission of his report to the Coroner, Dr Gold did not hear anything further about the matter.

Surviving Night Duty

Case History

In December 2004, a JMO was found guilty of unsatisfactory professional conduct before the Medical Board following the death of a 10 year old girl who had been under the JMO's care.

The JMO, who graduated in January 2000, was working in the Emergency Department (ED) of a regional hospital in January 2002 when the girl was brought in by her father. He gave a history that his daughter had been sleeping in the top of a bunk bed when she fell and hit her head. When found by her father, the girl was conscious and crying. She complained of a headache and about an hour later she became agitated and vomited. He then decided to take his daughter to hospital for review. The patient was initially seen by the triage nurse who assessed her Glasgow Coma Scale (GCS) at 15 and noted the patient complained of a headache and was upset. The patient was then assessed by the JMO.

At the Medical Board hearing the JMO's assessment of the patient was found to be inadequate in a number of areas:

1. There was a failure to properly re-assess the patient's GCS. The patient only opened her eyes after being spoken to and pressed on her chest. This should have resulted in her GCS score being reduced and it should have alerted an experienced doctor to the possibility of decreasing consciousness warranting further observation. The JMO did not ask basic questions to ascertain the patient's level of consciousness and understanding.
2. There was a failure to examine the patient's ears to look for leakage of CSF or blood.
3. There was a failure to conduct a full physical examination including a proper neurological examination and spinal assessment.
4. There was a failure to assess the severity of the patient's headache or ask if she still felt nauseous.
5. The JMO attributed the patient's failure to comply with his instructions as the patient being uncooperative and 'difficult' rather than recognising this as a sign of a worsening neurological state.

Expert opinion concluded that the JMO should have observed the patient in the ED for four hours or discussed her presentation with a more senior medical practitioner. She also should have been sent to a tertiary hospital for a CT brain scan. Instead, the JMO discharged the patient home. The patient subsequently lapsed into unconsciousness and, despite transfer to a tertiary hospital by helicopter, she died of a massive intracerebral bleed.

At the time of seeing the patient, the JMO was in his 20th hour of a 24 hour shift. He had seen approximately 54 patients and had only had two brief breaks during that time. The Medical Board found that 'anyone who is in the 20th hour of a continuous duty must have reduced capacity to assess the situation when it presents itself'. The Medical Board's view was that this factor must have contributed to the JMO's failure to properly diagnose and manage the patient's condition. Nevertheless, the Board imposed stringent conditions on the JMO's registration, including the need to work in a supervised position for 12 months. Unfortunately, the JMO was not a member of a medical defence organisation (MDO) and so he was not entitled to the support of an MDO throughout the disciplinary proceedings. Therefore the JMO was personally responsible for the costs of the legal representation at the hearing.

Introduction

Working long shifts, or at night, can have adverse consequences for you and your patients because it increases the risk of making poor decisions or even mistakes. From a medico-legal perspective, a mistake made when you are tired is still a mistake. There is no lesser standard of care for tired doctors. Fatigue is no defence, although it may be used in mitigation in disciplinary proceedings. Therefore, it is important to prepare for night shifts, including managing your sleep patterns, so that you can minimise the risk to both you and your patients. The aim of this article is to provide you with some tips on how to prepare to work at night.

05: Surviving Night Duty (cont.)

Healthcare is a 24 hour a day service and night duty is a necessary part of a JMO's work. By actively managing your sleep during this time, you can ensure your safety and that of your patients.

did you know?

> 20 – 25 hours without sleep reduces psychomotor performance to the level of someone with a blood alcohol concentration of 0.10%.

> The risk of being involved in a road traffic accident on the journey home is more than doubled in doctors who have worked a 24 hour shift compared to those working shorter shifts.

> JMOs who work longer hours have higher rates of serious medical and diagnostic errors.

