

specialists bulletin



St Vincents & Mercy Private

A newsletter for our Specialists and General Practitioners

SPRING 2009

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Director's Office

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Workplace

National Registration

Recently, exposure draft of "Bill B" of the *National Registration and Accreditation Scheme for Health Professions* was published by the Australian Health Ministers' Advisory Council. There is a 5 week consultation period after which Ministers will consider feedback and submissions for draft *Bill C*.

There are a few new elements in the exposure draft. First of all, registration will be national, and divided into 6 classes, General, Specialists, Provisional, Limited (which further subdivides to postgraduate training or supervised practice, area of need, public interest, teaching or research), non-practising, and student. If you are registered on 30 June 2010 with the existing boards, you will automatically be registered on 1 July. The Boards will advise you of your category and type of registration well ahead of 1 July. National boards will also register students from 2011, and each board will decide the point in the program from which students must be registered according to the level of risk for the public.

State and Territory boards of each profession will be committees of the National boards, and members of State and Territory boards will be appointed by the Minister in the State or Territory. The national office will be in Melbourne, and each State and Territory will have an agency office which handles registrations, complaints and tribunals. There will also be simplified complaints arrangements, with a single point of contact for members of the public. Complaints will then be passed to the relevant national board which will assess the complaint with an independent Public Interest Assessor.

Mandatory reporting will also be introduced, whereby practitioners must report a registrant who they believe has engaged in a reportable conduct, defined as:

- i) practising while intoxicated by drugs or alcohol,
- ii) engaging in sexual misconduct in professional practice, and
- iii) placing the public at risk of substantial harm through either a physical or mental impairment affecting practice, or a departure from accepted professional standards.

From 1 July 2010, boards will need to complete criminal and identity history checks for all health practitioners registering for the first time, and all other registrants will have to make an annual



declaration on criminal history matters when renewing registration. The boards will also have power to conduct ad hoc criminal history and identity checks.

Accreditation and registration will be national thereby removing the need for practitioners to obtain separate registration in each State. Accreditation authorities will submit standards and accredited programs of study for national board approval. They function independent of the government, but Ministerial Council reserve power on accreditation standards. Existing standards and approved programs will transition as is to the new scheme on 1 July 2010. Additional professions will be covered from 1 July 2012, including Aboriginal and Torres Strait Islander clinical health workers, Chinese medicine practitioners, and medical radiation practitioners. There will be specific information sharing and privacy protection for both members of the public and registrants, with tailored privacy, and freedom of information provisions based on Commonwealth law. This information can be shared with a number of government agencies, and also international regulatory authorities.

An important point to take note of is that Continuing Professional Development will be a condition of practice for all registrants other than non-practising and students. SVMPH will endeavour to help all our visiting medical specialists satisfy this condition by implementing audits, peer review and tutorials in the near future.

Alastair Mah

Medical Administration Registrar

Medications and the Hospital: Non-admission related drugs

The vast majority of hospital stays are paid by the Health Funds on a case payment basis. That essentially means that one payment amount covers everything that happens in an admission including complications such as infections requiring expensive antibiotics. The Hospital covers these admission-related expenses as part of its agreement with the Funds. However, the Hospital does not cover as part of the admission cost medications that are not related to the admission and this is the reason that we request patients bring in their own medications. These need to be in the original packaging so that the pharmacists can verify the authenticity of the medication. The various tablet dispensing packs, whilst convenient for patients, are unfortunately not sufficient as there are no standards governing their dispensing and they are not tamper proof. Patients may be charged for the prescription of these drugs which regularly causes some unhappiness. It is worth reminding your patients to bring their medications with them to avoid this situation.



Message from the CEO Hands Off Private Health

Since the election of the Rudd Government in 2007, private health insurance has been under attack. Firstly, changes to the Medicare Levy Surcharge and the proposed means testing of the 30% rebate. Not satisfied with that, the Government commissioned the Productivity Commission to conduct a research study into public and private hospitals. The purpose of the study is to review the performance of public and private hospitals, with particular regards to the cost of performing clinically similar procedures and the rate of hospital acquired infections.

The pundits were hoping that the Productivity Commission would find that public hospitals were more efficient than private hospitals and delivered superior quality of care. This would give them credible ammunition to launch another attack on the 30% rebate.

