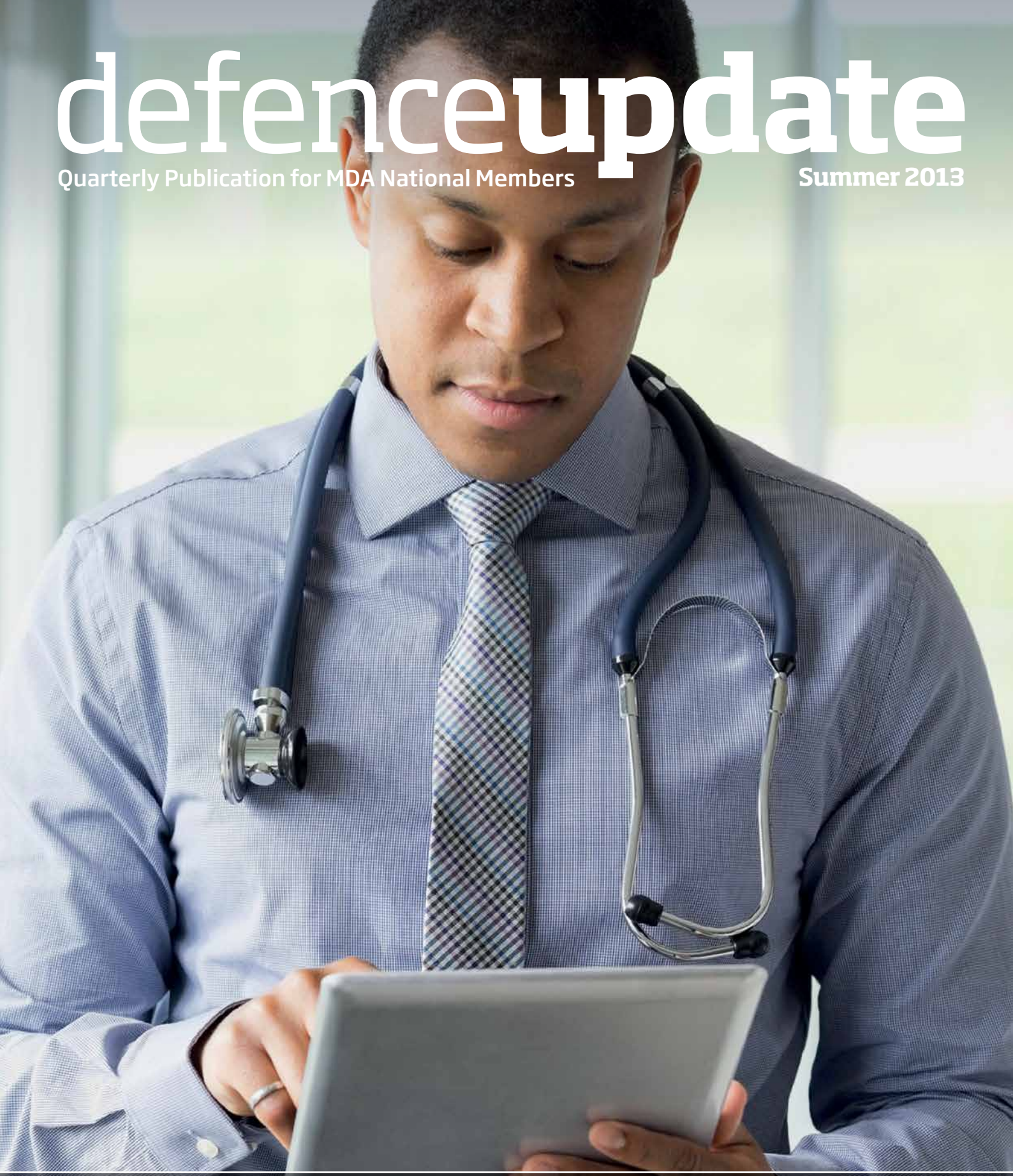
defenceupdate

Quarterly Publication for MDA National Members

Summer 2013



MDA National
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Editor's Note

The practice of medicine brings many rewards, but it is often stressful and demanding. "How are you?" is a question that our Medico-legal Advisory team frequently asks Members when they contact us to discuss an adverse event or other medico-legal issue.

The findings of *beyondblue's National Mental Health Survey of Doctors and Medical Students* (on page 13) suggest that this is a question we could ask many of our colleagues, especially young doctors and female doctors.

The main finding that stood out for me on reading the survey results was the apparent greater resilience of doctors to the negative impacts of poor mental health. Very few of the surveyed doctors reported being highly impacted by their mental health symptoms in the domain of work or self. Further, doctors reported higher rates of treatment for both depression and anxiety than the general population. The findings suggest that, despite having high levels of distress, doctors are more likely to seek treatment than others and are able to manage some of the negative effects of mental health symptoms.

In his wonderful book, *Second Victim: Error, Guilt, Trauma and Resilience*, Sidney Dekker describes resilience as the ability to adapt and change in response to challenges and problems that fall significantly outside a person's experience base. Importantly, Dekker reminds us that resilience should not be seen as a property that exists inside an individual only, but as a feature of individuals in their environments; and resilient outcomes are best predicted by environmental protective factors. How we develop resilience in ourselves, our colleagues and our environments represents an important challenge for us all.

I would like to take this opportunity to wish you and your family a safe, restful and enjoyable festive season and New Year. Thank you to our many Members and colleagues who have contributed their knowledge and shared their stories in *Defence Update* during 2013. On behalf of MDA National, we look forward to continuing the discussions in 2014.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

From the President

Dominique-Jean Larrey: the lessons from Napoleon's Surgeon at Waterloo

Dominique-Jean Larrey (1766-1842)

As part of my aid work, I recently travelled to an area of protracted military conflict. It was a sobering experience especially as I met a number of doctors whose professionalism and commitment to their work seemed exemplary. Indeed, while the stressful nature of their practice was obvious, equally so was the strength of their ethical and professional duty that seemed to overcome concern for their own comfort and safety.

Whilst visiting the region, I also met an Australian Orthopaedic Surgeon who explained how the values of many such doctors have been shaped by examples including the French field surgeon, Dominique-Jean Larrey.

Born in 1766 in Beaudean, a small village in the Pyrenees, Larrey became one of the most revered surgeons in history. After serving as a surgical apprentice to his Uncle Alexis for six years in Toulouse, he later studied in Paris and was supervised by the great French surgeon, Desault, who was Chief of Surgery at the Hotel Dieu.

Of course when war came, Larrey signed up for duty and became a field doctor in Napoleon's army. He soon recognised the need for better organisation on the battlefield, as victims often died before they could receive any medical assistance. He therefore organised the *Ambulance Volante* or "flying ambulances" – horse-drawn wagons for collecting and carrying the wounded from the battlefield to base hospitals. Moreover, his surgical attention to the wounded on *both* sides of the battlefield was a noble and ethical concept for which Larrey was widely admired by men in the ranks. It is considered that his revolutionary ideas for the equitable care of the wounded have survived to modern times in the form of the Red Cross.

Because of these and other great surgical accomplishments, Larrey was highly respected by friends and foes alike, being adored by the French public and much admired by his colleagues. Indeed, Larrey was an exponent of some of the key elements of medical ethics in his work, namely beneficence and justice – the former being the need for a practitioner to act in the best interests of the patient while the latter concerns the fair distribution of scarce health resources and just decisions when it comes to who gets what treatment.

