Future leaders Communiqué

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Victorian Institute of Forensic Medicine

65 Kavanagh Street,

Southbank, VIC, 3006, Australia

Next Edition: July 2018

GUEST EDITORIAL

Dr Danielle Forbes

Welcome to the April 2018 issue of the Future Leaders Communiqué. In this issue, we will review the coronial inquest into the death of a woman shortly after her attendance at a small rural hospital. The doctor presiding over this patient's care was a junior doctor who was operating in an under-resourced and under-supported environment. This is not an uncommon experience for junior doctors, so we have decided to explore this area further in this issue.

As junior doctors working within a hectic public health care system, it is important to be aware of our limits and operate within our current scope of safe practice. This can be difficult when we are asked to work above our capacity, or are placed in situations where we are not as supported as we should be. Extending ourselves professionally is necessary, but it is imperative that this development occurs under appropriate supervision. As in the case described in this issue, I have frequently been placed in situations where I have been 'out of my depth'. One example was during my first HMO (House Medical Officer) year, where I was told by my medical workforce unit that I would be covering the work for a gastroenterology advanced trainee while that person attended a conference. Many of us have been asked to cover our specialty registrars on leave and, as described in this case, the vast majority of us will one day face our first rural rotation with varying levels of preparedness.

The challenge of maintaining the fine balance of staffing and supervision is faced daily by our medical workforce units, mostly made up of non-medically trained staff who do not always have a full understanding of the specific skills required for each job description. It is therefore essential as junior doctors that we realise our limits and ensure we are placed in jobs that meet our level of experience. It is also essential, as we progress through our careers, that we are cognisant of providing adequate support and open lines of communication to our junior colleagues.

These lines of communication can exist in a myriad of forms, particularly in a developed and remotely interconnected world. Junior doctors are inexperienced. It is inevitable that we find ourselves in situations that we have not yet been. With this in mind, and reflecting on the case described, it is important to consider the ways in which we minimise harm to others when we are doing things we are not particularly comfortable with, and how we best ensure that we do not leave ourselves open to the psychological and medicolegal crises that can be brought upon us by not proceeding as a 'peer' would.

Firstly, recognising that in a 21st century we are never truly alone. There are always colleagues available to discuss the case at hand. In a public hospital there should always be someone who is on call for you to contact if you are at all unsure of your assessment or plan. Having a sound knowledge of guidelines available to you is helpful when going into a potentially isolating situation. And of course, never forgetting the medicolegal mantra of 'document, document, document.' Unfortunately, upon medicolegal review, the best advice in the world was not received if it was not documented in black and white.

For better or worse, dealing with uncertainty is part of our job, and as such it is important that we learn to manage unfamiliar situations safely. As described in the case and subsequent commentaries, it is essential that we are comfortable with our environment, study our resources, and always know who and when to ask for help.

EDITORIAL

Danielle Forbes is a third-year basic physician trainee at Western Health in Victoria. Her career interests include oncology, palliative care, rural and regional medicine, and medical education. She studied medicine at a rural clinical school and spent her first two years as a doctor working in a regional centre.

Danielle's edition of the Future Leader's Communiqué highlights some of the challenges that junior doctors face when there is an expectation on them to work independently, and in relative isolation. This most commonly takes place in regional settings, but it is not unusual for a junior doctor working in a major metropolitan hospital to experience the same difficulties.

A junior doctor may be surrounded by a cast of thousands, but will feel they are walking entirely alone if there is no proactive support, supervision, or training in place for them.

A regional rotation as a junior doctor can be an invaluable experience in developing resilient work practices and a wide-range of procedural skills, but it can also be a time of intense anxiety and insecurity.

Being involved in an adverse medical incident while on a regional rotation can lead to a sense of inadequacy and self-doubt, emotions that potentially haunt a junior doctor for the rest of their medical career.