Supporters of private health insurance and the 30% rebate were not surprised to find that in its draft report, the Productivity Commission concluded that on a casemix adjusted basis, private hospitals were more efficient than public hospitals. In Victoria, the difference was \$124 per casemix adjusted separation in favour of private hospitals.

The Productivity Commission reported that the measurement and comparison of infection rates is not straightforward. From data collected by state governments, the Commission stated that private hospitals have lower infection rates than

public hospitals but that this could be misleading as private hospitals generally treat patients with lower infection risks.

Whilst private health insurance and private hospitals are weathering the impact of all this change and scrutiny, the Rudd Government has also commissioned another study. The National Health and Hospitals Reform Commission has produced a final report, *A Healthier Future For All Australians*. The Government is currently conducting forums around Australia to air the findings of this report and to refine what will be its proposed action plan for health care reform. The intention of this reform is to improve the efficiency, effectiveness and quality of the Australian health care system. These reforms could herald the biggest changes since the introduction of Medicare by the Hawke Government in 1983.

Relying on the age old adage, "it's not broken then don't fix it," it is time for politicians and regulators to fully appreciate the vital role that private health insurance plays in Australia's health care system. Private hospitals account for 60% of all surgical cases and nearly 70% of other procedures and are doing so very efficiently and effectively with high quality outcomes.

The focus of governments should be on achieving the same standards in public hospitals, and community and aged care settings. ■

Martin Day
Chief Executive Officer

■ Workplace

WHO Surgical Safety Checklist

Recently the World Health Organisation (WHO) developed a Surgical Safety Checklist that it recommends as a minimum safety requirement for all patients undergoing surgery or procedures. Its aim was to reduce the number of surgical deaths, post op complications and preventable adverse events by addressing important safety issues such as inadequate anaesthetic safety practices and poor communication. The checklist is divided into 3 parts, *Sign in*, *Time out*, and *Sign out*, correlating to the pre-op, intra-op and post-op stages respectively. It has been fully endorsed by both the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists. It recently attained "Page 3 Status" in *The Age*.

At St Vincents & Mercy Private, we currently have a *Team Time Out Policy* in place, which is not dissimilar to the WHO checklist. However, it is not as comprehensive as the WHO checklist, and it is not a formalised process whereby all individual check items are ticked off. The current policy maintains that a verbal *Team Time Out* needs to

take place prior to each procedure, and, if it does not happen, it is entered into Riskman. The exception to the rule is when it is an emergency, and in this situation it needs to be documented in the medical record. There is no formal post op checklist at present, although it is likely that the points mentioned in the WHO *Sign out* checklist were discussed at some time during the procedure.

The WHO surgical safety checklist is an excellent tool to reduce avoidable adverse events and post op complications and was the subject of an article in the *New England Journal of Medicine* (NEJM 2009; 360:491-499). The Hospital will adopt a similar format checklist following discussion with the Medical Advisory Committee and the various campus Anaesthetic and Operating Room Committees. This is going to be trialled at Mercy during October and November and will be then rolled out to the theatres at St Vincent's and Vimy. The checklist system will become part of Hospital policy and will become part of theatre routine. ■

■ Feedback

Letter to the Editor

Dear Bill,

I read your article in the recent Specialists Bulletin with interest. I note contributions to the Bulletin are invited. Would you accept a dissenting view for publication?

With respect, I think you may be wrong. There is no objective and scientific evidence that the 'historical model' of public and private medical practice in this state has 'run its course'. To the contrary I believe it as a model that has been and remains vital, efficient and most importantly serves our patients incredibly well. With free movement of people and ideas within and between thriving public and private sectors it is, I believe, the envy of those involved in health care around the world.

The American model of major private teaching hospitals grew from a culture different to ours. A culture of private philanthropy and private tertiary education provided an environment in which charismatic leaders like the Mayo brothers could build an institution like their eponymous clinic, from the bottom up. This has to be set against a totally dysfunctional public medical sector and a private health system where people live in morbid fear of the economic consequences of ill health and the predations of managed care.