Of course, many doctors like Larrey find themselves working in difficult circumstances and/or areas where ethnic groups are in conflict with one another; places where each side can view the other through lenses of negative stereotypes rather than their shared humanity. However, even in times of military conflict, doctors are often there to remind policy makers that those demonised as "others" are almost always "just like us"; and that war is more often than not, a futile endeavour.

It is reputed that after Napoleon was exiled to the island of St Helena, he wrote: "Larrey was the most honest man and the best friend to the soldier"; while in his testament, the Emperor rewarded his courageous surgeon: "To the French Army's Surgeon General, Baron Larrey, I leave a sum of 100,000 francs. He is the worthiest man I ever met."

So Larrey led a noble professional life because he understood the values that those who provide medical care in difficult circumstances should embrace. He also reminds those in peaceful and prosperous countries like our own, that many of our professional colleagues work in less tranquil places and make a remarkable contribution to those in need. Likewise, I remain impressed by the doctors I recently encountered. They have a clear comprehension of their ethical duties and it is extraordinary that they conduct their professional lives so selflessly. I hope you will find Larrey's story inspiring.

And as another year comes to a close, I wish to extend my gratitude to our Mutual and Insurance Board, the President's Medical Liaison Council (PMLC), and to our management team and staff, who have again energetically contributed to the success of MDA National during 2013. We remain fortunate to have such a fine and dedicated group of people to support, protect and promote the interests of Members and their patients, and be advocates for the medical community.

Finally, on behalf of MDA National, I would like to wish you and your family an enjoyable and refreshing festive season and a successful 2014.

A/Prof Julian Rait
MDA National President

Notice Board

Paul v Cooke – Failure to Diagnose Did Not Cause the Harm

In our *Defence Update* Summer 2012 edition, Enore Panetta outlined a claim against a Radiologist for the failure to diagnose a cerebral aneurysm on an angiogram. The aneurysm was diagnosed three years later. The patient underwent coiling of the cerebral aneurysm and suffered a stroke when the aneurysm ruptured during the procedure. While the Radiologist was found to have breached his duty of care in failing to diagnose the aneurysm, the claim was dismissed because the risk of intra-procedural rupture of the aneurysm had nothing to do with his failure to diagnose it.

The claim proceeded to an appeal which was dismissed on 19 September 2013. The Court of Appeal found that even if the cerebral aneurysm had been diagnosed earlier, the patient would still have faced the inherent risks of a procedure she willingly chose to undergo (*Paul v Cooke* [2013] NSWCA 311).

Strong Financial Results for 2013

MDA National achieved a commercially solid result for Members in 2012/13 growing net assets to $145 million, delivering more Member education than ever before, increasing Membership by more than 7% and retaining 98% of our practising Members. Our *2013 Annual Report* has been distributed to Members and is also available online at **mdanational.com.au**.

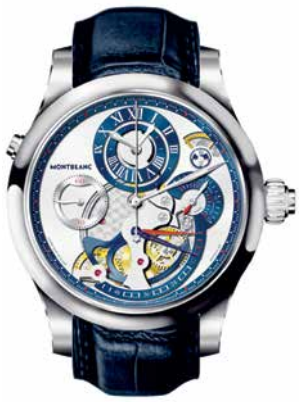
A/Prof Michael Hollands Joins Mutual Board

MDA National warmly welcomes A/Prof Michael Hollands who has just joined our Mutual Board. An accomplished General Surgeon, the current President of the Royal Australian College of Surgeons and Chairman of the Committee of Presidents of Medical Colleges, A/Prof Hollands will add significant value to MDA National's Membership as part of our governing body.

Alprazolam to Become Schedule 8

Members are reminded that from 1 February 2014, alprazolam will be rescheduled to Schedule 8. Therefore, if prescribing alprazolam to a patient after this date, the legislative requirements for obtaining a permit or authority for Schedule 8 drugs will apply. For more information visit **defenceupdate.mdanational.com.au/misuseofopioiddrugs/.**

Exclusive Montblanc Offer for Members



Are you looking for an exceptional gift? Or perhaps you just want to treat yourself to something special this Christmas...

The prestigious Montblanc brand has an exclusive offer* for MDA National Members:

- 20% discount on writing instruments, leather goods and jewellery
- 25% discount on watches and eyewear.

You can also personalise your purchase with complimentary engraving and embossing.

To take advantage of this offer, contact Ryan Goldberg on 0431 755 446 or ryan@goldmark.net.au.

* Excludes Montblanc Limited and Special Editions.

Congratulations!

Congratulations to MDA National Member, Dr Jared Watts who won The Anatomy of Complications Workshop grant, sponsored jointly by MDA National and The Anatomy of Complications. The grant, worth $2,899, secured Dr Watts a coveted place in The Anatomy of Complications Workshop. The two-day workshop is an intensive program for Obstetrics and Gynaecology registrars designed to improve performance in the area of complication prevention and management in surgery.

Dr Jared Watts with Pip Brown, MDA National Relationship Manager (WA).

"Best course I have ever done. Thanks once again to MDA, much appreciated!"

- Jared

Privacy Law Reforms

On 12 March 2014, changes under the *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth), which amends the *Privacy Act 1988* (Cth), come into effect. The existing 10 National Privacy Principles (NPPs) will be replaced by 13 Australian Privacy Principles (APPs), designed to protect the privacy and confidentiality of individuals in a fairer and more transparent manner.

The impact on medical practices

The changes are not expected to add major obligations on medical practices; however, the following issues should be considered:[1]

- A medical practice must have a privacy policy clearly specifying what information will be collected, how it will be used, and a process for individuals wishing to complain about privacy breaches. This requirement is more prescriptive than the previous NPP requirements.
- Where practicable, the privacy policy must be provided in the format requested by the individual, e.g. by email.
- If a medical practice uses an overseas transcription service, it should ensure that the overseas recipient has the same or similar levels of privacy protection as specified under the APPs. Where the overseas recipient does not have the same level of protection, the practice must obtain the individual's consent to transfer the information. Prior to this, the practice must inform the individual of what countries the information is going to and how to complain about a privacy breach in that country.
- In limited circumstances, a medical practitioner is permitted to use or disclose information about a patient to lessen or prevent a serious threat to the life, health or safety of any individual or to public health or safety (note the word "imminent" has been removed in the APPs).

Who oversees compliance with the changes?

The Office of the Australian Information Commissioner (OAIC) is now responsible for this and the Information Commissioner has significantly greater powers to encourage and enforce compliance. These powers include investigation and audit, making determinations and commencing legal proceedings. The Information Commissioner may also impose a fine on an organisation (up to $1.7 million) or individual (up to $340,000) for a breach of the legislative requirements. However, it is unlikely that a medical practice, doctor or their staff will be fined unless their conduct represents a serious and/or repeated breach.

What actions are recommended before March 2014?

It is recommended that medical practices audit existing policies and procedures to identify any areas of concern. The findings can be used to facilitate a revision of the practice's privacy policy to ensure compliance with the APPs.

An ideal tool to assess existing policies and processes against the APPs is the OAIC's *Privacy Act reforms – Checklist for APP entities (agencies)* available on the OAIC website: **oaic.gov.au/privacy/privacy-resources**.