Senior medical staff must never allow archaic attitudes towards junior staff to prevail in the workplace. The occasional, *"well that was how it was when I was a junior doctor, I survived it, why shouldn't they?"* is incongruous, lacking insight and compassion. Such an attitude is fraught with danger in the care of the patient. As well as arming themselves with a list of resources and a voice that is prepared to speak up when feeling 'out of one's depth' junior doctors can make a big difference by supporting each other. Junior doctor survival guides exist in many healthcare networks, and if they do not, ask why? Junior doctors are content experts of the types of non-clinical challenges they might encounter in their rotations, so they are best placed to share their expertise. Work together, write a guideline, and change the way things are done for the better.

FURTHER READING FOR EXPERT COMMENTARIES

https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/chest-pain

'Better Health Channel Victoria' is a useful website that lists information for patients relating to a range of conditions and treatments. Promoting awareness of these resources will encourage healthcare practitioners to communicate more effectively with their patients, and may prompt patients to be more likely to seek medical attention for worrying symptoms.

http://www.ruralhealth.org.au

The 'National Rural Health Alliance' website has lots of factsheets about health issues relevant to rural/regional Australians including one on the cardiovascular risk profile as well as information on the challenges of working rurally as a doctor.

https://www.heartfoundation.org.au/for-professionals/clinical-information/acute-coronary-syndromes

The National Heart Foundation guidelines on Acute Coronary Syndromes were referred to in this edition's case. The guidelines and supporting tools can be accessed via this link.

http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Post%20Graduate%20Medical%20Council/JMO-Survival-Guide-2018.pdf

The 2018 WA JMO Survival Guide, published by the Postgraduate Medical Council of Western Australia, is one example of an excellent resource that has been put together by medical peers, with the aim of educating and supporting the junior medical officer workforce. Sections include tips and traps for young players, handover, and surviving after hours.

ACKNOWLEDGEMENTS
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DISCLAIMER
All cases that are discussed in the Future Leaders Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of, the individual Coroner, the Coroners Court, Department of Health, Department of Forensic Medicine, Victorian Institute of Forensic Medicine or Monash University. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroners Court jurisdiction.

FEEDBACK
The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: flc@vifmcommuniques.org

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CASE THE HEART OF THE PROBLEM

Case Number:
COR 2610/06(0) Qld

Case Précis Author:
Danielle Forbes
BMedSci., MBBS.
Basic Physician Trainee

CLINICAL SUMMARY

Mrs M was a 47-year-old teacher who presented to a small rural hospital with her husband for investigation of chest pain she had been experiencing through the day. She was reviewed at the hospital by two nurses and a junior doctor. This review entailed a thorough history and examination, as well as an ECG. Blood tests were not performed as pathology services were not available at this rural hospital. Mrs M was discharged home with a provisional diagnosis of musculoskeletal chest pain and treated with ibuprofen. She died in her sleep later that night.

PATHOLOGY

An autopsy was conducted which found the cause of death to be cardiac arrhythmia due to severe coronary artery atherosclerosis.

There are some inconsistencies regarding the nature and sequence of events that occurred and conversations had during Mrs M's brief period in hospital.

INVESTIGATION

The case was referred to the coroner due to the sudden nature of Mrs M's death. Depositions were made by all relevant parties, including Mrs M's husband, Mrs M's friend whom she had spoken to while on her way home from the hospital, the two treating nurses and doctor from the hospital, as well as the policeman who attended the house on the night of her death. Representatives from the nearest major hospital to the rural centre were also called to give evidence, and an expert opinion was heard from an emergency medicine physician.

There are some inconsistencies regarding the nature and sequence of events that occurred and conversations had during Mrs M's brief period in hospital. The main points of contention were around the communication to Mrs M and her husband of the possibility of cardiac causes for her chest pain, and the need for this to be further investigated and excluded at a major hospital.

One point of discord in the testimonies was the suggestion that Mrs M had expressed a reluctance to attend the nearest major hospital, due to an expected waiting time of greater than seven hours. This point was refuted by Mrs M's husband, however both nurses from the rural hospital and a family friend of the deceased suggested that this view had been heard.

