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New Zealand
Medical Indemnity
Insurance
Inihua Rata O Aotearoa

From Paper to Practice

A guide for resident doctors in training

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Now, you're an RMO. For many doctors, this is one of the hardest parts of their career...

Welcome

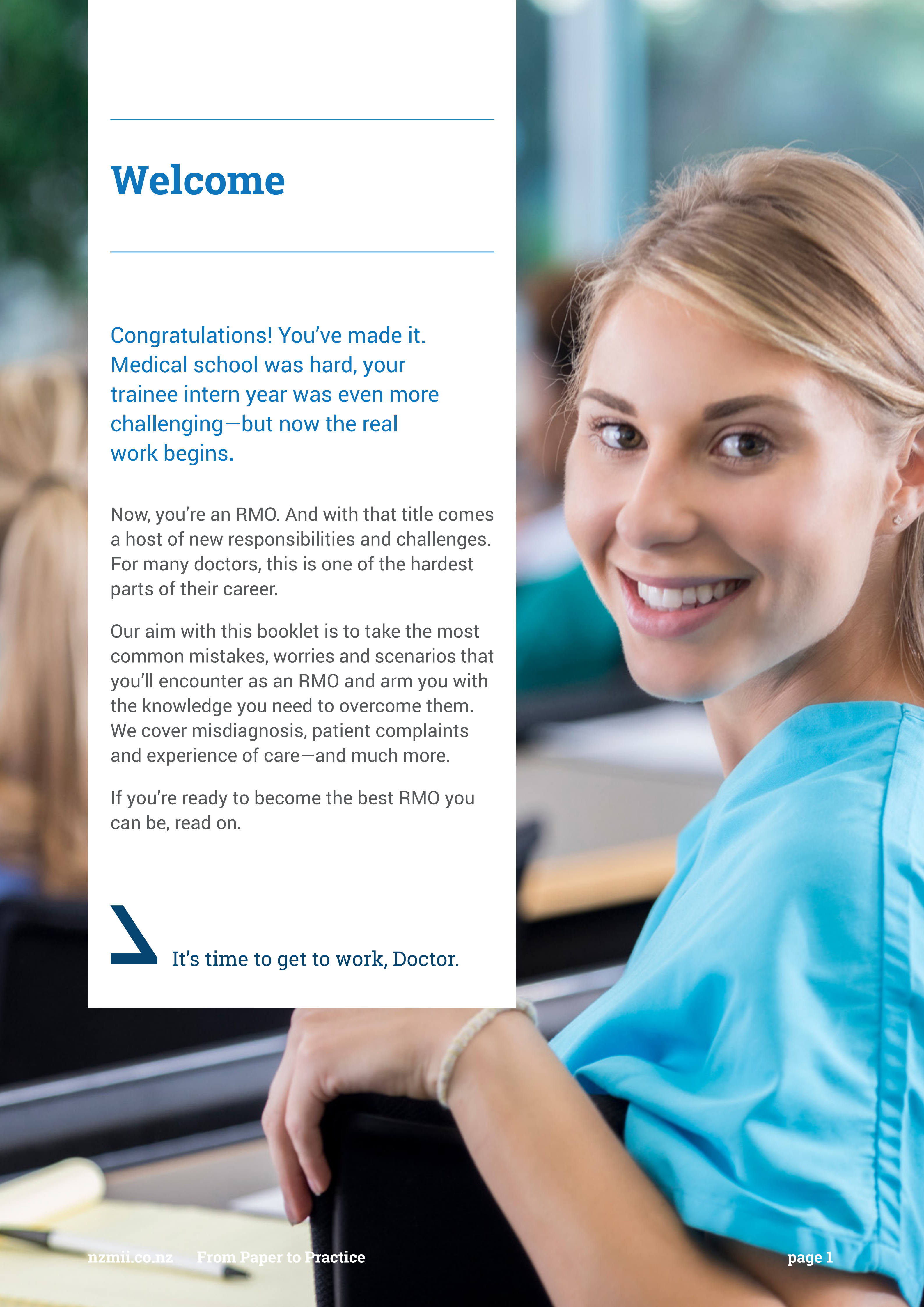
Congratulations! You've made it. Medical school was hard, your trainee intern year was even more challenging—but now the real work begins.

Now, you're an RMO. And with that title comes a host of new responsibilities and challenges. For many doctors, this is one of the hardest parts of their career.