What should a privacy policy cover?[2]

A privacy policy should cover:

- the kind of information collected
- how and for what purpose it is collected, held, and used
- disclosure to any other persons or agencies, the identity of those agencies, what is disclosed and for what purpose/s
- the process for an individual to access the information, for what purpose and why
- where access by the individual is withheld, why, and how the individual is notified
- consent process for the collection of information and situations where consent is not required
- complaint process for individuals who wish to complain about a breach of privacy or confidentiality
- whether information may be disclosed to overseas recipients and to what countries.

Although not required under privacy law, it is also recommended that the practice's privacy policy addresses:

- staff training and confidentiality agreements
- policy review timeframes
- processes for dealing with unauthorised access to individuals' health information, including who must be notified in the event of a breach.

Allyson Alker, MDA National Risk Adviser

1 Office of the Australian Information Commissioner website at oaic.gov.au/privacy/privacy-act/privacy-law-reform accessed on 27 Sept 2013.

2 Office of the Australian Information Commissioner. Australian Privacy Principles: Privacy Fact Sheet 17. Canberra: OAIC, 2013.

Rural Medical Practice **Managing Risks**

Enore Panetta discusses some of the challenges associated with rural medical practice and outlines some useful strategies and tips to manage risk.

Australia's population and health services resources are both concentrated in the larger and essentially coastal urban population centres. Rural General Practitioners (GPs) are central to the delivery of health services outside of the urban centres – many operate as the only GPs within their regional community. According to the Rural Health Workforce Australia's *Medical Practice in Rural and Remote Australia 2012* report, as of November 2012:

- a total of approximately 7,400 GPs worked in rural and remote Australia – of which approximately 40% worked in NSW and Victoria (largely in inner regional areas)
- approximately 2,500 GPs worked in outer regional to very remote areas – this being the norm for the larger, less populated states of Western Australia, Queensland and South Australia as well as the Northern Territory.

The number of regional and remote practitioners has steadily increased in recent years. GPs have been attracted to rural practice by the opportunity to offer communities "complete care" and practise a "full skill set" whilst enjoying a rural lifestyle. However, it is clear that not all GPs within rural and remote areas enjoy a more favourable work-life balance.

Rural medical practice is clearly and unavoidably different from urban practice. Accordingly, the types of medico-legal issues that arise and the risk management strategies to manage them are also somewhat different.

Professional isolation

The obvious challenge for rural and remote GPs is that of professional isolation. Rural communities often lack or are located long distances from hospital services, diagnostic and imaging services, specialist services, mental health services and allied health professionals. The treatment risks posed by this reality are magnified by the fact that in many such communities, the GP is the first point of contact for many people in need of health care, regardless of whether he or she is the most appropriate health professional to consult. Accordingly, due to the practical difficulties and inconvenience for patients to access specialists and more appropriate health services, rural doctors may commonly find themselves providing care outside their usual experience and competency without optimal supports and safeguards for their patients. In particular, rural GPs have fewer opportunities to obtain peer consultation and multidisciplinary perspectives for complex assessments.

However, notwithstanding these limitations and challenges, the legal standard of care applies, namely that which can reasonably be expected of a person professing that skill. Inexperience is no defence for an action of medical negligence. For the same reasons, the standard expected of a rural practitioner is the same as his or her urban counterpart.[1]

Tips

Although rural GPs have the opportunity to provide "complete care", they must remain conscious of the limits of their competency and be vigilant in balancing the interests of the patient, particularly regarding the need for hospital, specialist and diagnostic services. The quality of such assessments can be improved by:

- developing networks of clinical support and consultation
- use of electronic communication and telehealth – opportunities for specialist consultation have improved for rural doctors
- continuing professional development.

Maintaining connections with colleagues in the region and throughout the country via meetings and electronic communication is worthwhile in staving off professional isolation and preventing significant departures from standards of care.

Complex patient profiles

GPs in rural and remote areas experience a greater diversity in patient presentations. Rural and remote patients generally do not seek medical help as vigilantly as urban patients and many, due to age, life habits (e.g. higher smoking and alcohol consumption levels) and less education are in poorer overall health. Further, rural GPs are likely to be called upon to manage more instances of emergency treatment, obstetrics and other procedures without referral. Accordingly, the care provided in rural and remote areas is complex.

Tips

Dealing adequately with complex presentations includes:

- having appropriate knowledge and skills – which requires increasing and maintaining knowledge and skills through continuing professional development; keeping up-to-date with new developments; and ensuring one's practice reflects current standards
- recognising the need for hospital, specialist and diagnostic services to identify and address the treatment needs of the patient
- managing referral and patient transfer requirements with care, and maintaining appropriate information and record-keeping levels to allow specialist and secondary services to efficiently address the patient's needs with the benefit of the rural GP's treatment history.

Maintaining professional boundaries

Establishing and maintaining professional boundaries is also a challenging aspect of rural practice, particularly in circumstances where the option of transferring the patient to another GP is not readily available. In small communities there is more potential for community members and practitioners to blur their professional and social interactions, e.g. patients see the practitioner as their friend or may seek informal consultations in social settings. Section 8 of the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors* states that "doctors must display a standard of behaviour that warrants the trust and respect of the community" and that:

"Good medical practice involves:

8.2.1 Maintaining professional boundaries.

8.2.2 Never using your professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient…"

Tips

GPs need to consciously reflect upon the need to establish and maintain appropriate boundaries in their practice, both within and particularly outside of their surgeries, by:

- communicating with patients in a manner not likely to confuse professional, social and personal boundaries
- limiting the provision of medical advice and treatment to the formal setting of the surgery.

Vulnerability to mental health risks

Rural GPs face particular challenges that can contribute to or exacerbate depression and anxiety. Many face long working hours and on-call responsibilities coupled with significant workforce shortages. The lack of health service resources and backup for the practitioner and the general sense of professional isolation can be significant and constant sources of stress. Not surprisingly, rural practitioners are at risk of occupational "burnout".

Tips

Rural GPs must be conscious of their own state of physical and mental health and its impact on their professional competence, and should:

- recognise unrealistic professional and personal expectations, particularly in a rural setting where it may be natural or romantic to be seen, and to want to be seen, as a "one-stop shop" for all health matters
- have and maintain their own treating general practitioner
- recognise the signs of depression within themselves and seek professional assistance as appropriate – see information below on *beyondblue*, MDA National's Charity of Choice.

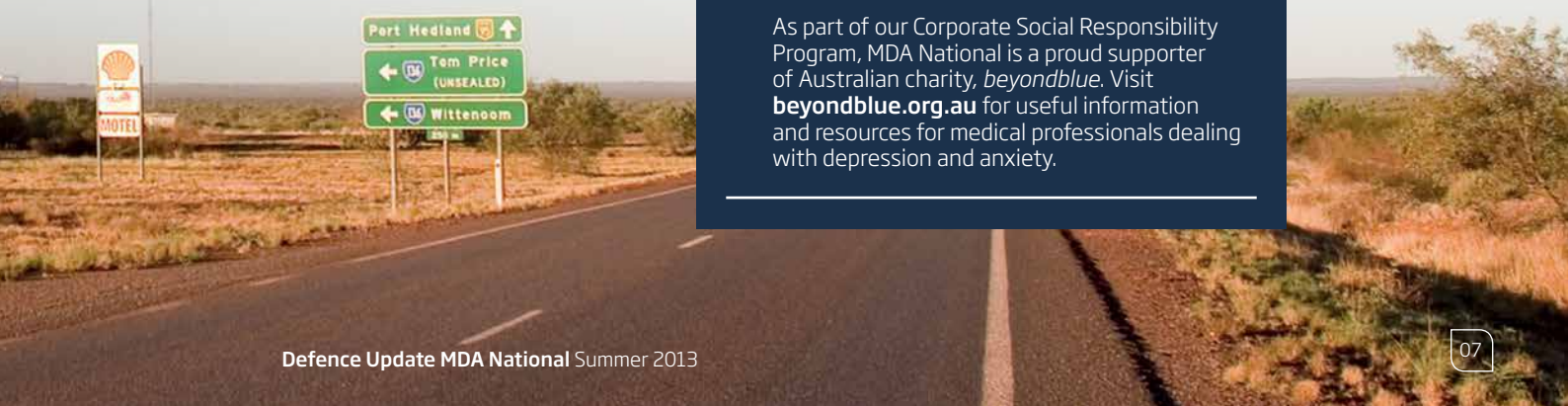
Enore Panetta is a director at Panetta McGrath Lawyers, Perth.

