defenceupdate

Publication for MDA National Members

Winter 2018

MDA National
Support Protect Promote

Editor's Note

One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.[1]

This is the final sentence in a talk given to students at the Harvard Medical School by Dr Francis Peabody in 1926.

Dr Peabody was Harvard's Professor of Medicine at the Boston City Hospital. He was renowned for his compassion and wisdom in patient care. An inspiring teacher and talented administrator, he was universally admired by his patients and his colleagues. In short, Dr Peabody embodied medical professionalism.

Many of the disciplinary cases against doctors involve lapses in professionalism. On pages 13-14, Canadian physician and academic, Prof J Donald Boudreau, defines and discusses the evolving conceptions of medical professionalism. Like Dr Peabody, Prof Boudreau emphasises the importance of the patient's perspective: for a patient to feel as if they were heard and recognised as an individual worthy of respect.

This edition of *Defence Update* also includes practical advice and tips about how to manage subpoenas for medical records (pages 9-12), what you need to know about cybersecurity in your practice (pages 6 and 15) and the My Health Record (page 7) which will become an 'opt out' for all Australians in 2018. And on page 8, Prof Wendy Brown and Prof Ian Caterson discuss the Australia and New Zealand Bariatric Surgery Registry.

Finally, it's time to renew your MDA National Membership. On page 5, our Member Services team outlines the steps involved in completing this year's renewal.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

1. Peabody FW. The Care of the Patient. JAMA 1927; 88:877-882.

Defence Update **Online**
Visit **defenceupdate.mdanational.com.au**

In This Issue

Doctors for Doctors

Could sponsorship be the key to greater diversity?

Women now make up over 50% of medical school graduates, but medical women still remain under-represented in decision-making and leadership roles.

Gender equity is part of a broader diversity issue in medical leadership. Unconscious bias creates barriers to inclusion, performance, engagement and, ultimately, innovation. Last year I had the privilege of attending Harvard as part of their Women Executives in Healthcare program, to explore why this might be. I learnt how gender barriers and unconscious bias impact career development and progression, and how 'sponsorship' could help advance more women through the pipeline and grow leadership diversity.

Sponsorship is a process where senior leaders provide emerging leaders with active, targeted, deliberate support aligned with career progression needs. We know it more commonly as giving someone an 'opportunity to shine', show 'they've got what it takes' or see if they 'sink or swim'. In a two-way relationship built on trust, the sponsor stakes their reputation on their protégé, therefore requiring outstanding performance in return.

Unlike mentors who are usually consulted privately for personal or professional guidance, sponsors invest their own leadership capital to advance others' careers – providing public endorsement, visibility and opportunity within the workplace. While both mentors and sponsors are important, women tend to be over-mentored and under-sponsored. The natural tendency to promote and provide opportunities to those who think and behave like existing leaders and fit entrenched leadership norms, means men are more likely to be sponsored. As sponsorship objectively increases career outcomes, this disadvantages women and other under-represented groups in their career progression.

I've since reflected on the course of my career and how I've grown as a result of sponsorship. Whilst I've had several mentors over the years, it was being put forward for high-profile, challenging, stretch assignments outside of the expectations of my day-to-day role that changed my career trajectory. Personally, it allowed me to step outside my comfort zone and translate skills to new areas for which I had little prior experience, growing my capability and confidence. Professionally, it gave me greater visibility and raised my profile leading to further opportunities to demonstrate what I could do.

Sponsorship begets sponsorship – greater visibility opened external doors for me (e.g. board positions), creating networks of new sponsors and additional opportunities to develop broader skills, further enhancing the leadership value I brought back to the workplace. My growing leadership capital has enabled me to sponsor others in turn. Sponsors benefit too – they advance further and faster in their own careers by investing in future talent, becoming better leaders themselves and creating a pipeline for their organisations.

Whilst sponsorship does need to be earned, when used effectively and transparently, it can help overcome barriers related to unconscious bias to identify and develop the diverse medical leaders needed for the future.

I take this opportunity to acknowledge and thank my mentors and sponsors.

Dr Mellissa Naidoo (MDA National Member)
Chair, Queensland State Advisory Committee
Medical Administrator, Queensland

Notice Board

Advance Care Planning – New Laws in Victoria

On 12 March 2018, the *Medical Treatment Planning and Decisions Act 2016* commenced in Victoria, designed to empower people to make their own medical treatment decisions which reflect their preferences and values. The Act provides statutory recognition of advance care directives, and also provides for the making of medical treatment decisions on behalf of persons who lack decision-making capacity.

If a person lacks decision-making capacity and is in need of medical treatment (other than emergency treatment), a health practitioner must first make reasonable efforts to locate the person's advance care directive (ACD) and/or substitute decision maker before administering the proposed treatment. In the absence of both, a separate process applies that may involve obtaining consent from the Public Advocate before administering significant medical treatment.

Read more about this in our Medico-legal Blog: **mdanational.com.au/resources/blogs/2018/03/changes-to-victorian-advance-care-planning-laws**

SafeScript Prescription Monitoring in Victoria

In late 2018, the Victorian government will commence implementation of SafeScript – computer software that will allow prescribers and pharmacists real-time access to prescription records for high-risk medicines (S8 drugs and some S4 medicines, including benzodiazepines).

Online registration for access to SafeScript will open later in 2018. More information on SafeScript is available at: **health.vic.gov.au/public-health/drugs-and-poisons/safescript**.

MORE MEMBER BENEFITS

Worried about cyber risk?

We recently launched our Cyber Risk Program, a collection of cyber risk initiatives:

- **Cyber Risk Education** for **MDA National Members and Practice Indemnity Policyholders** which includes access to resources by global cyber experts, quarterly cyber risk updates, and cybersecurity education sessions.
- **Complimentary Cyber Risk Cover** for **MDA National Practice Indemnity Policyholders** until 30 June 2019, including a 24-hour cyber crisis hotline and cover up to $100,000* in the aggregate against cyber-related privacy breaches, network security liability, media liability, cyber extortion, data loss, business interruption and incident responses.

