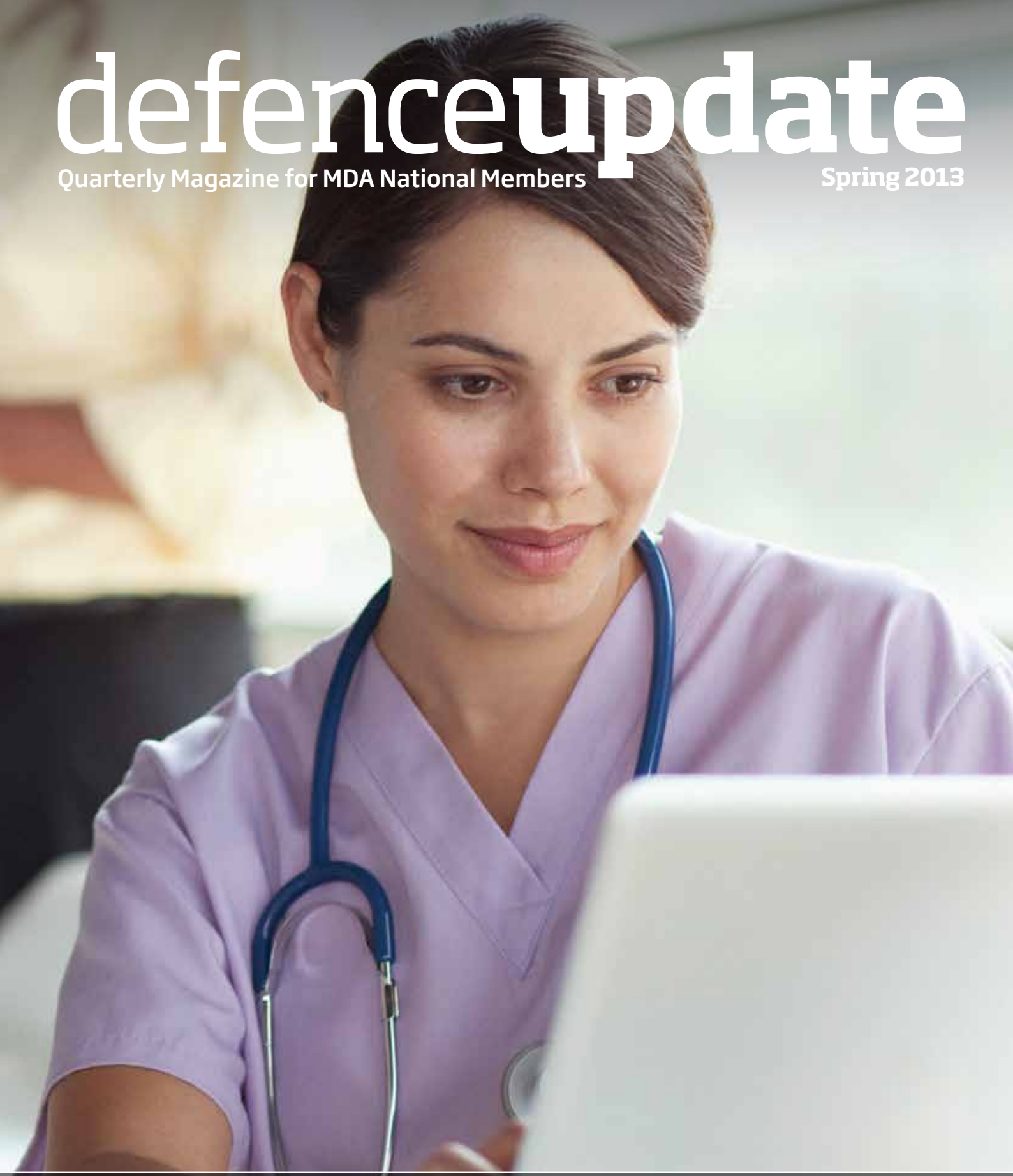
defenceupdate

Quarterly Magazine for MDA National Members

Spring 2013



MDA National
Support Protect Promote

Revalidation in the UK

Private Patient Arrangements in the Public Health System

Security of Electronic Records

Medico-legal Feature: Online Professionalism

MDA National CaseBook

Editor's Note

Our 2013 Medico-legal Minefield Forums explored communication technologies, particularly telehealth and social media. In this issue of *Defence Update*, we continue this discussion.

To find what Members said about the Medico-legal Minefield Forums visit **youtube.com/user/MDANational.**

On page 9, our pull-out feature examines professionalism in the online environment, including the vexed issue of doctor rating websites. Other articles in this issue explore online reputation management (page 13) and security issues associated with electronic medical records (page 8) – a reminder that these communication technologies not only bring exciting new opportunities but also potential risks for the unwary.

The Medical Board of Australia recently commenced a "conversation" about the potential introduction of a revalidation process for Australian medical practitioners. On page 6, solicitor Andrew Truby outlines the revalidation process which was introduced in the United Kingdom in 2012.

Closer to home, A/Prof. Julian Rait discusses the challenges of professional regulation in Australia with the introduction of the National Registration and Accreditation Scheme three years ago, and he highlights the importance of cultural change in improving complaints handling and regulation issues (page 3).

I hope this issue of *Defence Update* helps to keep you informed about important changes and challenges in our medico-legal landscape. As always, we welcome your comments and feedback about these topics.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

From the President

Building an improved partnership with healthcare regulators

In recent years a number of public policy decisions have been made, leading to some questionable experiments in the delivery of health care.

One obvious explanation for this is that policy makers have been subject to various cognitive biases in their decision-making. For example, "planning fallacy" is a tendency of our political leaders to underestimate the time, costs, and risks of decisions and at the same time overestimating the benefits of those same actions. Accordingly, the planning fallacy frequently results not only in substantial cost overruns but also in significant benefit shortfalls.

One interesting experiment has been the introduction of the Australian Health Practitioner Regulation Agency (AHPRA). The Health Practitioner Regulation National Law came into force on 1 July 2010. The introduction of the scheme was heralded by the then Federal Health Minister Nicola Roxon as a new era in professional regulation, whereby 10 (now 14) health professions would be regulated by nationally consistent legislation under a National Registration and Accreditation Scheme.

However a subsequent Senate Inquiry in 2011 (Finance and Public Administration References Committee) revealed that AHPRA was not delivering successful outcomes in health policy. The Senate Inquiry report was critical of a number of the Agency's failures, and indicated that these could have significantly compromised the nation's health services.

Giving evidence on behalf of MDA National, Dr Sara Bird and I did concede to the Inquiry that the introduction of the National Scheme was an extraordinary logistical undertaking, replacing 65 acts of parliament and having 10 national boards replace 82 state and territory registration boards with a new organisation, staff and national registration standards. That failures occurred through such a complex undertaking was obviously regrettable, but was also to some degree, inevitable.

However, at the time MDA National was encouraged that AHPRA acknowledged its failings and would endeavour to improve its performance. Furthermore, a number of recommendations were made by the Senate Inquiry to improve AHPRA's functioning but it would seem that few of these have been acted upon.

MDA National also believes that there could be greater awareness of the importance of cultural change in improving the complaints handling and registration issues with doctors. Certainly our experience in medico-legal matters supports the observation that models that are less adversarial are inherently safer. In particular, we have long held deep reservations as to the wisdom of the mandatory reporting provisions under Section 140 of the National Law. MDA National is aware of several instances where the provisions with respect to impaired practitioners have been interpreted or implemented to the disadvantage of those practitioners who had initially self-referred themselves for appropriate medical care.