1 Geissman v O'Keefe (unreported, NSWSC, Simpson J, 25/11/1994) at [51] White B, McDonald F and Willmott L. *Health Law in Australia*. Thomson Reuters, Sydney, 2010; 228.

Do you have any tips?

Are you a rural practitioner? Share your tips and comments online at **defenceupdate.mdanational.com.au/rural-medical-practice.**

As part of our Corporate Social Responsibility Program, MDA National is a proud supporter of Australian charity, *beyondblue*. Visit **beyondblue.org.au** for useful information and resources for medical professionals dealing with depression and anxiety.



Recording of Consultations

How should you respond if a patient asks to record a consultation? MDA National Medico-legal Adviser, Dannielle Stokeld outlines the medico-legal issues to consider.

With the ease and availability of technology, it is becoming increasingly common for patients to ask to make a recording of a consultation. While such a request raises important issues of trust and consent, there may be circumstances where a recording may facilitate or enhance a patient's care; for example, a patient with a new diagnosis of cancer where the purpose of the recording is to assist in the recall and sharing of information about prognosis and proposed treatment. In such scenarios, recordings can be a useful information aid and may significantly improve the transfer of medical information to patients.

Is a patient able to make and use a recording of a consultation?

There is specific legislation enacted in each state and territory that regulates the making of a recording of a "private conversation", and the communication and publishing of that recording (see Table 1). A consultation between a patient and doctor would be considered a private conversation for the purposes of the legislation.

From time to time, MDA National receives calls from Members after a patient has recorded a consultation in a clandestine manner and posted this information online. Depending on the jurisdiction, the express or implied consent of all the parties to the conversation may be required to make a recording of that conversation. This issue of consent also arises in relation to communicating or publishing the recording. While in some jurisdictions the consent of all parties is needed, this is not consistent across all states and territories. Specific advice should be sought based on your circumstances.

Table 1: State legislation regulating the making and use of audio recordings

Queensland	*Invasion of Privacy Act 1971*
New South Wales	*Surveillance Devices Act 2007*
Victoria	*Surveillance Devices Act 1999*
South Australia	*Listening and Surveillance Devices Act 1972*
Western Australia	*Surveillance Devices Act 1998*
Northern Territory	*Surveillance Devices Act 2007*
Tasmania	*Listening Devices Act 1991*
Australian Capital Territory	*Listening Devices Act 1992*

What should you do if a patient asks to record the consultation?

As a first step, you should consider the intention, or the reason, for the patient's request to make the recording. Surveys of Australian doctors suggest issues such as patient confidentiality and medico-legal concerns have been raised as reasons for reluctance to agree to recording of consultations. While it is understandable to feel a level of suspicion when receiving such a request, studies show that there are benefits associated with audio recordings of consultations, including greater patient satisfaction and improved recall of information.[1] If you agree to the consultation being recorded, you may wish to ask the patient for a copy of the recording so that it can be placed in their medical record to form a permanent record.

If you feel uncomfortable with the request, you should express that discomfort to the patient and inform them that you would prefer not to have the consultation recorded. Another option in these circumstances is to offer to provide the patient with a written summary of the consultation or invite them to have a family member or friend present during the consultation. If the patient is insistent and you feel uncomfortable to proceed, it may be necessary to end the consultation and inform the patient that they will need to see another doctor. Before doing so however, you must be satisfied that the patient's presenting complaint does not require urgent treatment. If urgent treatment is required, you have a duty and a professional obligation to provide medical care as reflected in the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*[2] irrespective of the circumstances surrounding the consultation.

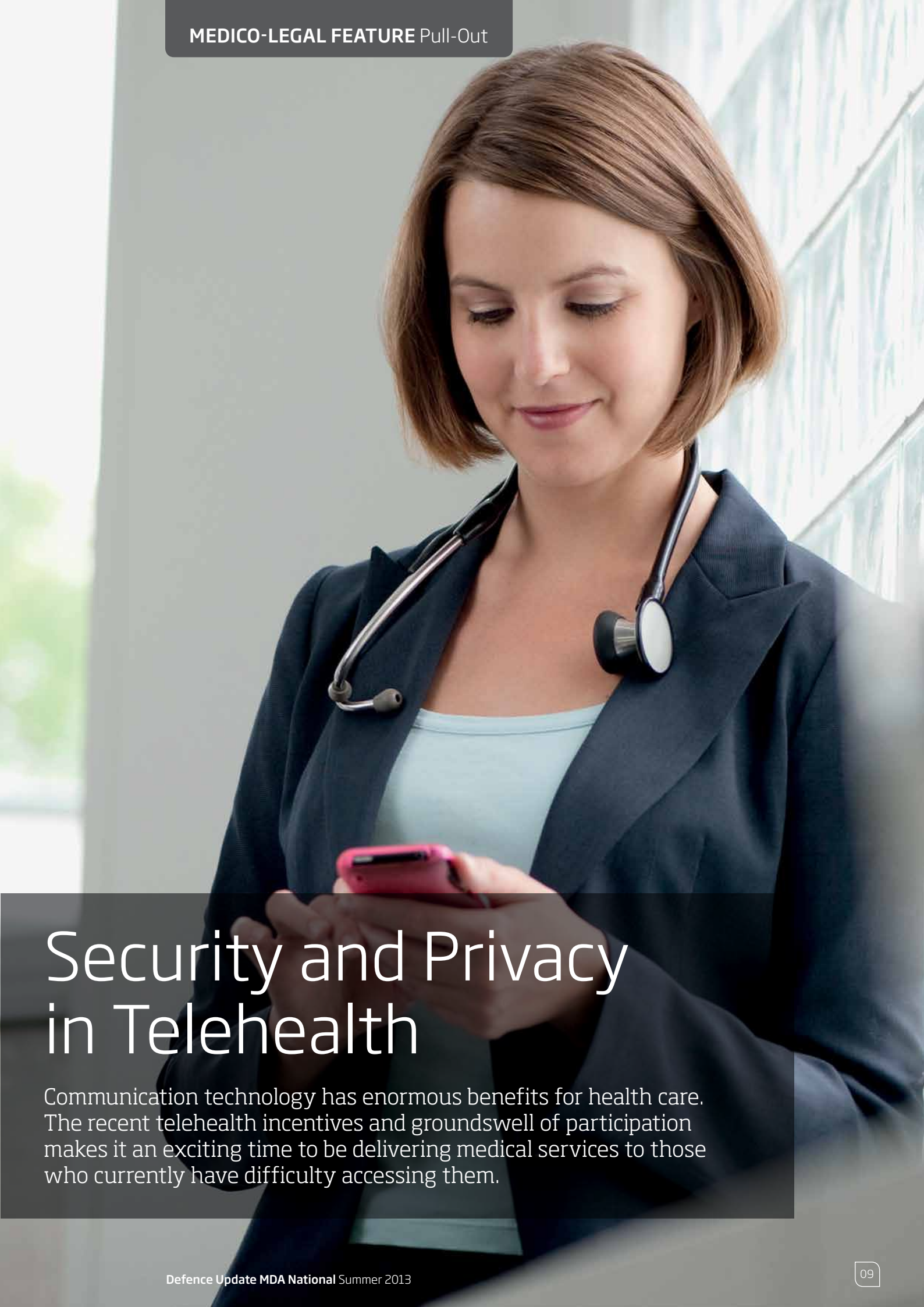
For advice and further information, you can contact our Medico-legal Advisory Service on 1800 011 255 or email advice@mdanational.com.au.