Our aim with this booklet is to take the most common mistakes, worries and scenarios that you'll encounter as an RMO and arm you with the knowledge you need to overcome them. We cover misdiagnosis, patient complaints and experience of care—and much more.

If you're ready to become the best RMO you can be, read on.

It's time to get to work, Doctor.



Avoiding common mistakes

Every doctor makes mistakes: can we talk about that?

From students to registrars, even the most experienced medical professional can have an off day. That's the truth, but it isn't an excuse—especially when there are guides like this to help you get wise to the dangers of mistakes in your first year as a resident doctor.

Here are the most common problems you need to stay vigilant against:

1) Not learning

You've worked hard to reach this point. From high school to medical school to your first placement, becoming a resident doctor is nothing but hard graft. Along the way, you'll have learned a thing or two, and it can be easy to think that you've got the answers. But, as you've learned, what's "easy" isn't always "correct".

The reality is that you'll make mistakes in your first year as a resident doctor. About 13 per cent of all admissions to public hospitals are associated with an adverse event i.e. a medical error, and at least some of those will be the result of your actions.

But this isn't a time to feel afraid. This is the time to be vigilant, and willing to learn from your mistakes. Work with your colleagues and seniors to spot these mistakes before they happen, and rectify them when they inevitably occur anyway. Show up, own up, fix it: simple.

2) Uninformed consent

Getting consent from your patients is a lot more complicated than a simple “yes” or a signature on a form. There will be times when the procedure is complex for the layman, and your patient **must** understand it in order to provide informed consent.

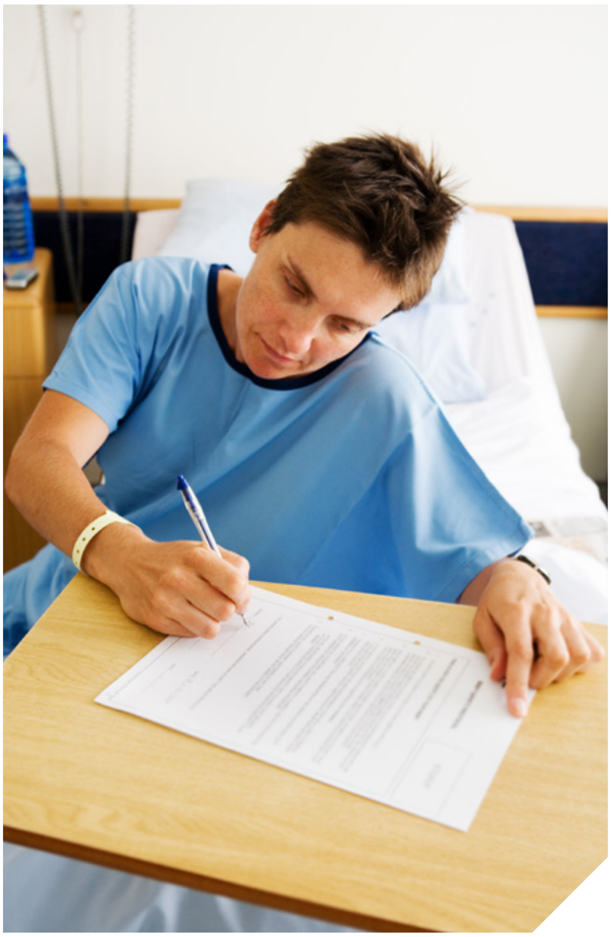
These are the challenges that every doctor faces, from fresh graduates right through to specialists. It is one thing to perform a procedure or provide a curative programme, but quite another to explain how and why it works, and what any potential negative outcomes might be, in a way that someone not trained in medicine can understand.

Failing to get **informed** consent can result in a whole host of issues, not least of which is a patient that suffers unduly from unexpected side effects of your care. Here’s a rule of thumb to follow: if a procedure, pill or programme can harm a patient in some way, **make sure they know the potential negative outcomes and how to recognise them**. Take the time to explain in full what your chosen treatment will entail, and ask your seniors if you’ve covered everything. Don’t dip into medical jargon, and **repeat** as many times as necessary to get it across.

3) Failure to work as a team

Doctors are not the only healthcare professionals at work in the hospital. Nurses, allied health practitioners and a host of other healthcare workers operate as a team to provide care to the patients that come through the hospital doors. New doctors often make the mistake of misunderstanding or underestimating the capabilities of other members of the healthcare team.

Take nurses, for example. All of those medications and treatments you’ve been prescribing will often be administered by a nurse. If a nurse with decades of experience came to you and queried a prescription you made, it would be wise to listen.



