firstdefence

Publication for Doctor in Training Members

Spring/Summer 2017

MDA National

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Education Facilitation Team – Seeking Expressions of Interest

Are you a doctor with a passion for teaching and learning, keen on helping to deliver practical, engaging, medico-legally informed education to fellow Members and the medical profession?

MDA National's face-to-face education sessions share knowledge from the experiences of Members and staff to support doctors in providing safe medical care. We use contracted Member facilitators to do this and, to better serve our Members, we are expanding the diversity of specialties and career stages in our facilitator team.

Expressions of interest are invited from Members who are enthusiastic about delivering high quality face-to-face education and who will thoughtfully fulfil this paid role's key performance indicators. Ongoing support and comprehensive topic training are provided to our facilitators.

If you are interested in becoming an MDA National education facilitator, please contact **peaceofmind@mdanational.com.au** for more information.

Re-scheduling of Codeine

Medicines containing codeine will no longer be available without a prescription from 1 February 2018. Codeine is an opioid drug closely related to morphine. It can cause opioid tolerance, dependence, addiction, poisoning and, in high doses, death. Codeine is increasingly a drug of abuse in Australia and the overall rate of codeine-related deaths more than doubled between 2000 and 2009.

More information is available on the TGA website: **tga.gov.au/codeine-info-hub#education**.

Privacy Legislation Update

On Thursday 22 February 2018, mandatory privacy breach notification obligations will commence for all medical organisations covered by the *Privacy Act 1988* (Cth). This applies to most doctors working in private practice. Privacy breaches may include patient health and financial information, contact details and identifiers. Importantly, not all privacy breaches are "eligible" for reporting.

For more information

- read the article, Privacy Breaches – New Obligations, in *Defence Update* Spring/Summer 2017 (available at **defenceupdate.mdanational.com.au/articles/privacy-new-obligations**)
- visit the Office of the Australian Information Commissioner website: **oaic.gov.au**.

First Defence Online
Visit **firstdefence.mdanational.com.au**.

Broken Doctor, Broken System

I am a doctor with a mental illness. There, I've said it. This is something I am no longer ashamed of, as mastery has come with my remission. But at the times of greatest need, I was unable to acknowledge my illness even to myself.

I won't detail the stressors on junior doctors because, by now, most of you would be familiar with that perfect storm. Although these issues were present in my case, they weren't the only cause or contributing factor. The real let down was when I became vulnerable and felt unsupported by the medical system to remain well, rehabilitate and return to the vocation I loved.

Death, disease and disabilities formed my medical curriculum. Dealing with these things didn't. There was no acknowledgement that feeling emotional or overwhelmed might be valid and understandable, or even the norm. The good doctor was impervious – so I must be broken.

This meant I hid when I should have been reaching out. To whom, I wasn't even sure. Sometimes I would fall in a heap, and a job might be tacked together which would earmark me as defective and deficient. When unable to work, I heard nothing from the medical fraternity or hospital I was proud to be a part of. I never spoke to, let alone heard of, any doctor in my situation.

The dissociative experience of seeing both sides of the therapeutic relationship was profound. There is nothing like seeing your own medication chart in action. This isolation did nothing to help my perception of hopelessness, and was actively detrimental to my recovery. Returning to work was the hardest thing I ever did. In a reactive system without policies or protocols, I was scared every day to fail what seemed to be my only chance.

But over time, with support and luck, I've become better. I would not change this experience as it has shaped who I am today. I'm inspired to share my story so others might not feel so alone, and may see that they too can recover. I've been allowed a deeper understanding of my patients which enriches my work. I'm thankful every day for the ability to practise, as well as the great number of privileges and pleasures I have beyond medicine.

Relapse is a realistic possibility, and sometimes I still face challenges. I've worked hard at improving my personal resilience, thinking patterns and work-life balance. I have made rational decisions about how and where I practise and what I can expect of myself.