1 Tattersall MHN, Butow PH. *Consultation audio tapes: an underused cancer patient information aid and clinical research tool.* The Lancet Oncology 2002; 3:431-37. Ong LML, Visser MRM, Lammes FB et al. *Effect of providing cancer patients with the audiotaped initial consultation on satisfaction, recall and quality of life: a randomised, double blind study.* J Clin Oncol 2000; 18:3052-60.

2 medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

What do you think?

Share your comments with us at *Defence Update* online **defenceupdate.mdanational.com.au/recording-consultations.**



Security and Privacy in Telehealth

Communication technology has enormous benefits for health care. The recent telehealth incentives and groundswell of participation makes it an exciting time to be delivering medical services to those who currently have difficulty accessing them.

Security and Privacy in **Telehealth**

Telehealth uses communication technology to bring together people separated by distance for health related matters.

It covers a number of services including a general practitioner consulting by phone or video with a specialist with or without the patient present; direct patient care by one doctor; remote patient monitoring; professional medical education; and patient and community education. Telehealth can increase quality of care, reduce adverse events, and improve efficiency. It enhances and complements traditional health care, rather than replaces it.

If you decide that telehealth is a good option in a particular circumstance, how do you ensure security and patient privacy?

Modern technology is a chance to improve patient privacy

There has always been a risk that information communicated by phone, fax or regular post might be seen or intercepted by unintended recipients. With new technologies, we should embrace the opportunities for enhanced information security. Greater security is essential because electronic communication can very easily be seen by a large audience when it "goes wrong". Stored data can be violated over a long period of time, compared to data that is only transmitted once, such as a telephone call.

General telehealth security points

- Be familiar and comply with privacy and confidentiality of health information requirements (state and federal).
- It is each doctor's responsibility to ensure that telehealth delivery systems are adequate – get assurances from your vendor.
- Good information technology (IT) support is essential. Standard IT providers are not necessarily security experts. Use reputable companies and follow peer recommendation. Ensure your IT support providers are aware of, and act in accordance with, relevant medical practice guidelines and standards. Bennett et al (2010) lists potentially useful questions to ask and matters to discuss with those responsible for your IT security regarding telehealth services.[1]
- Employ clinical software that uses a secure clinical messaging system.[2]

Video consult security

"The general privacy requirements for video consultations relating to confidentiality, patient consent and security of patient information and medical records, are the same as for face-to-face consultations… Video consultations should be conducted using secure infrastructure or encryption. If the possibility of a third party interception exists, the patient should be told and asked for their consent to proceed."[3]

- Transmitting audio and visual information separately increases security,[4] e.g. mute the sound over a video link and speak over a phone.
- Ensure physical privacy of the patient so that others cannot overhear or walk in.
- Skype™ has not been deemed "unsuitable" for telehealth consultations,[5] but may be inappropriate due to privacy, confidentiality and quality issues.

Email security

If clinical messaging systems cannot be used and you must use email, remember that identifiable health information should not generally be sent by email – particularly unencrypted transmission. What doctors need to look at is encryption of the server to server transmission.[6] Talk to your IT support staff about server to server email encryption.

When email encryption is not practicable, weigh up whether the benefits warrant the risk of electronically transmitting confidential information. Consider password protecting or encrypting attachments if you cannot encrypt the email itself, e.g. portable document format (PDF) files can be encrypted.

Always check use of the "BCC" field when sending information to multiple recipients and confirm the email address the patient wishes to use for information about their health care.

Equipment pointers

- Have offsite information backup that is not physically connected to the main system.
- Use firewalls and current anti-virus and anti-malware software.

- Introduce policies for staff about the appropriate use of internet and email. "Use of external applications, software, websites and programs that can transmit information outside the practice poses a considerable security risk". Have your technical service provider block specific sites and applications.[2]
- Position monitors to maintain information confidentiality.
- Manage the security of all portable devices.
- Have a security risk assessment.

Tips for texting

- Do not communicate specific health information in text messages. Text messaging is essentially the same as leaving messages on an answering machine in that many people may readily access the information.
- It is fine to send a text message appointment reminder just identifying the doctor's name and the date and time of the appointment, but do not say what the appointment is for.
- You must first ensure that the patient consents to their contact details being used this way – include this on the patient registration form and have systems to regularly check that patient contact details remain current.

Nicole Harvey, MDA National Education Services

1 Bennett K, Bennet A, Griffiths K. *Security Considerations for E-Mental Health Interventions*. J Med Internet Res 2010;12:e61. Available at: jmir.org/2010/5/e61/.

For a full list of references visit defenceupdate.mdanational.com.au/telehealth-security-privacy.

Privacy laws in relation to telehealth

- Doctors must take reasonable steps to protect personal information from misuse and loss and from unauthorised access, modification or disclosure.
- Patients must be advised of and consent to how their personal details will be collected, stored and used.
- Australian privacy laws also apply to information sent overseas.
- Specific consent to overseas (cross border) transfer of information needs to be obtained from patients. Prior to giving consent, patients must be advised of the following:
  - where the information is being sent, i.e. which countries
  - the privacy protection laws in that country and how patients may complain about a breach of their privacy
  - that by consenting to the cross border transfer, patients may not have any recourse under Australian privacy law.
- The Australian Privacy Principles (APPs) come into effect on 12 March 2014. Notably, in relation to telehealth, the APPs introduce additional responsibility and consequent potential liability associated with disclosing information overseas if the international recipient violates privacy.
- See the "Privacy Law Reforms" article by Allyson Alker (page 5 of this issue) for more information about changes associated with the APPs.

Embrace telehealth but ensure patient care and privacy are never compromised.

What do you think?

Share your comments with us at *Defence Update* online **defenceupdate.mdanational.com.au/telehealth-security-privacy.**

Telehealth
A General Practitioner's Point of View

Dr Michael Civil

Video consultations offer a very effective means for patients to consult with distant specialists without the need to travel potentially great distances in Western Australia.

They also offer an alternative for patients who are less able to consult face to face with their medical specialists. For example, elderly patients often find travelling into the busy city distressing and therefore rely on friends or relatives to take them to their appointments. The ability to offer a video consultation can avoid this inconvenience for patients, also saving them time and money.

Following the introduction of Medicare incentives to conduct video consultations in a General Practice setting, in July 2011 the Stirk Medical Group carried out over 350 video consultations with their patients and a remote specialist. During these consultations, the patients were supported by a local clinician, with this role often being performed by the patient's usual GP.