The same goes for the other healthcare staff in your hospital. You can’t be with every patient at all times, so even an orderly who mentions a patient is in discomfort should be listened to if you want to provide the highest level of care. You’re in a team; take advantage of the support this provides!

4) Poor record-keeping

Good record-keeping can be the difference between a healthy patient with the right treatment and a once-healthy patient that is suffering from an unknown malady.

Any retrospective correction to the patient record must be **clearly shown** as an alteration, complete with the date the amendment was made, and your name.

Without each and every one of these requisites filled, treatment could be misinterpreted and applied incorrectly—especially if there is the need for more than one correction. Don't doubt the importance of record-keeping: if an adverse event does occur, good records can prove your actions were the right ones, for the right reasons.

5) Unclear prescribing

On the topic of record-keeping, you should also remain vigilant against prescription errors. An extra 0 at the end of a dosage can seriously hurt your patient, as can providing something the patient is allergic to. In fact, these kinds of mistakes are so prolific they can be the cause of up to 70 per cent of medication errors.

Usually, prescription errors aren't the result of ignorance or incompetence on the part of the prescriber, but rather simple communication errors: doctors' handwriting has a notorious reputation for illegibility, after all, while the use of abbreviations for certain medications can make it even more unclear.

6) Breaching confidentiality

You'll have had patient confidentiality drilled into your head since day one, and here we are about to do it again. But as many times as you may have been told, it's still very easy to breach confidentiality and get yourself in serious trouble.

A reminder of what's included in patient confidentiality: names, descriptions, photos, demographics, treatments, place of treatments, personality, quirks, and so on. Anything that could be used to describe the patient should be confidential.

You should be wary of breaching confidentiality even while still in the hospital. Lifts, canteens, printed documents, open wards, A&E departments—they're all spaces where people talk about their patients or to their patients. The same can be said for social media outside of work. Even if you are talking **to your colleagues**, always be aware that people can overhear. If in doubt, don't shout it out.

Summary

Learning, consent, teamwork, record-keeping, prescriptions and confidentiality: if you can master these six common areas for doctor mistakes, you'll have eliminated one of the major pain points for malpractice in New Zealand. ›

Dodging misdiagnosis

There are two kinds of medical malpractice that are rooted in misdiagnosis: wrong diagnosis, and missed diagnosis.

The first can be described as identifying a problem, but choosing the wrong diagnosis for the symptoms, while the latter is failing to identify a problem at all.

Both can be equally dangerous, but for different reasons.

How it happens

There are many reasons why misdiagnosis occurs, but we've found that there are three common themes:

THEME 1: **Making assumptions based on symptoms**

In a busy hospital, especially when acute admitting, it can be very easy to simply take the first diagnosis that appears to fit. A touch of Occam's Razor: the simplest explanation is usually the most correct one. Unfortunately, this isn't always the case.

Take meningitis, for example. The early symptoms of this illness can seem very similar to other viral illnesses, such as the flu. In busy environments with less experienced doctors, this has led to cases where people have been wrongly diagnosed, and have suffered severely as a result.

There can also be scenarios where the patient is suffering from multiple problems with overlapping symptoms, and the doctor only diagnoses one

of them. Fibromyalgia and irritable bowel syndrome, for example, have a significant number of overlapping symptoms. A doctor whose diagnosis ends at the IBS part may fail to deal with the fibromyalgia part. This can lead to a missed diagnosis.

THEME 2: **Not listening to the patient**

Regular check-ups and check-ins are integral to continual patient health no matter their illness; it's just the frequency of the visits that change. Unfortunately, here in New Zealand we have a culture of just "sucking it up", and people often fail to go to the doctor even when their symptoms change or don't get better. In lieu of an overarching cultural shift, it's up to you as a doctor to ensure your patients have the motivation and knowledge to check back with you.

That means listening **completely** to the patient, and not making the common mistake of interrupting or stopping a patient after they have ticked all the boxes for what you assume they're suffering from. Let them tell their story and record all symptoms they consider noteworthy (and prompt them if they seem reticent. Even if you diagnose them with something common, if they return and their symptoms have gotten worse, those notes you took in the beginning could be key to uncovering a less obvious problem. Failing to do so could result in the wrong diagnosis.

The same is true for a missed diagnosis. If a patient comes to you with issues that don't seem to adhere to anything particularly dangerous, you still need to chase them up after a few days to check if their symptoms have worsened. Better yet, tell them **when you interview them** exactly what red flags to look out for that would prompt them to let you know or return to the hospital. Be specific, e.g. a change in mucus colour, blood in stool, etc. The more specific you are, the more likely they are to let you know and you can avoid a **missed diagnosis** from your first consultation.