Preparing for Night Shift

- Get plenty of sleep before your first night shift - if you have not slept or rested since waking the previous day, by the time you come off your first night shift, you will have been awake for 24 hours or more.
- To avoid this, try to have a long lie in, ideally until about midday, on the morning before you start.
- In addition to lying in late, taking an afternoon sleep is an extremely important way of making sure you are well rested before you start a night shift – take your sleep in the afternoon rather than just before coming on duty, because early evening is one of the times when your body is most alert, and so sleep will be more difficult at this time. Ideally this rest should last at least two hours, to incorporate a beneficial period of deep sleep.

Surviving Night Shift

- The circadian nadir is between about 3am and 6am - this is when the body is programmed to be at its least active.
- If possible, take a nap while on duty – naps as short as 10 to 45 minutes have been shown to provide positive benefits to shift workers. Your nap should last no longer than 45 minutes to avoid having to wake up during a period of deep sleep. Set an alarm before you nap to ensure you do not fall into a prolonged deep sleep and to give yourself enough time to recover fully from your snooze.
- Throughout the night shift, maximise your exposure to bright light, including light from a bright desk lamp or normal overhead lights. Exposure to light during night shift has an alerting effect on the brain and improves performance.
- Eat and drink properly rather than miss meals. Eat a full meal before you come on duty, have 'lunch' halfway through your shift and have an easily digestible meal before trying to sleep when you get home, if you are hungry. There is some evidence that a high-protein, low-carbohydrate meal is best for maintaining night shift alertness.
- Caffeine may be used in small amounts as a stimulant to help keep you awake. The effects of a cup of coffee or caffeine-containing drink can start being felt within as little as 20 minutes, and may last for up to three or four hours. By taking a small dose of caffeine just before you nap, its effects should start to be felt about the time you return to duty and may overcome the sleep inertia you feel after the nap.