A simple patient feedback survey was performed following the video consultation to assess patient satisfaction with the process and to highlight potential problems and issues from a patient's perspective. High levels of patient satisfaction were found in the analysis of the survey results. Patients particularly appreciated being supported by their local GP and having the consultation in a familiar environment they felt comfortable in.

Anecdotally, the support clinicians assisting the patients in their video consultation also found the process educational and useful for managing the care of their patients.

The Stirk Medical Group made a conscious decision to have the video consultation technology contained within a standalone unit. This unit comprised an entry level desktop box, high definition screen, wireless internet connectivity and reasonable quality audio equipment. The total financial outlay for such a unit would have been less than $2,500.

The practice ensured a quality broadband wireless router was used to optimise signal strength throughout the surgery. This fully independent unit was able to be wheeled into the consulting room during the video consultation and the support clinician was able to access patient clinical records via the normal desktop clinical software, without concerns that the technology would have an impact on the function of the clinical software.

By having a fully independent unit, security and privacy concerns were addressed as any potential hacking of the session (a relatively small risk in my opinion) could not access any clinical records.

Despite some initial reservations that the predominantly elderly patients might find a video consultation uncomfortable, the very positive results we have had as a practice have left me in no doubt that this is an important adjunct to services that we can offer in General Practice.

Video consultations will not replace the gold standard of a face to face consultation, but they do have an important place in the provision of quality health care to patients.

Dr Michael Civil is a rural GP, Medical Director at Stirk Medical Group and a Member of MDA National.

National Mental Health Survey of Doctors and Medical Students

MDA National's Charity of Choice, *beyondblue*, released the results of its National Mental Health Survey of Doctors and Medical Students last month.

Completed by more than 14,000 doctors and medical students in Australia, the survey is believed to be the first in the world to provide a mental health snapshot of such a large proportion of a country's medical community.

The health and wellbeing of doctors has been an integral part of MDA National's Member support since our organisation was founded in 1925. Our association with *beyondblue* over the past year as part of our Corporate Social Responsibility Program has further fostered our commitment to promote mental health awareness throughout the medical community and, in particular, to our valued Members.

A key outcome of the launch of the survey findings is an action plan to better support Australia's doctors and medical students. The survey identifies the challenges faced by the medical profession and outlines how they can be tackled, including initiatives such as the development of a mental health strategy for the Australian medical community to promote good mental health; the development of guidelines around working hours; better mental health education in universities to reduce stigma; and awareness campaigns.

As an advocate for our Members' wellbeing, MDA National is continuing to lobby state and federal governments to implement mandatory reporting exclusions for treating doctors, similar to that in WA. We believe such exclusions would reduce some of the barriers to medical practitioners and students seeking medical assistance and better manage mental health and wellbeing.

The final report from the survey can be accessed online at: **defenceupdate.mdanational.com.au/national-mental-health-survey**.

Proudly supporting beyondblue

Supporting, **protecting** & **promoting** doctors' mental health

The key findings of *beyondblue*'s landmark survey included:

- **One in five medical students** and **one in 10 doctors** had suicidal thoughts in the past year, compared with one in 45 people in the wider community.
- A number of **vulnerable subgroups** exist within the medical community; these include female doctors, young doctors, doctors working in rural and remote areas, and Indigenous students.
- More than **four in 10 students** and a **quarter of doctors** are highly likely to have a minor psychiatric disorder.
- Among **doctors, 3.4%** are experiencing very high psychological distress, much greater than the wider community.
- **Oncologists** are the most psychologically distressed specialists while **doctors who do not deal with patients** (e.g. researchers, administrators) think about suicide most often.
- **Male doctors** work longer hours (46 per week on average) and engage in more risky drinking; but **female doctors** are more psychologically distressed and think about suicide more often.
- **Young doctors** work longer hours (50 per week on average), are far more psychologically distressed, think about suicide more, and experience more burnout than their older colleagues.
- **Perceived stigma** is rife with almost **half of respondents** thinking doctors with a history of depression or anxiety are less likely to be appointed, and 40% agreeing that doctors with a history of depression or anxiety were perceived as less competent than their peers.
- The most **common source of work stress** reported by doctors was related to balancing work and personal responsibilities; other sources of stress included too much work (25%), responsibility at work (20.8%), long work hours (19.5%), fear of making mistakes (18.7%), bullying (4.5%) and racism (1.7%).
- **Barriers to seeking treatment and support** for mental health conditions included fear of lack of confidentiality or privacy (52.5%), embarrassment (37.4%), impact on registration and right to practice (34.3%), preference to rely on self or not seek help (30.5%), lack of time (28.5%) and concerns about career development or progress (27.5%).

Member Risk Management Program

A key component of MDA National's commitment to support and protect Members, and promote good medical practice, is assisting Members to identify and respond to risk issues in their practice. The issues of concern are those that expose Members to the risk of legal or disciplinary action against them. This service to Members is provided by our Support in Practice (SiP) team.

In April 2013, the SiP team relocated to Sydney to develop and strengthen the existing relationship with our Claims and Advisory Service. This provided an ideal opportunity to review the existing risk management program to ensure it provided appropriate support for Members. As a result, the MDA National program will now have a two-level approach.

Level 1 – Early Intervention Program

This level is designed to identify and address risk concerns early so that events of a similar nature might be prevented in the future. This may be offered to a Member with, in some cases, only one claim or complaint. Member participation at this level is strongly encouraged as research has suggested early intervention has considerable potential to reduce the likelihood of further risk issues occurring.[1]

Level 2 – Member Risk Management Program

This level is designed to address risks for those Members who have a more complex claims history. Members offered assistance in this category are provided with a targeted and focused risk management program. Participation at this level can, in some circumstances, be a condition of ongoing indemnity cover with MDA National Insurance.

Responding to a Member's risk

In order to determine how MDA National will respond to a particular Member's needs, a review of the frequency, nature and complexity of a Member's claims over a period of time is undertaken by representatives of the SiP, Claims and Advisory Service and Underwriting teams.

Should a Member be suitable for participation in the Level 1 or Level 2 program, the SiP team will contact the Member directly and discuss the assistance that can be provided to best meet that Member's individual needs.

The range of Member risk management and support varies and may be in the form of:

- a phone discussion or meeting
- provision of resources, materials or articles
- recommendation to attend a workshop or educational activity provided by MDA National
- a practice visit, including discussion with practice staff and review of practice systems
- meetings, interviews or mentoring with a peer or colleague.

Most Members on the Level 2 program require a practice visit to enable a targeted and individualised program to be developed.

Ongoing support

Once assistance has been provided, the SiP team will maintain contact with the Member to assess progress, provide further assistance to reduce risks and, where relevant, to ensure compliance where risk management is a formal requirement.

The SiP team

MDA National's risk advisers have extensive experience in healthcare risk management with a strong commitment to supporting Members. Their advice is based on:

- claims data analysis
- the experience of MDA National
- legislation and standards
- literature.

The SiP team can be contacted on 1800 011 225 or by email at peaceofmind@mdanational.com.au.

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1 Bismark MM, Spittal MJ, Gurrin LC, et al. *Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia.* BMJ Qual Saf Published Online First:[12 April 2013] doi:10.1136/bmjqs-2012-001691. Available at qualitysafety.bmj.com/content/early/2013/02/22/bmjqs-2012-001691.full.