*Cyber Enterprise Risk Management Insurance Policy is arranged by Jardine Lloyd Thompson Pty Limited (ABN 69 009 098 864, AFSL 226 827), underwritten by Chubb Insurance Australia Limited (ABN 23 001 642 020) and can be accessed by new and current MDA National Practice Policyholders until the earlier of 30/06/19 or their ceasing to hold a current MDA National Practice Indemnity Policy. The Cyber Enterprise Risk Management Insurance Policy terms, conditions, exclusions, limits and deductibles apply.

Travelling soon?

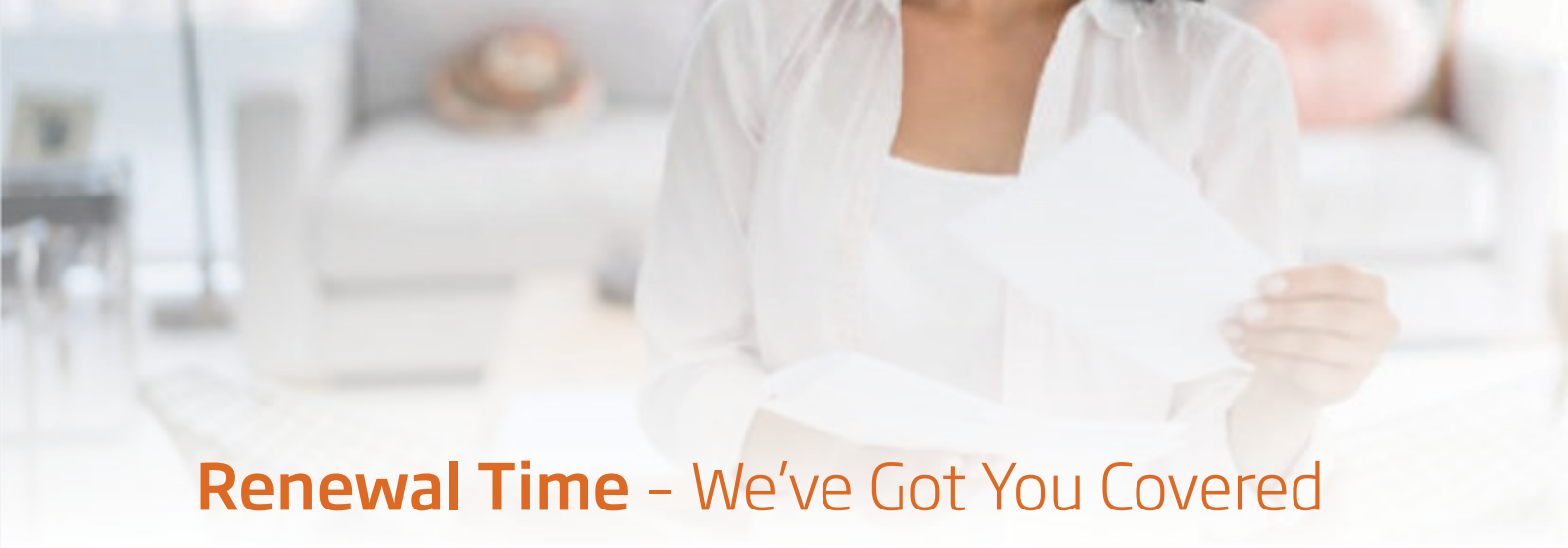
Enjoy a 15% discount on eligible QBE Travel Insurance policies:#

- *Annual Multi-Trip Policy* – unlimited trips in a 12-month period
- *International Comprehensive Policy* – for single international trips
- *Australia Comprehensive Policy* – for single trips within Australia (including Norfolk Island)

And if you're a Qantas Frequent Flyer member, you'll also earn one point for every $2 spent on your selected QBE Travel Insurance policy.#

Subject to the terms and conditions of the relevant QBE travel insurance policy. Check the PDS to see if the policy is right for you.

You must be a Qantas Frequent Flyer member to earn and redeem Qantas Points. A joining fee may apply. Membership and the earning and redemption of points are subject to the Qantas Frequent Flyer program terms and conditions found at Qantas.com/terms. Qantas Frequent Flyer members can earn 1 Qantas Point per AU$2 spend on eligible QBE Annual Multi-Trip, International Comprehensive and Australia Comprehensive Travel Insurance Policies.



Renewal Time – We've Got You Covered

You should have recently received your 2018 Renewal Notice via post and email (if we have your email address).

Renew your Membership and Policy by 30 June 2018

If the information on your Renewal Notice is correct, you can make your payment online via our Member Online Services or by phone on 1800 011 255. If you have set up a direct debit arrangement, we will debit your nominated account on the scheduled dates listed on your Renewal Notice.

Your Renewal Notice includes:

- your tax invoice/receipt which is valid upon payment
- your Certificate of Insurance which can be used as proof of indemnity upon payment.

A copy of your Certificate of Currency and Payment Receipt will be emailed to you upon successful receipt of your payment. If we do not hold a valid email address for you, these documents will be posted.

You will also be able to download a copy of your Certificate of Currency as part of our online renewal service.

Tell us about any matters arising from your practice

Early notification enables us to support you better and can help prevent matters from escalating. Ensure you have informed us of all claims, complaints, investigations, employment disputes, or any incidents you are aware of that may lead to a claim for indemnity under your Policy. This is a requirement under your Policy.

Review the risk category changes

Please read the ***Risk Category Guide 2018/19*** and the ***Significant Changes to the Risk Category Guide*** (accessible from the Downloads section at mdanational.com.au) to ensure you have selected the most appropriate risk category and estimated the most accurate Gross Annual Billings for your practice. This may affect your premium and cover under your Policy. If there is a change to the level of cover you require, please contact us and we will re-issue you with a revised Renewal Notice.