It is our view that the requirement of treating practitioners to breach traditional doctor-patient confidentiality is counter-productive to a cooperative and self-reporting culture of health care. Practitioners should continually be encouraged to voluntarily seek medical care. Indeed, at least one state government, the Government of Western Australia, has seen that legislating such a breach of trust in a doctor-patient relationship could be inappropriate. Western Australia declined to ratify the mandatory reporting provisions of colleagues by treating doctors and so we continue to lobby for these provisions to be reconsidered on a national basis.

In addition, some industry regulators adopt a more "systems focused" approach to their work, which I think could be modelled by AHPRA. For example, the experience of our insurance company (MDA National Insurance) as a regulated financial institution is that we feel that the Australian Prudential Regulation Authority (APRA) distinguishes itself by working with industry and by trying to understand how to narrow the gap between regulatory expectations and actual practice. We would contend that, like APRA, AHPRA should consider becoming a partner in regulating the health professions, and become more focused on developing a culture of good faith with practitioners. Such an approach is more likely to cultivate greater professionalism and system safety.

Equally, AHPRA requires increasing support and co-operation from health professionals and improved access to information, rather than simply being asked to inflexibly interpret the National Law and impose strict sanctions upon practitioners.

A/Prof. Julian Rait
MDA National President

Notice Board

New AHPRA Guide and Fact Sheets

In June 2013 AHPRA published new guides for health practitioners and the community about how notifications are managed in the National Registration and Accreditation Scheme. *A guide for practitioners: Notifications in the National Scheme* (the Guide) and series of fact sheets aim to explain to medical practitioners what happens when AHPRA receives a notification about them. The Guide outlines what happens after a concern has been raised, who decides what happens, how AHPRA works with health complaints entities and what medical practitioners can expect from the AHPRA processes. Members can access the Guide and fact sheets at **ahpra.gov.au/Notifications/Fact-sheets.aspx**.

Medical Registration Reminder

Members are also reminded that medical registration is due for renewal by **30 September 2013**.

What's On?

MDA National continues to promote your professionalism and wellbeing with our *Practical Solutions to Patient Boundaries* and *Keys to a Healthy Practice* workshops. We will also be hosting the Cognitive Institute's *Mastering Professional Interactions* in Sydney (September) and Perth (October) and will run educational sessions at various state and national conferences.

For a full list of events taking place between September and December visit **defenceupdate.mdanational.com.au/whats-on-spring-2013**.

Help Your Mutual Go Greener – Online *Annual Report* 2013

In response to Member feedback, MDA National is planning to publish our *Annual Report* online from 2013 onwards for your convenience, enhanced interactivity and greater environmental sustainability.

If you would instead prefer to receive a hard copy of the 2013 *Annual Report* by mail please email peaceofmind@mdanational.com.au before **1 October 2013**.

Thank You!

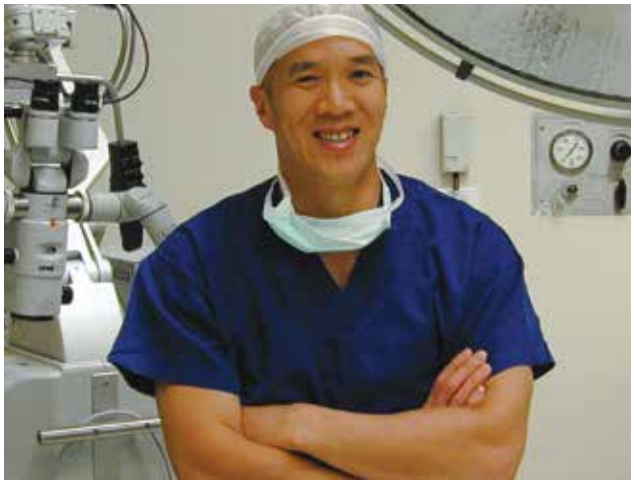
Thank you for renewing your Membership and Policy with MDA National. We are committed to supporting, promoting and looking after the long term interest of our Members. We believe that our ongoing success can be attributed to our understanding of the medical profession and commitment to deliver expert and reliable services.

If you have any questions about your Membership or Policy email us at peaceofmind@mdanational.com.au or call our Member Services team on 1800 011 255.

Most Trusted Australian

Congratulations to MDA National Member, Dr Charlie Teo AM, on being named as the most trusted Australian by *Reader's Digest* magazine.

Dr Teo is a neurosurgeon and the founder of the Cure for Life Foundation which funds research into brain cancer. For more information on the Cure for Life Foundation visit cureforlife.org.au.



Dr Charlie Teo AM, NSW.

The Criminality of Treatment – Dr Patel & Beyond (Part 4)

Introduction

Dr Patel survives another court battle. Earlier this year a Queensland jury acquitted Dr Patel of the murder of Mr Morris, a former patient. On 29 June 2010, a Queensland jury found Dr Patel guilty of Mr Mervyn Morris' manslaughter. However, in 2012 the High Court of Australia dismissed all charges against Dr Patel, relating to four patients because of a miscarriage of justice, but ordered a retrial. Following these events, the Queensland Director of Public Prosecutions (DPP) filed new charges against Dr Patel in relation to Mr Morris' death.

Why is it Dr Patel was acquitted by another jury in 2013 of Mr Morris' manslaughter? Is this the end of the matter for Dr Patel?

The High Court

Dr Patel had been convicted of three counts of manslaughter and one count of unlawful grievous bodily harm in the course of surgery on four patients while at Bundaberg Base Hospital. Section 288 of the Queensland Criminal Code (the Code) enshrines a legislative obligation to preserve life, and until this case, it was thought that obligation only applied to the actual performance of the surgery – requiring that surgery be performed with a reasonable standard of care and skill. The High Court determined that the prosecution's conduct, in changing their focus mid trial, had led to a miscarriage of justice. However Dr Patel was unsuccessful in persuading the High Court that s288 of the Code[1] should be restricted in its application to the performance of surgery alone and not expanded to the decision to operate or to advise.

Mr Mervyn Morris

On 20 May 2003, Mr Morris (75 years old) was admitted to Bundaberg Hospital with rectal bleeding. On 23 May 2003, Dr Patel performed a sigmoid colectomy and colostomy. No bleeding point was found but the operation was straightforward and without complication. On 30 May 2003, Mr Morris suffered a wound dehiscence and a repair was performed. Mr Morris died on 14 June 2003.

Claim by the prosecution

Noting the High Court's interpretation of s288 of the Code, the prosecution abandoned allegations of surgical incompetence, focusing the case on fitness for surgery, incorrect diagnosis and post-operative care.

Although the operation was performed "well enough", the prosecution argued that Mr Morris responded poorly to the operation which lead to cardio-respiratory failure, hypoalbuminaemia and fluid overload, malnutrition, and septicaemia.

The jury finds Dr Patel not guilty

The jury trial commenced in early February 2013. The jury heard evidence from experts and colleagues. A prosecution expert told the jury Dr Patel "conservatively" treated Mr Morris but that unexpected complications (not necessarily related to the operation) may have left Mr Morris permanently weakened. He was of the view that Mr Morris had an abdominal infection (one week after the procedure), which ultimately caused his death.

After five weeks of evidence and 48 hours of deliberations, on 13 March 2013, the jury found Dr Patel not guilty of the manslaughter of Mr Morris.

What now for Dr Patel?

As with all jury trials we will never know the reasons behind their finding. They appear to have accepted that Dr Patel's management, while possibly deficient, was not grossly negligent or capable of a criminal finding. One could theorise that the trial was run in a different political environment – so the stigma around Dr Patel was diluted.

