

Newsletter

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ACLM

AUSTRALASIAN COLLEGE OF LEGAL MEDICINE

President's Report

Cause of Death Certification

The cause of death certificate ('death certificate') is an essential component in the process of notifying a death to the registrar of Births, Deaths and Marriages in the relevant state or territory. Moreover, it gives authority for a funeral director to arrange disposal of the body. Doctors have a responsibility to ensure the appropriate completion of a death certificate, for reasons that include:

- statistical and public health purposes, to enable the development and evaluation of measures to improve the health of the population;
- legal purposes, for example life insurance or the validity of a will;
- family purposes, to allow family members to know what caused the death and whether the death has implications for other family members;
- safeguarding against the disposal of a body where the death could require further investigation.¹

Neate et al conducted a retrospective case study of deaths that had been referred to the Coroners Court of Victoria by the Registry of Births, Deaths and Marriages between 1 July 2010 and 30 June 2011, where a coroner determined the death resulted from external causes.²

Apart from the fact that these deaths ('reportable deaths') had not been reported to a coroner by the certifying doctor at the time of death, the authors found that only 3% of the death certificates issued did not require alteration, with nearly 50% of cases requiring major changes to the stated cause of death.³

The main issues included:

- listing the mode of death, for example multi-organ failure or cardiac arrest, rather than a pathological condition, for example myocardial infarction, pneumonia or dementia, as a cause of death;

¹ Bird, S., 'How to complete a death certificate: a guide for GPs' (2011) 40(6) *Australian Family Physician* 446.

² Neate, S et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402.

³ Ibid 405.



- failure to list conditions in a logical causative sequence;
- problems determining whether a condition caused or contributed to the death;
- inclusion of conditions unrelated to the death, that is, including all co-morbidities whether related to the death or not.⁴

Neate et al considered that inaccurate completion of the death certificate may result in a poor understanding by the family of the cause of death, initiation of unsupportable civil claims, an unnecessary investigation, or the prevention of an investigation, of deaths and inaccurate mortality data.⁵

The authors found that nearly all the deaths analysed had resulted from trauma, with the three main injuries being fracture complicated by pneumonia, fracture only, and head injury.⁶ In 6.6% of the cases, a coroner directed that further investigation

was required, including request for witness statements and aged care facility protocols, as well as extensive reviews of the health care provided.⁷

Several possible reasons for doctors not reporting deaths that required reporting to the coroner at the time of death were discussed, including:

- poor understanding of the statutory obligations to report;
- differing medical and legal interpretations of terms, such as 'unexpected' or 'unnatural';
- uncertainty regarding a causal connection between trauma and the death, especially if separated by a significant period;
- problems determining whether deaths surrounding a medical procedure are reportable;
- misconceptions that deaths are only reportable when they are 'suspicious'.⁸

⁴ Ibid.

⁵ Ibid.

⁶ Neate, S et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 403.

⁷ Neate, S et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 404.

⁸ Neate, S et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 405.

4 Barnes et al examined the alternative circumstances where a doctor does not issue, or is not likely to issue, a cause of death certificate.⁹ In Queensland as in most other jurisdictions, the death then becomes a reportable death.¹⁰ It was observed that of 4,416 Queensland deaths reported to the coroner in 2010-2011, there was 42% where no death certificate was issued, with 27% health care related deaths and 25.6% being violent or otherwise unnatural deaths.¹¹

The authors observed that deaths where no death certificate is issued are apparent natural causes deaths, mostly due to a treating doctor either not being located, unavailable or unwilling to issue a certificate.¹² While not being willing to issue a certificate may be reasonable in some circumstances, the authors point out that in other cases a failure to access relevant information or a misunderstanding of the doctor's obligations to issue a death certificate in appropriate circumstances, results in deaths being reported unnecessarily.¹³

A common misunderstanding is the degree of certainty required as to the cause of death. Under the Births, Deaths

and Marriages Act 2003 (Qld) the doctor need not be the treating doctor and, having regard to the information about the deceased's medical history and the circumstances of the death, need only form an opinion as to the probable cause of death.¹⁴

Due to the significant proportion of apparent natural causes deaths entering the coronial jurisdiction with the associated costs,¹⁵ Barnes et al conducted a trial over an 18 month period, where deaths that resulted in no certificate being issued were triaged by the coronial registrar. In the first 12 months of the trial, 666 apparent natural causes deaths were reported by police, with 37.1% resulting in a death certificate ultimately being issued without the death formally entering the coronial jurisdiction.¹⁶

The authors argued that while doctors should never be discouraged from seeking advice from a coroner before issuing a death certificate, there are many cases where clinicians could obtain and consider collateral medical history information from other treating doctors to inform a considered opinion as to the probable cause of death, without the involvement of the coroner.¹⁷

⁹ Barnes, M. et al., 'Intake rigour: ensuring only "reportable deaths" become coroners' cases' (2014) 21 *Journal of Law and Medicine* 572.

