

First Defence

JMO'S + DOCTORS IN TRAINING

MDA National

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01: Editorial



Communication is the cornerstone of good medical practice. It is not just with our patients, however, that the chain of communication can go awry and lead to adverse outcomes.



For many reasons, communication failures between health professionals do occur and contribute to unfavourable outcomes. The focus of this issue of *First Defence* is on the handover process in a training hospital setting. In this situation, the frequently changing staff must hone their communication skills in order to provide consistency in patient care.

MDA National Medico-legal Advisor, Dr Sara Bird, has again provided advice and information on the topic and illustrated some of the issues involved in an interesting case study.

Two shorter vignettes provide examples of communication problems; in one case, too little and in the other, far too much!

And finally, we attempt to communicate effectively with you with an article for all those doctors with itchy feet, who need to know what to do with their MDA National Insurance when they go overseas.

We hope you enjoy this edition and learn much from it.

Siobhan Carroll
Publications Co-ordinator





02: Decisions, decisions...options for the overseas doctor

Like many doctors, you may consider travelling overseas during the early years of your career, either as a resident, or during your specialist training.



IMPORTANT FACTS:

- MDA National Insurance provides cover on a 'claims made' basis. This means you are only covered for incidents which occur while you have an active policy and are reported to us while you have an active policy. A break in the continuity of your cover will affect your ability to report incidents to us and you may not be indemnified for them.
- A Non-Practising Endorsement (a change to the standard Professional Indemnity Insurance (PII) Policy terms), allows you to remain an MDA National Insurance policyholder. Therefore, upon your return to practice in Australia, you do not need to apply for a new insurance policy; you simply need to notify us to reactivate your cover. This endorsement gives you the option to still report matters to MDA National Insurance whilst overseas (that is, matters that occurred during your practice in Australia under your MDA National Insurance Policy, that have only just come to light). Your premiums are reduced appropriately during the period that you are not practicing in Australia. It is also important for you to be aware that should you request a Non-Practising Endorsement your policy will still fall due for renewal at 30 June each year.
- MDA National Insurance will not provide cover in the USA or Canada for any period of time. The reason for this is that local indemnity insurers are best placed to handle the risks and intricacies of law in these regions. We can assist you to identify a local provider. >

We frequently receive calls from our members, requesting information about their indemnity options during a period of overseas travel. Equally often we find that the nomadic lifestyle of an overseas locum means that indemnity insurance renewal information is misplaced and indemnity cover expires.

In this article, we will explain some of your indemnity options if you decide to include overseas work as part of your training experience. >



02: Continued

> WORKING <3 MONTHS

If you intend to work overseas, you will obviously require indemnity. For periods of three months or less, you can request indemnity from MDA National Insurance under your existing policy. All requests must be submitted in writing and are subject to approval by our underwriters.

TRAVELLING ONLY <3 MONTHS

If you are travelling for less than three months and will not be working, there is no need to make any change to your arrangements with us. Whatever you do, ensure that your contact details remain current, or that you use a reliable agent in Australia so that if your policy becomes due for renewal while you are out of the country it does not inadvertently lapse.

TRAVELLING ONLY >3 MONTHS

If you do not require indemnity from us for a period of greater than three months, you can apply for a Non-Practising Endorsement. In this circumstance, your annual premium will be reduced accordingly.

The effect of the Non-Practising Endorsement is that we will not indemnify you for claims or investigations arising out of the provision of medical services after the date you nominate as your last day of practice in Australia. However, this endorsement still allows you to report previous incidents to us until you request reinstatement of your PII policy.

WORKING >3 MONTHS

If you intend to work for a period greater than 3 months, we recommend that you seek indemnity from a provider in the country in which you will be practicing. It is our belief that, in the case of a claim, it will be far more efficient and safer to manage it within that country with the guidance of professionals who understand the particular jurisdiction.