After this decision, Queensland prosecutors filed proceedings for a new trial against Dr Patel for causing grievous bodily harm to Mr Ian Vowles.

A new jury, armed with a new set of facts and hearing from different experts, may arrive at a different outcome. The prosecution will undoubtedly learn from procedural problems faced at this trial. Whatever view one holds about Dr Patel, a finding of criminal conduct arising from surgical treatment must indeed have a high burden of proof. The acquittal by the jury perhaps recognises this high burden.

Kerrie Chambers is the Senior Partner in the Health Group at HWL Ebsworth Lawyers and Feneil Shah is an Associate.

1 Sections 291, 303 and 320 of the Code create the offences of unlawful manslaughter and grievous bodily harm.

Read the other articles in this series at:

defenceupdate.mdanational.com.au/dr-patel-part4.

A Pit-Stop on the **Road to Revalidation in the UK**

Planning to practise medicine in the UK? Then there's more than the eleven-month long winters you'll need to prepare yourself for! Obtaining Registration and a Licence to Practise from the General Medical Council (GMC), the body that regulates medical practitioners, is a prerequisite. Apply for these early, preferably before you travel, to avoid upset and disappointment later on.

Passport, visa and GMC documentation all in order? Now prepare yourself for revalidation...

Revalidation came into force at the end of 2012, and is the process by which virtually all licensed medical practitioners in the UK, including trainee doctors, must demonstrate to the GMC every five years that they are up to date and fit to practise. The cornerstone of revalidation is that doctors must undergo *annual* appraisal culminating in an enhanced appraisal undertaken by a Responsible Officer (normally the medical director of the doctor's employing organisation known as a designated body) at the end of the five-year cycle. The Responsible Officer will make recommendations to the GMC as to whether (subject to there being no health or probity concerns) a doctor should be revalidated but the GMC will *have the final say on whether to revalidate a doctor – and, therefore, whether to challenge any recommendations which seem perverse or are unsupported by evidence.*[1]

Historical backdrop

As far back as 1975, the Merrison Committee[2] suggested that there should be some form of "relicensure" for doctors. And there matters lay until a series of medical scandals[3] brought the issue into the spotlight again and highlighted that *self-regulation had been found wanting and the GMC proposed revalidation as a consequence.*[1]

Dialogue between the GMC and the medical profession about what would and would not constitute a fair and robust system for revalidation was slow and protracted. By 2005 the GMC were on the verge of introducing a scheme, until their plans were scuppered by Dame Janet Smith, Chair of the Shipman Inquiry, who expressed serious misgivings[4] about what was being proposed. She highlighted in particular that the GMC may have oversold revalidation as providing reassurance to patients and the public that each doctor on the register was up to date and fit to practise when the model did not involve direct GMC assessment of a doctor's practice. Further, a doctor may be deficient but not quite deficient enough for the GMC to invoke its fitness to practise procedures. Eight years later, revalidation is at last in place.

Professor Sir Peter Rubin, Chair of the GMC and the first doctor to revalidate in the UK, said that *this is the biggest change in medical regulation since the GMC was established in 1858.*

This may overstate the point a little, especially as the pace of change in medical regulation post-Shipman has been phenomenal; the current medical regulatory landscape is almost unrecognisable from what it was in 2005 or indeed

at the time of the Merrison report when the Committee said that they could *never imagine that the GMC could ever hope to dictate rules for doctors!* There is no doubt, however, that the road to revalidation has been a somewhat rocky one.

Key principles and themes

The GMC provides a wealth of well written and easily-accessible guidance on its website[5], which sets out the parameters within which a doctor's fitness to practise and clinical knowledge will be assessed.

At the heart of revalidation is annual appraisal, and as ever with the GMC (and rightly so), reflection is the key. The purpose of revalidation from the GMC perspective is that it is not supposed to be a superficial tick-box exercise; rather it is intended to provide a meaningful opportunity for a doctor to reflect on their clinical practice and how they may develop and modify it as a result of that reflection.

The framework consists of four key domains against which fitness to practise will be assessed at the five-yearly enhanced appraisal:

1. knowledge, skills and performance
2. safety and quality
3. communication, partnership and team work
4. maintaining trust.

If you read nothing else, you should read *Good Medical Practice*[6] and the linked Framework document[5] before you leave the sunny shores of Australia, as they will tell you all you need to know about the clinical standards, conduct and ethical behaviour that the GMC expects from doctors practising in the UK.

Effectiveness

In today's austere economic environment, the cost of revalidation, currently £2.75 million[7], is probably the primary concern of critics who query if it will deliver value for money. The GMC say that they have never considered the purpose of revalidation to primarily identify "bad apples", but to affirm good practice.[1] In comparison to the cost, however, while the aim of ensuring continued high standards across the board for all doctors is of course a laudable one, the process itself may turn out to be somewhat of a blunt instrument. These and other issues such as increased bureaucratic burden on doctors, the ability to ensure fairness within a system which is inherently subjective in nature and, most importantly, the difficulty in identifying the real benefits which revalidation will bring in terms of increased patient safety will no doubt provide fertile ground for further commentary in the future.

All that said, in terms of patient protection, time may show there are potential gains to be had. Certainly revalidation will ensure that every doctor will have a meaningful appraisal on a regular basis, which will hopefully lead to more proactive, preventative regulation and better standards on the ground.

What it means for you

Remember, participation in revalidation is not optional; *Good Medical Practice*[6] imposes a positive obligation to engage with the process and failure to do so could lead to the withdrawal of your licence to practise. Appraisal is not like cramming for your finals; you will need to maintain an evidence-based portfolio and gather information throughout the five-year cycle. Provided you plan, document and review then all should be well. Although potentially onerous, the new regime could be a positive and insightful experience for doctors and contribute to an improved patient experience and increased patient safety. For those who have no plans to visit the UK, this article may be dismissed as (thankfully) academic but beware where the GMC lead (at least in the UK), others will follow, meaning their revalidation model may well be replicated in other jurisdictions in the future, including Australia...

Andrew Truby is a solicitor at Berrymans Lace Mawer LLP, UK.

Read our short update on Revalidation in Australia in *Defence Update* Winter 2013 at :

defenceupdate.mdanational.com.au/notice-board-winter-2013.

1 Rubin P. *Revalidation: A General Medical Council Perspective.* Clinical Medicine 2010;10, (No.):112-113. Available at: rcpjournal.org/content/10/2/112.full.