¹⁰ *Coroners Act 2003* (Qld) s 8(3)(e).

¹¹ Barnes, M. et al., 'Intake rigour: ensuring only "reportable deaths" become coroners' cases' (2014) 21 *Journal of Law and Medicine* 572, 574.

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ Section 30(2).

¹⁵ For example, the initial police investigation, transportation to a forensic pathology facility, coronial administrative action and addressing next of kin concerns.

¹⁶ Barnes, M. et al., 'Intake rigour: ensuring only "reportable deaths" become coroners' cases' (2014) 21 *Journal of Law and Medicine* 572, 579 – 580.

¹⁷ Barnes, M. et al., 'Intake rigour: ensuring only "reportable deaths" become coroners' cases' (2014) 21 *Journal of Law and Medicine* 572, 583.

In conclusion, there are significant issues in relation to doctors accurately completing cause of death certificates, which can lead to avoidable adverse consequences. Moreover, medical knowledge of the interface with the coronial jurisdiction and the issuing of a death certificate is not well understood. This can result in either a reportable death not being reported or a death unnecessarily entering the coronial jurisdiction.

Education focused on enhancing medical knowledge and skills in relation to accurately completing death certificates where deaths are from natural causes, or where a death may be reportable, is clearly required.

To this end the College will be conducting a one-day cause of death certification workshop in Brisbane in November with the aim of improving death certification and particularly to enhance the doctor's understanding of his or her obligations relevant to the coronial jurisdiction.

Annual Scientific Program

Jayelle has put together a very exciting draft program for this year's ASM in Perth. Topics to be covered include state regulation of medical cannabis, clinical trials in private practice, best interests in non-consensual clinical drug trials, tooth whitening issues, drug supplies in disasters, novel psychoactive substances and cannabis in pregnancy.

Other topics include the ethics of pharma sponsorship in hospitals, off-label prescriptions, the law and ethics of disabled persons, nano-safety and therapeutics, the ethics of therapeutics in paediatrics and opiate prescribing and real-time reporting. It should be a great meeting so please join us!

Dr Don Buchanan

ACLM President



Recent Developments in Medical Negligence Law in the UK

Based on the article:

'Bolam' to 'Montgomery' is result of evolutionary change of medical practice towards 'Patient-Centered Care'

Lee, A. *Postgraduate Medical Journal* 2017; 93:46–50.
doi:10.1136/postgradmedj



The United Kingdom Supreme Court judgement in '*Montgomery v Lanarkshire Health Board*'¹ has finally consolidated the law on standard of care of doctor with regard to duty on disclosure of information to patients regarding the risks of proposed treatment and possible alternatives.² Doctors in UK are now obliged to take "*reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.*"³ The '*Montgomery*' case has raised the standard of reasonable test as the focus is now on 'reasonable patient' rather than 'reasonable doctor'.

In '*Montgomery*' the plaintiff was not told about the risk of shoulder dystocia which would be 9-10% among diabetic mothers. The defendant doctor agreed of the high risk but her reason for not discussing the risk was because the risk of grave problem for the baby resulting from shoulder dystocia was very small. If the condition was mentioned, she believed that all women would request caesarean section. Evidence from expert witnesses from both sides held different opinions on disclosure of small risk of serious complications. However the risk of elective caesarean section nowadays is minimal so it would not be seriously detrimental to the health of patients in contrast to the '*Bolam*' case (there were limited options for treatment of depression in the 50's so ECT was the only hope for the patient).⁴

Would '*therapeutic exception*' be justifiable in the '*Montgomery*' case to withhold information?



Would it be feasible to expect doctors to know enough about patients to predict what patients want to know?

'Montgomery' has adopted 'Sidaway',⁵ 'Pearce'⁶, and further refinement by 'Roger v Whitaker'⁷ with regard to doctor's duty to take reasonable care to ensure the patient is aware of any material risks involved in the recommended treatment and the alternatives.¹ In 'Whitaker',⁷ one particular duty arising from doctor-patient relationship is to provide information from the needs, concerns and circumstances of the patient notwithstanding remote risk of 1 in 14,000 suffering from sympathetic ophthalmia. A patient like Mrs. Whitaker has special need, as she made clear of her great concern of no injury to her good eye, by requesting whether something would be put over her good eye to ensure that nothing would happen.⁷ The doctor ought to be aware of the particular patient's circumstances and whether a reasonable person in the patient's position would be likely to perceive a risk as being significant.