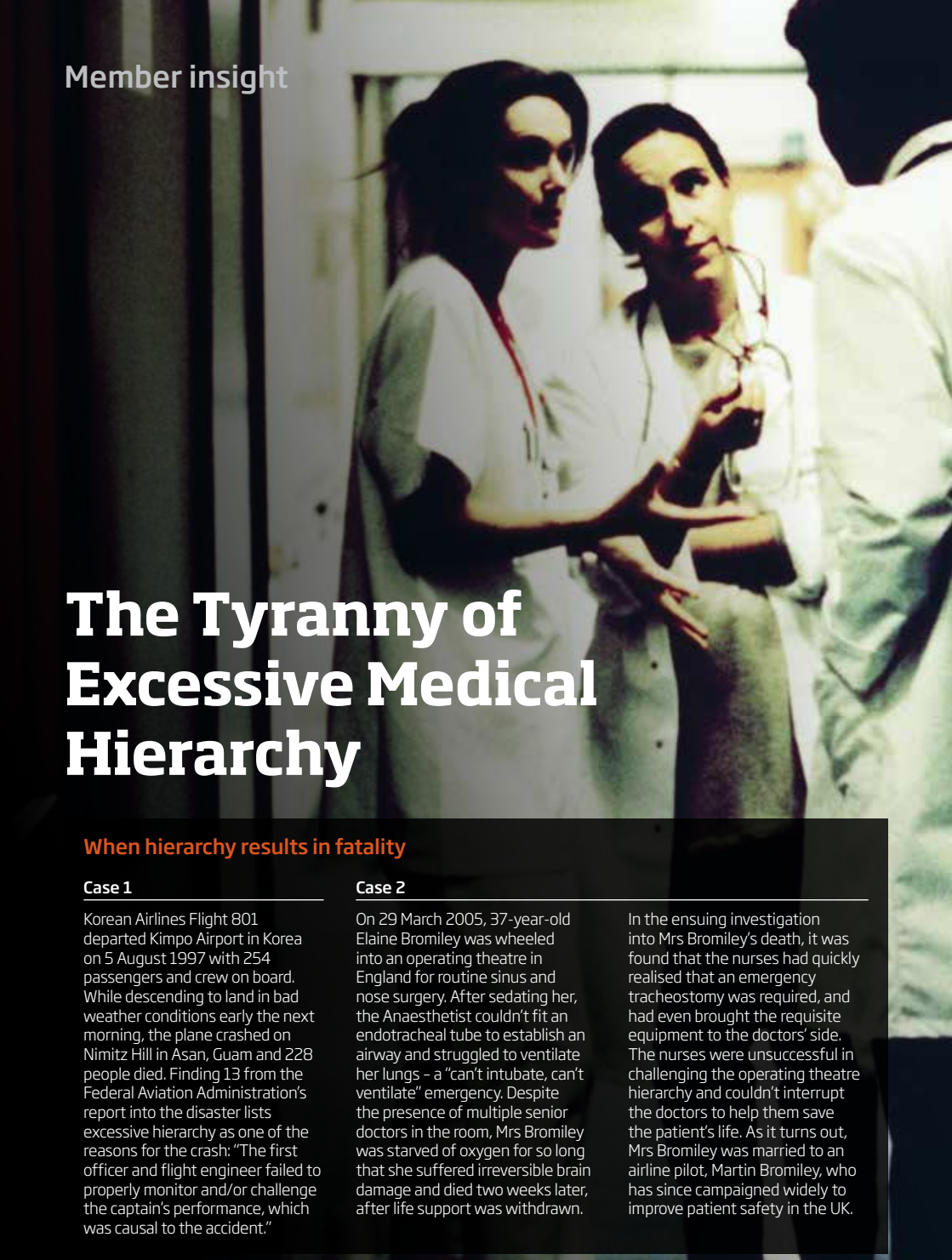
I hope I have the insight now to reach out for help early. But for all of us, seeking support must be acceptable and accessible. It's one thing to focus on doctors' resilience, but this is futile unless we also recognise that everyone has a breaking point. Our medical culture needs to change, and we need a commitment to doctors' welfare because that improves conditions for us all. As medicine moves from illness to wellness, why not start with ourselves?