Much is made of the number of specialists accredited at a large hospital like ours and those who are not 'active'. Where's the problem? It provides a vast resource of personnel to call upon for support and choice. I believe the mechanics of the accreditation process and especially the re-accreditation process is unnecessarily laborious and time consuming in this 21st century. The Medical Register is a public web based document. We cannot now be registered unless we have appropriate insurance. It can be taken as a legislated 'given'. For the rest of the documentation, if cost were an issue, a small application or annual reaccreditation fee would be appropriate. If 1200 specialists were charged \$50 each it would quickly eliminate the totally uninterested and fund at least one full time staff member to handle the paperwork!

Much is made of our lack of 'engagement' with the hospital. Do you really want 1200 tertiary educated 'experts' engaging with your 'hospitals internal processes'? Modern hospitals function in an environment of extraordinary legislative and regulatory complexity and many of the roles traditionally filled by part-timers are best left to the professionals.

Similarly the hospital is not needed and may not be the best body to assist 'in professional development, research and medical education'.

From a personal point of view, the College of Anaesthetists provides a Continuing Professional Development/ Continuing Medical Education Programme that I have participated in for 15 years. From my private practice my research has produced over a dozen articles published in peer-reviewed journals and I have contributed to the education of medical students, nurses, ambulance officers and anaesthetic assistants.

It may be that 'the relationship between private hospitals and their specialists is changing'. As an administrator, you may see change engineered in a certain direction as desirable. There are no doubt aspects of the model that could be improved. The provision of out of hours emergency anaesthetic cover for those institutions that have emergency departments is an obvious one. It can be fixed. However I believe the outcome that you champion is not unquestionably desirable.

Historically the people of Victoria have benefited from a tradition of Catholic health care in which the Mercy and St V's stood at the apex. This is a tradition of health care that is open, accessible, solid and caring. Denied flexibility and autonomy the medical workforce of our private hospitals run the risk that they will be subsumed to the interests of the insurance companies and their shareholders in the travesty of managed care, by stealth if not by declaration.

The big losers will be the hospitals, our professions, our traditions of ethical, compassionate healthcare and most importantly and tragically our patients.

If we are in discussion we are not in conflict.

Dr Pat Hughes
(Anaesthetist)

Editor's reply

Dear Pat,

The distinction that existed between public and privates in Australia was that privates only dealt with elective and generally low-to-mid level cases and the publics did the rest, particularly the emergent and complicated work. This is disappearing because of the movement of privates into the emergent and complicated area, public expectations of a hospital providing end-to-end care and difficulties that the public sector has in servicing the demand. The medical model of care in private hospitals is back in the old days. As evidence, look at the difficulty all the privates have in filling rosters for emergency work. It is a repeated source of complaint to me from surgeons about finding anaesthetists for emergent cases.

Vimy Private update

The Refurbishment of Vimy is progressing well. The new CSSD located on the Ground floor opened in early May. The new 7 bay PACU was opened in June and now provides a much brighter, roomier area for patients and staff to work and recover in.

The refurbishment of the Day Surgery is complete and became fully operational in late September. A new reception now greets patients and provides them with a pleasant atmosphere, large waiting area and scenic views across Kew. After much anticipation, we welcomed the opening of the final two theatres in mid August. It has taken 15 months of solid work to achieve 4 'state of the art' theatres and we are certainly very proud of the results.

The final stage of the operating suite refurbishment involved converting the old theatres into storage, write up areas and waiting bays. This stage was completed in September. Refurbishment of the inpatient ward is scheduled for the next financial year. We would like to thank all VMP's and staff for their patience and understanding during this extensive refurbishment period and we look forward to working together to ensure Vimy Private continues to provide an excellent service to the community.



Complaints waiting for surgery

A cause of a significant number of complaints that the Hospital receives from patients regards the time they wait for surgery, particularly in day surgery. Patients assume that they will be operated on soon after they arrive and get very annoyed after an unexpected two to six hour wait.

Patients have left the Hospital without getting their operation because of the wait. We're not happy with this situation because the patient is not happy, our nursing staff receive the brunt of these complaints and the Hospital's reputation is damaged as the patient assumes that the Hospital organises the lists.

As I see it, there are two solutions at the moment. The first is staggering the admission times for patients having a procedure. Some surgeons and anaesthetists already do this but I understand that not all VMP's are comfortable with this idea. The second is for you to tell your patients as part of your procedure planning that there may be a delay after arriving and how long their wait is likely to be.