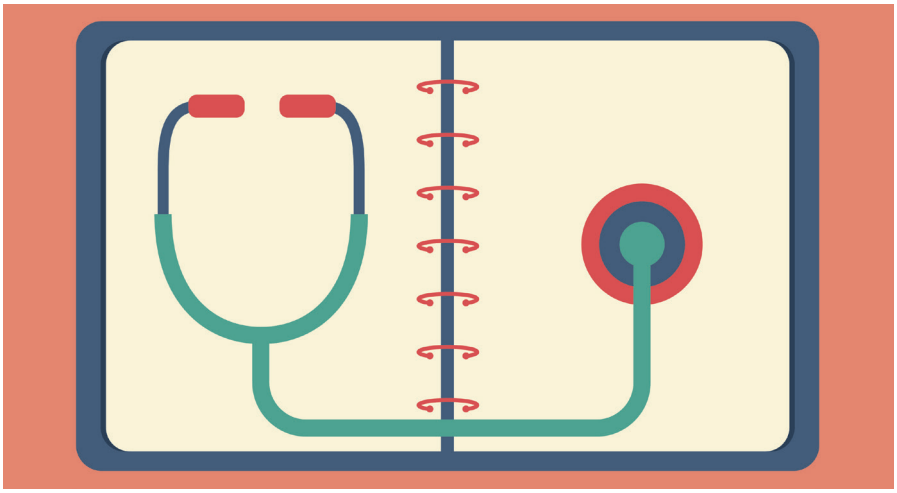
The coroner's assessment of the evidence concluded it was more likely than not the treating doctor did discuss the need for blood tests to exclude a heart condition.

Mrs M's husband claimed that at no time was the possibility of cardiac chest pain raised with him or his wife, and that it was not suggested to him that essential blood tests to rule out a cardiac problem should be performed at a larger hospital.

The doctor acknowledged that he believed the chest pain at the time to be musculoskeletal in nature, however stated that he had advised the Mrs M that he could not exclude a cardiac source of pain and had recommended that they travel to a major hospital for further tests.

The coroner's assessment of the evidence concluded it was more likely than not the treating doctor did discuss the need for blood tests to exclude a heart condition. It was noted, however, that at no time did the doctor insist upon Mrs M travelling to another hospital for further investigation. The decision to go home instead of going for further testing, although possibly influenced by the likelihood of a long wait time, was done so without the true risk of being discharged without full testing made clear to Mrs M and her husband.

Expert opinion regarding normal procedures for evaluation of chest pain in emergency departments concluded that it was an error to have sent Mrs M home. The National Heart Foundation guidelines were referred to, which characterised her presentation as being at an 'intermediate risk' of acute coronary syndrome and therefore the professional recommendation would be that exclusion of acute coronary ischaemia was necessary. This would entail a measurement of serum troponin and an ECG, both at the time of presentation and repeated some hours later. Cardiac monitoring should also occur in the intervening period. The coroner heard that although a patient always has the right to forego these investigations, they should be aware that they are going against the advice of the treating medical professionals and established guidelines.



CORONER'S FINDINGS

The coroner concluded that the treating doctor made an error in the assessment of Mrs M. Although he performed a thorough history and examination and came to the conclusion that this was likely musculoskeletal pain, he failed to follow the guidelines in place to ensure that the serious condition of myocardial infarction was not missed.

Specifically, he failed to impress upon the family the importance of having this condition excluded and the need for Mrs M to be reviewed in a larger hospital. The coroner highlighted the concerning issue of lack of supervision and experience of the junior doctor who was alone in reviewing patients at this small rural hospital. The level of responsibility required to safely fulfil the job of sole doctor in a remote hospital was not matched by the level of experience and preparedness of the doctor placed in that position.

Knowledge of systems, risk assessment, and common pitfalls are best learnt over years of practice and, unfortunately, are difficult to grasp from the theoretical curriculum of medical school.

Two options were suggested: either send doctors that were at a more senior level in the future, or provide junior doctors with specific training beforehand and have clear channels of communication available to them if they require advice or assistance.

The coroner recommended that, in future, junior doctors should only be sent on rural secondments if they are adequately prepared beforehand, and if open lines of communication to senior medical staff are always available.

