defenceupdate

Quarterly Magazine for MDA National Members

Winter 2012

MDA National
Support Protect Promote

A Claim for a Wrongful Life?
A Claim for a Wrongful Birth?

What are the Keys to a Healthy Practice?

Medico-legal Feature: Personally Controlled Electronic Health Record

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MDA National CaseBook

Editor's Note

Very few medical negligence claims actually proceed to a trial. Indeed, it is estimated that less than 5% of litigated claims proceed to a hearing. In this issue of *Defence Update*, we examine two recent medical negligence claims which did proceed to trial.

On pages 6 and 7, Kerrie Chambers discusses some novel aspects of the "wrongful birth" claim involving Keeden Waller, who suffered a stroke a few days after his birth in 2000. On pages 16 and 17, Alice Cran outlines a claim involving the failure to adequately follow up a clinically significant test result and highlights some perennial risk management issues that arise from this case.

Two important initiatives which will have an impact on medical practice and medical defence organisations are described in this issue. Our pull-out feature discusses the Personally Controlled Electronic Health Record (PCEHR) system which will be introduced on 1 July 2012. This new medical record system represents a significant change in the way in which patients' records are managed, not least of which is the fact that patients have control over who can have access to their PCEHR, and its content. A/Prof Julian Rait discusses the proposed introduction of the National Disability Insurance Scheme and National Injury Insurance Scheme on page 3.

Finally, for those Members who have not yet renewed their Membership, on page 5 our Member Services team provides some tips on how to make your renewal easier, including accessing our comprehensive Member Online Services.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In this Issue

From the President

Pursuing Improved Outcomes for the Disabled

Every six months, my patient Peter rises well before dawn to travel three hours to attend our clinic in the city. I have been seeing Peter twice a year for the past twenty-two years, and thankfully I have been able to preserve his eyesight. But Peter is almost completely paralysed from a hereditary peripheral demyelinating disease that has slowly but surely made him profoundly disabled over the life of my professional career.

Peter can no longer transfer to or from my examination chair, and is no doubt frustrated by his increasing immobility and dependence. Yet Peter is someone who remains a delight to care for because of his perennial cheerfulness, ever-present charm, and obvious concern for those who care for him.

Therefore recent proposals for national disability and injury insurance schemes are exciting prospects, as indeed they must be for many doctors, because of the potential to improve the lives of people like Peter and ease the burden on their carers.

In Australia, around 4.5 million people – or about one fifth of our population – have a disability of some kind. Of these, around 760,000 people under 65 years of age have a severe and profound disability (in that they require help with a core activity or task), while another 500,000 are primary care givers and a further 2.4 million provide non-primary care[1]. Those Australians with a profound or severe disability will hopefully receive direct funding to administer their own care package in the future, and provide choice and autonomy as to the care that they receive. For example, it is proposed that cerebral palsy would fall under the National Disability Insurance Scheme (NDIS) and hopefully this will lead to better compensation for all cases of cerebral palsy, while resulting in a reduction in medical indemnity insurance costs for doctors.

However, there are also proposals for a parallel National Injury Insurance Scheme (NIIS) for catastrophic accidental injury that would include injuries arising from medical treatment. And unfortunately, reaching a definition of "medical accident" and creating a sound no-fault support scheme appears potentially more complicated. Despite the efforts of the Productivity Commission, there remains considerable uncertainty as to the ultimate cost of such a scheme and to what extent doctors will be expected to fund the no-fault component (in addition to fault-based claims) through their insurance premiums.

MDA National is particularly concerned that any savings obtained by directing catastrophic injuries away from the fault-based tort system will be lost because there will likely be many more no-fault claims within any new scheme[2]. Indeed, the predicted savings from legal expenses identified by the Productivity Commission might not eventuate if patients are still entitled to sue for other heads of damage, including pain and suffering and/or loss of income. In addition, there will remain the strong likelihood that culpability will still be apportioned by Medical Board investigations after many so-called "accidents", leading to all the usual costs and intense anxiety for the practitioners involved.

So while there is no doubt that the present system of disability and accident compensation could be improved, new measures to support catastrophic medical injuries will need to be carefully costed and planned. And any separate Injury Insurance Scheme will need to maintain the existing standards of accident compensation and provide the same benefits as the NDIS or ultimately, simply be combined into one comprehensive scheme.

MDA National therefore looks forward to continued dialogue with the Productivity Commission to remove such uncertainty, and ensure that any expectation that the medical profession contribute to the funding of National Injury Insurance will not impact on medical indemnity costs, otherwise Australians will pay more for their medical treatment.

So in accordance with our Hippocratic principles, Australian doctors will very likely support an improved system of care for the disabled and catastrophically injured, provided that greater justice and equity can be achieved at reasonable cost.

A/Prof. Julian Rait
MDA National President

1 Manne A. *Two Nations: The Case for a National Disability Insurance Scheme. The Monthly Essays: The Monthly.* August 2011. Available at: www.themonthly.com.au/case-national-disability-insurance-scheme-two-nations-anne-manne-3636

2 New Zealand Department of Labour. *Quality Assurance Review of Price Waterhouse Coopers June 2009 Valuation of ACC's Outstanding Claims Liabilities.* Sept 2009; page ii.

Notice Board

Dr Chris Baughman

MDA National recently lost a good friend and supporter – Dr Chris Baughman.

Regrettably Chris unexpectedly passed away on April 4. Our condolences and best wishes go out to Chris's family and wide circle of friends and colleagues.

Chris was on MDA National's President's Medical Liaison Council until recently and has acted as a strong advocate, ambassador and facilitator for us in SA and beyond. He was charming and intelligent and had been a great and effective part of the MDA National "extended family".

A very tragic loss to both MDA National and the medical profession generally.

Your Renewal: Risk Category Guide Changes

Every year we review our risk categories to ensure that the scope and level of cover we provide is the most comprehensive we can offer. The following changes have been included in the Risk Category Guide 2012/13:

- **A new General Practice category**
  Level 2 General Practice – Limited Procedures has been introduced. Some procedures that were previously categorised under the Level 3 General Practice Procedural category will now be covered under the new category. Please review the Risk Category Guide for the updated list of procedures.
- **Amended wording for Post Graduate and Doctors in Specialist Training category**
  The wording has been amended to clarify the intent that this category is appropriate for Members who are undertaking their initial specialist program, with an appointed supervisor for all aspects of their work outside the training post or program.

MPS International Conference London, UK – 15 & 16 November 2012

Registration is now open for the first international event by the Medical Protection Society (MPS) – *Quality and Safety in Healthcare: Making a Difference.*

MDA National has partnered with MPS to deliver this two day conference that will see leading international experts in healthcare addressing quality, patient experience, safety culture, cost and professionalism.