MOVE OVERSEAS WITH NO IMMEDIATE PLAN TO RETURN

If you are moving overseas for an indefinite period of time, you may still apply for a Non-Practising Endorsement and renew it on an annual basis until you return to practice in Australia.

If you don't know when, or if, you will return to Australia, you can cancel your PII policy. In this circumstance you will need to investigate run-off cover. Run-off provides cover for any new claims arising from incidents that occurred while you were working in Australia and your PII policy was active.

In such a situation, MDA National Insurance offers a Run-off Indemnity Policy (Run-off Policy). The Run-off Policy is renewable on a yearly basis, for up to three years. After this time you should become eligible for the Federal Government's Run-off Cover Scheme (ROCS). (for a detailed explanation of ROCS please contact our Client Services Advisers).

If you do cancel your PII policy and purchase run-off cover, then return to Australia after a few years, you will need to re-apply for a new PII policy. Our staff can then explain the options regarding the 'tail' from your previous PII policy.





MDA NATIONAL POLICY		CONSIDERATIONS	RETURN TO AUSTRALIA
WORKING < 3 MONTHS	Covered under existing PII policy, after approval by us	Make arrangements for renewal if away at that time	No action needed
WORKING > 3 MONTHS	Apply for policy endorsement and maintain 'Report Only' cover while away	Seek new provider in country of employment	Reinstate PII policy
	OR > Resign and purchase Run-off Indemnity Policy	Seek new provider in country of employment Make arrangements for yearly renewal of run-off cover	Apply for a new PII policy and request information on retroactive cover
	OR > Resign without purchasing Run-off Indemnity Policy	Seek new provider in country of employment	Re-apply for a PII policy and apply for retroactive cover
HOLIDAY < 3 MONTHS	No change to the policy	Make arrangements for renewal if away at that time	No action needed
HOLIDAY > 3 MONTHS	Apply for policy endorsement and maintain 'Non-Practising' cover while away	Make arrangements for renewal if away at that time	Reinstate PII policy
	OR > Resign and purchase Run-off Indemnity Policy	Make arrangements for yearly renewal of Run-off Indemnity Policy	Apply for a new PII policy and request information on retroactive cover
	OR > Resign without purchasing Run-off Indemnity Policy		Re-apply for a PII policy and apply for retroactive cover



If no run-off cover is purchased there will be no indemnity available to you if a claim arises from your work in Australia whilst you are overseas. You will therefore be personally liable for all associated legal and claims costs.

Some common situations are outlined in the table above. Because every case is different, it is most important that you notify us of your intentions regarding work and travel so that your policy can be amended accordingly. Our Client Services Advisers will be able to assist you further in making your decision.



03: Handover - Have you got the message?

In recent times the importance of doctors' communication skills has been widely recognised. It has become a focus for recruitment and training in both medical schools and the workforce, in order to ensure that all doctors acquire the necessary skills required in order to effectively communicate with their patients.



Communications skills training to improve the doctor-patient relationship has become common, including training in specific circumstances such as breaking bad news to patients. However, the doctor-patient interface is not the only place where vital miscommunications occur. The importance of successful communication between health professionals should not be ignored. Problems in information transfer between health professionals are a frequent cause of adverse patient outcomes, especially in a hospital setting.

Reviews of adverse events and claims data reveal that communication failures in the chain of care are responsible for a significant proportion of adverse patient outcomes. Indeed, a retrospective Australian study of hospital admissions found that communication problems were the most common cause of preventable patient disability or death and were nearly twice as common as those problems due to inadequate medical skills. >



> Developing and fine tuning skills in this aspect of communication will improve patient care and minimise the possibility of errors and adverse patient events.

A recent study which examined how communication failures contributed to mishaps found that poor communication is not simply the result of poor transmission or exchange of information. Communication failures were far more complex and related to hierarchical differences, conflicting roles and role ambiguity and interpersonal power and conflict. A clearer understanding of these dynamics is required to improve communication between health professionals.