Feedback

Letter to the Editor

Continued from page 3

Some years ago, there was a proposal to put an emergency dept in this Hospital. This was withdrawn because the medical staff would not support after hours work.

I was not proposing a move to the US system but rather looking at using their private hospitals as models for our future private teaching hospitals.

The problems of a large list of VMP's are that

- 1) these people are not available for support and choice and,
- 2) quality. The best way we have of knowing whether a VMP is any good is seeing his or her work.

Credentialing is a pain for the doctor and the hospital. The changes that the privates are implementing are being driven by government and bodies such as the ACHS. Some privates already have an annual fee. I am currently not brave enough to try that here but thanks for the idea!

Regarding engagement with the Hospital, I don't envisage the whole 1200 but I would like a bigger pool of people to call on than the "usual faces".

I'd actually say that the Hospital is needed for continuing professional development as I've been approached by an increasing number of VMP's who no longer have any public involvement asking how the hospital can assist them in CPD. We are looking at ways to do this as we realise that fully private doctors have big problems with this. I know that the other big Private Hospitals are doing similar things as a way of retaining people. I have a firm view that a way of maintaining and fostering high quality care is through education and research.

We currently do this with nursing and it has led to increased quality and retention of nurses. A key way Private Hospitals are attracting VMP's to work with them is offering them research facilities and support. It is possible that the Federal Government will impose requirements on Hospitals like us to become involved in the training of the large wave of medical students coming down the chute as the public sector will not cope.

A significant driver for change is competition. To survive, a private hospital needs quality VMP's that put most of their work through that hospital. Given that the number of specialists is relatively fixed, that means a) inducing the ones you've got to move more of their work to you and/or b) pinching VMP's from other places. Good VMP's want to put their patients in places that offer high quality care which means nurses, resident medical staff, education, research etc. The Epworth redevelopment is a significant risk to us – where do you think they think the VMP's to fill those extra beds and theatres are going to come from? It's not Cabrini.

I agree with your views about the benefits of Catholic health care in Victoria. There is no doubt that Government and the insurers have influence but the way to deal with them is through providing the best quality care. The insurers are not a completely malevolent beast in that they at least pay some care to ensuring that hospitals move to best practice guidelines e.g. DVT prophylaxis, infection control and so on. ■

Bill Kelly
Editor

Workplace

Changes to Pre-Admission Services

After several months of researching emerging practices in Pre-admission Clinics, we are pleased to launch our new Pre-admission Information Booklet and Patient Registration and Pre-admission Documentation which will be introduced to St Vincents Private, Mercy Private and Vimy Private. These documents will be an adjunct to our newly enhanced service which will offer improved risk screening of your patients and notification to those involved as well as offering an on site pre-admission clinic for face to face assessment pre-operatively.

In consultation with a number of VMPs and staff within the Hospital, we have identified ways to minimise issues such as unplanned overnight HDU and ICU admissions, cancellation of surgery and conversion of day stay patients to overnight stay. We have also looked at the

information we receive from patients and how we manage that once it comes to us so as to avoid forms being separated.

The result is new documentation which includes two separate booklets – a colour booklet for the patients to keep that now has far greater information about risks associated with hospital admission and less "hotel type" information. The second booklet is to be returned to the hospital by the patient intact (therefore no perforations) and will include:

- Consent
- Registration
- Patient Health Questionnaire (and a summary page for Pre-admission staff to use.)

To replace the Medical Pre-Admission summary in our current booklet we have also produced a separate Pre-admission Referral Form that

Continuing Professional Development

Credentialing of VMP's

In the last Bulletin, I wrote about how the private hospital environment in Australia is changing. One obvious change is in the area of credentialing doctors to work in hospitals in general and private hospitals in particular. All hospitals in Australia are moving to a national model of credentialing away from a variable and, in some cases, ad-hoc system of checking the qualifications and skill sets of doctors. This has been in progress for some time but has been dramatically accelerated by the events in Queensland, New South Wales and Victoria over the last few years. A common thread through those cases was a failure in adequately credentialing the doctors involved. We are moving to the national model using the system developed by the Victorian Department of Human Services as defined in their publication *Credentialing and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy handbook*. The major differences in the national model are a more rigorous credentialing process, the clinician defining their scope of practice and then the Hospital being satisfied that the clinician's stated scope of practice is correct. The size of the application has jumped from the old single double-sided sheet to 14 pages. Similar changes are occurring to the reapplication forms.