AUTHOR'S COMMENTS

Surviving the deep end

"*The only source of knowledge is experience*" – Albert Einstein

Junior doctors are, by definition, inexperienced. They may be well read, well versed in current literature, and competent in clinical assessment but there is an art to medicine that can only be learnt with years of practice and shared experience.

Knowledge of systems, risk assessment, and common pitfalls are best learnt over years of practice and, unfortunately, are difficult to grasp from the theoretical curriculum of medical school.

Although it is easy to state with the benefit of hindsight that the junior doctor in the case described was inadequately supervised, achieving the appropriate degree of supervision, in practice, remains a challenge.

The junior doctor featured in this case made an error in this higher judgement. By all accounts he performed a thorough history and examination of the patient in front of him, performed the tests he had available to him (i.e. an ECG) in an attempt to exclude serious pathology, formulated a diagnosis, and enacted a plan for management of that diagnosis. He has also recognised the potentially serious cause of Mrs M's chest pain and his inability to fully exclude it in his under-resourced setting.

The error has come from his understanding of the degree to which further monitoring and tests should be insisted upon – a very difficult judgement call for a junior staff member to make. Unfortunately, resources available to him that could have guided his judgment were not utilised and the extent of his communication with the family regarding his insistence that they seek alternative medical assistance were not documented.

Although it is easy to state with the benefit of hindsight that the junior doctor in the case described was inadequately supervised, achieving the appropriate degree of supervision, in practice, remains a challenge.

A certain amount of autonomy to make decisions is crucial to developing the higher-level skills necessary for progression in medicine. While supervision appears enshrined in our long established hierarchical medical system, the practicalities of ensuring its adequacy must continue to be at the forefront of our minds.

This case describes a devastating outcome of a situation in which many junior doctors frequently find themselves – doing a job they do not yet feel qualified to do without adequate supervision.

When reviewed from the junior doctor's perspective, and assuming, somewhat bleakly, that this organisation of work will continue in the health system as it currently stands, this case teaches us to always recognise when we are out of our depth and to take extra care in ensuring our decisions are discussed with people more senior than ourselves. When reviewed from the perspective of senior clinicians and hospital administration, this case encourages enforcement of adequate and non-confrontational supervision as well as provision of education and preparatory skills for doctors being sent on such secondments.

KEYWORDS

Junior doctor, rural, chest pain, supervision, guidelines

PREPAREDNESS - THE ROLE OF INSTITUTION, SUPERVISOR AND INDIVIDUAL

Dr Sean Fabri MBBS
Supervisor of Intern Training
(Western Health)

The tragic outcome of Mrs M's case prompts a natural emotional response: sadness for her and her family; soul-searching (*what did we do wrong/ what could we have done better?*), and determination to improve the care given to future patients in the same situation.

I'm going to discuss the responsibility for improvement at a personal junior doctor level (preparedness), at the level of the rural hospital (supervision), and at the level of the hospital which sends junior doctors to staff the rural emergency department (rostering).

Preparedness

Chest pain is regarded as one of the top three presentations to adult emergency departments, comprising about 4% of patients triaged (for your interest, the other two are abdominal pain and shortness of breath). While I offer no criticism of anyone involved in Mrs M's care – I don't know all the facts and extenuating circumstances, I wasn't there – it serves as a reminder that all medical and nursing staff should be aware of the protocols which will guide their decision making on a daily basis.

Supervision

Junior doctors can't be expected to absorb the plethora of available protocols (let alone confidently apply them in the messy real world) without some guidance from senior doctors. Our judgment isn't perfect from day one. It develops.

Medicine has been guilty of having a culture of throwing junior doctors into the deep end - letting them solve their own problems toughens them up, right?

Actually. No.

While this *'sink or swim'* approach has been debunked, it is sometimes still used as a tacit justification for minimal supervision in departments that are understaffed. This can happen in a rural, regional and metropolitan setting.