One should move to the '*prudent patient test*' focusing on what the patient would want to know.

Doctors are expected to spend more time and tailor their disclosures according to individual patient's priorities and concerns as people have different needs for information. The recent document of the General Medical Council (GMC) on outcomes of graduates has stipulated the need of doctors to determine the extent that patients want to be involved in decision making, and doctors should provide explanation, advice, and reassurance.⁸ A team at the University of Western Ontario published a series of papers on 'the patient-centred clinical approach' and one core value was found to be identification of patients' priorities so that appropriate clinical decisions would be made.⁹ The Australian Medical Council has also classified communication with patients and encourages patients to be responsible in managing their own health as good medical practice.¹⁰

¹ UK Supreme Court. *Montgomery (Appellant v Lanarkshire Health Board (Respondent) (Scotland)*. [2015] UKSC 1

² Lewis C: Editorial: Consent to treatment: Supreme Court discards Bolam principle. *Medico-Legal Journal* [2015]; 83 (2): 59-61

³ Sokol DK: Update on the UK Law on consent. *BMJ* 2015; 350: h1481

⁴ *Bolam vs Friern Health Management Committee*. [1957] 1 W.L.R. 582 (QB)

⁵ *Sidaway Board of Board of Governors of the Bethlem Hospital and the Maudsley Hospital*. [1985] A.C. 871 (HL), 876

⁶ *Pearce v United Bristol Health Care NHS Trust*. [1999] P.I.Q.R.

⁷ *Roger v Whitaker* [1992] 175 CLR 479 F.C. 92/045

⁸ General Medical Council Outcomes for Graduates. *GMC (Tomorrow's Doctors): Working with doctors Working with patients*. London: GMC, 2015. http://www.gmc-uk.org/Outcomes_for_graduates_Jul_15.pdf_61408029.pdf

⁹ Brown J, Stewart M, McCracken E, McWhinney, IR, Levenstein J. The patient-centred clinical method. 2. Definition and application. *Fam Pract* 1986; 3: 75-79.

¹⁰ Australian Medical Council. Good medical practice: A code of conduct for doctors in Australia. AMC, 2010. <http://www.amc.org.au/index.php/about/good-medical-practice>.

8 A patient-centred approach, empathy and holistic care are the core skills of family physicians. Family doctors would play a very significant role as it would neither be fair nor feasible to expect any clinicians who have not been attending the patients for a substantial period of time to cover a wide range of health issues and to predict patients' concerns and worries. Doctors, particularly surgeons, would often be uncertain which clinical risks should be disclosed and discussed with patients, and often underestimate the implication of a small set of risks on patients.¹¹ However, the provision of pre-operative information can no longer be tailored according to the capacity of patient to retain information as patients should no longer be passive recipients of medical care in the 21st century with accessibility to wide range of data on their conditions and treatments from the internet.¹²

Hospital specialists should work more closely with patients' family doctors before deciding on appropriate disclosure of information. Choosing an appropriate action for each problem and sharing the understanding of the problems with the patient are key tasks in general practice consultation.¹³ This would facilitate unfolding any hidden agenda and particular concerns.

Is the new law unnecessarily harsh for doctors?

Sotok stated that it would still be a matter of judgement by doctors not by law and the law is not demanding the impossible.¹⁴ Although more claims might result based on loss of chance in Australia, such as '*Chappel v Hart*', in which the attending doctor failed to disclose the availability of a more experienced surgeon for a particular procedure,¹⁵ the factual causation must be followed by second aspect of causation, the scope of liability that the patient would only claim if the risk materializes as in '*Wallace v Kam*'.¹⁶ In modern health care, responsible bodies of medical opinion really means judicious use of the best current evidence in making decisions about care of patients,¹⁷ and also strong emphasis on patient-centred care.⁸⁻⁹ This would bridge not only the two different standards (professional v reasonable person) but also legal and medical perspectives regarding disclosure and consent.

Prof. Albert Lee

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¹¹ Bismark MM, Gogo AJ, Clark RB, Gruen RL, Gawande AA, et al. Legal disputes over duties to disclose treatment risks to patients: A review of negligence claims and complaints in Australia. *PLoS Med* 2012; 9(8): e.1001m283 doi: 10.1371/journal.pmed. 1001283

¹² Foy MA. Informed Consent: Where are we in 2015? *Bone Joint J* c2015; 97-B; 1159-61

¹³ Stoot N, Davis R. The exceptional potential in each primary care consultation. *JR Coll Gen Pract* 1979; 29: 201-5.