Dr Sara Bird, along with MDA National Vice President, Dr Beres Wenck and Associate Professor Rosanna Capolingua will be hosting a session on **Tort Law Reform: 10 Years On, Where Are We Now?**

Register Now

For more information about the conference programme, speaker details and how to register visit

mpsinternationalconference.org

MDA National's Perth City to Surf Team

This year we're taking our *Live Well, Work Well* program to the next level by entering the Perth City to Surf on 26 August. Our inaugural team is made up of Members, family and friends and MDA National employees.

Preparation for the big day has already begun with our team participating in complimentary group training sessions with our qualified accredited Exercise Physiologist, Dr Rob Suriano. We'll also keep team motivation levels high with weekly virtual group training pep-emails on fitness, conditioning and nutrition.

Want to join our team or know more?

There is still time to join our team but hurry, places are limited! Visit **www.perthcitytosurf.com** or email us on CityToSurfTeam@mdanational.com.au

Above: WA Relationship Manager, Pip Brown with our event Ambassador and West Coast Eagles player, Mark Le Cras.

Your Membership and Indemnity Policy is due for renewal on Saturday 30 June 2012.

This year your renewal is due on a Saturday. Select from a range of payment options to make renewing before the due date quick and easy.

Communicable Disease Cover at no additional cost when you renew

MDA National understands the risks of practising medicine and that contracting a communicable disease may impact your career and personal life.

Your 2012 Insurance Policy^ provides for a one off lump sum payment in the unfortunate event you contract a communicable disease during the period of insurance.* There's no need to opt in, sign any forms or pay an additional premium.

Renew the easy way

The easiest way to renew your policy is via our Member Online Services (MOS). It's quick, accessible at any time, secure and all major credit cards are accepted.

Visit **www.mdanational.com.au** and click Renew Online.

If you'd like to make any changes to your Renewal Notice or have any questions about your policy, please contact our Member Services team on 1800 011 255 or email us at peaceofmind@mdanational.com.au.

Other important policy updates

Legal Costs

The limit of legal costs payable for certain employment disputes will change from $150,000 to $100,000 in the aggregate for each policy year however the extent of cover for employment disputes remains unchanged.

Our Right to the Conduct & Control Proceedings

We have clarified the process in the event that a Member withholds consent to settle a matter for which we provide indemnity under the policy.

Terminology & Policy Structure

The Policy Schedule is now referred to as the "Certificate of Insurance".

Please refer to the 2012/13 Professional Indemnity Insurance Policy PDS and Policy wording document for details of the Terms and Conditions of the policy.

How to renew?

1. Check your details

Check that your details appear correctly on your Renewal Notice including any recent changes to your address, contact details or your practice. Please let us know if they are incorrect or need updating.

2. Check the Risk Category Guide

There have been changes to our General Practice, Post Graduate and Doctors in Specialist Training categories, so it's important you check that you are in the correct category. It may make a difference to the premium you are paying and your cover under the policy.

3. Report any matters

Let us know of any claims, complaints, investigations or circumstances that you have become aware of, if you haven't done so already. Early notification increases our likelihood of preventing matters from escalating.

4. Make payment

If your renewal is correct, you can make your payment online, over the phone, via mail or Bpay.

We've Extended Our Hours.

You can now contact our Member Services team between the hours of 8.30am to 8.00pm (AEST) or 6.30am to 6.00pm (AWST) Monday to Friday on 1800 011 255.

^The Professional Indemnity Insurance Policy issued by MDA National Insurance on or after 1 July 2012

* Subject to the terms, conditions and eligibility requirements of the policy

A Claim for a Wrongful Life?

A Claim for a Wrongful Birth?

The Claims of Keeden Waller

Kerrie Chambers, Partner HWL Ebsworth reviews a "wrongful life" claim which was recently heard in the NSW Supreme Court.

Keeden Waller was born on 11 August 2000. He was conceived with the assistance of IVF treatment. A few days after his birth he suffered a stroke caused by antithrombin deficiency (AT3) – a condition inherited from his father. Keeden has severe brain damage and multiple injuries.

The Waller family have issued NSW Supreme Court proceedings seeking compensation for Keeden's disabilities. They allege Dr Christopher James, obstetrician and fertility specialist, was negligent for failing to take steps to investigate the impact of the father's antithrombin deficiency on a foetus. They say they were deprived of an opportunity to "...understand the possibility of the transmission of it (AT3)...". As a result of this alleged act of negligence the Wallers say they had lost the opportunity to:

1. defer the IVF process until embryos with AT3 deficiency could be identified and isolated
2. use a sperm donor
3. terminate the pregnancy.

This is the second occasion Dr James has been a defendant to an action by the Wallers in respect of his management of the pregnancy. In 2006 Keeden made legal history when he, as one of three plaintiffs, asked the High Court to determine if a cause of action existed for the person born as a result of the "negligent" continuation of a pregnancy[1]. In other words, are damages available to the child who, but for the negligent continuation of the pregnancy, would not have been born to a life with severe disabilities. In common parlance this is known as a "wrongful life" claim.

By a majority of six to one the High Court dismissed the claim concluding that the notion of life as compensable damage could not be considered or evaluated by the court, and could not therefore be recognised by the law. The court's findings are based in what they thought was the logical impossibility of comparing nonexistence (which cannot be experienced) to a damaged existence. The finding led to the conclusion that no meaningful assessment of damages could be made in such a case.

While the findings of the High Court prevented Keeden from pursuing his action for damages, it did not operate as a bar to a claim by his mother for the cost of raising a child born as a result of an alleged act of negligence. It is her claim for such damages that has recently been heard by the NSW Supreme Court – we are awaiting judgment.

A claim for the cost of raising a child born as a result of an act of negligence is not novel. Mrs Waller's claim does, however, have two interesting aspects to it.

Firstly, what is the scope of the duty an IVF specialist owes to fully inform patients of the risk of genetic disorders. As the case has been reported in the press[2] Mrs Waller says that when Dr James was told of the father's AT3, he handed the couple the name and phone number of a genetic counsellor on a Post-it note. The Wallers allege the note was given in the context of a discussion about fertility and the number was the switchboard of the hospital and not the counsellor's direct line.

"There was a duty of care on the part of Dr James to ensure that both he and the Wallers understood that this problem could be passed on and for there to be proper counselling and discussion about the other options they had, including the option of an anonymous sperm donor", counsel for the Wallers, David Higgs, SC, said.

Lawyers for Dr James argued it is not the responsibility of anIVF specialist to find out whether rare genetic conditions, such as antithrombin deficiency, can be passed on from father to son. If a duty is found to exist the court will have to determine whether Dr James' efforts, as reported in the press, were sufficient to discharge that duty of care.