Maintaining continuity of patient care in a hospital setting between work shifts is vitally important and extends beyond an individual doctor or team. The goal of handover is the accurate and reliable communication of task specific patient information across shift changes, thereby ensuring a relatively safe and

effective continuous work environment [1].

Medical and nursing staff keep track of patients' conditions using handwritten records and charts and verbal handover. Handover is highly dynamic, relying heavily on interpersonal communication as an essential component of the process.

Typically, handover occurs across varying levels of experience, knowledge and roles. It is one of the most commonly performed tasks in medicine and plays a vital role in the continuity of patient care. It requires your full participation and concentration...even if you are tired at the end of a shift, or overwhelmed at the start of a new one. Especially then!



COMMUNICATION BREAKDOWNS IN THE HOSPITAL HANDOVER PROCESS ARE CHARACTERISED BY:

- Insufficient or inaccurate data
- Illegible medical records
- Mistimed or delayed information
- Poorly organised data
- Insertion of 'pseudo-information'
- Cognitive overload.

SPECIFIC PROBLEMS IDENTIFIED WITH HANDOVER INCLUDE:

- Lack of format or structure producing inconsistent information
- Medical records containing too much information and taking too long to transfer information
- Handwritten records are illegible or incomplete
- Incorrect or error prone information is transferred
- Inability to identify patients of concern and locate the replacement doctor; and
- Communication breakdown causing duplication of test results.



03: Continued

BEST PRACTICE MEDICAL HANDOVER MODEL [2]

	Giver of information	Receiver of information
BEFORE	<ul style="list-style-type: none"> • Decide on priority patients • Note priority information as on prompt card, write clearly • Decide on time and location free from distractions • Inform Receiver 	<ul style="list-style-type: none"> • Ensure you have a pen and a pad on which to make notes • Remind yourself what you need from the handover • Check with the Giver that you know the time and place
DURING	<ul style="list-style-type: none"> • Talk through priority patients, referring to notes • Answer any questions • Check understanding is shared • (Optional- give receiver the notes) 	<ul style="list-style-type: none"> • Actively listen • Question to clarify • Note what you think are the priorities • Check your understanding • Make notes
AFTER	<ul style="list-style-type: none"> • Ensure your case notes reflect what was covered in the handover • Reflect on your effectiveness, note improvements to make next time you hand over 	<ul style="list-style-type: none"> • Refer to notes • Carry out interventions • Update case notes • Reflect on your effectiveness, note improvements to make next time you get a hand over



Reference

- [1] Bomba DT, Prakash R. *A description of handover processes in an Australian public hospital.* Australian Health Review. February 2005 Vol 29 No 1 68-79.
- [2] Bradbury M, Cumming J. *Royal Manchester Children's Hospital,* 3 December 2003



04: To call or not to call... a handover fiasco



Dr Cleanskin was a JMO on her first week of night duty, covering the surgical wards. She met Dr Chop, the surgical registrar, for handover. He promptly informed her that he was sitting his primary exams the following day. He made it very clear that he did not want to be disturbed 'unless it was a real emergency'. Dr Cleanskin reverently agreed that she would try to avoid waking him if possible.



At about 11.30pm she was called to the general surgical ward to review a 38 year old patient who had undergone a total thyroidectomy earlier that day. The patient was complaining of tightness in her throat and some difficulty breathing.

The JMO reviewed the patient's medical records and noted that she had undergone the thyroidectomy for a papillary cancer. The patient had been reviewed by the surgical registrar post operatively who noted "Routine post op care - usual obs. Do not remove neck dressing".

Dr Cleanskin reviewed the patient and confirmed the history of a sensation of difficulty breathing and pressure in the neck. On examination, she noted that the patient appeared anxious. Her pulse, blood pressure, respiratory rate and temperature were normal. Pulse oximetry was normal on room air. Respiratory and cardiovascular examination did not reveal any abnormalities. >



04: Continued



> In view of Dr Chop's specific instructions in the notes, the JMO decided not to remove the dressing to inspect the neck wound. She thought that the patient's symptoms were probably caused by post operative pain, ordered a stat dose of morphine for analgesia and asked the nurses to call her if there were any further problems.