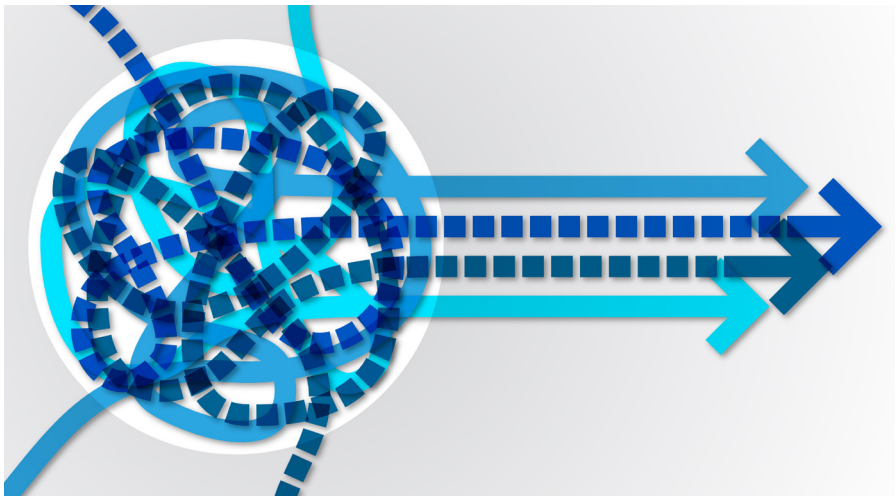
Can individual departments, or for that matter, individual practitioners, have an impact on this type of pervasive culture? *Absolutely*. The more people who adopt a new approach, the less reasonable the old method comes to seem, and eventually a tipping point is reached which sets the new standard.

It is an absolute obligation that junior doctors are able to communicate with senior practitioners at all times, *and that this communication be free of emotional baggage*.

Rostering

One of the suggestions from the coronial inquest into Mrs M's death was to ensure that any junior doctor sent on rural rotation needed to have undertaken the 'Continuing Rural Skills Enhancement Course'.

Is restricting the pool of suitable doctors a big problem? Surely, with hundreds of junior doctors, the medical workforce unit is spoilt for choice when rostering someone to a rural rotation, and as the employer, can roster staff and mandate training without having to engage in complex negotiations. In reality, rostering is a painstaking task.



Junior doctors working in a metropolitan hospital are often markedly reluctant to do a stint at another site especially if they perceive it to be remote. They see this as venturing into an unknown environment away from their usual supports.

Despite the fact that reports from returning junior doctors are quite positive, there is little incentive to complete a module of training which makes one a more attractive candidate for being *'sent to the country'*. Mandating such a course implies rostering attendance, checking compliance and maintaining currency of credentialing among the pool of junior doctors. It's not an easy task, but it is made easier when the course is supported by authorities.

A typical scenario facing a metropolitan hospital's medical workforce unit is as follows:

- 'George' is being performance managed
- 'Petra' has needed support for mental health issues
- 'Ruby' is the sole carer for her mother who has just had a stroke
- 'Cliff' has a crucial exam coming up
- 'Magda' would be perfect but has just returned from a six-month rural rotation
- 'Terry' has already mentioned having serious thoughts about resigning early, and if his last rotation is an unpopular one, you are 99% certain he will.

There is often no real consequence for junior doctors who resign partway through the year, so saying "just do it" is not effective.

The system relies on that pool of junior doctors who take responsibility for doing difficult or unpleasant tasks, who appreciate the needs of the rural community, who are compassionate towards each other, who seek supervision and stand up for themselves when it is inadequate, who prepare themselves for upcoming challenges and obtain necessary training, and who, thankfully, make up the vast majority of our junior professional colleagues.

JUNIOR DOCTORS IN A RURAL HEALTH SYSTEM

Mr Ian Campbell MB BS FRACS
Director of Surgery
and
Prof Alan Wolff MD FRACGP FRACMA
Director of Medical Services

Wimmera Health Care Group, Horsham, Victoria

Making the correct diagnosis is not always easy. Quite different clinical conditions can present with similar symptoms. Unfortunately, doctors are subject to the same subconscious cognitive biases when making decisions as everyone else. For example, doctors often make a decision about the diagnosis very early on in a consultation, and then subconsciously give greater weight to further data that becomes available that supports their diagnosis, and downplay or ignore further data that disputes the diagnosis.