CaseBook

Varipatis v Almario: An Exercise in Futility

On 21 December 2012, the Supreme Court of NSW found a GP negligent for not referring a morbidly obese patient for bariatric surgery in 1998. This decision was successfully overturned on appeal in April 2013. Dr Sara Bird outlines the facts of the case and discusses its significance for medical practitioners.

Case history

Mr Almario attended Dr Varipatis, a GP, from August 1997 until February 2011. Dr Varipatis had a special interest in nutritional and environmental medicine. Mr Almario, 53 years of age, sought out the GP because he believed his ill health was the result of exposure to toxic chemicals in his previous workplace. The patient had a BMI>40 and a number of co-morbidities, including diabetes and sleep apnoea.

In June 1998, Dr Varipatis referred the patient to a respiratory physician who, in turn, gave Mr Almario a referral to the Obesity Clinic. When the patient returned to see Dr Varipatis on 30 July 1998, they discussed the recommendation to attend the Obesity Clinic. The patient said he had found in the past that weight loss had not helped his symptoms and he did not intend to pursue the referral.

The GP also referred the patient to a Gastroenterologist, a Urologist and, in early 2000, to a Surgeon for a cholecystectomy.

Mr Almario was subsequently diagnosed with cirrhosis in 2003 and in 2011 he was diagnosed with liver cancer secondary to the cirrhosis. The cirrhosis was thought to have been caused by non-alcoholic steato-hepatitis.

Medico-legal issues

The claim proceeded to hearing in 2012 and judgment was handed down on 21 December 2012.[1] The trial judge found that the GP had breached his duty of care in failing to refer the patient (now a plaintiff):

1. to a Bariatric Surgeon by 30 July 1998
2. to an Obesity Clinic or Endocrinologist
3. to a Hepatologist by the end of September 2000.

However, the trial judge found that only the failure to refer the patient to a Bariatric Surgeon by 30 July 1998 was causally related to the development of cirrhosis and subsequent liver cancer. In this regard, the trial judge stated that more was required of the GP on 30 July 1998 when he discussed the Respiratory Physician's recommendations:

...it was not sufficient simply to make the option known to Mr Almario, for what it was worth, and then leave him to take it or leave it, which I find Dr Varipatis did. More proactive involvement was required... in my judgement Dr Varipatis at that time ought to have referred Mr Almario to a specialist in obesity management and even assisted in making the appointment for him to attend.[1]

Mr Almario was awarded $364,373.48. This amount had been discounted by 20% to represent the contributory negligence of Mr Almario in not adhering to the opportunities he had been given to lose weight.

In April 2013, the Court of Appeal rejected the finding of breach of duty by the GP:

A General Practitioner may be obliged, in taking reasonable care for the health of a patient, to advise them in unequivocal terms that weight loss is necessary to protect his or her health, to discuss the means by which that may be achieved and to offer (and encourage acceptance of) referrals to appropriate specialists or clinics... evidence did not demonstrate any obligation, or indeed power, on the part of a medical practitioner to do more than that. If the plaintiff refused to take the firm advice of his General Practitioner, and of experts to whom he had been referred, there was no breach of duty on the part of a General Practitioner in failing to write a further referral. The duty of care stopped short of an exercise in futility.[2]

Discussion

This Court of Appeal decision clarifies the extent of the duty of care of medical practitioners to advise patients of treatment recommendations and to ensure the compliance of patients with their advice.

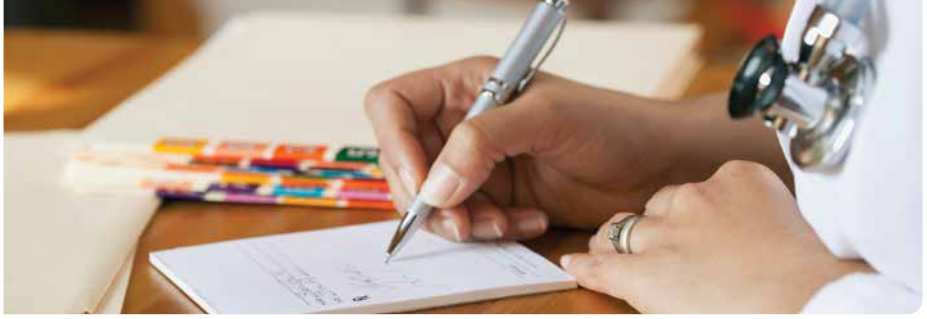
The decision confirms that a patient cannot hold a doctor legally responsible for their own failure to follow medical advice. Once a patient has been properly informed by their doctor of any investigation results and treatment recommendations, it is up to the patient to decide whether or not to follow this advice. The law recognises that there is legally effective "informed consent" but also legally effective "informed refusal".

Summary points

- Once a medical practitioner has appropriately informed a patient of their management recommendations, it is ultimately up to the patient to decide whether or not to follow this advice.
- A patient cannot hold a medical practitioner liable for the consequences of not following medical advice which they have understood.

1 *Almario v Varipatis* (No. 2) [2012] NSWSC 1578
2 *Varipatis v Almario* [2013] NSWCA 76

CaseBook



Exercise Caution: Fitness Certificates and Medico-legal Risks

How do you deal with requests for "fitness certificates" to certify that a patient is physically able to perform specific activities? Where risks are not properly assessed, the doctor may be exposed to claims or complaints where harm arises in relation to the patient's participation in the activity.

Case history

The patient needed a "fitness certificate" to be completed by a doctor before joining the local fishing club. Questions included whether the patient could safely tolerate the following situations:

- Spine: able to tolerate brief impacts through the spine when sitting in a boat at sea.
- Cardiovascular: able to outswim a great white shark over 100 metres and re-enter a boat.

Discussion

A "fitness certificate" involves a doctor providing a medical clearance that certifies a patient is physically able to perform specific activities or jobs. Such certificates involve assessing the risk of an adverse outcome, taking into account a patient's physical function and health status.

This must then be weighed against the physicality of the planned activity, including an understanding of the likely intensity, duration and frequency of the activity.

However, this information will usually not be available to the doctor and may be under (or outside) the control of the requesting party. Appropriate assessment by the doctor may be impractical, impossible or overly onerous.

Fitness certificates may also expose a doctor to claims or complaints where harm arises in relation to the patient's participation in the activity if this risk has not been properly assessed. Complaints may also arise where a doctor refuses to complete the request.

The request for a medical clearance is often an attempt by the requesting party to shift their legal liability to the doctor, where normally the requesting party has a responsibility to appropriately implement reasonable risk management policies and procedures.

A "fitness certificate" involves a doctor providing a medical clearance that certifies a patient is physically able to perform specific activities or jobs.

Dealing with fitness certificate requests

Arguably, where a doctor has received an appropriate fee and patient consent, they have an ethical obligation to provide factual information required by the requesting party. However, this does not imply that the doctor must follow the format of the request and/or provide their opinion.

Under the Medical Board of Australia's *Code of Conduct* (at 8.8 – Medical reports, certificates and giving evidence), a doctor has an obligation to be honest, accurate, and to take reasonable steps to verify the content of a report and not deliberately omit relevant information.

MDA National's advice is to provide the requesting party with a relevant factual health summary including clinical information such as past history, co-morbidities, physical limitations and medications. Relevant negatives may also be significant (e.g. patient has not undertaken cardiac stress testing). Future management plans such as referrals and further testing should be included.