2 Merrison Committee was formed by the government to look into the modernisation of the medical profession.

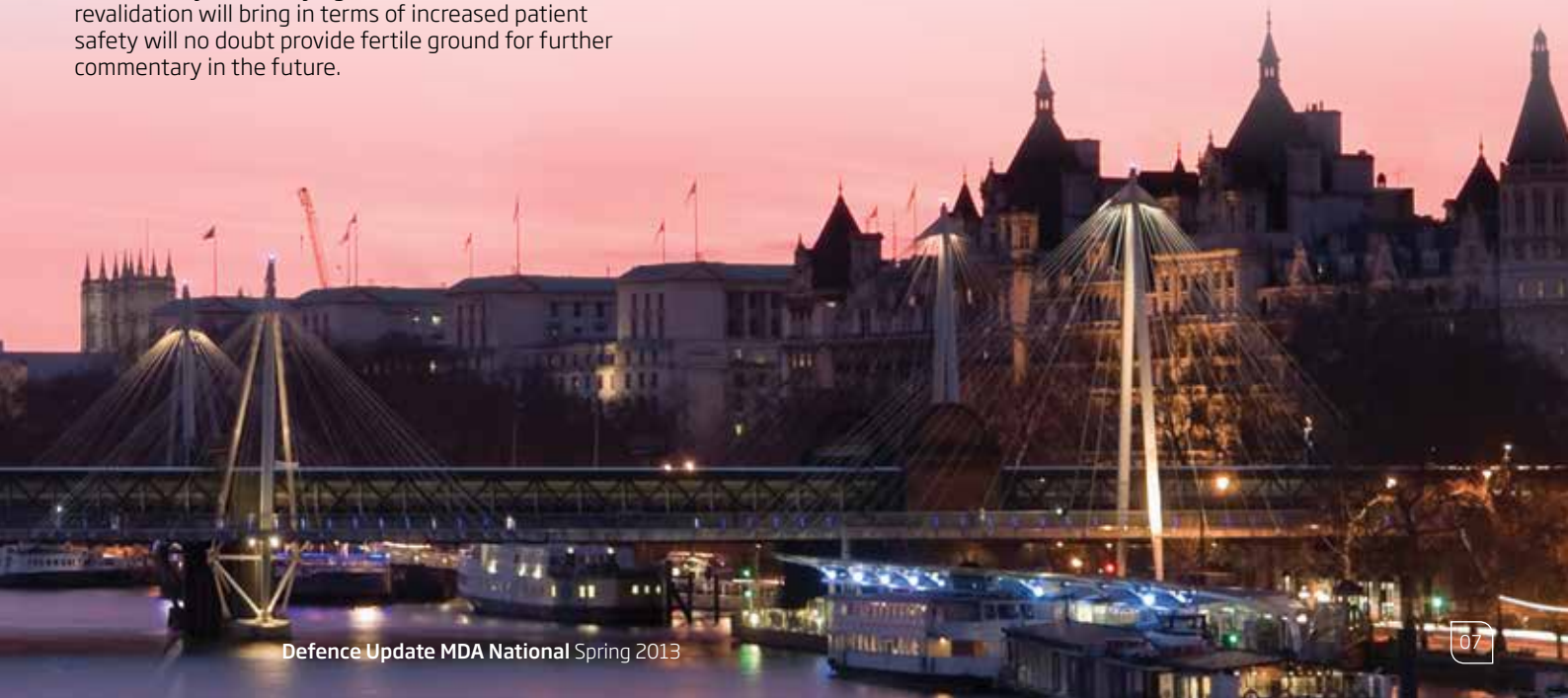
3 In particular, the Bristol Royal Infirmary Inquiry.

4 Final Report of the Shipman Inquiry – 27 January 2005. Available at: webarchive.nationalarchives.gov.uk/20050129173447/the-shipman-inquiry.org.uk/finalreport.asp.

5 GMC *Good Medical Practice Framework 2013*. Available at:.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp.

6 *GMC Good Medical Practice* – March 2013 version. Available at: gmc-uk.org/guidance/good_medical_practice.asp.

7 GMC statement of financial activities for the year ended 31 December 2011.



Security of Electronic Records

Sitting at your practice computer one morning, you are surprised to see an alert flash up on the screen – your computer has been hacked and your patient records encrypted. A ransom of several thousand dollars is demanded before the hackers will decrypt your records to enable access.

Cyber-crime is not new, however the targeting of health practices has recently appeared as an emerging risk. In December 2012, the widely publicised[1] hacking and encryption for ransom of a Gold Coast medical centre's records brought this issue to the attention of doctors and public alike. Media sources stated that there had been 11 similar intrusions in Queensland during 2012.[2]

Prevention

While no security measures are foolproof, it is essential that preventative action is taken by practices to minimise the risk of data loss and intrusion. Private sector organisations are required to take reasonable steps to protect the personal information they hold from misuse, loss or unauthorised access.[3,4] From March 2014, significant civil penalties may apply.[5]

The Royal Australian College of General Practitioners (RACGP) *Computer and Information Security Standards* (CISS) provide a helpful guide[6] including:

- the need to maintain appropriate security measures (including firewall/antivirus software)
- having an adequate backup system
- seeking appropriate technical support
- formulating a disaster recovery/business continuity plan (in a worst case scenario, what will you do to ensure you are able to maintain continuity of care and recover your lost data and records).

Adequate, reliable and timely database backup is critical. The interval period between backups will dictate the minimum amount of data that *cannot* be recovered in the event of data loss. Backups need to be rotated, securely stored off-site (thus not accessible to network intrusion) and periodically tested for integrity. Your computer system and configuration should also be backed up (although less frequently).

Recovery

In the event of data loss it is critical to know where your most recent backup is located. Loss of documents cover is provided under the MDA National Practice Indemnity Policy and Professional Indemnity Insurance Policy and includes indemnification for reasonable costs and expenses incurred in replacing or restoring certain lost or damaged documents, subject to the terms and conditions of the Policies.[7]

If your records and backups are damaged, third party technical assistance may be required to try and rebuild the records. This is expensive and time consuming and it may only be possible to partially recover the lost data, requiring manual re-entry of the data.

Privacy breach

In the event of a third party intrusion into your practice software, there may also be a privacy breach if the records can be accessed by the intruder. In a situation involving the theft of a practice database, this may include the breach of a substantial number of confidential and sensitive medical records.

The Office of the Australian Information Commissioner (OAIC) has a helpful guide discussing how such a data breach can be addressed.[8] Patients may also lodge a complaint to the OAIC in the event of a privacy breach.

When responding to a privacy breach, there are four steps to consider[9]:

1. containment and assessment
2. evaluation of risks associated with the breach
3. notification (which is currently not mandatory and may result in an investigation by the OAIC)
4. prevention.

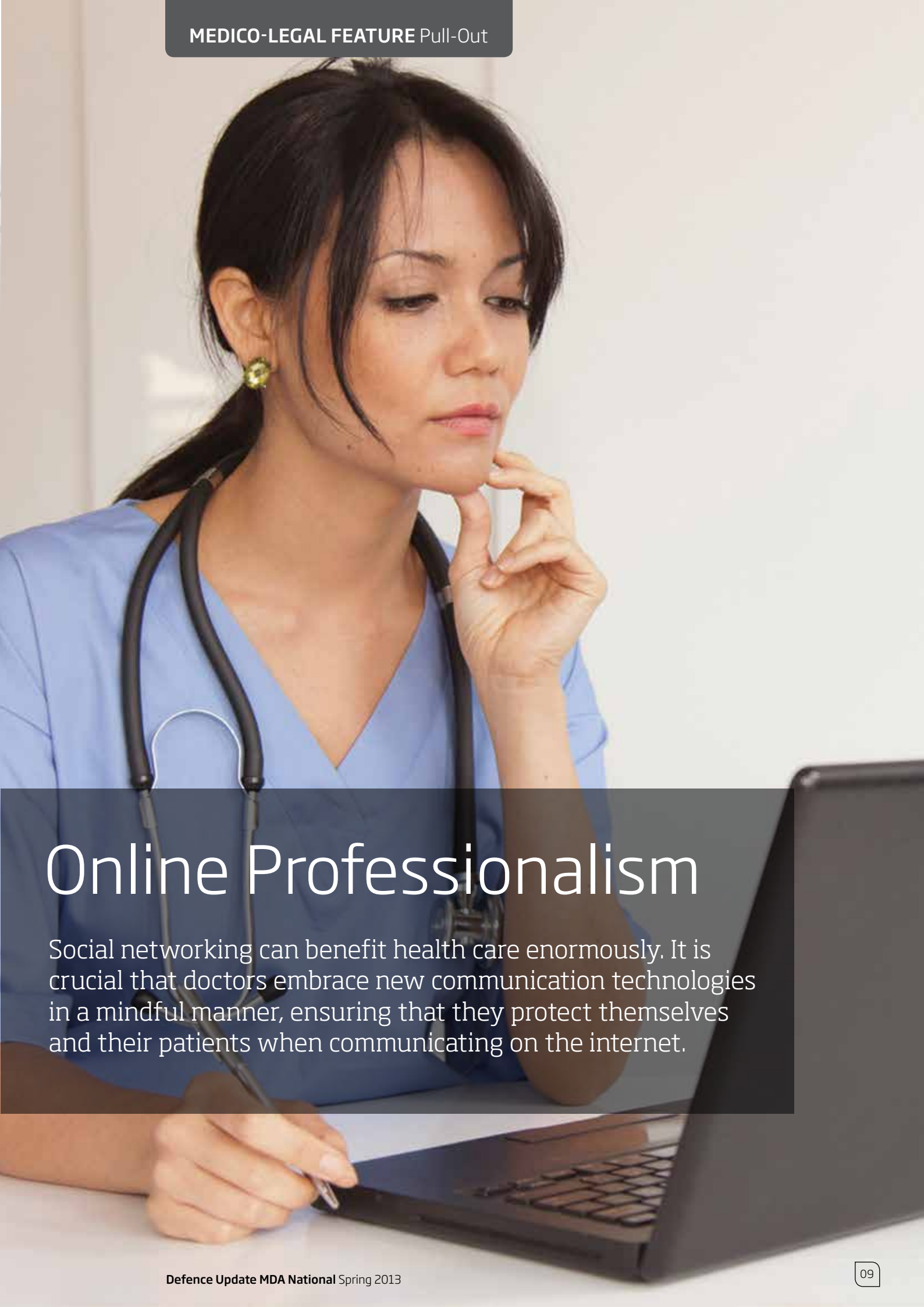
Computer intrusion, data loss and privacy breaches are serious matters that can cause significant disruption to practices and result in claims, complaints and investigations. Members can seek advice from our Medico-legal Advisory Service on 1800 011 255.