¹⁴ Sokol D. Let's raise a glass to the ordinary sensible patient. *BMJ* 2015;351:h3956

¹⁵ *Chappel v Hart*. [1998], High Court of Australia. 156 ALR 517.

¹⁶ *Wallace v Kam*. [2013] HCA 19

¹⁷ Strauss DC, Meirion Thomas J. What Does the Medical Profession Mean by Standard of Care. *Journal of Clinical Oncology* 2009; 27(32): e192

The Case

An unconscious elderly man was brought by ambulance to an Emergency Department. He had reportedly taking an overdose of sedatives the previous day in a suicide attempt.

His adult children arrived soon after and insisted that the patient receive no medical intervention because he had given a verbal advance directive for no resuscitation. They requested that he be discharged back to their care, to die at home.

Background

The patient lived independently with no psychiatric history. Recent community investigations had raised the possibility of cancer although this was yet to be confirmed. The patient informed his family that he preferred to commit suicide at home, alone, while he had control over his affairs. He had insisted that he did not want any medical intervention. There was no written advance directive or suicide note.

In ED the patient was unconscious. Concerns included dehydration and the risk of pulmonary aspiration with hypoxic brain damage.

The interim plan was to provide basic care – including airway protection, intravenous fluids, and oxygen as needed. In view of the family's objections, the hospital lawyer was phoned for advice.

The Lawyer's interim opinion was that the patient had issued a binding verbal advance directive against medical intervention that should be complied with. Staff could be vulnerable to a complaint of assault (battery) if they intervened against the patient's wishes.

The scope of an Advance Directive is addressed in New Zealand law. The leading case is *Airedale NHS Trust v Bland* (1993, AC 789 [HL]) which has been adopted in New Zealand. The Bill of Rights Act 1990 s11 states that *"Everyone has the right to refuse to undergo any medical treatment."*

The Health & Disability Commissioner's (HDC) Code of Health & Disability Services Consumers' Rights Regulations 1996 includes Right 7, to make an informed choice and give informed consent:

- 5) *"Every consumer may use an advance directive in accordance with the common law.*
- 7) *Every consumer has the right to refuse services and to withdraw consent to services."*

These Regulations specify that an **"advance directive** means a written **or oral** directive -

- (a) *by which a consumer makes a choice about a possible future health care procedure; and*
- (b) *that is intended to be effective only when he or she is not competent."*

10 **Emergency medicine specialists** argued against the advice to withhold intervention. Their concerns included their vulnerability under Section 179(1) of the Crimes Act:

“Every one is liable to imprisonment for a term not exceeding 14 years who - ...

(b) aids or abets any person in the commission of suicide.”

Section 41 justifies the use of *“such force as may be reasonably necessary in order to prevent the commission of suicide.”*

Section 151 provides a general “duty to provide necessities and protect from injury”:

“Every one who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessities is under a legal duty -

(a) to provide that person with necessities; and

(b) to take reasonable steps to protect that person from injury.”

Attempted suicide is often covered by the Mental Health (Compulsory Assessment & Treatment) Act 1992. Compulsory treatment is warranted if a patient has a relevant mood disorder: *“an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it (a) poses a serious danger to the health or safety of that person ...”*

The validity of the patient’s advance directive was undetermined – including whether he had acted with adequate understanding of the diagnosis and prognosis of the lesion that concerned him, and whether he had contemplated that withholding treatment could leave him with hypoxic brain damage. His competency had not been formally assessed.

These uncertainties were significant enough to warrant the provision of basic life-supporting care, pending further details and a psychiatric assessment. This was discussed with the family. The patient subsequently recovered and was assessed days later by mental health services as being competent and not depressed. He was eventually discharged.

The issue of medical intervention in cases of self-harm is fraught for acute care clinicians who must make critical decisions about life-saving treatment in short time frames, often with incomplete details. Even the judiciary have acknowledged this pressure. In a recent case regarding euthanasia, Justice Collins noted that, *“Judges have been asked to determine complex legal issues, sometimes urgently, in a context in which philosophical, moral, ethical and clinical viewpoints are deeply divided.”*¹

An expert legal opinion was subsequently provided by barrister Jenny Gibson (funded by the Medical Protection Society). I have taken some liberties in summarising some key points from this detailed and

¹ Seales v Attorney-General [2015] NZHC 1239 at [17]

Uncertainties regarding the validity of the patient's advance directive were significant enough to warrant the provision of basic life-supporting care.

comprehensive advice. It was noted that the verbal advance directive as relayed by the family was untested. The validity of an Advance Directive is determined on the basis of several factors, including the patient's competence, the absence of undue influence, whether the patient had sufficient relevant information, and whether the directive was applicable to the specific circumstances of the case as faced by clinicians.