It is worth stating the major principles underlying the changes in the Victorian model:

- the overriding interest of credentialing and defining the scope of practice should be the safety and quality of the care that patients receive from health professionals
- credentialing and defining the scope of practice needs to sustain the confidence of

the public and the professions through demonstrable impartiality

- credentialing and defining the scope of practice, however, must be primarily be concerned with supporting and embedding good practice: the majority of doctors are good doctors who strive to be better.
- credentialing and defining the scope of practice should be embedded into organisational clinical governance processes.

The first important change is the explicit commitment to patient safety which also underpins the requirements for police checks and *Working With Children* checks that are now a requirement for credentialing and re-credentialing. Some VMP's have felt that the declaration on their medical registration is sufficient in terms of avoiding the need for a police check. Unfortunately, the Medical Practitioners Board of Victoria currently does no cross-referencing of that declaration with the police so continued registration does not remove our need for the check. This may change with the move to national credentialing (see cover article, *National Registration*).

The second change is the assumption that a Hospital, by credentialing a doctor, is responsible for the actions of that doctor in caring for patients. One of the Hospital's legal advisors expressed it this way: "The appointment of a doctor at your hospital is an endorsement of that doctor to the community." It is his view that this is the approach that the courts are taking and it is certainly informs the approach that we now take to credentialing. ■

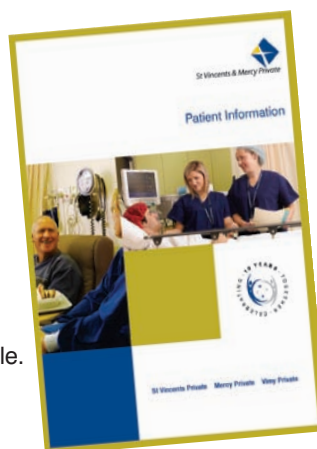
enables VMPs to complete a direct referral to the Pre-Admission Clinic (this has already been trialled by some VMPs with favourable feedback.)

In conjunction with the new paperwork, we will be launching an improved Pre-admission Advisory Centre that will use a scoring system which incorporates three categories:

- GREEN** Patients require no further assessment. Phone call day before to confirm admission
- ORANGE** Patients who require a phone follow up and possible coordination and review of pathology results +/- Anaesthetist or other specialist notification
- RED** Patients who require a face to face assessment +/- Physician assessment / follow-up + coordination of pathology or radiology all completed in consultation with the admitting Surgeon.

Pre-admission Clinics will take place at St Vincents Private and Vimy Private so for those VMPs currently happy with the service – this will not change. For others, it will provide an enhanced service to that currently available.

These documents have been recently presented to the Medical Advisory Committee and the Anaesthetic and Operating Committees. In the forthcoming weeks Pre-admission staff will be visiting rooms to introduce the new paperwork and process to VMPs and their staff. If there are any concerns, please feel free to contact Chris McShane or Angela Honeysett on 9928 6832. ■



Use of imaging equipment in the operating rooms

There have been a number of occasions lately where image intensifiers have been used by medical staff who are not licensed to do so. This is against the Radiation Act (2005) and relevant regulations and may expose the patient to unnecessary and unknown doses of radiation. Such misuse requires notification to the Radiation Safety section of the DHS and exposes the VMP, the Hospital and the imaging provider to subsequent litigation. Obviously, this must stop forthwith. Under no circumstances may a VMP or staff member who is not licensed to use a particular piece of equipment do so.

Temper Tantrums

Without going into any details, there has been a recent spate of VMP's losing their temper and upsetting nursing staff. This is unacceptable and has led to much unhappiness amongst the nurses involved and is clearly against the values of this Hospital. This behaviour can lead to formal investigations for bullying and harassment which staff members can take directly to WorkSafe. If you feel particularly exercised by an issue, don't take it out on the staff around you. Come and speak to me, the local Director of Nursing or Martin Day.