Julian Walter, Medico-legal Adviser, MDA National.

For a full list of references visit defenceupdate.mdanational.com.au/security-of-electronic-records.

What do you think?

Share your comments with us at *Defence Update* online **defenceupdate.mdanational.com.au/security-of-electronic-records.**



Online Professionalism

Social networking can benefit health care enormously. It is crucial that doctors embrace new communication technologies in a mindful manner, ensuring that they protect themselves and their patients when communicating on the internet.

Online Professionalism

Online communication can create a false sense of detachment yet the same professionalism standards apply to online conduct as the "real world". So be extremely careful of privacy and professionalism in all cyberspace environments, e.g. blogs, medical education websites, and personal and professional networking sites. The permanence, searchability, copying ease, and lack of control over audience, differentiates online networks from "traditional" public meeting places.

Examples of medical social media use

Positive results

- Using Google and Facebook to find contact details for an emergency patient's next of kin.
- Support blogs for patients and caregivers.
- Web discussion boards for doctors, e.g. journal article and case analysis.

Adverse outcomes for doctors

- The Medical Board of New South Wales warned a doctor about "... flippant and at times derogatory comments about patients" on social media.[1]
- An Australian junior medical officer (JMO) faced disciplinary proceedings for filming a hospital resident medical officer association's picnic day skits and putting them on YouTube. This was deemed to have brought the hospital's reputation into disrepute.*
- A JMO in the UK was suspended for six weeks after calling a senior colleague an inappropriate name on a social network.[2]
- Medical job and training applications have been unsuccessful because of information found online.

*Based on a real event but details altered for privacy.

How to protect your patients

Breaching confidentiality is the main risk of doctors networking online. Be aware of and abide by patient privacy and confidentiality laws. Even descriptions of a specific case or patient history without providing names or other personal information can be enough to allow others to identify a patient and violate these laws.[3]

Consider carefully whether the patient is truly de-identified before making an online post. Enquiring about a person's health over social media can easily breach confidentiality and a single posting about an unidentified patient may be compromised by other postings.

Blurring of boundaries

Increased use of social media and greater availability of personal information on the internet makes maintaining professional boundaries more challenging. Patients may learn personal information about their doctors that can cause distress and affect the therapeutic relationship, e.g. a patient may Google their doctor and find they are affiliated with a religious group that is anti-abortion or may see them smoking.

Strongly avoid online networking relationships with past or present patients. "Friending" a patient online creates a dual relationship (doctor and friend; even if you think the online friendship is not truly "personal", the patient may view it differently) which can adversely impact the therapeutic relationship.

Also be very prudent about allowing colleagues (including employers, nurses, allied health professionals, administrative staff and students) to view information about your personal life.

How to protect yourself

Anything posted online can be traced back to the person who posted it, despite usernames. Consequently doctors "... should be very careful about any information that they post, and particularly careful about making offensive comments or jokes, sharing information about unprofessional activities or content produced by others, or joining or creating groups that might be considered derogatory or prejudiced".[4]

Irrespective of tight privacy settings, a certain amount of information about you on sites such as Facebook is always publicly available. It is not uncommon for employers to search job applicants' Facebook profiles and online presence generally.

An individual or organisation may be held liable for publishing comments posted by a third party that may be misleading, defamatory, or discriminatory. If it is possible for content on a website such as a Facebook page or a blog to be deleted, then the page needs to be carefully monitored and problematic content deleted or appropriately dealt with as soon as possible.[5]

What about doctor review websites?

Appraisal sites are increasingly popular, e.g. RateMDs has reviews of 190,000 globally. Positive reviews are more common than negative ones.[7]

Read your reviews occasionally – they can provide good information.

If a doctor feels truly compelled to, they may post a careful response following an online patient review which is critical of them. Ensure it is patient-centred and demonstrates willingness to take on feedback. Do not respond when angry and do not breach patient confidentiality. Keep it simple, e.g. "Thank you for your feedback. I am committed to improving my practice and have taken your comments into consideration". We strongly recommend you seek advice from our Medico-legal Advisory Service before you post any response.

Doing nothing is an option and better than doing something which may escalate the disagreement.

If you can identify the patient who wrote the review, talk to them in the "real world". Such discussion may prompt them to take down the online post or add compliments to it.

"All new media are in the public domain and physicians must be continually mindful of privacy, prudence and professionalism when communicating online."[8]

By Nicole Harvey, Education Services, MDA National.

For a full list of references visit www.defenceupdate.mdanational.com.au/online-professionalism.

Tips for safeguarding patients

- Always get a patient's express consent (and include this in the medical record) before putting any information about them online, including photographs, and note the consent within the post.
- Viewing and/or commenting on a patient's blog, social network or other online presence risks possible professional boundary violations and patient complaints. The recording of such information in the records without the consent of a patient should be carefully considered due to the risk of complaints.
- Do not discuss patients on social media.

Hints to help you

- If you would not say something under your name in a hard copy magazine, do not say it online.
- Check your intent before posting – social media comments are often self-serving.
- Do not ignore your online "character".
  - › Keep a check on it and take control, e.g. using Facebook, LinkedIn® or Twitter means these sites will generally appear first in search results.[6]
  - › Do not allow photographs of yourself that could be considered unprofessional to appear online.
- Never make belittling comments online which are in any way related to your work.
- Always acknowledge conflicts of interest even if you think you are anonymous.
- Know your site privacy settings, make them as tight as possible, and check them regularly.
- Be aware of the online communication policies of organisation(s) you work for.

Online professionalism – more information

Members can also access further information on this subject through the Education Resources section of the **Member Online Services website**.