Should Dr James be found to have breached his duty of care, damages will follow for the costs of raising Keeden. The court will need to determine the extent of the damages. As Mrs Waller's cause of action predates the introduction of the NSW *Civil Liability Act* she is not restricted to claiming damages only for the additional costs incurred in rearing a disabled as opposed to a healthy child.[3]

Mrs Waller is asking the court to compensate her for the costs she has and will incur in rearing Keeden, a child much loved, but one she says would not have been born but for Dr James' alleged negligence. Parental responsibilities are generally thought to cease at the point when a child finishes full time education. This is either at the end of schooling or, for some, at the end of a university education. However the court has been asked to consider whether the defendant should be asked to pay the cost associated with raising a child beyond this age. Similarly, and bearing in mind this is a claim by the mother for compensation for expenses she has and will incur, should she be awarded damages for the costs of raising Keeden beyond her death, assuming he survives her? A parent does not incur costs beyond death.

The Wallers are asking the court to extend the current position in respect of duty of care and damages flowing from an unwanted birth. These are challenging considerations, the outcome of which has yet to be decided. If successful, the damages will be many millions. Given the complexity of the issues involved, and the potential value of the case, it is perhaps not unusual that the case has taken several years to come before the court and we have seen a change of lawyers since Keeden took his case to the High Court.

1 Waller v James [2006] HCA 16

2 The Sydney Morning Herald. 2012. Available at: www.smh.com.au/nsw/keedens-stroke-not-related-to-inherited-disorder-20120201-1qsr0.html#ixzz1q4taBtvl

3 S.71 Civil Liability Act restricts the claim for damages for wrongful birth to the additional cost incurred to rear a disabled child.

What do you think?

Share your comments with us at *Defence Update* online **www.defenceupdate.mdanational.com.au/wrongful-birth**

Checking to **Save Lives**

There has been much discussion around the introduction of the WHO Surgical Safety Checklist[1] and as Dr Patrick Lockie discovered, anecdotal evidence would still suggest considerable reluctance from surgeons.

Many hospitals, including the two I work in, struggle to convince proceduralists of the worth of the WHO checklist, although most have embraced a "correct patient correct operation correct side" procedure. This procedure is, of course, only part of the WHO checklist.

Pronovost's work[2] at Johns Hopkins ten years ago using a checklist and a "care bundle" for insertion of central lines, was the first well publicised medical checklist. Since then the results of use of other checklists have been published,[3-6] and all have shown reduction of error and improved patient outcomes. Despite the seemingly incontrovertible evidence, use of checklists throughout medicine remains scant even within those institutions of recognised checklist "champions" (Gawande, personal communication).

The following is a selection of some of the studies published in the last few years.

Author/Study	Year	Checklist	Outcome
Pronovost[2]	2004	As part of Central Line Insertion Bundle	Reduction in Central Line associated infections from 11.3 per 1000 catheter days to zero.
Catchpole[3]	2007	Handover from Surgery to ICU	Technical and information errors reduced by approx half.
Keystone[4]	2006	Insertion of Central Lines	Rate of blood infection reduced from 2.7 per 1000 catheter days to zero.
Gawande[1]	2009	WHO Surgical Safety	Death rate reduced 1.5% to 0.8%. Complication rate reduced 11% to 7%.
Joy[5]	2011	Handover from Cardiac Surgery to ICU	Technical error reduction from 6.5 to 1.5. Critical information omission errors reduced from 6.3 to 2.8 (per handover).
Bingisser[6]	2010	Handover in Emergency Department	50% reduction in duration of handover. Information errors reduced from 194/496 patients to 78/470.

There has not been any published evidence of a negative outcome from the introduction of a checklist or standardised protocol. There have however been warnings, and a recent publication[7] indicating that introduction of a checklist alone is not sufficient and that prompting the use of any checklist and review of the items on the list is necessary. Pronovost agrees checklists alone are a weak intervention when not accompanied by effective removal of barriers to their use.

Gawande has proposed reasons for ambivalence or even active opposition towards checklists in medicine. Loss of independent thought and initiative have been cited, as has supposed doctor subservience to nursing staff (who usually run the checklists). In situations of critical decision making a checklist might lessen what Gawande calls "expert audacity", a trait of early test pilots, and some surgeons I know. As flying became safer, it probably became less interesting for top gun pilots.

Others have proposed financial reasons as a barrier as there is no industry incentive to promote these initiatives. To quote Gawande (with my interpretation):

If someone found a new drug that could wipe out infections with anything remotely like the effectiveness of Pronovost's lists, there would be television ads with Shane Warne extolling its virtues, and detail men offering free lunches to get doctors to make it part of their practice.

Discussion of checklists usually evoke one of the following responses:

a) I have never had a problem and don't see the need.

b) Things are different in USA/UK/at my hospital.

c) It should help the nursing staff but doctors don't need to use a checklist.

d) Takes too long.

None of these objections are legitimate. (b), if true, would apply to any clinical study from overseas and other hospitals, and most checklists reduce time spent on handovers. I suspect reassurance from the pilot on your next flight that he had never had a crash, and therefore didn't need to use his take-off checklist would see you quickly leaving the aircraft, so (a) doesn't stand up either.

Non-medical people are increasingly aware of the usefulness of checklists in medicine. Nevada legislators went as far as passing a law in 2011, requiring patient safety committees to create and introduce checklists to improve safety. Quality committee members will be pleased to hear that financial penalties, not incarceration, apply for non-compliance.

In view of the published evidence it might also in future become difficult to defend a procedural error if a relevant checklist has not been utilised.

1 Haynes AB, Weiser TG, Berry WR, Lipsitz SR, Breizat AS, Dellinger EP, et al. *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population.* NEJM. 2009;360:491-9.

2 Berenholtz SM, Pronovost PJ, Lipsett PA, Hobson D, Earsing K, Farley JE, et al. *Eliminating catheter-related bloodstream infections in the intensive care unit.* Crit Care Med. 2004; 32:2014-20.