Review the Policy changes

We have introduced additional covers for 2018/19 and enhanced the Policy Wording to provide greater clarity. Please read the ***Combined Product Disclosure Statement and Policy Wording v.12*** and ***Summary of Significant Changes to the Policy*** included in your renewal pack prior to renewing for 2018/19.

Our Member Services team is here to help

If you have any queries about your Membership or Policy, or need changes to your 2018 Renewal Notice, please contact us on **1800 011 255** from Monday to Friday between 8.30am and 8.00pm (AEST) or email **peaceofmind@mdanational.com.au**.

Here's how our Members describe us:*

"I was talking to colleagues today and the conversation turned to which medical defence organisation to join – I had nothing but praise for MDA National."

Intensive Care Physician, QLD

* Sourced from MDA National's Reputation Audit Research (Feb 2017), publication surveys (Apr 2017) and Member feedback (2016/17).

What We Learnt About the **Cybersecurity Elephant**

For medical practices, cybersecurity generally feels like a very big elephant to confront – one that may be tempting to ignore. According to Prof Patricia Williams, Cisco Chair and Professor of Digital Health Systems at Flinders University, it's definitely much better to adopt another pachyderm adage, "You eat an elephant one bite at a time".

It's easy to feel scared by cybersecurity matters because:

- cyber-attacks in the media are only a small fraction of those happening
- they can affect patient safety and the financial bottom line
- health providers account for a large proportion of data breaches in Australia and globally
- for the 'bad guys', it's simply a numbers game with what they send into cyberspace. They've got nothing against you personally, but they can make a lot of money interrupting your business or demonstrating they've got the sensitive information you hold.

MDA National's *How to Avoid Catching and Sharing IT Woes* forum on 21 March 2018 included a Q&A panel session and talks by Prof Williams, Gae Nuttall (MDA National Risk Adviser) and Jonathan McCoy (Lawyer and Information Security Specialist). Held in Perth, the education session was moderated by Dr Jane Deacon (GP and Medico-legal Adviser), and over 50 Members and their practice staff attended.

Prof Williams broke the cybersecurity elephant down into a list of smaller bites for practices, including:

- roles and responsibilities
- managing systems access
- internet and email use
- backup
- mobile electronic devices.

Gae Nuttall was particularly struck when Prof Williams said, "People aren't the weakest link, they are the only link". Cybersecurity isn't a case of set-and-forget; people need to be constantly involved. "Trish's comment made it clear how very important staff training is," said Gae. "The whole team needs to understand their role in helping to prevent cyber problems."

And something Gae stated about privacy policies especially resonated with participants. The most common theme in what people were going to do differently as a result of this forum related to the practice's privacy policy. Having the legally required privacy policy establishes a culture and set of processes that help your workplace fulfil other responsibilities. "Your privacy policy must be clearly expressed, up to date and freely available," Gae emphasised. "An appropriate privacy policy ensures that privacy compliance is included in the design and implementation of your information systems and practices. There are handy templates available to help."

Another bite participants frequently said they would take up next because of what they learned was better planning for a data breach. Jonathan said people generally react to a cybersecurity incident "without due regard or logic". So being prepared is vital. Have you genuinely tested your digital backup system? Do you know what your provider says they'll do regarding your backup, and are they actually doing it?

Improving email use was another common actionable bite for attendees. Prof Williams gave a handy tip that if you're archiving a moderate number of emails containing sensitive information, then each email can readily be individually encrypted.

Dr Deacon's take home message was that cybersecurity has many different aspects: "It's not one thing, and it's important that we keep working on the various parts". Find a piece and chew.

Resources and more information

- MDA National. Disaster Preparation and Privacy Management – *Practice Managers Update 2016*. Available at: mdanational.com.au/resources/publications/2017/08/practice-managers-update#practice-managers-update-2016
- MDA National. Cyber Resources. Available at: mdanational.com.au/resources/articles-and-case-studies/2018/02/cyber-resources
- MDA National. Privacy resources. Available at: mdanational.com.au/resources/articles-and-case-studies/2018/02/privacy-resources

Keep an eye out for our future cybersecurity education activities available nationally.

MDA National Education Services

What You Need to Know About **My Health Record**

All Australians will get a My Health Record (MHR) by the end of 2018 unless they choose to opt out between 16 July and 15 October 2018.[1]

All doctors and frontline staff need to know:

- the basic concepts of My Health Record[2]
- the personal choice elements,[3] including that an individual may choose to not have a My Health Record created
- how My Health Record is used within the context of their organisation.

This article addresses some frequently asked questions to help you understand MHR.

Must I open a patient's MHR if I notice they have one?

No, you are not compelled to do so as a matter of routine, and you can decide whether you clinically need to access it.

Do I need to get consent to access an MHR?

No, as long as you are accessing the record to provide health care to the individual. Patients consent to this when they register for MHR. However, if you access it in their presence, it would be courteous to inform the patient. Patients can place controls on who can access their whole record or documents within their record. They can also view which organisations have accessed their record, and can get SMS or email notifications when an organisation first accesses their MHR.

Can my staff access an MHR for me if I am at the hospital?

Yes, if they have been authorised. Once a healthcare organisation is registered to participate in the MHR system, individual healthcare providers and other relevant employees can be authorised to access the system.

Where can I find more information?

Australian Digital Health Agency:

- *Shared Health Summary (example clinical document)*: digitalhealth.gov.au/files/assets/cdaexamples/cdasharedhealthsummary.html
- *Using the My Health Record System*: digitalhealth.gov.au/using-the-my-health-record-system

Royal Australian College of General Practitioners:

- *Digital Business Kit 1.5 My Health Record*: racgp.org.au/digital-business-kit/national-ehealth-records-system

Do I need consent when I upload documents?