THEME 3: **Not considering all alternative diagnoses**

It's never lupus: except when it is. Doctors need to consider all alternative diagnoses when consulting with their patients, or be at risk of a wrong or a missed diagnosis. The key to this is ordering the right tests to confirm or deny a particular problem. Bloods are a good start, but anything unusual in their results should prompt you to check further, even if the diagnosis that could result is rare.

Take creatinine levels, for example. If you detected this problem with your patient and failed to then pursue with a urine test, you could end up with a malpractice complaint and, worse still, a patient who has poor kidney function and didn't know until it was too late.

Summary

If you want to avoid misdiagnosis, you need to avoid assumptions about symptoms, listen to your patient from start to finish, and always follow up with tests or another check-up to ensure that the problem has gone or is on the way out.

Follow these rules, and your chances of misdiagnosis are that much lower. ›

Protecting patient confidentiality

Social media is now a core part of many people's lives: doctors included. It helps us organise and fraternise, meet up and catch up—but when medicine and social media mix, it can sometimes end in disaster for those who share their medical work online and breach patient confidentiality.

To help you figure out where the line is, and how to navigate patient confidentiality in the social sphere, we've put together this short guide. Time to get social.

Sharing details on social media

Social media can be considered as a public forum. You post something on Facebook, you tweet something on Twitter, you update your profile on LinkedIn: you have to assume that anyone and everyone will be able to see what you are doing.

There are settings you can adjust to reduce the sphere of people who can see it, but the reality is that privacy cannot be assumed no matter what kind of settings you have switched on. If it goes on social media, you should be comfortable with sharing it with the world.

Even after the images have been doctored and names have been removed, people can still identify themselves, their friends or their loved ones as subjects of a medical social media post simply by timing, geography or treatment/injury detail. You may have seen a colleague or a doctor from another practice or hospital share something on Facebook with a little bit more detail than they should have included. There are numerous examples of this in the news, with doctors being admonished for their failure to adhere to patient confidentiality.

Public posts are one thing, but surely the "private messenger" apps out there are different? Not really. Private chats are something of a misnomer, as they aren't necessarily all that private. Whether you are discussing medical detail with colleagues or with patients themselves, there is always the chance that you could have your account hacked and details exposed, or even something as simple as leaving yourself logged on a device and somebody stumbling upon it.

The bottom line is that, for all intents and purposes, social media should be considered a public space for doctors.

Taking and sharing images

Photographs can be exceptionally useful for diagnosis, treatment or review of a patient's condition, but they can also be traps for doctors who don't take care with consent. If you are intending to take a photograph of a patient, they must be able to give informed consent to the process, and you should take care to tell them exactly where this image will be used. This includes social media; some doctors ask for advice about their patients using social media channels, and may include a photo. Alternatively, you may wish to share this image as an educational tool in a Facebook group, for example.

However you use it, your patient must have the ability to both **know** and **understand** how the image will be used. This is particularly important for patients with mental disabilities, or those who may not engage with social media themselves and thus not have total understanding of what it means to have a photo "posted" online.

Even if the image doesn't include the patient themselves, you can still breach patient confidentiality with a photo. For example, there was a case when a group of young nurses took a photo with the placenta of a woman they had helped through childbirth. This was then shared on social media. Despite there being no identifying information about the patient, nor did their image appear anywhere, it was still considered a breach of confidentiality (not to mention inappropriate and the nurses were severely admonished.

This is why de-identification measures, such as blurring out faces and nametags, as well as ensuring you do not include any photographic evidence of where the patient was being treated, is so important. A lot of information can be gleaned from an otherwise minor detail in a photo.

When taking photos and intending to share them on social media, you must:

- Get **explicit consent** from the patient, and ensure they **understand** what is meant by "sharing", "social media", and so on.
- Let the patient know:
  - You are taking a photo,
  - What the photo will be used for (educational, clinical, etc),
  - Where the photo will appear (in their notes, on social media, etc), and,
  - How the image will be doctored to remove identifying information.
- Remove all identifying information, including identifiable marks, tattoos, faces, nametags, location and so on.
- Ensure that the image will only be used for clinical or educational purposes. Memes of patients are hardly appropriate.
- State explicitly in the post that you have patient permission to share this, and that this is confidential information and should be treated as such by other doctors.