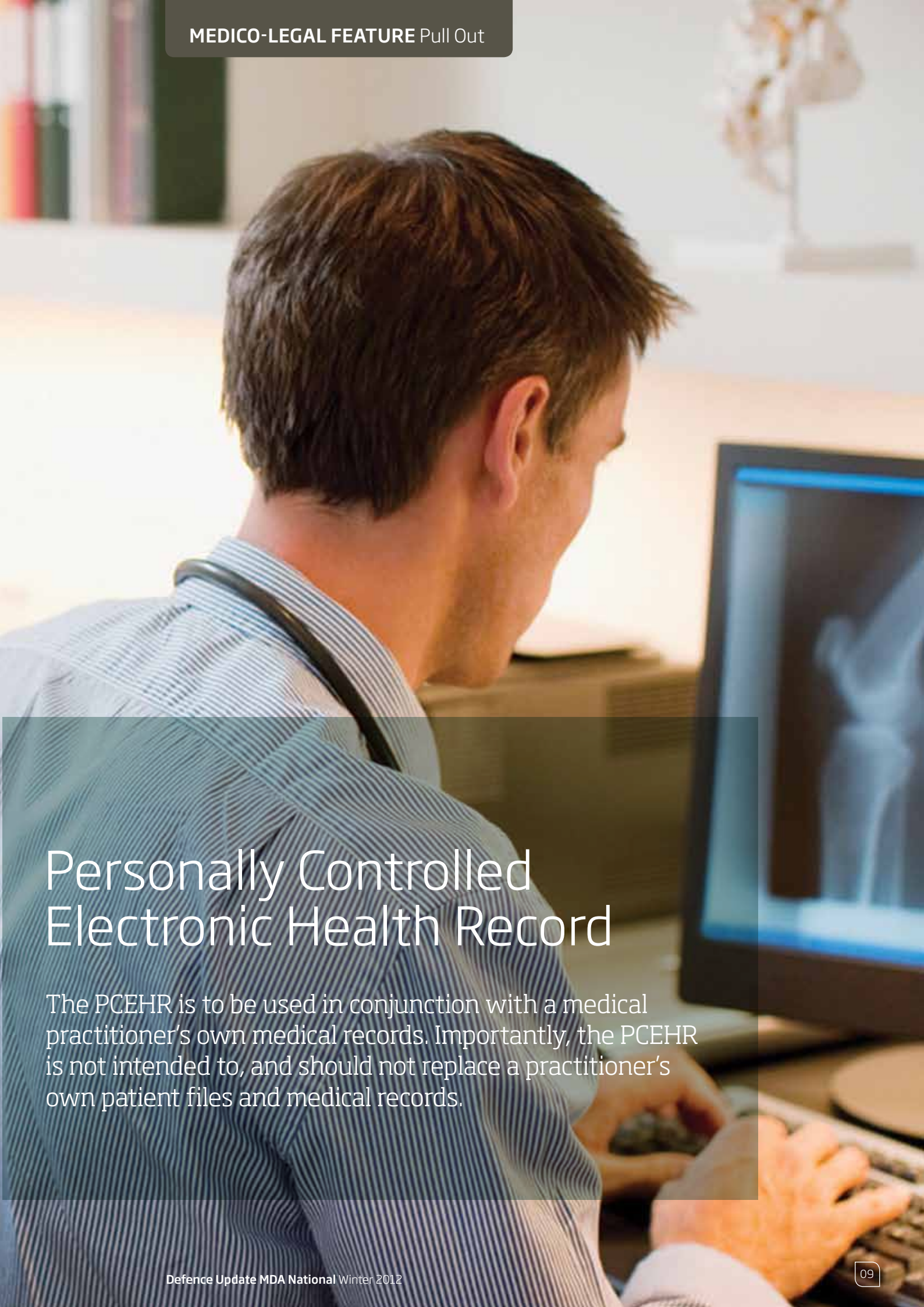
3 Catchpole KR, De leval MR, McEwan A, Pigott N, Elliot MJ, McQuillan A, et al. *Patient handover from surgery to intensive care: using Formula 1 pit-stop and aviation models to improve safety and quality.* Pediatric Anesthesia. 2007; 17: 470–8.

4 Pronovost P, Needham D, Berenholtz S, Sinopoli D, Chu H, Cosgrove S, et al. *An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU.* NEJM. 2006; 355 :2725-32.

5 Joy BF, Elliott E, Hardy C, Sullivan C, Backer CL, Kane JM. *Standardized multidisciplinary protocol improves handover of cardiac surgery patients to the intensive care unit.* Pediatr Crit Care Med. 2011; 12:304-8.

6 Rüdiger-Stürchler M, Keller DI, Bingisser R. *Emergency physician intershift handover - can a dINAMO checklist speed it up and improve quality?* Swiss Med Wkly. 2010; 24;140:w13085.

7 Weiss CH, Moazed F, McEvoy CA, Singer BD, Szleifer I, Amaral L, et al. *Prompting Physicians to Address a Daily Checklist and Process of Care and Clinical Outcomes: A Single-Site Study.* Am J Respir Crit Care Med. 2011; 15;184:680-6.



Personally Controlled Electronic Health Record

The PCEHR is to be used in conjunction with a medical practitioner's own medical records. Importantly, the PCEHR is not intended to, and should not replace a practitioner's own patient files and medical records.

Deborah Jackson, Manager, Claims and Advisory Services provides a comprehensive review of the Personally Controlled Electronic Health Record (PCEHR) system which will be introduced around Australia from 1 July 2012.

The PCEHR system is an opt-in system with patients (individuals/consumers), healthcare practitioners and healthcare organisations able to participate if they choose to do so. It is expected that for the majority of Australians who opt-in the nominated healthcare provider will be their general practitioner.

What is the purpose of the PCEHR?

The stated purpose of the PCEHR system is to address information fragmentation by allowing an individual to more easily access their own health information and make this information accessible to different healthcare providers who are involved in their care. This will result in:

- improved continuity of care by enabling key health information to be available where and when it is needed to ensure safe and ongoing care
- access to information about an individual's medicines, leading to safer and more effective medication management and reductions in avoidable medication-related adverse events
- enabling individuals to participate more actively in their healthcare through improved access to their health information
- improved diagnostic and treatment capabilities through enhanced access to health information
- improved care coordination for individuals with chronic or complex conditions by enabling the individual's healthcare team to make better informed decisions at the point of care.

What is included in the PCEHR?

The PCEHR contains:

- **A Shared Health Summary (SHS).** A summary of the patient's key healthcare events and activities, including medical history, allergies, current medications and immunisation history. The author and manager of the SHS is referred to as the individual's "nominated healthcare provider". The nominated healthcare provider is chosen by the patient and may be their GP, a registered nurse or Aboriginal and/or Torres Strait Islander health practitioner.
- **Medicare data.** This includes organ donation, past PBS medications and vaccinations. This information will be automatically populated in the PCEHR.
- **Event Summaries.** An Event Summary is used to capture key health information about significant healthcare events that are relevant to the ongoing care of the individual. Any participating healthcare provider can submit Event Summaries to the PCEHR system. An Event Summary is intended to be a "default" clinical document and used when none of the other types of clinical documents are appropriate.