When a patient registers for MHR, the patient provides a standing consent for documents to be uploaded to their MHR. So it is not necessary to obtain consent each time you upload a document, except for Shared Health Summaries (see below). However, the AMA recommends[4] informing patients when you upload all documents, particularly if the information is sensitive. If a patient requests that a document or a certain piece of health information not be uploaded, you are obliged to comply. Patients are able to remove documents you have uploaded, but not edit them.

What is a Shared Health Summary?

A Shared Health Summary (SHS) provides a patient's status at a point in time. These are especially beneficial for patients with chronic conditions or multiple co-morbidities.

To create an SHS a healthcare provider must obtain the patient's agreement that they are to be a nominated healthcare provider (NHP) for the patient. If you are not the NHP (but you are authorised) you can still access the patient's MHR, and you can upload clinically relevant information using an Event Summary which details significant healthcare events relevant to ongoing care, e.g. a new diagnosis or a clinical intervention. Any healthcare provider at an organisation participating in the MHR system can upload an Event Summary.

Can I bill Medicare for uploading to an MHR?

There are no MBS item numbers for uploading to an MHR. However, the time taken to prepare documents for uploading counts toward consultation time for billing the MBS, as long as the document preparation was part of providing a clinical service, and the patient was present.

What happens to the MHR on the death of a patient?

The record is retained in the system for 30 years (or if date of death is not known, for 130 years after their birth date). It will not be accessible to healthcare providers, but only where allowed by law for purposes such as audit or maintenance.

Does the MHR form part of the record for the purposes of a subpoena?

No, and a doctor does not have possession and control of the MHR. However if a doctor downloads documents from the MHR (e.g. a discharge summary or test results) into their own record, those documents will be part of the doctor's record for the patient and will need to be produced in response to a subpoena.

Claims & Advisory Services
MDA National

View the list of references at **defenceupdate.mdanational.com.au/articles/my-health-record-2018**

Improving the Quality and Safety of **Bariatric Surgery**

Clinical registries collect information about patients who have received medical care in a prospective and systematic way. This may be with the purpose of tracking a medical device, disease state or a particular procedure. When these variables are collected utilising pre-defined quality indices that have been agreed upon by experts as being clinically relevant and important, the benchmarked risk-adjusted data may be a valuable resource for providing feedback on outcomes to practitioners, patients, health services and device manufacturers.[1]

There are examples of feedback from clinical registries positively influencing patient care:

- The Australian National Joint Registry identified a poorly performing hip prosthesis that was ultimately withdrawn from the market.[2]
- Feedback from the Victorian State Prostate Cancer Registry has contributed to improved patient care and fewer positive surgical margins noted over a five-year reporting period.[3]

Bariatric surgery is a relatively young specialty and the procedures used are evolving rapidly. Unlike the introduction of new medications, new surgical procedures are usually introduced without high level of evidence supporting them, and with limited long-term data. Obesity is our most prevalent disease with 28% of Australian adults affected. This means there is high demand for the surgery, with demand at times outstripping the evidence base. This situation places patients at risk.

Recognising this risk, the Australia and New Zealand Bariatric Surgery Registry (BSR) was established by the Obesity Surgery Society of Australia and New Zealand (OSSANZ, now ANZMOSS) in partnership with Monash University, with the aim of monitoring the quality and safety of bariatric surgery in our countries, and using this data to improve outcomes. The pilot commenced in 2012. On the basis of this pilot, the Commonwealth Government funded a national rollout across Australia which is now almost complete. Rollout in New Zealand has commenced with the support of the device industry.

To minimise the potential for bias, it is important to make every effort to enrol all patients undergoing bariatric surgery in both countries, as well as to ensure every data field has near complete capture. For this reason, an opt-out process for patient consent has been utilised[4] and only a few outcome measures are collected. We collect demographics, operative details, device details, BMI and diabetes status at baseline. At 90 days, clinical indicators are recorded. At annual follow-up, we record weight, diabetes status and need for reoperation. Deaths may be reported at any time. Outcomes are reported through a de-identified annual report as well as individual, benchmarked reports to all participating surgeons.

Working on the principle of early recognition, the registry aims to identify performance that is more than two standard deviations from the normal. These "outlying" surgeons, procedures, devices or hospitals are managed through a three-step process involving validation of data and then feedback to the involved party with the aim of identifying issues and improving performance. If performance continues to be poor after these steps are taken, the involved party will be reported to the relevant regulatory authority.

The BSR has now captured over 40,000 procedures. We anticipate that by the end of this calendar year, we will have completed our rollout across Australia and New Zealand. Our pilot cohort is reaching five years post-surgery. This data, collected purposefully and prospectively across the whole population, will give us an unprecedented opportunity to provide the community with information on the outcomes of these operations and the change in diabetes in this population.

Based on the experience of other registries, it is hoped that by feeding back the data to all interested parties we will see an improvement in the quality and safety of bariatric procedures undertaken in our community. We would encourage all Bariatric Surgeons to participate in this important initiative.

BSR Australian Data at 31 December 2017

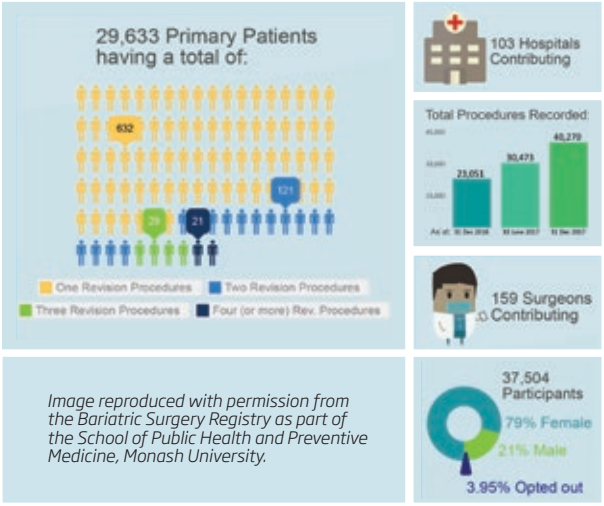


Image reproduced with permission from the Bariatric Surgery Registry as part of the School of Public Health and Preventive Medicine, Monash University.