Deleted information may not be truly deleted

Have you heard of the Right to be Forgotten? In the context of the internet, it boils down to the ability to make a mistake, and then eventually have that mistake be forgotten to the public at large and be able to “determine the development of their life in an autonomous way”.

In other words, it’s representative of how most human societies function: information is eventually forgotten.

Not so on the internet, which can act as an archive of the Greatest Hits of all of humanity’s biggest mistakes. That awkward haircut you had when you were 13? That’s on social media now, so there’s little chance it will ever truly be forgotten.

The same can be said of any patient information you put online. Anyone with access to your profile can simply scroll through your timeline or feed and eventually find that. That can cause serious trouble if the patient decides to rescind permission to share details later down the line.

But let’s say that does happen, and you delete the offending information. Job done, right? Not quite. By using internet tools like The Wayback Machine or even basic Google caching, it is sometimes possible to find old, deleted information—including patient details.

Anything you put online, even after being deleted, may be discovered again. This is why avoiding the common mistakes of social media and patient confidentiality is so important. If you make a mistake, it can be very, very difficult to fix it completely.

When sharing **anything** on social media, always remember that it may be more difficult to fix any mistakes than first thought.

Summary

Sharing patient information on social media can be a minefield. In most cases, our advice is not to do it, but if you absolutely must, ensure you get **extremely explicit and informed consent** from the patient, and **ensure you delete any and all identifying information**. Even then, if you have to delete the post, you may discover it can still be found by savvy internet users.

Always be cautious when mixing social media and medicine! ›

Perfecting patient experience of care

A happy patient means a happy doctor, but the high levels of stress and the enormous workload of working in a hospital can make it easy to forget that.

To help you put the patient at the centre of your practice, here are a few reminders of what patients want—and some new tips and tricks to provide it.

To be noticed

Patients don't want to be defined by their problem, nor as their position as a patient. The importance of patient experience in healthcare is centred around registering that these patients are people, not numbers, and not a disease to be cured as quickly as possible.

What happens when this goes wrong?

If you fail to take proper notice of your patient and simply "sweep them along", you can end up with problems regarding uninformed consent. When a patient isn't kept up-to-date with changes to their diagnosis and/or treatments, you can end up with a situation where they don't know what it is they are being treated for, what they are being treated with, and what the negative outcomes of this treatment might be. They might give consent, but it's not informed consent.

> Patients don't want to be defined by their problem, nor as their position as a patient.

DO

- Call your patient by name
- Keep the patient informed about changes in diagnoses and/or treatments
- Explain treatments and diagnoses in an understandable way
- Make them comfortable physically, especially those with accessibility issues
- Ensure the patient feels like they are a part of the process, not just a problem.

DON'T

- Refer to patients by appointment time
- Rush through the appointment
- Make any assumptions about consent.

To be heard

Being sick or in pain can be an anxiety-inducing ordeal for many patients, especially if it has reached the point where they are having to visit the hospital. You can alleviate this anxiety by making sure the patient is heard; that they know you, as their doctor, are taking their experiences into account as well as your own.

What happens when this goes wrong?

Failing to listen to patients fully and making assumptions about their symptoms/diagnosis can easily lead to misdiagnosis, either by diagnosing incorrectly or missing a problem altogether. Patient experience is one of the primary avenues of information for a doctor. You must make sure you take advantage of it.

DO

- Listen actively
- Acknowledge concerns
- Respect preferences
- Ask about their experiences and symptoms and allow them to explain in full
- Ask "what questions do you have?" instead of "do you have any questions?"
- Ensure the patient feels that their concerns are being heard, not just ignored.

DON'T

- Interrupt
- Stare at your screen while the patient is talking
- Make assumptions about diagnoses based only on your own observations.

To feel safe

Most people don't often go to hospital unless it's an emergency, and those who do can be suffering from serious and/or chronic illnesses. Your patients want to feel confident in your abilities as well as you as a person, and want to know that you take their preferences and fears into account.

What happens when this goes wrong?

If you fail to remain empathetic and sensitive to the experience of the patient, it can be easy to fall into a breach of care. An aggressive word, a snippy remark, even a poorly timed facial expression or a failure to follow up with the patient in time can all result in a complaint.

DO

- Ask if it is okay to proceed with a test or treatment e.g. "Is it okay for me to take your blood pressure?"
- Ask non-medical questions about their work, hobbies, likes and dislikes, etc
- Explain any changes to procedures e.g. prescription processes
- Sit down with your patient rather than stand over them
- Ensure the patient feels comfortable before, during and after your care, not anxious.