It is important for junior doctors to realise that all doctors make diagnostic errors. Hopefully, they make less diagnostic errors as they become more experienced as they have had time to make mistakes themselves or see others make mistakes and learn from these experiences. However, making clinical errors can still have a significant effect on doctors at any time in their careers, and they can become the so called "second victim" after the patient, when things go wrong. Importantly, making an error can also inappropriately influence how a doctor will manage patients with similar presentations in the future by, for example, over investigating low risk patients to avoid again missing the diagnosis.

There are a number of specific lessons to be learned from this case:

Ischaemic chest pain can present in many ways and at any age. Therefore, in any patient with undiagnosed chest pain, a myocardial cause needs to be excluded. There are many protocols for this but basically it requires serial ECGs and serial troponin levels. There may be a temptation to say that 'the emergency department is too busy', 'the patient is too young', 'I am sure this is "reflux"', or 'the patient was doing heavy lifting yesterday'. However, it is important to keep in mind that ischaemic heart disease is common and can be fatal.

Some people try to "beat the system". In the case in question the patient and her husband went to a small rural hospital rather than the base hospital. This was to save an alleged seven hour wait in the emergency department. In reality, this patient would have been triaged as ischaemic chest pain and seen promptly. It is possible, but never absolutely certain, that if the patient had gone to the major hospital first that a better outcome may have been achieved.

When an untoward event occurs, and becomes the subject of a court hearing, several expert witnesses will often be called upon to give their opinion. Often, none of these witnesses will ever have worked in small hospitals on their own and many would never have worked outside a major teaching hospital where highly skilled staff, and 24/7 blood tests, angiography and isotope studies are readily available. It can be difficult for such experts to fully appreciate the difficulties clinical staff face in small and isolated hospitals.

Whatever training a junior doctor has, eventually they will be placed in a position where they have to stand alone and make decisions. As mentioned in the accompanying comments, help should be always available somewhere in the world. The one thing we remember from our intern orientation, was the deputy director of medical services putting up a slide of an analogue telephone. His point was that, 'this is a telephone, ring anyone anywhere in the world for assistance as it will be cheaper for the hospital and probably better for the patient if you ask for help when you need it.' Communication modalities have progressed significantly since then, but the fundamental advice is sound and if you don't know what is happening or are out of your depth, ring someone somewhere in the world for help. Don't feel embarrassed to ask for help, we have all done it throughout our careers, not just as junior doctors, and we continue to do so. In addition, hospital administrations have an obligation to ensure that appropriately experienced staff are always on call and available to provide immediate advice to junior doctors and to attend promptly if required.

Although hospitals have limited resources, in 2018, those hospitals who provide patient or emergency department services, and do not have an onsite pathology laboratory, should have an i-STAT blood analyser available to perform simple pathology tests such as electrolytes, blood gases, and haemoglobin and troponin levels.

Our final message is that as a doctor you should do your absolute best to act in the patient's best interests and advise them of your own recommendations in the given circumstances. Your recommendations are much more important than conforming to strict timelines determined by health authorities. Even in young people, if you are concerned, you should urge them to have the full investigations for the relevant condition performed, even if you think the likelihood of finding serious pathology is low.

COMMENTS FROM OUR PEERS

"As junior doctors, we are asked to have many difficult conversations with patients on a daily basis. Conversations surrounding risk and acting against medical advice can be tough to get right. Whenever I get the chance I like to observe senior staff have these conversations. I have learned a lot from seeing what works and what doesn't, and trying it out my own way when I can."

"Taking care of ourselves and each other when on isolated placements is so important. I have done many rural placements away from my family and friends, and it's easy to become burnt out. Be kind to everyone you meet, we all work within the same straining health system."

"When placed in such a situation and things do not 'feel right', I always try to revert to the 'mum' rule: if this patient was my mum, what would I want for them? This gives me the confidence to escalate the situation, and seek help from my seniors."