Recovering from Night Shift

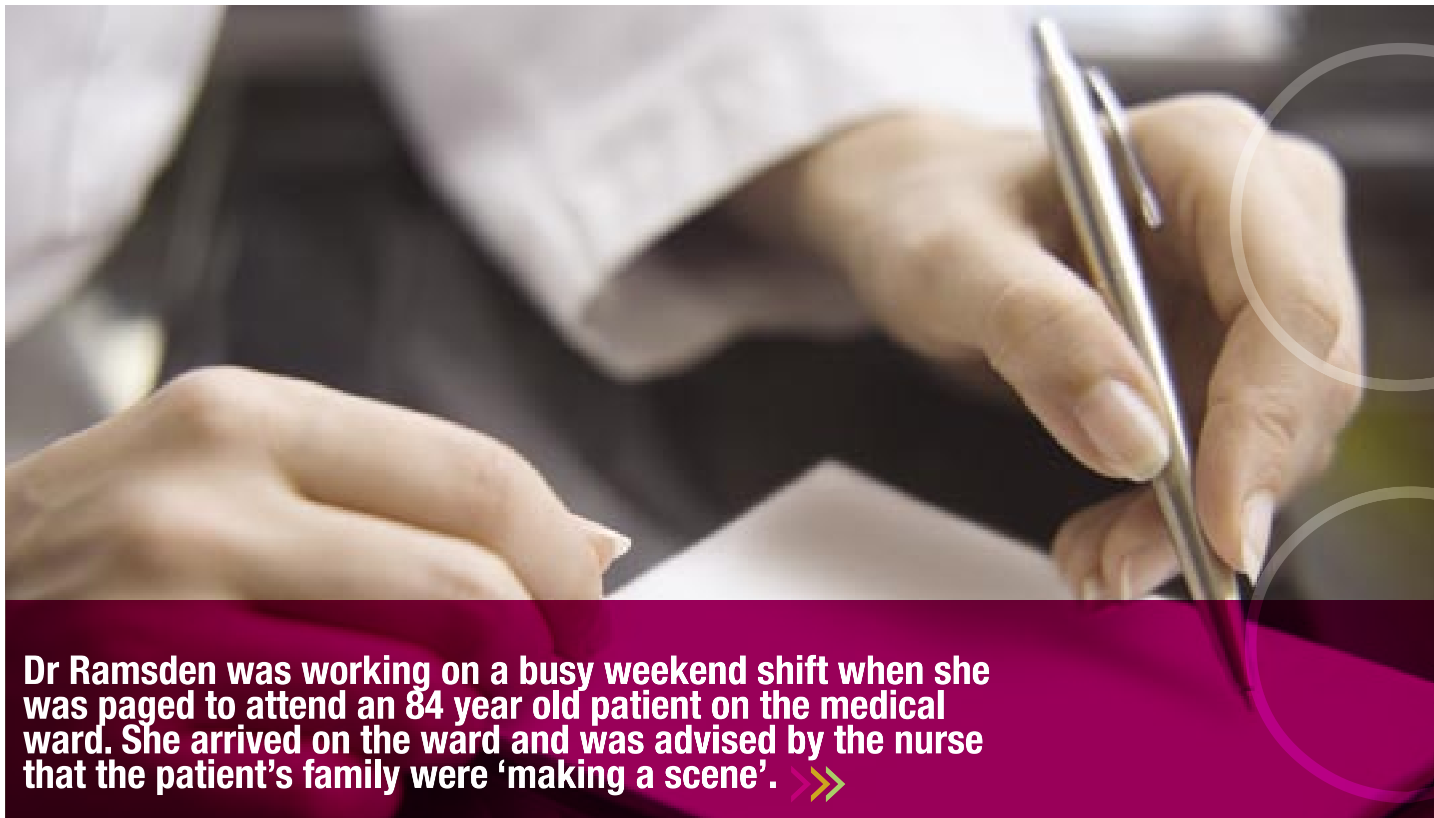
- If planning a long drive home, consider the risks to yourself and other road users. Despite the inconvenience, it may be better to use public transport or the sleeping accommodation at the hospital.
- If you have to work more nights and you are not driving home, wear dark sunglasses to minimise your exposure to sunlight. Bright sunlight should be avoided because it is one of the triggers for re-setting your internal body clock back to its normal daytime schedule.
- As soon as you get home, the best thing to do is to try and sleep – shift workers who get to bed by 10am tend to sleep for at least four hours, whereas those who retire at midday sleep for an hour less. If you are hungry or thirsty, have something to eat or drink first.
- Avoid alcohol because it tends to disturb the stages of deep sleep.
- Sleeping tablets are not recommended to keep you asleep after a night shift because of their potential hangover and addictive effects. Consult your GP if you think they are necessary; you must never self-prescribe.
- If this is your final night shift, have a sleep when you get home from work. When you wake up, get out of bed and do normal daytime things. Make sure you receive some extra exposure to daylight, and try to go to bed early that night.

References

Horrocks N, Pounder R. *Working the night shift: preparation, survival and recovery – A guide for junior doctors.* London: Royal College of Physicians, 2006

McEvoy R D, Lack L L. *Medical staff working the night shift: can naps help?* MJA 2006; 185: 349-350

An Unfortunate Analogy



Dr Ramsden was working on a busy weekend shift when she was paged to attend an 84 year old patient on the medical ward. She arrived on the ward and was advised by the nurse that the patient's family were 'making a scene'.

The nurse asked Dr Ramsden to sort out the situation. Apparently the family members had just arrived from interstate and felt that the patient should not be receiving palliative care. Dr Ramsden had not previously been involved in the patient's care so she briefly reviewed the medical records and noted that the patient was receiving palliative care for metastatic breast cancer. The patient was known to have widespread metastases in her lungs and brain and was on a morphine infusion for analgesia. She also had severe underlying ischaemic heart disease and Type 2 diabetes.