Theatre clothing outside the theatre complex

I recently received a letter from a surgeon raising the issue of staff, but particularly doctors, moving outside the theatre complex in theatre gear at both Mercy and St Vincent's Private. He is rightly concerned about the risk of infection to surgical patients. I thought it an opportune time then to remind you of the Hospital's policy on theatre wear. The relevant parts of the policy, which complies with ACORN and HICMR standards, are:

- Perioperative attire is not worn outside the hospital building environs
- Perioperative attire is changed if contaminated outside the perioperative environment
- Over gowns are not worn to protect perioperative attire as per HICMR surgical attire policy

The assumption is also made that theatre attire worn outside restricted areas is contaminated and must be changed before re-entering the restricted theatre areas.

■ Policy

Medical Quality & Risk Committee

At a recent meeting of the Hospital Board's Quality and Risk Committee, it was resolved to set up a subcommittee whose purpose is to facilitate effective and on-going review of medical risk within the Hospital. Its key activity is to drive quality improvement with a focus on risk management and clinical safety.

The objectives of the Committee are:

- To identify and examine key areas of medical risk inclusive of credentialling, structure and practices within the organisation.
- To provide recommendations where problems or opportunities relating to the improvement of patient medical care is identified.

■ Best Practice

E-Health and the standard of care

Dr Ryan Bosch of the American Medical Faculty Associates has stated that 'delivering good-quality health care is about a relationship'.¹

Traditionally this relationship is underpinned by six elements - choice, competence, communication, compassion, continuity and conflict of interest.² The importance of these components varies from relationship to relationship and may not be individually or equally important in every case. Significantly, these elements, in the face to face situation, prompt the development of trust between doctor and patient which is needed if good patient care and optimal outcomes are to be anticipated. However, does a remote encounter between a doctor and a potential patient, such as teleconsulting, constitute the establishment of or the continuation of a doctor-patient relationship. If so, then a legal connection is created. In other words, what, if any, aspect of the electronic delivery of health care establishes a duty of care? Is a doctor-patient relationship established through the use of e-mail, websites, telephone consultations or telephone advice to medical colleagues regarding a specific patient?

The issues surrounding technology-based patient consultations have attracted the attention of, not only the profession itself, government and professional organisations but also regulators, e.g. medical registrations boards, medical indemnity insurers and their industry organisations. Doctors would agree that a physical examination is an accepted standard of practice in the consultation and diagnostic process, at least at the initial consultation. This has been reiterated by medical registration boards both informally and formally. However, in the telemedicine or internet/e-mail based context a physical examination is not possible, thus creating a potential medico-legal difficulty for the doctor. For this reason it can be readily understood why registration bodies and medical indemnity insurers have a significant interest in telemedicine and e-health practices.

Telephone communications between patients or would be patients and their doctors provide

useful information regarding what constitutes a doctor-patient relationship in this regard. There has been little litigation with respect to e-health in Australia but in an American jurisdiction it was found that telephoning for and making an appointment did not constitute the creation of a doctor-patient relationship³. However, the NSW Supreme Court has been of the view that once an appointment has been made a person becomes a patient of the practice even if they had not been seen by the practice previously (*Alexander v Heise* [2001] NSWSC 69). The assessment of the nature and extent of the duty of care in these circumstances owed to a new patient, not yet assessed, will of course depend on the circumstances particularly the nature of the referral (if any). However, if any indication is given of an intention to provide medical care or advice given then a relationship is created.

In the electronic non-telephone environment it is likely that the same rulings will apply. Doctors need to be cautious in their use of e-mail and other electronic means of interacting with potential patients and to recognise when their actions using these means may constitute the establishment of a doctor-patient relationship with all its attendant responsibilities. The use of e-mail poses particular difficulties in addition to the absence of personal contact. History taking is more difficult and there is considerable scope for diagnostic error as the nuances and subtleties of a face to face interaction are lacking. Chat rooms are likely to be more problematical in this regard as involvement in a 'conversation' could reasonably be expected to constitute advice or direction and therefore a duty of care may be established. ■

Jonathan Burdon

September 2009

1. Bill Saporito, 'The e-health Revolution', *Time Magazine* (New York), 20 June 2005.

2. Emanuel J. Ezekiel and Nancy Neveloff Dubler, 'Preserving the Physician-Patient Relationship in the Era of Managed Care' (1995) 273 *Journal of the American Medical Association* 323, 324.