DON'T

- "Let them loose" at the end of the session. Follow up with them and secondary/tertiary healthcare providers
- Give in to exasperation; this might be obvious to you, but it isn't for your patient
- Put yourself in a position where your empathy is low e.g. high levels of stress. Patient-centred care begins with you.

Coping with patient complaints

Receiving an official complaint about your conduct or competence as a healthcare professional can be an alarming experience—but preparedness is half the battle.

Here's what you should expect if you are on the receiving end of a patient complaint, and how to deal with it quickly and professionally:

1. **The complaint is made**
2. **Investigating the complaint**
3. **Responding to the complaint**
4. **HDC investigation**
5. **Provisional opinion**
6. **Final report**

STEP 1: The complaint is made

Complaints can be sent to a number of different bodies: The Medical Council, The Health and Disability Commissioner (HDC), coroners, or even an employer to name a few. The vast majority of the time, complaints will be sent to the HDC, so we will focus on this process here.

You can receive a complaint either in writing or verbally. If it is the latter, you should receive a transcript of the complaint. If it is the former, you will receive a copy of the email or letter.

Complaints can be made either by the patient themselves, or a representative i.e. a guardian, parent, spouse, etc.

The **most important thing** to do as early as possible is to contact your insurer. Ideally, you would actually get in touch with your insurer **before** the official complaint comes in—if you have had an experience that you think may result in a complaint, we encourage you to get in touch with us straight away. Even at these early stages, medicolegal support can be extremely helpful.

Once you have received your copy of the complaint, remember to stay calm. It's never a pleasant experience having a complaint laid against you, but the next few stages are made far easier with a cool head and a careful process.

STEP 2: Investigating the complaint

Once you understand the nature of the complaint, you will need to formulate a response to your patient. It is **imperative** that this response is carefully constructed, and that requires information.

As such, you should gather all pertinent data for this complaint, including patient records. What you want to do here is to **refresh your memory of the incident** if necessary and **check to see if the complaint is valid**. Did you make a mistake? How? When? Where? Why? Why not?

STEP 3: Responding to the complaint

Your response to the complaint can decide whether or not the HDC officially investigates you themselves. They are relying on you to provide the baseline context of your side of the exchange, and as such you should write a response that is equal parts sympathetic and authoritative—and remember that this response will be read by more than just the complainant themselves. Send this to your medicolegal advisors **before** you send it anywhere else. They will help you to construct a reasonable response that truly puts your perspective forward.

Begin by directly addressing the issue that has been identified, and explain in detail what happened and why, and, perhaps most importantly, if necessary, what steps are being taken to ensure that it does not happen again. If you find yourself or your facility to be at fault, this is the stage at which you might apologise. Answer any questions in the complaint itself, ensure you have a clear chronological account of what happened, and remember to get advice from your medical indemnity provider on the content of your response.

STEP 4: HDC investigation

If the HDC does decide to investigate further, they will ask you and potentially your organisation for additional information such as clinical notes, internal reports, policies and procedures, hospital records, eye-witness accounts, and so on.

After this fact-gathering, the HDC may seek advice from an expert in the field on what went wrong, and what should have been done instead.

If the HDC does not decide to investigate further, they will notify you of their decision at this stage.

STEP 5: Provisional opinion

Once the HDC has performed its investigation, it will provide you with a provisional opinion, which is the initial decision that it will make about whether there has or has not been a breach of the Code of Rights.

You will be sent a letter that outlines this decision, and the reasons behind it.

If you receive an unfavourable outcome, you get the opportunity to respond and correct any factual errors. The medicolegal advice offered by your insurance provider is imperative throughout this process also.

Make sure you speak to your medicolegal advisors if you receive an unfavourable provisional opinion.

STEP 6: Final report

The decision from the HDC cannot be argued once it has been made in the final report. This report will lay out in detail as to whether there has been a breach of the Code of Rights, to what extent, why, where and how, and usually the next steps and recommendations as a result of this decision.

This may include further education for you and/or your team, changes in processes, adjustments to training, change illegible/rejected and in extreme cases, fines or censure.

Once this has been finalised, this is the last stage of this complaint process. But remember, if at any point you are confused about what you need to do next, get in touch with your medicolegal advisors and clarify. Your advisors will be talking to you at every stage regardless, but don't be afraid to speak up yourself. The complaints process can be long and arduous; make sure you know what you need to do to hurry it along and get a better outcome.