Prof Wendy Brown & Prof Ian Caterson
Australia and New Zealand Bariatric Surgery Registry

View the list of references at **defenceupdate.mdanational.com.au/articles/anz-bariatric-surgery-registry**

Subpoenas for Medical Records

Apart from appearing complex and time consuming to deal with, subpoenas can also cause concern about what doctors must do to comply, and what it means for the confidentiality of their patients' records.

Subpoenas to Produce Medical Records

Members regularly call MDA National for advice after being served with a subpoena for the production of medical records. This article addresses some of the common questions and concerns.

Subpoenas, summonses and orders to produce (which we will call subpoenas for this article) are issued by various courts and tribunals. A number of state and federal authorities have the power to compel production of records (e.g. WorkCover, Guardianship Boards). Investigators from the Australian Health Practitioner Regulation Agency (AHPRA) can compel production under Schedule 5 of the National Law.

1. What is a 'Subpoena to Produce' and do I have to comply with it?

A 'Subpoena to Produce' is an order of the court or authority and should not be ignored.

2. How should I deal with a subpoena for the production of records?

For a subpoena to be valid:

- it must sufficiently identify the party in possession of the documents requested under the subpoena
- it should be stamped with a court seal (some electronic subpoenas may not be stamped)
- it should be served within the timeframe noted on the subpoena
- it may be accompanied by conduct money. The rules about whether conduct money is payable, and if so, how much, can vary between the different jurisdictions
- some jurisdictions require a declaration (which will be included with the subpoena) to be signed when the documents are produced.

Read the document carefully as it will contain a lot of helpful information. Some things to look for are:

- *Parties* – names of parties (e.g. plaintiff, defendant) are usually shown on the first page; one of them is likely to be your patient
- *Issuing court* – top left-hand corner of page one (e.g. Family Court)
- *Issuing party* – name of the person or law firm who issued the subpoena – do not send the documents direct to the issuing party, unless specified to do so in the order (e.g. Notice of Non Party Disclosure in ACT or Queensland)
- *Schedule* – a description of documents to be produced. You are obliged to send only the documents requested. Observe any date ranges or other limitations on what should be sent.

3. Does a subpoena override my duty of confidentiality and privacy to my patient?

Patient authority to release the information is not required, and compliance with a valid subpoena is one of the exceptions to a medical practitioner's duty of confidentiality and privacy. Although you are not obliged to do so, you may wish to inform your patient about the subpoena and your obligations to comply with it.

4. I am worried about releasing these records to the "other side".

Keep in mind you will be releasing the documents to the court, not to the issuing party or any parties to the proceedings. The court will ultimately determine access to those records by other parties. A party can object to the production of the records to the other party.

5. Can a subpoena be challenged?

It is preferable to try and reach an agreement with the issuing party to either set aside or narrow the scope of a subpoena. Confirm any agreement in writing. If this is not possible, the recipient can apply to the court to seek to have the subpoena set aside or to have its scope narrowed. Seek advice from MDA National in this situation.

There are limited grounds for challenging a subpoena which include:

- **abuse of process** – the subpoena was issued for reasons other than the purpose of obtaining information relevant to the legal proceedings
- **oppression** – the terms of the subpoena are so wide and insufficiently precise that compliance (including collation and production) would impose an onerous obligation on the practitioner, or where a subpoena is issued for the purpose of 'fishing' for information
- **public interest immunity** – rarely a court may exclude a document from production even if relevant if it would be adverse to public interest to disclose it. This usually only applies to documents that may affect national security or some other extraordinary public interest.

6. I did a report for a lawyer and they are claiming Legal Professional Privilege (LPP) – does that report have to be produced?

This is a very particular category of documents, and you should obtain advice from MDA National on how to manage any disclosure obligations. Generally, you would contact the lawyer who is claiming LPP and ask them whether they maintain their claim of LPP. If so, you may be able to send a copy of the report to the court in a sealed envelope and alert the court to the claim for LPP, and also notify the lawyers for the parties.

7. What if there is information in the medical records which I believe, if released, would place my patient at risk?

Records may contain information which should not be disclosed, e.g. the address of a victim of domestic violence or any other information which might identify their whereabouts. You should obtain advice from MDA National on how best to manage this.

8. Do I have to send my original records?

Most jurisdictions make provision for you to send copies of your records. Read the schedule carefully to identify which documents and records you must produce, and pay attention to any requests for photographs or diagrams. You should also note the dates carefully, as you may not be ordered to produce all of the records. Ensure you only produce the records and documents identified in the schedule.

9. What if I don't have any documents?

Send a letter to the court or tribunal with a copy of the subpoena, advising them that you do not hold any of the medical records or documents listed in the schedule.

10. I received some money or a cheque when I was served with a subpoena. What is this?

Under the rules of various courts and tribunals, 'conduct money' must be provided at the time of serving the subpoena. This is to enable the issuing party to cover the recipient's costs in complying with the subpoena. Any costs claimed must be considered reasonable, and can include administrative and printing costs – but it is not contemplated that you can recover costs at the rate of your professional fees. If the sum of money provided is inadequate, you can seek an additional payment by contacting the issuing party (on the front page of the subpoena) and letting them know your estimate of the actual costs e.g. photocopying or printing.