Sources of assistance

- Doctors' Health Advisory Service: **dhas.org.au**
- Lifeline Australia: **lifeline.org.au**
- The *beyondblue* Support Service: **beyondblue.org.au**
- MDA National – Doctors for Doctors Program: **1800 011 255**

Dr Sarah Newman (MDA National Member)
General Practice Registrar

Dr Newman is the co-chair of the AMA WA Doctors in Training Welfare Subcommittee. She is also the recipient of the RACGP Award: *WA Registrar of the Year 2017* and the AMA WA Camille Michener Legacy Award: *Junior Doctor of the Year 2017*.



The Tyranny of Excessive Medical Hierarchy

When hierarchy results in fatality

Case 1

Korean Airlines Flight 801 departed Kimpo Airport in Korea on 5 August 1997 with 254 passengers and crew on board. While descending to land in bad weather conditions early the next morning, the plane crashed on Nimitz Hill in Asan, Guam and 228 people died. Finding 13 from the Federal Aviation Administration's report into the disaster lists excessive hierarchy as one of the reasons for the crash: "The first officer and flight engineer failed to properly monitor and/or challenge the captain's performance, which was causal to the accident."

Case 2

On 29 March 2005, 37-year-old Elaine Bromiley was wheeled into an operating theatre in England for routine sinus and nose surgery. After sedating her, the Anaesthetist couldn't fit an endotracheal tube to establish an airway and struggled to ventilate her lungs – a "can't intubate, can't ventilate" emergency. Despite the presence of multiple senior doctors in the room, Mrs Bromiley was starved of oxygen for so long that she suffered irreversible brain damage and died two weeks later, after life support was withdrawn.

In the ensuing investigation into Mrs Bromiley's death, it was found that the nurses had quickly realised that an emergency tracheostomy was required, and had even brought the requisite equipment to the doctors' side. The nurses were unsuccessful in challenging the operating theatre hierarchy and couldn't interrupt the doctors to help them save the patient's life. As it turns out, Mrs Bromiley was married to an airline pilot, Martin Bromiley, who has since campaigned widely to improve patient safety in the UK.

The need to address hierarchy issues

In April 2017, Prof Sir Liam Donaldson, the World Health Organization Envoy for Patient Safety and former Chief Medical Officer for England, visited Sydney and addressed a patient safety seminar, lamenting the lack of progress we have made in health care to reduce avoidable harm. In particular, Sir Liam drew a comparison with the airline industry, noting they had worked deliberately to counter a reluctance of co-pilots to challenge senior pilots, a factor in multiple accidents and near-misses. "Hierarchy is alive and well in health care and it needs to be addressed in a similar, robust way," he implored.

Any doctor in training working on the coalface of the public hospital system knows this all too well. I remember trying to query a Psychiatrist's request to order a non-urgent abdominal x-ray to assess for constipation in a young adult, something I had been taught to avoid, particularly in the young. Before I even had time to explain that the radiation exposure for an abdominal x-ray was equivalent to taking seven chest x-rays and to suggest an alternate plan that I felt was safer for the patient, the consultant yelled at me in the busy nurses' station, "I'm the psychiatrist, when I tell you to order an x-ray you order an x-ray!" No one else said a word, and I have no idea what the nearby medical student made of this role-modelling. Somewhat to my shame, I ordered the x-ray, fearing repercussions.

The need to review training and workplace factors

As has been widely reported in the Australian media, three doctors in training died by suicide in NSW between September 2016 and January 2017. Since then, I've heard of several suicides of doctors in training in Victoria, plus a medical student's suicide in Tasmania. There may have been more, but they usually go unreported by the media and no one has been tasked with collating data. On 4 April of this year, three colleagues and I wrote to the NSW Minister for Health, Brad Hazzard, about their deaths. We briefly offered other doctors and medical students the chance to support our letter and were inundated with over 150 co-signatures.