On entering the patient's room, Dr Ramsden was greeted by several family members who all simultaneously expressed concern and anger about the patient's condition. The family were concerned that the patient was not receiving 'active treatment' for her medical condition. Dr Ramsden asked the family to leave the room while she examined the patient. She noted that the patient was drowsy but rousable. The patient did not appear to be in any pain. When asked if she had any concerns, the patient replied that she was comfortable. Dr Ramsden went outside to discuss the patient's condition with her family. She felt that the patient was receiving appropriate treatment for her terminal cancer and tried to explain the situation to the family; namely, that the patient's cancer was incurable and the best management was to keep her comfortable and pain free. In discussing the patient's condition with the family, Dr Ramsden used the analogy of a car, explaining that her condition was like that of a 'vintage car that had broken and could not be repaired'.

The following week, the Director of Clinical Training asked to see Dr Ramsden. He advised her that a letter of complaint had been received from the patient's family and asked her to prepare a response. In the letter, the family expressed their distress that Dr Ramsden had compared the patient to a 'broken down old car that was only good for the scrap heap'.

Dr Ramsden sought advice from MDA National on how to respond to the letter of complaint. While she denied that she had described the patient as 'only good for the scrap heap', she acknowledged that with the benefit of hindsight her car analogy was not appropriate. In her response, Dr Ramsden apologised and expressed her regret for the distress and concern that her comments had caused. She provided her letter of response to the Director of Clinical Training who forwarded it to the patient's family. She also discussed the situation with the Director of Clinical Training and acknowledged that at the time of seeing the patient she felt overwhelmed by the family's reaction and her own workload. She felt that no matter what she said or did, the family would remain unhappy and angry about the situation.

She acknowledged that her comparison of the patient's condition with that of a car was not a useful comment in the circumstances. A few weeks later, the Director of Clinical Training informed Dr Ramsden that the family had accepted her apology and the matter was now at an end.

09: Risk Management: Receiving Gifts

Nearly every doctor will at some stage receive a gift from a patient. Gift giving is usually motivated by gratitude or custom and is given without any expectation of reciprocity.

However, acceptance of such gifts can also be regarded as unethical, as it has the potential to negatively interfere in the doctor-patient relationship. While the act of giving and receiving a gift may sit at the minor end of boundary violations, the doctor may in fact be on a 'slippery slope'.

So how should one regard and react to a patient who presents you with a gift? The best advice is probably take nothing for granted and reflect upon the motivation of the gift, the giver and its timing.

The vast majority of gifts given by patients come with no strings attached and are simply a demonstration of their gratitude. The patient has no expectation of special or preferential treatment – now or in the future. Some patients, however, may assume that their gift entitles them to additional or 'questionable' services – eg extension of sick leave certificate, favourable insurance reports, appointments on demand etc. The doctor may find it more difficult to turn down such requests having accepted a gift or feel some obligation that influences their clinical judgement. Other patient motivators include – to be remembered, to be tolerated or it may even be an attempt to equalise the power structure in the patient-doctor relationship – especially for those patients who have been humiliated by the sick role.

It may not always be easy to guess the patient's motivation. The best way to measure whether an action is ethically acceptable is to ask – is the giving and receiving of this gift in the best interests of the patient?

Token and modest gifts of appreciation that are in proportion to the service you have provided are not of great concern. Acceptance of the gift can be acceptance of the giver and if the doctor rejects the gift it could be interpreted by the patient as lack of regard for their wishes resulting in a damaged relationship.

Gift-giving that should raise concern include:

- the timing of the gift, eg at discharge versus on Valentine's Day
- the gift's monetary value
- its personal specifity
- where the meaning to the patient is more than just gratitude

Where you believe a particular gift is inappropriate, it should be politely declined while avoiding offending or embarrassing the patient. Explaining the rejection in terms of a general policy or ethical obligation may help a patient to understand that the rejection is not personal. If something is accepted for any reason, it is not advisable to have cards and gifts on display in your practice as this may give the impression to your patients that such behaviour is expected. At the end of the day you will need to ask yourself can the gift stand up to the scrutiny of other patients, your colleagues and the public?