Social Networking – Stories of Success and Strife
Visit **defenceupdate.mdanational.com.au/socialnetworking.**

Effective Patient Engagement in the 21st Century

Image: A/Prof. Michael Greco and Dr Lesley Palmer.

In the Autumn 2013 issue of *Defence Update*, A/Prof. Julian Rait wrote about the rising tide of the patient's voice in helping health organisations improve their safety and quality performance. There is now clear evidence of the association between patient experience, clinical safety and effectiveness, and health outcomes.[1,2] The challenge for health professionals and organisations is how to gather patient feedback in real-time that is meaningful and useful in driving quality improvements. This is why Patient Opinion was established in the United Kingdom in 2005 by two doctors (Dr Paul Hodgkin and Dr James Munro). It is now the leading not-for-profit online site for patients throughout Britain to share their healthcare experiences, and for health services to subscribe to its services.

The Patient Opinion platform is now operating in Australia (patientopinion.org.au). It makes it safe, easy and effective for the Australian public to give their feedback to the health services they rely on, and in doing so, encourages those services to become more open, transparent, responsive and patient-centred. Herein lies the challenge. With the advent of social media, health services are now under greater public scrutiny than in the past.

The power for the patient voice to be heard lies in having a platform that allows transparency and an opportunity for health services to be fearless in publicly addressing concerns and telling their patients in an open forum that they are listening and value their feedback (good or bad). When the health service truly engages with their patients in a non-confrontational environment, patients have tangible evidence that they are being listened to. This on-line form of engagement can be a scary prospect for the health service but pales in comparison to the angst a vulnerable patient might feel when addressing issues on a personal level with the health service.

Our experience at Patient Opinion shows that often patients do not want to complain about their healthcare experience, but would rather offer a comment anonymously, whether good, bad or indifferent. Such comments have been shown to be linked to actual hospital performance.[3] Furthermore, there is evidence that comments posted upon the Patient Opinion website lead to less complaints by patients because they have had the opportunity to "be heard".[4]

The impact of this transparent and public form of engagement is clearly evident in the experience of British health services.

They are now engaging in constructive conversations with their patients, and demonstrating improvements to their services. The following three stories are examples of this.

- **patientopinion.org.uk/opinions/80438**
- **patientopinion.org.uk/opinions/82035**
- **patientopinion.org.uk/opinions/84805**

The question is not whether Australian health services will participate with online public and independent platforms. Patients are already posting their comments online. What health services are encouraged to do is to become part of the conversation rather than simply be the topic of the conversation.

A/Prof. Michael Greco is the founder and Chief Executive of Patient Opinion Australia and Dr Lesley Palmer is a Board Member.

1 Doyle C, Lennox L, Bell D. *A systematic review of evidence on the links between patient experience and clinical safety and effectiveness.* BMJ Open 2013; 3:e001570;doi:10.1136. Available at: bmjopen.bmj.com/content/3/1/e001570.full.

2 Matthew P. Manary MSE, Boulding W et al. *The patient experience and health outcomes.*. N Engl J Med 2013; 368:201-203. Available at: nejm.org/doi/full/10.1056/NEJMp1211775.

3 Greaves F. Pape UJ, King D et al. *Association between web-based patient ratings and objective measures of hospital quality.* Arch Intern Med 2012; 172: 5. Available at: archinte.jamanetwork.com/article.aspx?articleid=1108770.

4 Research findings from the University of Birmingham and Tavistock Institute, involving over 1200 people who had used the Patient Opinion website. Available at health.org.uk/areas-of-work/programmes/patient-opinion-research-programme.

Online Reputation Management

The use of social media and online information has now become an integral part of health care. Dr Sara Bird discusses strategies on how to manage and monitor your online persona as a medical practitioner, with a view to minimising risk and maintaining your professional reputation.

What are patients doing online?

Patients use social media to:

- access health information and healthcare providers
- discuss and/or monitor their health and that of others
- evaluate healthcare practitioners and providers.

While it is estimated that less than one in five patients have consulted a website which reviews and rates medical practitioners/healthcare providers, the use of these sites is increasing. In 2011 the UK Health Minister commented:

I wouldn't think of going on holiday without cross referencing two guide books and using TripAdvisor. We need to do something similar for the modern generation of health care.

Patient satisfaction metrics are now part of the UK revalidation process. There is an opportunity for the medical profession in Australia to drive and manage the process of rating and reviewing healthcare practitioners and providers.

It is worth noting that the vast majority of online ratings are favourable and, in one recent study, 88% of online reviews of doctors were positive.[1] Specific strategies on how to deal with a negative online review are discussed in our Online Professionalism pull-out feature on page 11.

How are doctors using social media?

Many doctors now have their own practice website which provides information about their practice and also general health information. Personal websites tend to rate high in search engine results and, in particular, websites that facilitate sharing of information will boost search engine optimisation.

The use of other social media networking sites can also be an important part of managing your professional reputation. These include:

- LinkedIn® – includes an online resume and focuses on professional networking.
- Facebook – a professional Facebook page can contain information about your practice and be linked to your practice website. Settings can be adjusted so that only the page administrator is allowed to post content. It is important for medical practitioners to separate their personal and professional Facebook sites.
- YouTube – a video streaming service which can include interviews with practitioners and patient information videos.
- Blogs – website entries which are generally displayed in reverse chronological order and enable practitioners to share topical and/or evidence based health information with patients, colleagues and the community.

What are the risks?

The Australian Health Practitioner Regulation Agency's draft *Social media policy* states that practitioners should only post information that does not breach their professional obligations, such as the *Code of Conduct* and *Guidelines for advertising of regulated health services*[2], by:

- not breaching confidentiality and privacy obligations (such as discussing patients or posting pictures of procedures, case studies, patients or sensitive material which may enable patients to be identified and/or without having obtained consent in appropriate situations)
- presenting information in an unbiased, evidence informed context and not making unsubstantiated claims.

Section 133 of the National Law provides:

A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that:

a. is or is likely to be false, misleading or deceptive; or
b. offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or
c. uses testimonials or purported testimonials about the service or business; or
d. creates an unreasonable expectation of beneficial treatment; or
e. directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

Tips on managing your online reputation[3]

- Ensure your presence is consistent across all social media applications – e.g. use exactly the same name and photograph.
- Titles and key words/tags are important to optimise search engine results.
- Content should be of high quality, up to date and include references for further reading.
- Post or update often as this will improve search engine results.
- Incorporate images and/or videos into your social media communications.
- Include links to all your social media sites to make it easy for people to share information about you.
- Ensure you comply with the Medical Board of Australia guidelines, including the *Social media policy* and *Guidelines for advertising of regulated health services*.
- Track website activity e.g. by using Google Analytics.

Further reading

Pho K, Gay S. *Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices*. Greenbranch Publishing, Phoenix, 2013.

For a full list of references visit: defenceupdate.mdanational.com.au/online-reputation-management.

Private Patient Arrangements **in the Public Health System**

There are a number of different private patient arrangements in place throughout the public health system in Australia. Under some arrangements, medical practitioners are said to be providing services to private patients pursuant to a right of private practice.

Common features of these arrangements include:

- the medical practitioner is employed or appointed at a public hospital and is remunerated by the state/territory for treating public patients in the public hospital
- patients attending public hospitals have a right to elect to be treated as a private patient
- the public hospital may grant practitioners a right to admit and treat private patients in the public hospital
- private patients will be referred to the medical practitioner concerned
- the medical practitioner (in most cases) will not be remunerated by the public hospital for treating private patients admitted under their care, but will bill the patient privately. Those patients may, generally speaking, claim under Medicare and/or their private health insurance for the services provided.