We figured that three young doctors taking their own lives within just four months was the final straw in a decades-old, multifactorial mental health problem in our profession. And we believe it warrants a special commission of inquiry into the training and workplace factors that affect doctors' wellbeing. We articulated to the Minister how such an inquiry ought to proceed, and sent our request with a letter of support from the NSW branches of the Australian Medical Association and Australian Salaried Medical Officers' Federation. However, a response arrived over a month later, politely declining our suggestion.

In his response, the Minister referred to the Junior Medical Officer Wellbeing and Support Forum that he had directed the Ministry of Health to convene on 6 June 2017. I attended this forum and was impressed by the Minister's comments, and that he stayed for the entire afternoon. In his closing address, he all but committed to introducing a WA-style exemption in the NSW mandatory reporting law, something the NSW Medical Council also supports. As has been argued for years, this would be an excellent change – but it is not enough.

The need for systemic change

In addition to changing mandatory reporting, it would help if doctors in training weren't so scared and unsupported in claiming all the overtime we work. It could then be clearer how much the current system demands, and department "business cases" could justify employing more doctors by saving on overtime.

It would help if we borrowed from the airline industry, and not only introduced safer rostering practices but addressed extreme power differentials by, for example, using only first names instead of distancing junior team members from their senior colleagues with selective use of the "Doctor" title.

It would help if the colleges had to justify low pass rates for their assessments despite having such intelligent candidates, abolished all-or-nothing exams that are hugely expensive and run only once a year, and perhaps even lost their monopolies.

And, I still believe, it would help if at least one jurisdiction funded an inquiry that properly investigated these and other factors affecting trainee wellbeing, with a commitment from the outset to developing and implementing reforms, similar to the Garling inquiry from the early 2000s.

In the meantime, it helps so much that families of doctors like Chloe Abbott and Andrew Bryant have spoken openly about their loved one's suicide – so that this enormous and urgent problem can no longer be ignored as an abstract statistic and, instead, becomes as human for all of us as it has been for so many bereaved families for all these years.

Dr Benjamin Veness (MDA National Member)
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You can follow Ben on Twitter **@venessb**

Please see 'Sources of assistance' on page 3.

The original version of this article was published in MJA InSight, 19 June 2017.

WHAT I LOVE ABOUT
Intensive Care Medicine

The strange world of intensive care medicine is completely unknown to most patients, and even most doctors. So what does this specialty have to offer the prospective Intensivist?

Dr David Ransley

To a junior doctor working in a busy hospital, the Intensive Care Unit (ICU) is a foreign environment with the sickest patients, highly-skilled nurses and specialised equipment. While it can be an imposing place at first, the ICU has so much to offer the junior doctor, even those not planning to become Intensivists.

Beyond the ordinary spectrum of illnesses

Every hospital specialty is responsible for a scope of conditions – Cardiologists see heart failure, General Surgeons see bowel obstruction, Respiratory Physicians see pneumonia. While these teams will comfortably handle most spectrums of disease, when the patient is critically ill they are best off in the ICU. This means Intensivists are the experts of not only the severe end of all diseases, but also the patients that cross the boundaries of the "single organ specialties". In the ICU, you will see the worst of everything and manage conditions beyond the scope of any other team.

Big picture thinking

Having to consider the complex interplay between all the organ systems lends itself to big picture thinking. This is the extreme end of considering the whole patient, where a holistic view of the situation must be developed. Life-changing decisions must be made for, and with, patients – often without the ability to ask the patient for their preference. Intensivists must develop comprehensive communication and quick thinking skills to manage difficult decisions, and the satisfaction that comes from this process will help you enjoy your career.

