



FIRST DEFENCE

JMOs + DOCTORS IN TRAINING

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welcome...

Welcome to the second edition of First Defence, MDA National's newsletter for JMOs and Doctors in Training. Thank you to those members who took the time to provide us with feedback on the first edition. The response was overwhelmingly positive, and we have collected your ideas for future editions.

Given the popularity of the case studies in the last edition, we have provided many more for you this time around, highlighting different issues for your consideration in your day-to-day work.

Recent events in Queensland, where a Junior Doctor has been denied indemnity by Queensland Health for legal action being taken against him following an Emergency Department consultation, reiterate the importance of your personal Medical Indemnity coverage. Discretionary indemnity arrangements with your employer may not provide you with access to legal advice in situations of personal investigation, leaving you open to large legal fees.

Your membership of MDA National provides you with the peace of mind that our experienced medicolegal team will be there for you if such investigations occur, and that our network of doctors are on hand to provide peer support and assistance to minimise the stress of the experience.

Again, we hope that you find the following information useful. Feel free to provide criticism, advice or ideas to me at scarroll@mdanational.com.au

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When should I take extra care?

Obviously some situations are more prone to lead to medicolegal problems than others. High risk situations have been identified for adverse events involving JMOs, as detailed below. This list is not exhaustive, but you are especially vulnerable in clinical situations that are brief or unfamiliar.

In these situations, you should pay particular attention to history taking, review of the medical records, careful communications with the patient and accurate clinical documentation.

Here are some key 'Tips for avoiding Medico-legal Problems'

- If you are uncomfortable about making a clinical decision or performing a particular procedure - no matter how small - discuss it with your registrar or consultant.
- If you are uncertain about an issue then ask your registrar, consultant or other senior practitioner about it at an appropriate time.
- Make good, concise, contemporaneous notes. Remember that the purpose of the medical records is to allow another practitioner to continue the management of the patient's care.
- Be aware of the 'high risk' clinical situations for adverse events listed above.
- Maintain membership of an MDO. Remember that your interests and those of the hospital and other staff members may not always be the same. Independent representation of your interests is crucial and reassuring if faced with this situation.
- If you are involved in an adverse event related to a patient under your care, contact your MDO for advice. This will ensure that you follow correct procedure and produce an appropriate account of the event. It will also allow you to work through the distress you may be feeling about the event.

High Risk Situations for Adverse Events involving JMOs

- Clinical situations that are brief or unfamiliar
- Overtime
- Patients transferred from ICU or operating theatre to ward
- Paediatric patients
- Administration of IV medications
- Emergency department
 - Trauma
 - Failure to diagnose significant head injuries, particularly in intoxicated patients
 - Missed fractures
 - Lacerations - missed nerve and tendon injuries
 - Failure to diagnose medical conditions
 - Acute myocardial infarction
 - Meningitis
 - Depression and suicidality
 - Failure to diagnose acute surgical conditions
 - Subarachnoid haemorrhage
 - Appendicitis
 - Ectopic pregnancy

Hospital Indemnity

Hospital Indemnity is not applicable in all situations in which a doctor may find themselves requiring legal assistance. The following stories provide examples of such situations. The first shows that hospitals and the doctors working in them do not always end up on the same side of a medicolegal dispute. The second looks at actions taken against the doctor personally, which are not the responsibility of the Employer.

A CASE FOR THE CORONER

The RMO was rostered on an evening shift in the Emergency Department (ED). It was the RMO's sixth night of evenings and he was looking forward to some time off. Towards the end of his shift, the RMO saw an 8 year old girl who presented with dyspnoea and wheeze. According to the patient's mother, the 8 year old girl had recently suffered from an upper respiratory tract infection which had caused her asthma to deteriorate. That day, she had been using her Ventolin puffer every 1 to 2 hours. In the past, the patient had been hospitalised on several occasions with exacerbations of her asthma. On one occasion she had required intubation because of a sudden deterioration in her respiratory function, even though she was on maximal bronchodilator therapy.