3. 201 *Mich. App.* 239,506 N.W. 2d 264 (1993)

- To benchmark medical practices at STVMPH with national standards and best practice.
- To provide a forum for the benchmarking and sharing of medical risk management initiatives.

This Committee is also a joint committee with the Medical Advisory Committee and a number of MAC members, including Jamie Keck, are members of this committee. The Chair of the new Committee is Prof Tony d'Apice who many of you will know from St Vincent's Public Hospital.

The Committee held its first meeting in July and has recommended to the Executive that the medical Craft Groups be re-invigorated as a vehicle for promoting quality in clinical practice. This has been taken on board and meetings are being organised to discuss proposals for stronger groups with the various specialties.

Since then, a rolling plan to set up or re-invigorate various specialty groups has been developed and numerous meetings have been held. ■

■ Policy

Changes to the Coroner's Act 2008 (VIC)

How will the changes to the Coroner's Act impact on health services?

The Coroners Act 2008 (Vic) will commence on 1 November 2009.

Many of the changes will affect health services. This article is limited to identifying those particular changes that may have an impact on the health services. The definition of a reportable death and reviewable death have altered.

The changes for 'reportable death' under s 4(2) includes deaths occurring "during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure and a medical practitioner would not immediately before the procedure was undertaken have reasonably expected the death."

This extends the previous obligation of reporting a death, as the definition of a medical procedure has been broadened to include any procedure under the 'general supervision' of a registered medical practitioner and includes imaging, internal examination and surgical procedures. The effect that this change will have, in my opinion, is an increased level of reporting of deaths in health services. The onus will be on the medical practitioner to report the death 'without delay' whether they were present at or after the death. There are no definitions for 'being present at or after the death' or 'without delay'. Reportable deaths have also been extended to include any deceased person who has been discharged from an approved mental health service within the previous three months.

The Coroner will, under the new act, have a greater role for making recommendations s72(2) to "any Minister, public statutory authority or entity on any matter connected with a death or fire which the Coroner has investigated..." Where such a recommendation is made the recipient must provide a written response to the recommendation no later than three months after the date of receipt of the recommendations.

The purposes of the new act requires the Coroner to consider that family members affected by a death should, among other things, be kept informed of the particulars and the progress of the investigation. To that end, the senior next of kin must have access to any reports given to the Coroner as a result of a medical examination

performed on the deceased and a copy of the inquest brief. This may expose the documents provided from a variety of sources to greater scrutiny than previously. Health services should continue to be vigilant in the training and education of all staff in relation to their responsibilities to document in a factual and accurate manner.

The decisions of the Coroner following an inquest must be published on the internet. The reporting of such decisions will be consistent with other Courts including the County and Supreme Court decisions.

Another feature of the new act is the express reference under s70 to an apology. The section defines an apology as an expression of sorrow, regret or sympathy but does not include a clear acknowledgement of fault.

Finally, the privilege against self incrimination. Previously a person could decline to give evidence if there was a risk of being charged with a crime in relation to the death. The new act narrows the scope of the privilege to against self incrimination by requiring a person to produce a document irrespective of whether that document would tend to incriminate the person.

The new act places the Coroner in a greater position of making recommendations that must be responded to by the recipient of the recommendations. The changes also have the potential of a greater number of reportable deaths being investigated by the Coroner's office.

Health services should also consider the breadth of the documents to next of kin and to other interested parties. ■

Sabine Phillips and Russell Kennedy

Note from Bill Kelly: We are notifying the nursing co-ordinators to ask VMP's at the time of a patient's death whether notification to the Coroner is necessary. Please note that there are now fines for not reporting cases. My recommendation is to have a very low threshold for reporting cases to the Coroner from the 1 November.

Matching the patient to the hospital

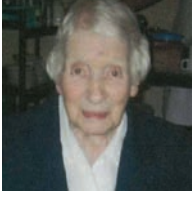
From time to time, patients need to be transferred from Vimy and Mercy campuses to St Vincent's Private for either ICU or CCU management. Often, this is due to an unexpected complication. There are, however, a number of patients whose type of operation or whose co-morbidities should have suggested that they have their original procedure at St Vincent's Private and go from theatre to either ICU or CCU. Operating on these sort of patients at either Vimy or Mercy exposes them to increased risk and I would urge VMP's to carefully stratify patients and do the sicker ones at St Vincent's Private. Operating time will be found at St Vincent's Private for these cases.