Applied physiology

The complex systems of the body and their interplay in times of critical illness are truly the domain of the Intensivist. Nowhere else in medicine will you see such vivid demonstrations of the principles of physiology on a daily basis than in the ICU. You will see the extremes of physiology, captured in front of your eyes through the many monitoring modalities.

Complex decisions underpinned by basic clinical science

While other specialties will have extensive evidence upon which to base clinical decisions, this is often not possible in the ICU due to the uncharted waters we so often navigate. The average ICU patient has multi-system disease with a background of multiple co-morbidities, and it is within this space that the Intensivist must operate. Decisions are often made on the basis of science in the absence of clinical evidence, supported by experience in managing critical illness.

Supporting colleagues

The downside to intensive care practice is often the lack of follow-up when patients leave your care. This means the prospective Intensivist needs to find satisfaction in their work from sources other than patient feedback. Every intern will have felt the relief that comes with a sick ward patient being taken to ICU. You will often find yourself supporting colleagues by looking after their most challenging cases. There is no other specialty that is able to manage such a broad range of conditions.

Endless possibilities

You don't have to work in a hospital long to have someone tell you, "We can't do that here". Whether it is advanced treatment modalities like ECMO and renal replacement, or even (in some hospitals) insulin-dextrose infusions, the general wards are becoming more restricted in what they can manage. You will never encounter this in the ICU where the team can manage any condition, treatment or technology. Sometimes the logistics are better dealt with in a specialty area, but the ICU team are always there to provide support.

No boring bits

Every specialty has its bread-and-butter conditions and intensive care is no different. The difference is that our bread-and-butter is often the worst a "single-organ doctor" will see for the year. Even the most routine ICU case will have its challenges, and this means you will never be bored.

Constant growth as a doctor

In most specialties you will be practising like a boss very early on, and you will reach your peak at fellowship. This means there is a limit to how much you will be able to grow as a doctor. In intensive care, even the most experienced specialist will often be faced with challenges. If you are after a job where you need to be constantly chasing higher standards, intensive care medicine is the path for you.

Dr David Ransley (MDA National Member)
Advanced Trainee, Intensive Care Medicine
Royal Hobart Hospital, Tasmania

Listen to David's podcast interview with Dr Norman Swan – ***What I Wish I'd known about Intensive Care Medicine*** – on the MDA National website: mdanational.com.au/Resources?c=podcasts

The Power of Passion for the Profession

Let's meet **Dr Dinesh Palipana**, the first quadriplegic medical intern in Queensland. He didn't let a car accident or quadriplegia get in the way of his passion for medicine. His story is an inspiration to us all.

As a kid, what did you want to be when you "grew up"?

Being a doctor wasn't even on my radar as a kid. I wanted to be a pilot and started flying planes when I was a teenager. After high school, I studied law. Then halfway through the course at the age of 22, I became ill with celiac disease, depression and anxiety – all of which made me think about life and what was important to me. I worked out that I wanted to make a difference and help people. Medicine is a good way to do this. It's intellectually challenging and definitely the career for me. From "day one", I haven't looked back. It's amazing.

What was the major turning point in your life?

I was 25 years old and in the third year of my medical degree. I lost control of my car on a wet night – the car aquaplaned and rolled. I was awake the whole time and realised I couldn't feel my legs. That was in January 2010. I spent eight months in hospital and much longer in rehabilitation. I'm now a quadriplegic with no movement in my hands, though my arms and my wrists work to a degree. For five years there was a lot of doubt as to whether I could resume medical studies.

I went back to medical school in 2015, graduated in 2016, and started internship this year. Interestingly, the car accident wasn't really a turning point; it was something that strengthened my conviction.

Does your quadriplegia limit you at work?

I've figured out ways of doing things. I can still position a stethoscope into my hands; then my fingers naturally curl around it and I can hold on without grabbing it. I can also slip a pen inside my fingers and scribble notes. It takes a bit longer and it's tedious, but it can be done. I've never had a patient react oddly to me. Sometimes they're surprised and ask questions, but no one has ever refused to be treated by me. The people around me have been amazing. I've been very fortunate in this way.