A request by a patient to deliberately omit relevant information should result in the doctor declining to assist. Opinions may be provided where the doctor is comfortable that these opinions are supported by appropriate facts and the doctor has relevant expertise. Otherwise leave such questions blank or suggest where further information might be obtained.

Sometimes it will be necessary to provide a referral to another health practitioner or other fitness assessor for further review. This may include medical referrals (e.g. stress tests, Occupational Health Physicians) or referrals to allied health providers (e.g. Accredited Exercise Physiologists, Physiotherapists) with specific expertise in this area.

Fitness certificates allow the requesting party to decide whether the patient is suitable for the task at hand or whether risk modification can be undertaken by the patient or the requesting party. It also allows the requesting party to seek further specific information where necessary.

Members seeking advice can contact our Medico-legal Advisory Service on 1800 011 255 or email advice@mdanational.com.au.

Summary points

- You do not need to answer every question or follow the format of the request. You should provide any information that you consider is relevant.
- Information provided might include a health summary; past history; co-morbidities; physical limitations; medications; and future management plans.
- If necessary, refer the patient to other fitness assessors or health practitioners with specific expertise in this area for further review.
- Be honest and accurate in your response. Only include information that you can verify and do not deliberately omit relevant information. If the patient requests you to omit relevant information, you may decline to complete the request.

Julian Walter, Medico-legal Adviser, MDA National

CaseBook

In-flight Emergencies and Good Samaritan Acts

What should you expect when a call is made for a doctor to attend an in-flight emergency? And are you protected if you agree to assist? The following case made headlines across the world when it was reported in 1995.

Case history

One hour into a 13-hour international flight, a 39 year old passenger developed acute breathlessness and left-sided chest pain.[1] Professor Wallace, an Orthopaedic Surgeon, responded to the call: *If there is a doctor on board could you make yourself known to the cabin staff?*

The passenger gave a history of having fallen off a motorcycle on her way to the airport. Following a brief physical examination, a diagnosis of a tension pneumothorax was made. Professor Wallace asked if medical advice could be obtained from the ground. It was not possible to receive immediate advice, so he decided to proceed with the insertion of a chest drain.

The aircraft's medical kit contained a scalpel, scissors, and a 14-gauge urinary catheter. There was lignocaine for use as a local anaesthetic. The following equipment was prepared: heated hand towels for sterile drapes, a modified coathanger as a trocar for the urinary catheter, a bottle of mineral water with two holes created in its cap for use as an underwater seal drain, and a length of oxygen tubing to attach the catheter to the drain. Cellotape was used to anchor the catheter to the oxygen tubing and brandy was used as a disinfectant for the introducer. Professor Wallace advised the passenger that she had a serious condition and an operation was required. He then proceeded to insert the chest drain into the left second intercostal space. As soon as the drain was connected, air was released from the pleural cavity and within five minutes the passenger had almost fully recovered.

Medico-legal issues

If a call for emergency assistance is made, an issue of concern may be the possibility of being sued in the event of an adverse outcome. The potential liability of a doctor who responds to an in-flight emergency is complex. While in Australia there is legislative protection for Good Samaritans, the law relating to Good Samaritan acts varies from country to country. The determination of jurisdiction of any action on an international flight may range from the country in which the aircraft is registered through to the country of citizenship of the passenger or doctor.

In any event, many major airlines have insurance policies which will indemnify doctors who come forward to assist in an emergency and, if required, doctors should seek written confirmation of indemnity from the aircraft captain.

Also, the US *Aviation Medical Assistance Act 1998* protects doctors who provide assistance on aircrafts registered in the US.

In addition to these protections, MDA National's Professional Indemnity Insurance Policy provides cover for any claims arising out of Good Samaritan acts regardless of the jurisdiction in which the claim is brought, including claims arising out of the US.

Discussion

It has been estimated that 44,000 in-flight medical emergencies occur worldwide each year (one emergency per 604 flights).[2] On-board assistance was provided by doctors in 48% of medical emergencies. Aircraft diversion occurred in 7% of cases and the death rate was 0.3%.

A recent study of 11,920 in-flight emergencies revealed that the most common problems were:

- syncope or presyncope 37%
- respiratory symptoms 12%
- nausea or vomiting 10%
- cardiac symptoms 8%
- seizures 6%
- abdominal pain 4%.[2]

Summary points

- The risk of a claim arising out of the provision of medical care during an in-flight emergency appears to be very low.
- When providing aid to a passenger during an in-flight emergency, Members are protected from liability by a combination of legislation, indemnity by the airline and their MDA National policy.

Dr Sara Bird, Manager, Medico-legal and Advisory Services, MDA National

1 Wallace WA. *Managing in flight emergencies: A personal account.* BMJ 1995; 311:374-376.

2 Peterson DC, Martin-Gill C, Guyette FX et al. *Outcomes of Medical Emergencies on Commercial Airline Flights.* N Engl J Med 2013; 368:2075-83.

What's On?

MDA National is promoting your professionalism and wellbeing in 2014 with a number of workshops and educational sessions.

February

4	Enhancing Patient Understanding – Health Literacy and Communication **Sydney, NSW**
8	Practical Solutions to Patient Boundaries **Perth, WA**
11	Enhancing Patient Understanding – Health Literacy and Communication **Melbourne, VIC**
19	Mastering Professional Interactions **Brisbane, QLD**

March

1	Practical Solutions to Patient Boundaries **Perth, WA**
5	Mastering Professional Interactions **Brisbane, QLD**
12	Keys to a Healthy Practice **Sydney, NSW**

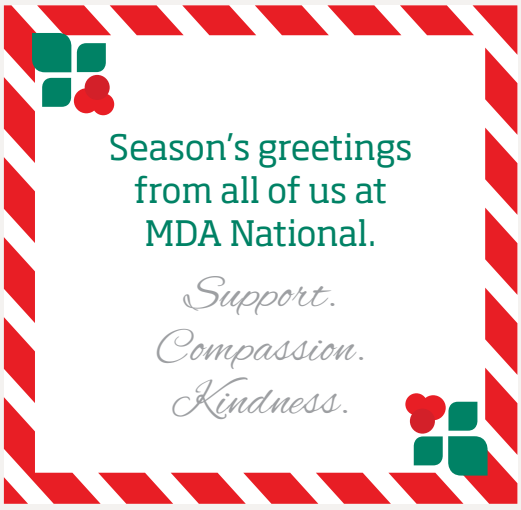
May – June

The Challenging Emotions of Difficult News – Making a Positive Difference at a Demanding Time.

Stay tuned for more information on this large group education event. Visit our 'What's On' page at **mdanational.com.au** for event details.

Find out more

To find out more or to register for any of the MDA National events: visit **mdanational.com.au**, email **events@mdanational.com.au** or contact 1800 011 255.



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Would you like to read *Defence Update* via your PC, smart phone or tablet?

You can now read *Defence Update* online at **defenceupdate.mdanational.com.au.**

If you would prefer to read *Defence Update* online, simply log on to Member Online Services (MOS) at **mdanational.com.au** and alter your preference on your Membership record. If you need assistance, contact our Member Services team on 1800 011 255.

You can also email us at defenceupdate@mdanational.com.au with the word "subscribe" in the subject line along with your name and Member number in the body of the email.

Have you moved? Have your practice details changed?

If so, please take a moment to notify us of your new information. To update your details, please call Member Services on 1800 011 255 or log on to the Member Online Services section of our website **mdanational.com.au**.

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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