Medical practitioners entering into these arrangements should give consideration to the following:

Compliance with the requirements of the *Health Insurance Act 1973*

- Should Medicare audit or investigate the medical practitioner, it will be the practitioner and not the public hospital that will be called to account for any irregularities or inappropriate billing. If there are any doubts about a particular arrangement and whether it infringes the provisions of the *Health Insurance Act 1973*, the practitioner should seek advice.
- If a medical practitioner is providing services in a public hospital and billing those patients under Medicare, it is the medical practitioner whose Medicare Provider Number is used for billing who is responsible for ensuring that patients are appropriately billed. If billing is undertaken by the public hospital on the medical practitioner's behalf, the practitioner should call for statements and review the billings under his or her Provider Number on a regular basis.
- The practitioner should also ensure the requirements of the Medicare Item Number are met. More often than not, the service will have to either be provided by the medical practitioner him or herself, or at the very least, involve the medical practitioner to some extent.
- If a service is provided by a medical practitioner who does not have his or her own Medicare Provider Number, e.g. a junior medical officer, then in most cases, Medicare should not be billed for that service.
- Ordinarily, public hospitals will not indemnify a practitioner for Medicare audits and investigations or hearings. While the MDA National Professional Indemnity Insurance Policy may cover the legal costs associated with these processes, the policy will not cover any amounts which may have to be repaid as a consequence of an audit, investigation or hearing.

How will the practitioner be remunerated for providing services under these arrangements?

- Medical practitioners might be entitled to keep all or some of the billings generated by the provision of services to private patients. Under other arrangements, the practitioner might be required to assign their billings to the public hospital.
- Practitioners should seek accounting advice to ensure they are appropriately recording all income derived when submitting their income tax returns, and claiming for any permitted deductions.

Does the medical practitioner have appropriate professional indemnity insurance?

- If state or territory indemnity arrangements are in place for the treatment of public patients, medical practitioners should determine whether this will extend to the treatment of private patients, and if so, whether there are any conditions that may apply.
- Contact MDA National Insurance to ensure there are no gaps in medical indemnity cover arrangements, particularly if there is any concern about the extent of the indemnity offered by the state or territory.

By Dominique Egan, Partner, TressCox Lawyers.

CaseBook

Needle in a Haystack

MDA National Medico-legal Adviser, Dr Jane Deacon outlines a case where a medical practitioner is swayed by the patient to undertake a procedure against her better judgement.

Case history

Mrs Green presented to her GP, Dr Menon, with a sore, red area on the dorsum of her hand, over her second metacarpo-phalangeal (MCP) joint. Dr Menon diagnosed a soft tissue infection and prescribed Flucloxacillin.

Three weeks later, Mrs Green returned. The infection had improved while she took the antibiotics, but had now returned. When Dr Menon examined her hand, she saw a faint black area and a lump suggesting a foreign body. Mrs Green then remembered that some weeks ago she had been doing some gardening and had pricked her hand around that area. An ultrasound was arranged and confirmed a 12mm object over the second right MCP joint.

When Mrs Green returned with the ultrasound report, Dr Menon's first reaction was to refer Mrs Green to a specialist, or the local emergency department (ED) for removal of the foreign body. However, Mrs Green was very reluctant to attend ED, and she said that she did not have time to wait there all day. She was uninsured and said that she could not afford to see a specialist privately. Mrs Green told Dr Menon that as it was only a bit of plant, or a splinter she could not understand Dr Menon's reluctance to proceed herself, and she encouraged her to "have a go".

Dr Menon infiltrated some local anaesthetic into the area and then proceeded to cut down onto the area of discolouration. She did not find anything at first, and she then extended the incision crossways, and located the piece of plant material and removed it. She then realised that she had severed one of Mrs Green's extensor tendons.

Dr Menon referred Mrs Green to ED for treatment. Tendon damage was confirmed and she was taken to theatre where the tendon damage was repaired. She spent three weeks in plaster, then a splint for a further three weeks. She attended therapy for several months and ultimately had a good result.

Medico-legal issues

Some weeks later Dr Menon received a letter from Mrs Green. She stated that she wanted compensation from Dr Menon for her lost wages and out of pocket expenses with regards to her medical treatment.

The case was reviewed by a medical expert who was critical of Dr Menon for the way in which she had undertaken the exploration of the wound in that she had incised across the finger rather than in a longitudinal direction. The matter was settled on a confidential basis.

Dr Menon was distressed by the experience as she stated that she had not wanted to explore the wound in the first place, as she was aware of the potential for tendon damage, but she had been talked into it against her better judgement by Mrs Green, who was a rather forceful woman.

Risk management strategies

Unless it is an emergency, do not undertake procedures when you are not confident. Although exploration of a wound to locate a foreign body would generally be considered a procedure that a GP would undertake, Dr Menon was aware that the location of this foreign body presented some potential hazards in terms of damage to nearby tendons. She considered that it would be better done by a specialist, but allowed her good judgement to be swayed by the patient.

Summary points

- Prior to undertaking any procedure, doctors should assess the situation and only proceed if they are confident to do so.
- Doctors are responsible for treatment decisions, and should not be persuaded to undertake procedures beyond their level of competence.

CaseBook

Failure to Warn – Untouched by the High Court

In a decision handed down in May 2013, the High Court of Australia held – unanimously – that a surgeon's failure to warn the patient of a risk of paralysis cannot be the *legal cause* of the neuropraxia that materialised following an unsuccessful spinal fusion.

Case history

The patient underwent spinal surgery for an intervertebral lumbar disc protrusion. Post-operatively, the patient had bilateral femoral neuropraxia, which was caused by him lying prone for an extended period during the surgery. The patient brought a claim in the Supreme Court of NSW and alleged that the surgeon failed to warn him of the following two material risks:

1. the 5% risk of permanent paralysis resulting from damage to his spinal nerves (this did not eventuate); and
2. the risk of temporary damage to the nerves in his thighs (this eventuated).

Medico-legal issues

At trial[1], the patient argued that he would not have undergone the surgery if he had been warned of either risk. The trial judge, Harrison SCJ, rejected this submission. Harrison SCJ, held that the surgeon breached his duty of care to the patient by failing to warn of the material risk of bilateral femoral neuropraxia. However, Harrison SCJ found that the surgeon's negligence was not the "legal cause" of the patient's nerve damage because the patient did not establish that he would have declined the surgery if warned of that risk. Relevantly, his Honour did not make a finding of whether the risk of paralysis was a material risk, which the surgeon was under a duty to disclose to the patient, nor whether he would have declined the operation if warned of that risk – as this risk did not materialise, he treated it as irrelevant. The trial judge found in favour of the surgeon.

The patient appealed against the Supreme Court decision to the NSW Court of Appeal.[2] In so doing, the patient argued that Harrison SCJ erred in holding that the surgeon's failure to warn of the risk of paralysis could not be the legal cause of his neuropraxia when, if he had been warned of paralysis, he would not have had the surgery. The Court of Appeal proceeded on the assumption that the patient would not have undergone the surgery if he had been warned of the risk of paralysis.

The majority considered that a causal relationship needed to exist between the surgeon's breach of duty (i.e. the failure to warn of the risk of paralysis) and the harm the patient actually suffered. The majority determined that risk of neuropraxia and the risk of paralysis were different and unrelated – the risk of paralysis was related to surgical skill and care whereas the risk of neuropraxia was related to necessary intraoperative patient positioning. The majority of the Court of Appeal therefore held that it was not appropriate for the surgeon to be held liable for the neuropraxia on the basis of negligence relating to a separate risk which had not materialised. The NSW Court of Appeal, by majority, dismissed the appeal.