  An Event Summary contains; event details including date of event and a reason for the visit (optional), allergies and alerts (optional), medicines (optional), diagnosis (optional), interventions (optional), diagnostic interventions (optional) and observations (optional).
- **Consumer entered data.** This includes a health summary which enables the individual to enter information in relation to allergies and medications and location of an advance care directive (if applicable). The consumer can also enter diary notes as a memory aid but these will not be visible to healthcare providers.

Personally controlled

The patient is able to exercise control over their PCEHR in the following ways:

- **To decide whether or not to have an active PCEHR.** As it is an opt-in model, individuals elect to register and create a PCEHR.
- **Access information in their PCEHR.** The patient (or their authorised or nominated representative(s)) can view any health information contained in their PCEHR.
- **The patient (or their authorised representative) may choose which information is published and accessible through their PCEHR.** They may request healthcare providers to withhold certain information from their PCEHR.

Access controls. Individuals or others who have been granted access to the PCEHR can determine and change access settings on their PCEHR. They can authorise access to their PCEHR by nominating other persons. They may be carers, family members and their nominated provider (the nominated provider can be their treating GP or other doctors).

Nominated providers or nominated representatives can be a medical practitioner, nurse practitioners, aboriginal healthcare workers and whoever individuals decide can be their nominated representative. The nominated provider can view the individual's PCEHR but they do not have the ability to provide consent on behalf of the individual.

Access to information within the PCEHR system can be moderated by a series of access controls managed by the patient or their authorised representative.

These include:

- **Establishing an access list.** This is a list of healthcare organisations that are permitted to access the individual's PCEHR. An individual can control how an organisation is added (or removed from the list).
- **Setting basic access controls.** These controls enable all healthcare organisations involved in providing healthcare to the individual to access the individual's PCEHR.
- **Setting advanced access controls.** These controls include setting up a Provider Access Consent Code (PACC). Without this code access to the individual's PCEHR is not possible, except in an emergency.
- **Emergency access.** Access controls may be overridden in situations where the individual requires emergency care in line with current legislation and practices.

The individual can have a clinical document removed from their PCEHR. The individual can also protect certain documents on their PCEHR from being viewed by establishing

document access settings. These access controls can allow documents considered sensitive by the individual to only be seen by a limited group of healthcare providers chosen by that individual. It is entirely up to the individual to decide to what degree they will restrict access to their PCEHR. Access will be essentially open to any healthcare provider legitimately involved in their care.

Medico-legal implications

It is essential when healthcare practitioners decide to opt- in that they fully appreciate that the PCEHR is to be used in conjunction with their own medical records.

The PCEHR is **not** to be used instead of a practitioner's own health records. The PCEHR is not intended to, and should not replace a practitioner's own patient files and medical records.

Patient control

The ability of the patient to set access controls and control their content creates a number of medico-legal implications for practitioners. General access means the PCEHR is accessible by any healthcare organisation that has access to the patient's PCEHR. Limited access means the patient has selected who will be able to access the records. In these circumstances a practitioner will not know that advanced access controls have been set and they do not have access to certain health information in a PCEHR. In an emergency situation access controls imposed by the patient are overridden.

If a patient has limited access to their PCEHR and the patient sees a locum doctor in a holiday destination this doctor may not be aware of the patient's medication or allergies as the patient may have changed this information on their consumer entered health summary. Therefore, the responsibility of this practitioner will be to make further enquiries and if necessary obtain consent from the patient to speak to their treating GP.

It is concerning that a patient may be able to set advanced access control. Health practitioners will not be advised if access to certain health information in a PCEHR has been restricted by the patient.

The SHS is a potential source of legal liability for practitioners where inaccurate and outdated information is uploaded by other health providers accessing the SHS.

Parental control

Parents have control of their children's PCEHR from 0 to 14 years. From 14 to 18 years this provides a challenging situation for practitioners where patients request that certain information not be included in their PCEHR and they request that they have control and the ability to determine access to their PCEHR. It has been determined that patients from 14 to 18 years of age are presumed to have capacity to make decisions in respect of their PCEHR. If a young person elects to manage their own PCEHR they can decide whether or not to participate in the PCEHR system and manage the access controls of their PCEHR, including choosing whether to allow their parent or legal guardian access. If an adolescent chooses not to manage their own PCEHR, the parent or legal guardian would continue to manage this person's PCEHR as an authorised representative. This provides a challenging situation for practitioners where patients request that certain information not be included in their PCEHR.

In relation to minors under the age of 14 years, a request to manage their own PCEHR will be considered on a case-by-case basis by the system operator of the PCEHR who is an authorised registration agent (not the practitioner).

Use of pseudonyms

A further potential source of legal liability for practitioners is the use of pseudonyms by patients when using the PCEHR. The motivation for the use of pseudonyms includes the fear of being traced when escaping family violence or the fear of exposure due to the public nature of their work. Pseudonyms would not indicate the individual's true identity. The use of pseudonyms provides a significant basis for inconsistent clinical decision making.

Financial penalties for misuse of information in the PCEHR

The PCEHR Bill provided that it would be an offence and civil penalties will be imposed on registered healthcare providers for intentional or reckless unauthorised collection, use and disclosure of health information contained in an individual's PECHR. Practitioners will frequently require and request information from the PCEHR and request this information from their administrative staff. The administrative staff would not have been granted access by the patients. As the legislation currently stands, this activity may attract a penalty. MDA National has been advised that this offence is not intended to capture any activity that is undertaken in usual clinical practice. However, we advise our Members to consider very carefully who will have access to the patient's PCEHR and the basis upon which access is sought.

It is essential that practitioners regularly change passwords and that they install appropriate anti-virus software to ensure that their computers are not vulnerable to unauthorised access.

Practitioners will become aware when the PCEHR has been changed by the patients. At the time this article was written, MDA National had been advised that if an event summary is amended the practitioner will be made aware and copies of the amended event health summary will now be available for the practitioner to view. This of course places an additional burden on the practitioner not only from a time management perspective but may potentially increase their medico-legal obligations to review the documents and consider whether these changes impact upon clinical decision making.

All these event summaries and shared health summaries are accessible on the PCEHR and the practitioner must review these documents and determine whether the information contained in these documents impacts upon patient care.

Want to know more?

Stay up-to-date by subscribing to *Defence Update* online **www.defenceupdate.mdanational.com.au/subscribe**

PCEHR
A GP Perspective

By Dr Beres Wenck
MBBS (Qld), FAMA
MDA National Vice President

One of the most difficult challenges in general practice is maintaining clean, and accurate data especially for our patients with many chronic problems and comorbidities. We try to have our "data clean" for all our patients but it is time consuming maintaining the accuracy.