What's a typical day in your life as an intern?

The life of an intern varies significantly depending on the rotation you do. This year, I've done rotations in vascular surgery, general medicine, emergency medicine; and short terms in O&G and psychiatry – all significantly different in workflow and lifestyle. I'm currently on holidays, so a typical day for this intern right now involves activities that deeply promote chilling out and a bit of fun!

I'm planning to spend more time in the emergency department (ED) over the next year, so I'll tell you a bit about what life is like there.

A typical day means waking up three hours before I have to be anywhere. It takes a long time to get ready when you have a spinal cord injury. My mum lives with me, and I have guys who help out on alternating days as I need help with a quite a few things.

Dr Dinesh Palipana

Then I roll into the ED where the person with the most urgent problem waiting the longest becomes my first patient for the day. Patients can be anyone with any kind of problem – a mum with her one-year-old who has trouble breathing, or someone's grandma with abdominal pain.

ED doctors (as with all doctors) have to be efficient as presentations can be urgent, and there are always lots of people waiting. I ask patients about their history, examine them, discuss with a senior doctor, and get moving with any management and investigations. The order and speed of this depends on how ill the person is. Then it's on to the next patient.

Our ED has a fantastic working environment, with a brilliant and approachable team. It also has very accessible space for me to get around in. Even the desks are at the right height. All of this allows me to be functional to the best possible extent.

Emergency is fast moving. You can help a lot of people and you need to think on your feet (or other load-bearing body parts, as is my case). Having said this, all the rotations this year had unique positives and challenges. There are always cases that tug at my heartstrings – these people stand out in my mind and reinforce my reasons for doing this job.

Are there any "heroes" who have inspired you?

My mum. She has been dedicated and selfless, and helped me so much. I don't have to look far to see a hero.

How hard was it to get an internship?

This was tricky. It took a long time and was a period of great uncertainty for me. All the other medical students got job offers through the normal recruitment campaign in June. It was January and I was floating around until the Friday before the Monday when everyone else was due to start work. I was having a beer with a friend when my phone rang at 2.30pm with a job offer – talk about unexpected! Until that point, I didn't think it was going to happen. I had to send back the paperwork by 4.00pm and I started work the following Monday.

Any words of advice for new medical students?

I once read this in a Warren Buffett book – ask any successful craftsman, artist, athlete, poet, or entrepreneur, and they will say they lose themselves in their craft. The phenomenon of losing a sense of time and place is the definition of finding your passion, your purpose in life. Find your passion. Let it consume you.

If the profession starts to feel like a chore, you need to find your footing again. This is important because medicine isn't just a job. It requires your heart and soul.

If something feels tedious, remember there are so many different things you can do within (and outside) medicine.

When Should I Report a Death to the Coroner?

A recent article on the ABC[1] highlighted the importance of doctors being aware of their obligations regarding when to report a patient death to the Coroner.

The primary role of the Coroner is to determine:

- the identity of the person who died
- the date and place of death
- the manner and cause of death.

The Coroner is mainly concerned with investigating deaths that occur in a number of unexplained circumstances.

The Coroner also has an interest in investigations which may result in recommendations as a means to preventing other similar deaths in the future. It is a legal requirement to notify the Coroner of all reportable deaths. This ensures a proper investigation of reportable deaths, and also assists with education aimed at preventing further deaths in similar circumstances.

Each state and territory has separate legislation which defines reportable deaths. Some of these definitions are very similar between states, but there are a number of differences. We recommend that doctors make themselves familiar with the requirements in the jurisdiction in which they are practising. These legislative provisions are summarised in a table in MDA National's medico-legal booklet: *Coronial Reports and Death Certification*.[2]

Completing a death certificate and reporting a death to the Coroner are mutually exclusive exercises.