At about 2am, Dr Cleanskin was asked to see the patient again. The patient was complaining of increasing pressure in her neck and the nurses thought there was some stridor. The JMO was concerned about the patient but she was not sure whether there was a serious problem. She did not want to wake the registrar because she did not think it was 'a real emergency' situation.

The nursing staff suggested that the JMO remove the neck dressing and inspect the surgical wound. However, she did not want to do this because the notes clearly stated that the dressing was not to be removed.

The JMO requested that the nursing staff continue regular observations and give the patient another stat dose of morphine for pain.

At 3am a Code Blue was called on the surgical ward. The patient had had a respiratory arrest. When the nursing staff removed the patient's dressing they found a large haematoma compressing her neck. They removed the surgical staples and evacuated the haematoma.

The surgical and anaesthetic registrars were in attendance

and the patient was successfully intubated and transferred to the Intensive Care Unit by the anaesthetic registrar.

On reviewing the medical records, Dr Chop noted that the patient had been seen twice by Dr Cleanskin prior to her arrest. He was extremely angry that she had not informed him of the patient's symptoms which were 'typical of a post thyroidectomy haematoma'. He then told Dr Cleanskin that the respiratory arrest could have been averted if 'she had known what she was doing or if she had called him before it was too late'.

WHAT ISSUES CONTRIBUTED TO THIS ADVERSE OUTCOME?

During handover, Dr Chop had asked Dr Cleanskin not to call him unless it was 'a real emergency'. However, the JMO did not have the knowledge or experience to recognise the potential emergency in the post thyroidectomy patient. She was not aware of the possible complications that could occur in a patient who had undergone a thyroidectomy. As a result she did not recognise the impending emergency caused by the neck haematoma.

Dr Cleanskin had not clarified with the registrar what situations comprised a 'real emergency'. Nor had she reviewed with the registrar a list of the priority surgical patients and any signs and/or symptoms to watch out for.

For his part, the registrar had not provided appropriate delegation or supervision of the JMO. He had not explained what he meant by a 'real emergency'. He had not even ascertained the JMO's level of knowledge

and experience with respect to surgical patients (remember, this was the JMO's first surgical term). It is dangerous to expect everyone else to have the same knowledge base that you do.

Most doctors rely heavily on what has been written in the patient notes. Dr Chop's notation in the chart meant that the staff were reluctant to remove the neck dressing. Additionally, the registrar had not outlined any potential problems, such as neck pressure, dyspnoea or stridor, which required his immediate senior review.

In this case, a more thorough handover and clarification of when to seek advice could have avoided the patient's respiratory arrest.