I click on the box "routine appointment" when I receive information that is necessary to be added to their health summary. A recent example is a patient who had haematuria that I referred to a urologist. The patient responded to the request to come in for an appointment. I reviewed the correspondence I had received with him and added to his record – right cystoscopy, right ureteroscopy and basket of stones (seven uric acid), right percutaneous nephrostolithotomy and insertion of stent. In addition, subsequent removal of stent and commencement of Zyloprim 300 mg daily. This information needs to be added to the health summary as I may not have time to add it when he returns for an incidental problem or renewal of his prescriptions for hypertension and hyperlipidaemia. I consider this good preventive care.

I believe GPs should be the nominated healthcare provider for the PCEHR as we are the only healthcare provider who has the clinical skills and longitudinal relationship with patients. Most of us are computer literate but time poor. I believe that we will be double handling data. It won't be as easy as sending our health summary to the PCEHR. We will have to complete another document. GPs are going to need appropriate support and funding to ensure that accurate and comprehensive information is in the health record and valued and trusted especially by the acute healthcare sector.

The information below is being provided to patients by the Medicare Local in my area:

How do I get an eHealth network record? Use the enclosed form including the details of your participating GP and your signature. Please return your completed consent form to your practice.

This has the potential to create havoc in the practice. Also I think there will be many patients wanting their GPs to explain the PCEHR which will be very time consuming.

What is my liability if the PCEHR has incomplete or flawed data?

You may be held liable if the data is incomplete or flawed. The PCEHR Shared Health Summary (SHS) is to be managed and have details added by the nominated healthcare provider. If you are the nominated healthcare provider then you are required to obtain information from the patient during the consultation to ensure (to the best of your ability) that the SHS is accurate and current.

Practitioners should endeavour to have a usual practice when they see a patient and this may include noting any changes in the consumer entered health summary and routinely questioning the patient regarding changes in relation to the SHS.

If a patient wants to have a PCEHR but asks for some important clinically relevant information to be withheld, can I refuse to participate in developing their PCEHR?

Yes, you can refuse to participate in the PCEHR system for that patient. The process is reliant on patients, practitioners and health organisations all opting in.

What is my liability if a patient removes a clinically important document or hides clinically relevant details?

At the present time the PCEHR does not enable a patient to remove clinically important documents. However, they can limit access to their PCEHR. This limited access may and is likely to affect clinical decision making and may in certain circumstances provide an incomplete clinical picture for some practitioners, particularly practitioners who are not the patient's usual treating doctor. This situation poses a potential medico-legal risk for doctors who opt-in to the PCEHR system.

If a patient adds information to their PCEHR (especially if it is lengthy and verbose) and there is some information in that if I had read, would have prevented a harmful incident, am I then liable?

Patients do have "consumer entered notes ". These notes are for the individuals (patients) and their representatives. These notes are not visible to healthcare providers; therefore practitioners should not have any legal exposure. In the event the practitioner becomes aware of what is in the notes and it raises an issue of clinical concern and they fail to act upon this information, then they may be held liable.

In circumstances where the patient has opted in to eHealth and the PCEHR and the treating GP has also opted in, does the practitioner have an obligation or duty to discuss any potential issues of the PCEHR with the patient?

The National E-Health Transition Authority (NEHTA) has responsibility to educate and provide information for all participants in the eHealth program. However, it is inevitable that patients will seek further information from their treating doctors who have also opted in to the PCEHR system. This may potentially be a source of legal exposure for the practitioner.

What are the Keys to a Healthy Practice?

How often have you and your practice staff wanted to improve your practice yet found attaining new goals to be a frustrating struggle? MDA National's Education Services team outlines some information regarding the key drivers of workplace excellence. Thinking about whether your team is strong in all of these aspects may assist you to overcome barriers to practice improvement.

Five key drivers of workplace excellence

According to a comprehensive Australian study, there are five key factors that drive excellence in any workplace. Hull and Read (2003) interviewed and surveyed hundreds of people from different workplaces of varying quality. While medical practices are not specifically discussed in Hull and Read's study, they state that their findings are relevant to all workplaces irrespective of industry.[1] Thus their results can be applied to medical practices. Although there are different types of medical practices, each facing unique demands, there are overarching principles which apply to all.

Hull and Read (2003) identified 15 factors that need to be present in the foundations of a workplace if excellence is to be achieved – of which five factors in particular have the most weight as potent drivers of workplace excellence. The five key factors are:[1]

- safety
- clear values
- having a say
- high quality working relationships
- workplace leadership.

These foundations of a "healthy" practice support optimal healthcare service and job satisfaction for all your staff.

High quality working relationships is the critical key

The presence of high quality working relationships was identified as the primary factor driving all others.[1] High quality working relationships among the team allow practices to respond to the changing environment and improve practice processes and care.[2] Strong working relationships increase "joy in daily work".[2] Happy staff are more likely to stay with the workplace and produce high quality work.

For high quality relationships to develop there needs to be:

- an atmosphere of mutual trust and respect[1]
- ongoing connection between all team members[1]
- a feeling of secure identity and self-worth in each team member[1]
- emotional competence[3]
- strategic effort.[2]

The other four keys to workplace excellence

Leadership

A great leader needs to:

- empower employees[1,4]
- support all staff in professional development[5]
- model professionalism, patient-focus, and respect for everyone's contribution[1,4]
- embrace a nonhierarchical leadership style[6]
- foster creativity[5,6]
- unify differences within the team.[6]

Clear values

Team members need to understand the workplace's purpose and expectations of behaviour.[1] They also need to know what makes the practice important and meaningful.[7]

Individual excellent workplaces demonstrate a variety of values; what is important is that they are explicitly stated and used to frame multiple workplace systems and structures[8], e.g. task prioritising and budget decisions.[7] Any inconsistencies or conflicts between actual actions and the values, due to competing priorities, need to be quickly and openly discussed.[1]

Safety

A workplace needs to create physical and psychological safety. Team members need to feel "protected by the system". This leads to emotional stability and improved outputs.[1]

There needs to be continual review of best practice and what is actually occurring in the workplace. Real safety is not about policies in a manual. "Feeling safe and secure comes from confidence, knowledge, training and particularly the experience of knowing that other people care for your wellbeing."[1]

Effective quality improvement activities are only possible when staff feel psychologically safe and able to contribute.[7]

Having a say

Team members being able to "have a say" allows them to make valuable contributions to the workplace and be independent. It brings "brains and heart" to work and that increases satisfaction and improves workplace outcomes. Individual initiative is encouraged in an excellent workplace.[1]

Conclusions

Strong workplace foundations allow practices to individually flourish

Many of the characteristics that make a workplace excellent – such as openness, inclusive decision making, and building strong relationships – overlap with what is strived for in patient-centred care. Thus developing these skills brings wide ranging benefits to a practice.