The RMO examined the patient and noted she was afebrile. Her respiratory rate was 30 and she was using her accessory muscles. There was intercostal recession and on auscultation the RMO noted widespread rhonchi. The patient was unable to use a peak flow meter. The RMO asked the nurse to give the patient some Ventolin via nebuliser and a stat dose of oral prednisone. He said he would review the patient in about 30 minutes.

The ED was very busy and the RMO saw several other patients in the interim. Just as he was about to finish his shift, the nurse told the RMO that the 8 year old girl with asthma was waiting for his review. The RMO ducked his head around the curtain and noted that the patient had fallen asleep. He quickly listened to the patient's chest and noted that the wheeze had settled. He told the patient's mother that she could take her home but she should continue to administer Ventolin via a nebuliser second hourly during the night. He also gave the mother a prescription for some prednisone syrup to be administered once daily for the next three days. The RMO told the patient's mother to bring her back to the ED if her asthma got any worse. The RMO quickly jotted a few notes in the medical records and left the ED, looking forward to a good night's sleep.

The following evening, as he arrived for his last evening shift, the RMO was greeted by the Director of the ED. The Director called the RMO into her office and said that the young girl he had seen with asthma the night before was brought in by ambulance in the early hours of the morning. She had had a respiratory arrest and, unfortunately, was unable to be resuscitated. The death had been reported to the Coroner. The Director showed the RMO a document outlining a treatment algorithm for children with asthma. She asked the RMO if he had seen it before and whether he had complied with it. The Director also asked the

RMO to prepare a report regarding his management of the patient. The Director wanted to provide this report to the hospital's solicitors that evening. She said that the RMO would be suspended from duty in the ED until after a complete investigation of the incident had been finalised by the hospital.

The RMO phoned his medical defence organisation (MDO) for advice. The MDO's medico-legal adviser discussed the matter with the Director of ED and asked for an extension of time in which to provide the report to the hospital's solicitors. The RMO subsequently met with his MDO and was provided with assistance in preparing his report for the hospital. The report was then forwarded to the Coroner.

Several months later, the RMO was informed that the Coroner intended to hold an Inquest (or hearing) into the young girl's death. The RMO was required to give evidence at the Inquest. It was clear that there was a conflict of interest between the hospital's ED Director and the RMO and it was impossible for the hospital's solicitors to represent both the Director and the RMO. Therefore, the RMO's MDO provided legal assistance and briefed a barrister to assist and represent the RMO at the Inquest. Expert opinion was obtained with respect to the management provided to the patient by the RMO.

At the conclusion of the Inquest, the Coroner found that the girl had died as a result of an exacerbation of her longstanding and unstable asthma. The Coroner made some recommendations with respect to the appropriate management of children who present to the ED with asthma. No specific criticism was made of the RMO's management of the patient.

palpitations all around...

The medical registrar was called to the Emergency Department (ED) to examine a 21 year old woman who had presented to the ED with palpitations and a feeling of light headedness. The registrar reviewed the brief medical records and proceeded to see the patient. The patient was sitting in bed wearing a hospital gown that was open at the front. The registrar drew the curtains around the bed and proceeded to take a full medical history. He then performed a routine cardiovascular examination. Following this examination, the registrar advised the patient that she was OK to go home.

The following day, the registrar received a phone call from the police advising him that the patient had made an allegation of indecent assault against him. The police asked the registrar to attend the local police station in order to provide a statement. Unfortunately, the registrar attended the police station unaccompanied and provided a statement without seeking advice from his MDO or a solicitor. The registrar was subsequently charged with indecent assault.