High Court decision

Not to be deterred, the patient appealed to the High Court of Australia (HCA).[3]

The HCA dismissed the appeal and confirmed that the patient was not to be compensated for the materialisation of a risk he would have been prepared to accept. In reaching this decision, the HCA made a value judgement that as the only risk which came home (i.e. the neuropraxia) was one the patient would have accepted anyway, he was not entitled to be compensated for it even if the combined warning was absent and might have made a difference to his decision to undergo the operation at all.

The majority considered that a causal relationship needed to exist between the surgeon's breach of duty (i.e. the failure to warn of the risk of paralysis) and the harm the patient actually suffered.

Discussion

The HCA provided a useful explanation of the difference between duty of care and causation, as the concepts can sometimes cause confusion among legal and medical practitioners, depending on the circumstances of a case. Duty of care is a "forward-looking rule" that is concerned with what is reasonably foreseeable. Causation is a "backward-looking rule" that addresses who (or what) was responsible for an injury. As these two concepts have a different focus, it is possible for a medical practitioner to breach his or her duty of care, but not be the cause of a reasonably foreseeable injury.

The HCA's decision confirms that if a patient is to succeed in bringing a failure to warn case, it is not sufficient for him or her to allege that their medical practitioner failed to warn of a material risk and should therefore be liable for a poor or unexpected outcome. Duty of care and causation are distinct concepts and need to be analysed separately. Although it is reassuring to know that a failure to warn of a material risk will not always be a "fatal blow" to medical practitioners if a claim is brought against them, it is vital that medical practitioners continue to warn patients about material risks relevant to any proposed medical or surgical treatment.

By Yvonne Baldwin, Claims Manager, MDA National.

1 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518.
2 *Wallace v Kam* [2012] NSWCA 82.
3 *Wallace v Kam* [2013] HCA 19 (8 May 2013).

Summary points

- A medical practitioner will not always be held liable if he or she has not warned the patient of a material risk.
- Notwithstanding this, a medical practitioner should always warn his or her patients about the material and inherent risks associated with any proposed treatment or procedure.
- All consenting/warning discussions that medical practitioners have with their patients should be clearly and comprehensively documented in the medical records, as this will provide contemporaneous evidence to support a doctor's assertion that the patient was appropriately warned.

What do you think?

Share your comments with us at *Defence Update* online **defenceupdate.mdanational.com.au/failure-to-warn.**

CaseBook

Unsuccessful Wrongful Birth Claim

In the Winter 2012 issue of *Defence Update*, Kerrie Chambers, Partner at HWL Ebsworth, reviewed the two claims of Keeden Waller. In May 2013, the Supreme Court of NSW handed down their judgment on the Wallers' second claim. The Supreme Court found that the Wallers had failed to establish liability on the part of IVF specialist, Dr James.

Case history

Keeden Waller was conceived by IVF, which was performed by Dr James. Keeden inherited antithrombin deficiency (ATD) from his father. Soon after his birth, Keeden suffered an extensive cerebral sinovenous thrombosis (CSVT). Keeden is now profoundly disabled.

The Wallers alleged that Dr James breached his duty of care by failing to inform or cause them to be informed of the hereditary aspects of ATD. They asserted if they had been informed, they would not have had Keeden.

Medico-legal issues

Two separate claims were filed by the Wallers. The first claim, which was a "wrongful life" claim[1] was dismissed by the High Court in 2006. As Kerrie Chambers noted in her previous article, the *logical impossibility of comparing nonexistence (which cannot be experienced) to a damaged existence*, led the High Court to the finding that no meaningful assessment of damages could be made.

The second claim brought by Keeden's parents was a claim for the cost of raising Keeden, alleging that he would not have been born but for Dr James' negligence.

During the Wallers' first consultation with Dr James, he gave them the contact details of a genetic counsellor. It was the Wallers' evidence that they did not have a clear understanding as to why this was given to them. They stated they tried to call the number once; however, they did not try again. No further discussions were had regarding ATD and Keeden was conceived by IVF.

While Justice Hislop held that Dr James did breach his duty of care by not making the purpose of the referral clear, their claim failed, as they were not able to provide any evidence that the CSVT was caused by the ATD deficiency. Justice Hislop was therefore of the opinion that the loss suffered was not a reasonably foreseeable consequence of Dr James' breach of duty.

The Wallers also tried to argue that Keeden would not have been born "but for" Dr James' breaches, and as a consequence, he would not have suffered the stroke and the subsequent losses. However, the Court found that the ATD had not caused Keeden any loss, as the stroke was not caused by the ATD.

While it was unnecessary for Justice Hislop to determine damages, he made some comments regarding damages in the event the matter was appealed. He stated that any damages would be limited to when Keeden turned 18, when his parents' legal obligations would cease. The other interesting point Justice Hislop made was that as the Wallers wanted a child, damages would have been awarded only for the losses occasioned by the CSVT, not the ordinary costs of raising a child. It is however important to note that this claim was prior to the introduction of the *NSW Civil Liability Act* (2002) which now limits any damages for wrongful birth claims in NSW to the additional costs of raising a disabled child.[2]

By Sharon Russell, Claims Manager, MDA National.

1 *Waller v James* [2006] HCA; (2006) 226 CLR 136.
2 S71 Civil Liability Act 2002 (NSW).

Summary points

- Doctors should discuss with patients the purpose of any referrals and the consequences of failing to attend.
- Practices should have a follow up system to track any patients who may be at risk if they fail to attend.

MDA National Limited (MDA National)

Election of Officers pursuant to 5F(1)(eb) of the *Electoral Act 1907*

ELECTION NOTICE

Nominations are called from eligible candidates for the election of:

Mutual Board Director (2)

Nominations will be accepted from Monday 16 September 2013.

Nomination forms are to be completed in accordance with the *MDA National Limited Election Rules* and must reach me no later than 12.00 noon on Tuesday 15 October 2013. Should an election be necessary, voting will close at 10.00 am on Friday 22 November 2013.

Candidate Statement: In accordance with rule 11(2) of the *MDA National Limited Election Rules*, included with the nomination form may be a statement in the English language not exceeding 200 words in length. The statement must be confined to biographical information about the candidate and statements of the candidate's policies or beliefs and is not to contain information that refers to other candidates or the Returning Officer considers to be false, misleading or defamatory. The statement is to be hand written, typed or printed on a single A4 page, or if it is delivered electronically, is capable of being printed on a single A4 page. The statement is to include the candidate's full name as requested on the ballot paper and details of where and how he or she can be contacted. Other contact details such as telephone numbers or email addresses may also be included. The candidate may include a passport size photograph of the proposed candidate's head or head and shoulders. The photograph should be recent, taken less than six months before the date of the nomination form. The Returning Officer may accept a less recent photograph if he or she considers that the photograph shows a reasonable likeness of the candidate.

HOW TO LODGE NOMINATIONS

By Hand: Western Australian Electoral Commission
Level 2, 111 St Georges Terrace
PERTH WA 6000

By Post: GPO Box F316
PERTH WA 6841

By Fax: (08) 9226 0577

Nomination forms are available either from any MDA National office, or by downloading them from the MDA National website at mdanational.com.au or from me at the Western Australian Electoral Commission. Originals of faxed nominations must be mailed or hand-delivered to the Returning Officer.

All Members! Have you changed your address?

If so, please advise MDA National of your new address.

Ian Botterill
RETURNING OFFICER

Phone: 13 63 06
Email: waec@waec.wa.gov.au

WESTERN AUSTRALIAN
Electoral Commission