10: Ugly Email

Dr Barnes was doing a gastroenterology term when she was involved in the care of a 34 year old male patient who had been admitted for management of his severe ulcerative colitis.

The patient had been transferred from a regional hospital. He remained in hospital for several weeks while his medication regime was adjusted and a number of investigations were carried out.

Before his discharge, the patient asked Dr Barnes if she would give him her email address so that he could keep her updated about his progress. She gave the patient her email address and subsequently received a couple of chatty emails from him about his medical condition and his home town. Dr Barnes sent brief responses wishing him well.

She was then horrified to receive an email from the patient containing some sexually explicit comments and photos. She immediately deleted the email and sought advice from MDA National on what else she should do. The medico-legal adviser assisted Dr Barnes in drafting a letter to the patient advising him that his recent email was completely inappropriate and that he should make no further attempts to contact her by email or in any other manner. Fortunately, Dr Barnes received no further contact from the patient.

11: Update Your Contact Details

Have you moved recently or are intending to do so in the next few months? Has your email address or mobile phone number changed?

To make sure that we can continue to contact you with important information regarding your medical indemnity, please complete this form and forward it through to us when you change any of your contact details.

*Name: ____________________

*Member Number: ____________________

Hospital/Area Health Service: ____________________

New Postal Address: ____________________

____

New Telephone Number: ____________________

New Fax Number: ____________________

New Mobile Number: ____________________

New Email Address: ____________________

** Must be completed if you wish the change to be recorded*

Fax the completed form to:

WA: (08) 9415 1493 All other states: (03) 9690 6272

Or post to your local office (address shown below)

Freecall: 1800 034 466 (WA) **1800 011 255 (all other states)**

Email: peaceofmind@mdanational.com.au **www.mdanational.com.au**

Perth
Level 3, 516 Hay Street
Subiaco WA 6008
Ph: (08) 6461 3400
Client Services Fax: (08) 9415 1493
Claims Fax: (08) 9415 1492

Melbourne
Level 1
101 Dundas Place
Albert Park VIC 3206
Ph: (03) 9915 1700
Fax: (03) 9690 6272

Sydney
Level 5, AMA House
69 Christie Street
St Leonards NSW 2065
Ph: (02) 9023 3300
Fax: (02) 9460 8344

Brisbane
Level 8
87 Wickham Terrace
Spring Hill QLD 4000
Ph: (07) 3120 1800
Fax: (07) 3839 7822

Adelaide
Level 24, Santos House
91 King William Street
Adelaide SA 5000
Ph: (08) 8233 5842
Fax: (08) 8233 5858

The information in *First Defence* is intended as a guide only and should not be taken as legal or clinical advice. We recommend you always contact your indemnity provider when advice in relation to your liability for matters covered under your insurance policy is required. The case histories used are based on actual medical negligence claims or medicolegal referrals; however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved. Insurance policies available through the MDA National Group are underwritten by MDA National Insurance Pty Ltd (MDA National Insurance) ABN 56 058 271 417, AFS Licence No. 238073. With limited exceptions they are available only to members of MDA National. MDA National Insurance is a wholly owned subsidiary of the Medical Defence Association of Western Australia (Incorporated) ARBN 055 801 771, trading as MDA National incorporated in Western Australia. The liability of members is limited. Before you make any decision whether to buy or hold any products issued by MDA National Insurance, please consider the relevant Product Disclosure Statement and Policy Wording. Contact us if you require a copy. Privacy: The MDA National Group collects personal information to provide and market our services or to meet legal obligations. We may share personal information with other organisations that assist us in doing this. You may access personal information we hold about you, subject to the Federal Privacy Act. The MDA National Group's Privacy Policy is available by calling us on 1800 011 255 or by visiting our website at www.mdanational.com.au If you wish to change your contact details or to be removed from our mailing list please contact us on 1800 011 255

clarity communications