On his return to the hospital, the registrar discovered that he had been suspended from duty. At this point, the registrar contacted his MDO for advice and a solicitor was appointed to look after his interests. The following day, the MDO's solicitor and medicolegal adviser met with the registrar. The registrar categorically denied the patient's allegations that he had indecently assaulted her by fondling her breasts. The registrar said that he had performed a full cardiovascular examination, including palpation of the apex beat and auscultation of the heart. After

submissions from the MDO's solicitor, the police ultimately withdrew the charges against the registrar, but not until four anxious months had elapsed. The solicitor also made representations to the hospital and the registrar was reinstated. However, the registrar's troubles were not all over. The patient subsequently made a complaint to the Medical Board and a further investigation into the allegations ensued. Eventually, some fifteen months after the incident, the matter was proceeded to a hearing. The patient's evidence was inconsistent and the registrar presented well. Ultimately, the Medical Tribunal found the registrar was not guilty of professional misconduct and the whole matter finally came to an end, but not without a considerable amount of anxiety and stress for the registrar. The registrar's MDO provided considerable support to the him during this time and also funded his legal fees which were in excess of \$80,000.



Some quick and interesting cases...

Take care with your signature...

Dr Quinn, was an intern on an orthopaedics term when she was approached by the de facto partner of one of the patients on the ward. The patient had undergone carpal tunnel surgery a few days earlier. The de facto asked Dr Quinn to sign a letter stating that the patient could not sign any documents because of her recent hand surgery. The intern dutifully completed the statement for the de facto.

A week later Dr Quinn was summoned to the Medical Superintendent's office. Apparently the de facto had used the intern's letter to withdraw all of the patient's savings from her bank account. The patient was extremely distressed and the police were investigating the matter. The patient had complained to the hospital about Dr Quinn's actions.

The intern contacted her MDO for advice. She was assisted in preparing a response to the hospital and the patient. This case provides a useful reminder of the importance of taking care of one's own signature!

The sparky's scaphoid...

A 22 year old apprentice electrician attended the Emergency Department (ED) having fallen off a ladder onto his outstretched hand. The intern in ED examined the patient and noted some tenderness over the radial aspect in the patient's right wrist. The patient complained of mild pain on movement of the wrist. There was no swelling. The intern ordered an x-ray of the wrist. This was reported as normal. A crepe bandage was applied to the patient's right wrist and he was discharged with advice to see his GP if the wrist pain did not settle. The intern made the following notes in the hospital records;
*"Fall onto outstretched right hand
O/E no swelling wrist
Some tenderness radial aspect wrist
X-ray NAD -> crepe bandage"*

Two years later, a solicitor acting on behalf of the hospital contacted the intern (now a medical registrar). The solicitor advised the doctor that the patient had commenced proceedings

against the hospital and the patient's GP alleging a failure to diagnose a scaphoid fracture. According to the Statement of Claim, the apprentice electrician patient was no longer able to work as an electrician and there was a claim for economic loss in excess of \$400,000. Not surprisingly, the doctor had no recollection of the particular patient and the consultation in the ED. The doctor contacted his MDO for advice. He was told that he should obtain written confirmation from the hospital's solicitor that he would be indemnified by the hospital with respect to the claim. Once this written confirmation had been received, he should cooperate with the solicitors and review the hospital's medical records. The MDO assisted the doctor in preparing a written statement for the hospital's solicitors. The claim was ultimately settled on behalf of the doctor and the hospital in the amount of \$450,000 plus legal costs.

An insulin incident...

The 58 year old insulin dependent diabetic patient was admitted for treatment of presumed gastroenteritis. The JMO completed the medication chart and charted '20U' of long acting insulin. The nurse on the ward was not familiar with the use of insulin and, in fact, was not familiar with treating diabetic patients. She read the JMO's order as 200 Units of insulin and proceeded to administer this dose to the patient. Soon after, the patient became clummy and lost consciousness. The diagnosis of hypoglycaemia was promptly made and appropriate treatment instituted. Fortunately, the patient did not suffer any long term adverse sequelae of the insulin overdose.

This case underscores the importance of avoiding the use of the abbreviation 'U' for Units of medication. When charting insulin or heparin, the word 'Unit' should be always be used (rather than "U") in order to prevent errors involving an overdose of these medications.



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