Compliance with a subpoena should not be withheld pending any discussion about the conduct money. If you cannot agree on the costs, you should still comply with the subpoena and produce the records within the timeframe specified. You can seek advice from MDA National about obtaining payment of reasonable costs.

11. When do I have to provide the documents?

The subpoena will indicate the date on which the records must be received by the court or tribunal. The subpoena may also indicate that documents which are posted must be received by the court or tribunal no later than two days before the return date on the subpoena. You should ensure that you comply with this requirement to avoid a potential penalty.

12. How do I send the documents?

The documents should be sent to the court in a sealed envelope with a copy of the subpoena enclosed. Unless the subpoena specifies otherwise, a photocopy of the documents should be sent. If originals are required, you should retain a copy of the documents. The documents should NOT be sent directly to the party requesting the medical records, unless this is specified in the subpoena.

You may also wish to send a cover letter with the documents – here is some suggested wording:

> *Dear*
>
> *I write in response to the enclosed subpoena. I enclose photocopies of the requested documents pursuant to the schedule in the subpoena.*

And a possible alternative paragraph:

> *These documents are personal medical records of a sensitive nature and I would be very grateful if the court could bear this in mind when determining access. I would also be grateful if the documents could be destroyed when no longer required by the court.*

13. Some letters from specialists state that the letter should not be released to a third party without the permission of the author. Should these letters be included when complying with a subpoena?

If the letters are included in the documents specified in the schedule of the subpoena, they should be sent to the court. The permission of the specialist is not required in these circumstances.

14. The subpoena has been addressed to me. I am a contractor and do not own and/or have care and control of the medical records. What should I do?

Generally, a subpoena should be addressed to the entity which owns the records. If that is not you, then the issuing party should be notified and they should issue a new subpoena to the correct entity.

Summary points

- Subpoenas to produce documents are important legal documents which should not be ignored.
- Read the subpoena carefully to ensure you understand the scope of the request and the date of compliance.
- Review the medical records before submitting to ensure you are sending the correct records, and that all records identified in the schedule have been included.
- If you have any questions or concerns, please contact our Medico-legal Advisory Services team on **1800 011 255** or email **advice@mdanational.com.au**.

Janet Harry
Medico-legal Adviser, MDA National

Case study

Responding to a Subpoena to Produce Medical Records

Dr Price, a GP, receives a subpoena to produce the medical records of one of her patients who was involved in a Workers' Compensation dispute.

Dr Price's receptionist is responsible for accepting service of subpoenas and preparing the necessary documents. The receptionist reviews the patient's voluminous medical records – and the overfilled appointment book for that week. She writes to the solicitor who issued the subpoena as follows:

> Dear Mr Stickler
>
> I refer to the subpoena issued to Dr Price. I am normally fully occupied with other tasks and copying this patient's voluminous medical records might not be possible in the allocated five-day timeframe. This situation is no doubt different in a legal practice where staff regularly photocopy documents, but I am constantly busy with patients and interruptions on the telephone.
>
> I am not sure exactly what documents you require. If you need the whole file I will employ an extra staff member solely for the purpose as I anticipate it will require four hours of continuous work to complete. No doubt you will immediately see why the $30.00 sent by you to cover costs is unreasonable.
>
> However, we are interested in our patient's wellbeing and therefore willing to try to comply with your request. I will instruct the staff member to copy and provide the medical records relating to the patient's injury, but we will exclude personal medical information that has no relevance to the case. The medical records also include a number of specialist letters which include the notation: 'Confidential: No reproduction of this letter without the permission of the author'. As I am not clear about the legality of copying these letters, I will not include them. Should you require these letters from me, I expect that you will obtain written authority from each of the specialists concerned.
>
> Please let me know if this is not satisfactory.
>
> Yours sincerely
> Ms Jones

By return email, the receptionist receives the following response from the solicitor:

> Dear Ms Jones
>
> 1. We note the contents of your letter.
> 2. We note that you have been served with more than five working days which is a sufficient timeframe for complying with the subpoena for production of records, as per the Court Rules.
> 3. We also refer you to the *Workers Compensation Act 1998* and advise that failure to comply with a subpoena is an offence.
> 4. If we can be of any further assistance, please do not hesitate to contact our office.
>
> Yours sincerely
> Mr Stickler and Associates

Dr Price phoned our Medico-legal Advisory Services team for advice. In view of the fact that the schedule of documents in the subpoena did not clearly identify the documents to be produced, the medico-legal adviser contacted the solicitor on Dr Price's behalf. Further advice was then provided to Dr Price to allow her to comply with the subpoena.

Following receipt of this information, Dr Price's receptionist sent a photocopy of the subpoena and the relevant documents to the Registrar of the Court by the return date.

The case history is based on an actual medico-legal case; however, certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Medical Professionalism
A State of the Art

The learned professions have their historical roots in the guilds of Europe. Given that members of guilds had achieved mastery of a specialised knowledge base, it provided justification for them to receive special treatment, rewards and respect.

In this article, I describe four conceptual lenses that can be used to consider and analyse professionalism as well as lapses in professionalism.

1. Social contract

It is important to underline that the guilds and their offspring – the professions – represent social constructions. Their members enjoy privileges, conferred on them by society primarily for society's benefit and, as a quid pro quo, they are expected to meet certain obligations. This implicit bargain has been called a "social contract". It defines, in broad terms, the mutual expectations between society and the medical profession. The social contract is an important lens through which one can understand professionalism.

2. Ethics or bioethics

This is probably the one most commonly associated with professionalism. Codes of conduct as well as statements describing the desired personal attributes of doctors and normative set of behaviours abound in the literature. Ethics and professionalism are intertwined and inseparable.

With respect to medicine, three major ethical theories have guided its practice:

- *deontology:* moral action is guided and constrained by principles and rules, including laws; these create professional duties
- *consequentialism:* (a subcategory of utilitarianism) the ends justify the means. Outcomes where benefits outweigh risks and harms, and are considered good for patients and society, provide the ethical compass of practice
- *virtue ethics:* the moral character of the doctor is seen as the guarantor of good and right behaviour.