For example, in this case it was unknown whether the patient had contemplated that the sedative overdose was sub-lethal and that withholding medical treatment could result in survival with hypoxic brain damage. In a scenario where the stakes are high (for the patient), the time frame is tight and where there is significant doubt about the applicability of the advance directive, it is reasonable to provide the minimum amount of treatment to preserve life until any doubt can be resolved. This applies more so in a case of attempted suicide where there is the untested possibility of mental disorder (such as depression or cognitive impairment).

In 2007, Kerrie Wooltorton presented to an ED in the UK, carrying a written advance directive (drafted with the assistance of her lawyer), requesting that she receive palliative care - without resuscitation - after taking an overdose of a toxin.

Hospital staff complied with her wishes. Following her death, the Coroner endorsed the hospital's non-intervention. However, in that case, the patient had previous competency assessments by mental health services.

Ryan and Callaghan addressed the Wooltorton case in an Australian context²: *"In all but extraordinary circumstances, a patient who refuses treatment after a suicide attempt can and should be given life-saving treatment, under either mental health legislation or the common law concept of necessity."*

To our knowledge, in New Zealand there has not been a successful prosecution of assault against a health practitioner who intervened against the patient's wishes in a case of self-harm.

Dr Garry Clearwater

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² Ryan CJ, Callaghan S. Legal and ethical aspects of refusing medical treatment after a suicide attempt: the Wooltorton case in the Australian context. *MJA* 2010; 193: 239-42



ACLM 2017 ANNUAL SCIENTIFIC MEETING

THE LAW AND ETHICS OF THERAPEUTICS

When

21 & 22 October 2017

Where

Parmelia Hotel Hilton

14 Mill St

Perth, Western Australia 6000

Register online now!

Members \$495 | Open \$595

Download the registration form and program from our website: www.legalmedicine.com.au/asm-2017

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ON THURSDAY 12TH OCTOBER.



PROGRAM HIGHLIGHTS & GUEST SPEAKERS

SATURDAY

Doctors Behaving Badly

Mr Paul Yovich SC

Barrister, Senior Counsel, Francis Burt Chambers WA

State Regulation of Medicinal Cannabis

Dr Andy Robertson

Deputy Chief Health Officer & Director of Disaster Management,
Department of Health WA

Re-examining ‘Best Interests’ in Non-Consensual Clinical Drug Trials

Dr Brent Hyslop

Clinical Senior Lecturer, Dunedin School of Medicine,
University of Otago NZ

Drug Supplies in a Disaster Response

Dr Andy Robertson

Deputy Chief Health Officer & Director of Disaster Management,
Department of Health WA

Novel Psychoactive Substances

Mr Colin Priddis

Director of Forensic Science, ChemCentre WA

College Dinner at 7pm

SUNDAY

Off-Label Prescription & the Best Standard of Care

Prof Vera Raposo

Faculty of Law, Macau University, China

Safety of Nano-Particles & Therapeutic Applications

Dr Wojciech Chrzanowski

Senior Lecturer, Australian Institute for Nanoscale Science and
Technology, Charles Perkins Centre NSW

+ many more topics presented by College speakers!

2017 ASM: THE LAW & ETHICS OF THERAPEUTICS

21 & 22 October 2017
Parmelia Hilton, Perth WA



QLD CAUSE OF DEATH CERTIFICATE WORKSHOP

18 November 2017
Hotel Jen, Brisbane QLD



EXPERT WITNESS TRAINING PROGRAM

2 & 3 December 2017
Next Hotel, Brisbane QLD



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Networking Events

The Medico-Legal Society of NSW Inc.

Upcoming Scientific Meetings

Date: 20 September & 15 November 2017

Australian Medical Association Queensland

Private Practice and Medico-Legal Conference

Date: 6-7 October 2017

Location: Brisbane Convention and Exhibition Centre, South Brisbane

The Medico-Legal Society of Victoria

'Progress with the Introduction of Medicinal Cannabis to Victorian Patients: A Challenge for Evidence and Clinical Care' by Prof. James Angus

Date: Saturday 14 October 2017, 6.30pm

Location: Melbourne Club, 36 Collins St, Melbourne

The Medico-Legal Society of Victoria

'Antenatal Consent for Vaginal Birth: Implications of Montgomery v Lanackshire Health Board' by Dr Amber Moore

Date: Friday 17 November 2017, 6.30pm

Location: Kelvin Club, 14-30 Melbourne Place, Melbourne



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