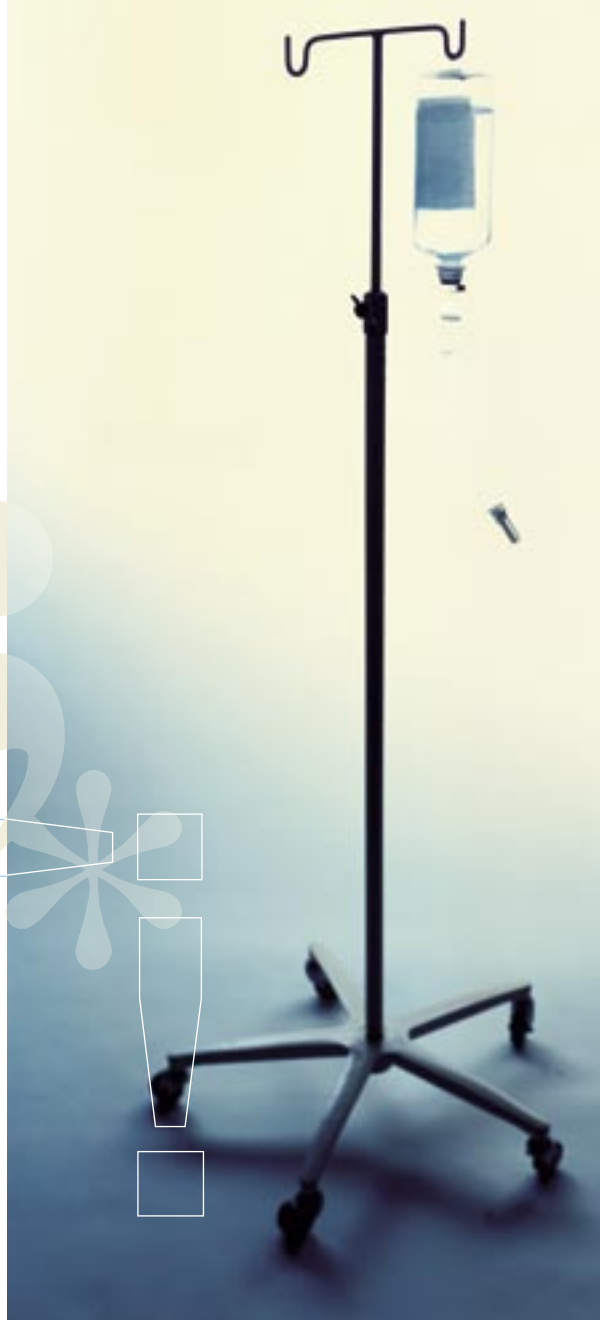
05: Vincristine...again

An 18 year old patient was undergoing chemotherapy as part of his treatment for leukemia. The treatment comprised;

- **Vincristine** - to be given intravenously
- **Cytosine** - to be given intrathecally.

The JMO's supervising oncology registrar was on a rostered day off and so the JMO asked one of the other registrars, who he knew well, to supervise the administration of the chemotherapy. The cardiology registrar agreed to assist, believing that his role was to simply observe the procedure. Due to a bed shortage, the patient was on the cardiology rather than the oncology ward. Tragically, the nursing staff and JMO got the syringes of medication mixed up and the JMO administered the Vincristine intrathecally instead of intravenously.

At least 23 incidents have been reported worldwide of Vincristine being injected intrathecally by mistake. Almost all of these incidents have proved fatal. In this case, the JMO did not carefully review the medications prior to administration. The experienced oncology registrar was not available and there was a misunderstanding about the role of the supervising registrar. Additionally, the treatment was being provided in a ward in which there was little experience in the administration of chemotherapy.





06: A well known politician



The JMO was asked to attend the morgue to certify a patient as deceased. On arrival, the JMO was given the patient's medical records. The JMO noted that the patient was a well known politician.

The morgue attendant told the JMO that the patient's body had a few 'unusual features'. He then ushered the JMO towards the bed on which the body had been placed. The JMO removed the sheet from the patient's body. He was rather shocked to see some unusual body piercings and tattoos on the politician's genitalia. He quickly performed an assessment and death certification.

On returning to the wards, the JMO joined in a discussion with some of the nurses and other hospital staff about the politician. The JMO disclosed the fact that he had just examined the patient's body and outlined in graphic detail the nature of the tattoos and body piercing. At a party later that evening, the JMO became involved in a further discussion about the politician.

The next day, the JMO was paged to attend the Medical Superintendent's office. A journalist had just contacted the Superintendent to ask for confirmation of rumours of 'certain irregular features' of the politician's body. The JMO was horrified that the information had been provided to the press. The Superintendent said that the patient's family had already been contacted by the journalist and they were extremely angry about the breach of confidentiality.

Medical practitioners owe a duty of confidentiality to all of their patients and this duty continues even after the death of a patient. JMOs should take care to avoid any 'gossip' or disclosure of information that they obtain about patients during the course of their work.



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