Having different professionals working together as a clinical practice is not easy. It takes reflection, discussion, knowledge and effort to build a great workplace. Ensuring that your practice has high quality working relationships, good leadership, clear values, safety, and an open environment in which everyone can "have a say" provides the foundation for true excellence.

MDA National can provide resources and advice to assist practice improvement efforts. Contact the Support in Practice team on 1800 011 255 or email peaceofmind@mdanational.com.au

If you are interested in participating in further education on the drivers of workplace excellence, email events@mdanational.com.au

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CaseBook

How Restrained are You?

Medico-legal Adviser, Janet Harry explores the use of "Restraint of Trade Clauses" in employment contracts in medical practices.

Case history

Dr X is an orthopaedic surgeon working in a large group practice. Over the years, Dr X experienced a number of changes to his place of employment. His employer had incorporated the practice (created a legal entity) in order to provide certain protections and benefits to the doctors who were employed there. The business was successful, and the employer opened two additional practices, located adjacent to major private hospitals. Dr X signed a contract of employment when he commenced with the practice, and another contract with the new corporation when it was established.

After five years, Dr X made the decision to commence his own private practice, and handed in his notice three months before his cessation date, as required under his employment contract. Shortly before he was due to leave, he was told that the employer intended to enforce the Restraint of Trade Clause in the contract. The restraint provisions prevented the doctor from doing any of the following for a period of two years after leaving the employment:

- He could not establish his new practice within a 5km radius of any premises from which his former employer operated.
- He could not approach, solicit business or entice away any patients who he had seen in his former practice.
- He could not approach any employee of his former practice to work for him in competition with his former employer.

Discussion

A Restraint of Trade Clause is a legal clause often found in employment contracts. The clause is used by employers in an attempt to protect the employer's legitimate business interests. In the area of medical practice, this will frequently include a geographical restraint, a restraint on contacting former patients, and a restraint on attempting to employ any persons who worked for the employer. There will generally be a specified time period, and this can be for a period of months or even for a year or more.

The effect on a medical practitioner who is wishing to set up his or her own practice is clear – careful consideration of any Restraint of Trade Clause is necessary to ensure that the terms are complied with. If the clause is breached, then the former employer can seek to enforce the Restraint of Trade Clause through the courts.

Notwithstanding the existence of a contract, the courts will usually only enforce Restraint of Trade Clauses if they are "reasonable". This is often a question which will turn on the facts of the case. The court's role is to balance the needs of the employer to protect their client relationships against the right of the employee to work freely and earn a living.

Dr X consulted MDA National when he was informed of the employer's intention to enforce the Restraint of Trade Clause, prior to leaving his employment. Through MDA National, Dr X was able to negotiate terms acceptable to both parties. Nonetheless, a number of restrictions applied to the doctor for a period of six months following cessation of his employment.

Members need to be aware that with continued growth and incorporation of medical practices, more complex terms and conditions of employment will be inevitable. If you find that there is a dispute as to the meaning, validity or impact of a Restraint of Trade Clause in your employment contract, we recommend that you contact our 24/7 Medico-legal Advisory Service on 1800 011 255. Additionally, before entering into an employment contract, we strongly recommend you consider obtaining independent legal advice.

CaseBook

Why Accurate and Current Medical Records Matter

With the commencement of the Personally Controlled Electronic Health Record (PCEHR) system in July 2012, Claims Manager, Alice Cran re-visits the timely issue of record management and the need to keep current and accurate patient records.

This issue was the focus of attention in the NSW Supreme Court case of C S v Anna Biedrzycka [2011] NSWSC 1213, involving follow-up of a patient undergoing HIV testing.

Case history

In 1999, patient Ms LB attended the medical centre where two of the defendant doctors practised with a number of other doctors. At that time, LB was living in Bondi.

On 30 March 2004, LB returned to the practice. She was then living at a different address in North Bondi. At the consultation, LB requested a test for sexually transmitted infections, including HIV. She was counselled by the attending doctor, Dr Biedrzycka, and arrangements were made for the pathology tests to be carried out by a nurse employed by the practice. LB was asked to return to the practice for the results in about a week's time.

At no stage during this visit did anyone confirm with LB that her address, as it appeared in the records, was current.

On 5 April 2004, another doctor at the practice, Dr Johnson, received a telephone call from the pathology laboratory. The laboratory indicated that the patient's results were equivocal with respect to the HIV test and that the patient needed retesting. Having received the advice, Dr Johnson wrote in the patient's records: "By phone, needs bloods repeated, pos result, needs repeat." That same day Dr Johnson directed the administrative staff of the practice to send a recall letter to LB.

LB next attended the practice of her own volition on 22 April 2004. She asked to see Dr Biedrzycka and was told she wasn't available. The patient then saw the next available doctor, Dr Gross. Dr Gross reviewed the pathology results on the computer. He interpreted LB's test results as negative, with the exception of candida. Dr Gross did not carry out any further enquiries and did not read the part of the patient's record that included Dr Johnson's note of 5 April 2004. Dr Gross advised the patient that her tests were clear except for the candida swab.

LB left the practice with the impression that it was safe to engage in unprotected sexual intercourse. LB advised her partner, Mr CS (the plaintiff in the proceedings) accordingly, and they engaged in at least one episode of unprotected sexual intercourse about one week after 22 April 2004.

On 12 May 2004, Dr Johnson was advised by staff that there had been no response to the patient recall letter. Dr Johnson directed that a telephone call be made to the patient, but those attempts were unsuccessful. A further letter of the same date was sent, again requesting LB to attend the practice as soon as possible. Dr Johnson also made an entry in LB's clinical records, which read in part that: "this patient needs her HIV serology repeated as there is a suggestion that the serology tests were POS."

The following day, the staff informed Dr Johnson that the telephone number for LB as stated in their records was incorrect. From that time until the end of May, Dr Johnson made various enquiries through the Sydney Hospital Sexual Health Clinic, ultimately resulting in a representative of the Clinic making contact with LB's father. LB attended the practice on 3 June 2004, and was told of the need for re-testing for HIV. The HIV test was subsequently confirmed to be positive.

Be specific when entering test results in a patient's medical records – this is particularly important in group practices where a patient may not be seen by the same doctor at each consultation.

Medico-legal issues

LB's partner, CS, contracted HIV and subsequently commenced proceedings against three of the doctors at the practice, together with the corporate entity that provided all relevant administrative services and facilities to the practice under a contractual agreement with the doctors. CS settled his claim with doctors Gross and Johnson, who agreed to pay damages to him. The remaining two defendants (one of whom was the corporate entity) had verdicts entered in their favour.