- If any of the circumstances listed in the table (referenced above) are present, a death certificate cannot be written and the death should be reported to the Coroner.
- If you are not able to form an opinion as to the probable cause of death, a death certificate should not be issued and the death should be reported to the Coroner.

Once the Coroner is notified of a reportable death, an investigation is conducted by the Coroner's office. This is likely to involve an autopsy, and doctors may be asked to provide copies of records on an urgent basis for the pathologist's assistance. Doctors may also be asked to provide a report outlining treatment provided to the patient. This request may be made some time after the patient has died, and you should ensure that their records are preserved in anticipation of such requests. We recommend that you seek assistance when drafting your report, even when it appears straightforward.

The number of investigations which proceed to a Coronial inquest is very small, less than 5% of all reportable deaths. However, where a death has occurred whilst a patient was in custody or care (for example, retained under mental health provisions or children in state care) there will be a mandatory inquest, and you should always seek assistance with such matters. Early contact with your medical defence organisation is advisable, so that you can obtain timely advice and support.

It is important to seek assistance in circumstances where you are unsure whether a death should be reported. You can contact our Medico-legal Advisory Services team for advice on **1800 011 255** or **advice@mdanational.com.au**. You can also contact the Coroner's office in the state or territory where you are working, and we can provide you with the appropriate contact numbers.

Janet Harry
Medico-legal Adviser, MDA National

1 ABC News. Hospitals Fail to Report Two More Deaths to South Australian Coroner. 1 July 2017. Available at: abc.net.au/news/2017-07-01/hospitals-fail-to-report-two-more-deaths-to-sa-coroner/8668998

2 MDA National. *Coronial Reports and Death Certification*; pp 6-7. Table 1: When Should I Report to the Coroner? Available at: mdanational.com.au/~/media/Files/MDAN-Corp/Publications/Coronial-Reports-and-Death-Certification.PDF?la=en

Medico-legal Post Box

In this edition, Dr Sara Bird answers a question about consent for surgery involving an 85-year-old patient with dementia.

Q **I am an orthopaedic registrar. An 85-year-old patient with a #NOF has been placed on my afternoon theatre list. The patient has advanced dementia. Her son, who is her substitute decision-maker, wants the patient to have the surgery and he has signed the consent form. However, the patient has an advance care directive (ACD) which states under the heading, Limited Care: No invasive procedures e.g. surgery.**

My consultant has said the surgery should go ahead because it is needed as part of providing palliative care to the patient. I'm not sure how to proceed.

Dr Sara Bird
Manager, Medico-legal and Advisory Services, MDA National

For advice or further information, call **1800 011 255** or email **advice@mdanational.com.au**.

Our Medico-legal Advisory Service operates on weekdays from 8.30am to 8.00pm (AEST), with access to emergency advice 24 hours a day.

A **An advance care directive (ACD)[1] which is applicable to the situation will take precedence over the substitute decision-maker's views.**

The common law recognises that an individual can complete an ACD that will bind a health practitioner who is treating that person, even if the directive refuses life-sustaining treatment. A 2009 NSW Supreme Court judgment[2] confirmed that if an ACD is made by a capable adult, is clear and unambiguous, and extends to the situation at hand, it must be respected.

I suggest you discuss the patient's wishes as outlined in her ACD with her son, including an outline of the management and likely course if surgery does not proceed. You might also want to inform your consultant and/or the hospital administration about the ACD and the potential disagreement about the patient's management.

Postscript

A few hours later, the registrar responded:

After talking to the team here and the patient's family, we have decided non-operative management is most appropriate.

Thank you very much for your help. It was quite an awkward and confusing position to be in – one that often comes up in ethical discussions at university and in training, but that you feel you'll never encounter.

1 MDA National. Advance Care Planning and Advance Care Directives. *Defence Update*. Available at: defenceupdate.mdanational.com.au/articles/advance-care-planning

2 MDA National. Advance Care Directives and the Law. *Defence Update*. Available at: defenceupdate.mdanational.com.au/articles/advance-care-directives

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