In contemporary contexts, in western countries such as Australia, the profession has tended to lean on a deontological approach. An archetypical expression of the nexus of professionalism with duty or rule-based ethics is the 'Charter of Medical Professionalism'. Created in 2002, the Charter identifies a set of 10 professional responsibilities; they are expressed as personal commitments (e.g. 'commitment to patient confidentiality').[1]

3. Competencies

This is an increasingly popular framework for describing and codifying professionalism. A competency refers to a doctor's ability that is itself related to a specific activity; one that integrates knowledge, skills, values and attitudes. Critically important to the definition is that a competency must be specified in behaviourally measureable ways. An example of a competency within the 'domain of competence' called patient care is, "The physician gathers essential and accurate information." Competency-based education (CBE) is now widely accepted as the organising principle for numerous graduate medical education programs, including many in Australia. It should be recognised that CBE is not without controversy and has many detractors. In the context of assessing and promoting professionalism, the requirement that competencies be subject to measurement represents an inherent challenge.

Many opinion leaders believe that personal dispositions such as curiosity, courage, creativity, commitment, compassion, and tolerance of uncertainty do not yield readily to measurement. Competencies, and their related entrustable professional activities, may indeed be useful in understanding basic professionally-based activities. However, a tension exists between the reductionism implicit in CBE and the inescapable nature of professional medical practice, i.e. one that is dynamic, unpredictable, nuanced, richly contextual and holistic. This tension suggests the need for caution in equating competencies too tightly with professionalism.

4. Professional identity

The most recent evolution in the teaching of professionalism revolves around the concept of professional identity formation. This refers to the idea that individuals, during the enculturation process of medical education, become a certain kind of person – that they acquire the identity of a doctor. In the words of the American sociologist Robert Merton, they come to "think, act and feel like a physician".[2] This is not to imply that medical students and doctors in training are obliged to disavow the core sense of who they are as individuals as they gradually transform into independent specialist practitioners.

Clearly, there are aspects of one's personal identity that are enduring; medical education generally does not efface these characteristics. However, the concept represents an acknowledgement that medical educators do not only teach knowledge and skills; they also instil values and attitudes. In short, they transmit a culture wherein students develop an identity as a professional. Thankfully, most of the time the new identity is well aligned with pre-existing values, beliefs and predispositions, and the process is therefore not one of deformation. Nonetheless, the journey may not be entirely free of tribulations or painful moments.

Learners and novice doctors need emotional support and guidance during the entire educational trajectory for their personal wellbeing and for effective integration of professionalism into their personas. Furthermore, educators must remain mindful that nurturing a professional identity must include attention to the attitudes and skills supportive of inter-professionalism and necessary for teamwork.

Defining professionalism

The four lenses considered so far – social contract, ethics, competencies and identity – all have clear roots within the profession. However, they are not generally part of the discourse of laypersons. The word 'professionalism' evokes a variety of meanings. A layperson will often use it to refer to the qualities of an individual – someone who executes tasks and discharges responsibilities with consummate skills, finesse, and sensitivity.

With respect to medicine, the skills and sensitivity the patient expects the most is that the doctor will listen to them and treat them in a way that respects their dignity. For a patient to feel as if they were heard and recognised as an individual worthy of respect is the indispensable quality of an encounter experienced as having been highly professional. It is noteworthy that the words and adjectives that we in the profession use are often quite different to those used by patients, even though the concepts are fundamentally aligned.

If we, members of the medical profession, as well as all of those working in institutions related to and supportive of the profession, such as organisations like MDA National, are to successfully aspire to the ideals of professionalism, we need to understand evolving conceptions of professionalism whilst never being wilfully blind to the patient's perspective. I would argue that attentive listening, dignity-preserving care and the maintenance of competence, in all its facets, are the 'summum' of professionalism.

Prof J Donald Boudreau (Guest writer)
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Prof J Donald Boudreau previously served as Associate Dean of undergraduate medical education and is currently a core member of the Centre of Medical Education, a unit focused on research in health professions education. He is a Professor of the Arnold P Gold Foundation which is dedicated to the promotion of humanism in medicine. He is also co-author of a book which has been published by Oxford University Press: 'Physicianship and the Rebirth of Medical Education'.

1 Medical Professionalism in the New Millennium: *A Physician Charter*. Ann Intern Med. 2002;136:243-46.

2 Merton RK. Some Preliminaries to a Sociology of Medical Education. Preface. In: Merton RK. Reader LG, Kendall PL. eds. *The Student Physician*. Cambridge, MA: Harvard University Press. 1957: vii-ix.

CaseBook

Cyber Risk – Are You Protected?

Cyber risk is a growing threat to Australian medical practices. The risk is further increased by the adoption of electronic health records and billing systems, cloud storage of medical records and the Federal Government's mandatory data breach[1] obligations. While you can't avoid cyber risk, it's important to ensure your practice is prepared for and protected against cyber-attacks.

Case study

The following is a loss scenario provided by Chubb Cyber Enterprise Risk Management, using information based on an actual claim.

Data Theft Results in Extortion, Business Interruption and Extra Expense

Cause of action: Breach of Contract and Negligence

Coverage triggers: Cyber Extortion, Incident Response Expenses, Data Asset Loss, Privacy Liability, Business Interruption, Recovery Costs

Type of organisation: Solicitor

Number of employees: 55

Annual revenue: $20 million

Description of event: An unknown organisation hacked a law firm's network and may have gained access to sensitive client information, including a public company's acquisition target, another public company's prospective patent technology, the draft prospectus of a venture capital client, and a significant number of class-action lists containing plaintiffs' personally identifiable information (PII).