Your contact details

It is your responsibility to keep your contact details up to date with us. We use the most recent information we have when we need to get in touch with you. Too frequently, we find that various address details have changed when we eventually track a particular VMP down for failing to return forms such as recertification. On a related topic, I would be grateful also if you could make sure your office staff pass any correspondence from us to you. I suspect that our material may sometimes be classed with the drug information brochures and get binned.

■ Staff news

Sr Mary Patrice Mc Sweeney rsm



The Sisters of Mercy farewelled one of their greats, Sr Mary Patrice McSweeney, at a funeral Mass in the Ursula Frayne chapel Fitzroy this

month. The ceremony reflected the dignity of a life well-lived, and the modesty of this quietly spoken woman who wanted no eulogy at her funeral.

Sr Patrice was well known and loved by all at Mercy Private. She started her nursing training at Mercy in 1943 and on graduation went on to complete midwifery at St Vincent's Maternity Hospital in 1948. She joined the Sisters of Mercy in 1949.

She worked at Mercy from 1952 until her retirement in 1988. She was Superior of the Mercy Private Hospital from 1972-74 and Mercy Maternity Hospital from 1975-77. She was the Supervisor of Patient Services at the Mercy Private Business Office until 1988.

In paying tribute to her at the September meeting of the Board of Directors, the Chairman Jack O'Connell said, "Sr Patrice was held in the highest regard by generations of nurses who trained at the Mercy. Her sound administrative ability and skilful leadership helped steer Mercy through the 70's. In many ways Patrice consolidated the foundations laid by Mother Francis Hanigan and Mother Philippa Brazill

on whose work the reputation of the Mercy Private was built. Patrice lived and breathed the Mercy ethos."

Sr Patrice brought to hospital administration a profound sense of vocational commitment and service. She was in awe of the skill of doctors who she regarded as partners with the Sisters in delivering the highest quality of patient care.

After her retirement and while the Sisters of Mercy lived at the hospital Patrice continued to visit staff and patients. She was one of the Mercy Private's greatest supporters and her passing marks the end of an era. ■

■ Staff news

Gassers versus Slashers

The wicket was prepared by Mick Smith and was said to be playing like day 1 of a test match. This was a test match, Gassers versus Slashers. 24 of Melbourne's anaesthetists and surgeons had come together on 29th March at Scotch College's main oval to do battle and raise money for the Scotch College Fire Relief Fund. Willow was to be wielded and leather dispatched.

The day was sponsored by Rohan Aujard (Pulse Pharmacy). Catering was provided by St Vincents & Mercy Private and raffle items were donated by Crazy John and Woodworm cricket equipment. A number of old boys were playing. They included David Hays, Peter Hays, Mal Tyers, Geoff Steele, Colin McKenzie and Peter Keast. Assisting the Gassers and Slashers on the day were Shaun Graf (Cricket Victoria) and Rodney Malcolm Hogg both who had represented Australia in the past.

The Gassers won the toss and sent the Slashers in to bat. Billy Sheahan, an international and state cricket umpire as well as James Dunn (3AW) had both volunteered their services for the day. They were quietly overheard on several occasions offering support (sledging) a number of batsmen and bowlers on technique and ability.

The surgeons were often seen slashing outside off stump while the anaesthetists were sometimes caught napping in the field. The Slashers were all out for 98 (P.Lugg 19 P.Girdlestone 2/8 P.Hays 2/6). The Gassers replied with 9/133 (C.McKenzie 29 ret



S.Nicolson 23 ret C.Norsworthy 2/20 S.Banting 2/8) and won the inaugural Gassers v Slashers cricket match.

Throughout the day both teams were ably supported by partners, family and friends. In particular Gaby Lyons, John Hays and Dick Grutner did a great job organizing the BBQ and collecting money. The day resulted in 3 torn hamstrings, 2 groin injuries, 1 torn quadriceps tendon, a grazed cheek, numerous torn heart muscles and plenty of bruised egos.

A total of \$13,074-79 was raised on the day.

Thanks to everyone involved, Scotch College and the Curators, Mick and Dallas, who allowed us all to enjoy the wonderful Main Oval.

A football match is in the planning stages for later this year. Watch this space. It should be interesting. ■

David Hays