Following settlement of the claim, doctors Gross and Johnson filed a cross-claim against the corporate entity seeking contribution towards the damages paid to CS under the settlement agreement. The doctors alleged that the administrative staff of the practice were negligent in failing to maintain proper records, leading to the patient being lost to follow-up. The corporate entity also filed a cross-claim against all three defendant doctors seeking indemnity under the services agreement that it had entered into with each doctor.

One of the issues that came before the court for determination was whether a duty of care extended to an indeterminate number of people with whom LB may have been in contact. In considering this, the judge pointed to the following issues:

- The corporate entity was in the business of providing health care and knew of the harm that would result to others (in this case, CS) if there was a failure to promptly notify a patient of a serious medical condition.
- The corporate entity had assumed responsibility for keeping accurate and current patient records.
- The harm to CS would have been averted had the corporate entity, through its administrative staff, complied with its own documented procedures for maintaining accurate patient computer records, including updating and modifying existing records.

Based on the above analysis, and having regard to the strict legislative requirements governing the notification and treatment of HIV, the judge found that the corporate entity did owe the patient and her sexual partner a duty of care.

The failure of the practice (i.e the corporate entity through its administrative staff) to keep accurate and current patient records was also found to be causally related to the harm suffered by CS. The fact that Dr Gross failed to review all of LB's test results on 22 April 2004, when advising LB that her tests were clear except for the candida swab, did not operate as an intervening act to absolve the practice of liability.

The court then considered the liability of Dr Johnson, who initially took the call from the pathology laboratory on 5 April 2004. It was found that Dr Johnson's entry in the patient's records was insufficient, in that it required other doctors at the practice to seek clarification from Dr Johnson with respect to his entry before being in a position to properly treat and counsel LB. Similarly, the judge found that Dr Johnson took insufficient steps to ensure the early recall of the patient.

Risk management strategies

It is clear from this case the importance of maintaining correct and current patient information. Some practical tips flowing from this case include:

- Keep patient information current by confirming contact details at each consultation. Don't rely on patients to volunteer this information.
- Ensure there is an effective system in place for recalling patients, including promptly following-up unanswered recall letters (see Section 1.5.3 of the RACGP Standards for general practices).
- Be specific when entering test results in a patient's medical records – this is particularly important in group practices where a patient may not be seen by the same doctor at each consultation.

What do you think?

Share your comments with us at *Defence Update* online **www.defenceupdate.mdanational.com.au/medical-records-matter**

CaseBook

Mandatory Disclosure of Confidential Health Information

A Load of Rubbish or a Legal Duty?

Does a doctor in private practice have an absolute duty to ensure the confidentiality of a patient's health record? Medico-legal Adviser, **Dr Julian Walter** examines this perennial medico-legal issue.

Case history

A GP received a letter from a local council requesting the release of confidential patient information.

The council had discovered illegally dumped waste, which included a discarded medication packet. The medication packaging had a prescription label with a patient's name, the prescribing doctor's name, as well as the date and the name of the pharmacy that had dispensed the medication.

The council then wrote to the GP (who was the prescribing doctor) requesting the full name, address and date of birth of the patient. The request was made under an obscure piece of environmental legislation (the *Protection of the Environment Operations Act 1997* (PEOA)) which carried a penalty in the form of an infringement notice if the GP did not comply.

The GP contacted MDA National's 24/7 Medico-legal Advisory Service to seek advice on whether they should release the information.

Discussion

A doctor in private practice does not have an absolute duty to ensure the confidentiality of a patient's health record. Disclosure is governed by the *Privacy Act 1988* (Cth). Several broad categories exist where disclosure may be permitted:

1. express or implied consent by the patient
2. mandatory disclosure under compulsion of law
3. an overriding duty in the "public interest" to disclose where there is a risk of harm or safety to the patient or others.

This case concerned a duty to disclose under compulsion of law. Typically this will involve issues such as court orders (including subpoenas, summons and search warrants), mandatory reporting (e.g. child abuse and notifiable diseases) and administrative disclosure (births and deaths). However in this case, the law was somewhat more arcane.

After examining the PEOA legislation and the National Privacy Principles (to ensure that the request represented a valid interpretation of the law and that no specific exceptions applied), we advised the GP that the release of the requested information was appropriate. A letter was provided for the GP to submit to the council outlining why the information was being released and the relevant concerns the release of information raised. We also advised the GP to inform the patient that their name, address and date of birth had been released to the council after legal advice had been obtained in relation to the council's request.

On this occasion, although the information requested by the council was still protected under privacy legislation, it was not particularly sensitive. However each case would be assessed on its merits – weighing up the sensitivity of the requested health information against the relevance and penalties of the legislation underlying the request.

Want more information?

If you would like more information about disclosure of confidential information, contact our Medico-legal Advisory Service on 1800 011 255 or email **advice@mdanational.com.au.**

What's On?

MDA National is supporting Members in 2012 by sponsoring a number of state and local conferences and events in collaboration with colleges and associations, as well as holding our own events specifically for MDA National Members.

We welcome you to come and visit us at any of the events below and others which are listed in full at **www.mdanational.com.au**

June 2012

8–10	Annual RDAQ Conference **Sanctuary Cove, QLD** conference.rdaq.com.au
23	SA Board in General Surgery Paper Day **Adelaide, SA** auss.org.au

July 2012

1–8	AMSA National Convention **Perth, WA** www.amsa.org.au
7	ASA / ANZCA QLD CME Meeting **Brisbane, QLD** www.qld.anzca.edu.au/events
7	AMA WA Charity Gala Dinner & Awards Nights **Perth, WA** www.amawa.com.au/Events/AnnualDinner.aspx

Find out more

If you'd like to know more about our events, sponsorship opportunities, or you have an event you would like to promote, visit **www.mdanational.com.au** email events@mdanational.com.au or call 1800 011 255.

August 2012

4	Bunbury Education Day **Bunbury, WA** www.mdanational.com.au
16–19	Joint SA, WA and NT ASM **Bunker Bay, WA** www.surgeons.org
24–26	QLD ASM **Stradbroke Island, QLD** www.surgeons.org
26	Perth City to Surf **Perth, WA** events.sportsnewsfirst.com.au/event/perthcitytosurf
29–2 Sept	Asian Oceanian Congress of Radiology **Sydney, NSW** www.aocr2012.com

September 2012

12–23	General Surgeons Australia Annual Scientific Meeting & Trainees Day **Hobart, TAS** generalsurgeons.com.au
29	ASA National Scientific Congress **Hobart, TAS** www.asa2012.com

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It is important that you notify us of your updated information to ensure you maintain continuous cover and to make sure that we can continue to contact you with important information about your medical indemnity.

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