A forensic technician hired by the law firm determined that malware had been planted in its network. Soon after, the firm received a call from the intruder seeking $10 million to not place the stolen information online.

Resolution: The law firm incurred $2 million in expenses associated with a forensic investigation, extortion-related negotiations, a ransom payment, notification, credit and identity monitoring, restoration services and independent counsel fees. It also sustained more than $600,000 in lost business income and extra expenses associated with the system shutdown.

Total costs associated with the event: $2.6 million

Discussion

Although the above case study involves data theft in a law firm, it's easy to see how such an incident could potentially happen in a medical practice, with serious consequences.

Loss of security of patients' medical records could breach privacy law, cause harm to patients, damage your practice's reputation, and significantly disrupt the practice's ability to function. Under Australian privacy law, a practice must take reasonable steps to protect personal information it holds from misuse, interference or loss; and from unauthorised access, modification or disclosure.[2]

MDA National's Cyber Risk Program

Ransomware in health care is on the rise, and an increasing number of doctors and practices have been contacting us to discuss data intrusions into their practice computer systems. To provide peace of mind, MDA National has recently launched its Cyber Risk Program – a collection of cyber risk initiatives:

- **Cyber Risk Education** for MDA National Members and Practice Indemnity Policyholders which includes:
  - › online access to case studies, articles and blogs by global cyber experts
  - › quarterly cyber risk email updates to support you in mitigating cyber risk
  - › cybersecurity education sessions.
- **Complimentary Cyber Risk Cover** for **MDA National Practice Indemnity Policyholders** until 30 June 2019, with cover up to $100,000* in the aggregate against cyber-related privacy breaches, network security liability, media liability, cyber extortion, data loss, business interruption and incident responses – which includes:
  - › a 24-hour cyber crisis hotline (1800 027 428)
  - › expert cyber risk claims managers to support your practice through a cyber-attack.

View the list of references at **defenceupdate.mdanational.com.au/articles/cyber-risk-are-you-protected**

*Cyber Enterprise Risk Management Insurance Policy is arranged by Jardine Lloyd Thompson Pty Limited (ABN 69 009 098 864, AFSL 226 827), underwritten by Chubb Insurance Australia Limited (ABN 23 001 642 020) and can be accessed by new and current MDA National Practice Indemnity Policyholders until the earlier of 30/06/19 or their ceasing to hold a current MDA National Practice Indemnity Policy. The Cyber Enterprise Risk Management Insurance Policy terms, conditions, exclusions, limits and deductibles apply.

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CaseBook

Anaesthetist's Negligence
Leads to Costly Consequences

Case study

Mr Hobson suffered from Noonan syndrome with associated lordoscoliosis of his thoracic spine. When he was 24 years of age, Mr Hobson sought advice from the Spine Clinic to see if surgery would improve his restrictive lung disease which was causing severe shortness of breath on exertion.

The Surgeon noted the patient had a significantly reduced vertebro-sternal distance due to his thoracic scoliosis. He thought the patient would benefit from surgical correction of his lordoscoliosis to increase his lung capacity and prevent further deterioration of his lung disease. The Surgeon discussed the option of combined anterior and posterior approaches in two stages: wedge osteotomies through the apex of his thoracic lordoscoliosis and subsequent posterior fusion of his spine. The first stage involved a thoracotomy, in conjunction with a Cardiothoracic Surgeon. The second stage was a posterior instrumented fusion from T2 to L1, following the anterior release to correct the lordoscoliosis to a more normal kyphosis of the thoracic spine.

On 13 November 2009, the patient underwent the anterior procedure which was uneventful. The original plan was to perform the second operation 10 days later; however, on 15 November 2009, the patient was found to have extrinsic compression of his left main bronchus with collapse of his left lobe and pneumonia. The ICU staff were having increasing difficulty maintaining the patient's oxygen saturation and asked that the second stage surgery be brought forward.

17 November 2009

The patient was reviewed and the treating team was of the opinion that surgery needed to be performed as soon as possible, or the patient might die as a result of his worsening respiratory problems. The on-duty Anaesthetist, Dr A, was contacted by the Surgeon.

12:30 – Dr A went to the ICU to satisfy himself that the surgery was urgent and to assess the patient's clinical status from an anaesthetic perspective.

14:40 – Dr A returned to the ICU with another senior Anaesthetist who had extensive experience in anaesthesia for spinal surgery. The Anaesthetist performed a bronchoscopy and found the left main bronchus compressed but permitting the insertion of the bronchoscope through the obstruction. The surgery was scheduled for the evening to facilitate the attendance of the Physician in charge of the spinal monitoring.

18:00 – The patient was taken to theatre. A double lumen tube was inserted which was able to be advanced far enough to splint open the left main bronchus. The anaesthetic agents administered were compatible with spinal cord monitoring.

19:15 – The patient was turned prone on a Jackson table. There was a slight decrease in blood pressure which was corrected with Metaraminol 0.5 mg. The CVP was 32. The blood gases at this time revealed: PO2 243 mmHg and PCO2 65 mmHg.

20:30 – The PCO2 had increased to 70.5 mmHg. There was decreased pH (7.027), decreased base excess and increased lactate (8.2 mmol/l). Dr A administered Vecuronium 4mg after informing the Surgeon that this would affect the spinal cord monitoring. The arterial carbon dioxide levels remained elevated. Dr A checked for mechanical problems, checking the breathing circuit and the position of the tube with the bronchoscope several times. He tried hand ventilation and considered the possibility of a pneumothorax and breath stacking in the left thorax. After ruling out respiratory and equipment-related causes, Dr A considered the cause was likely cardiac, even though the patient's blood pressure remained stable at 150 systolic.

20:50 – Dr A telephoned the Anaesthetist who had reviewed the patient in ICU and also the Cardiothoracic Surgeon who was involved in the first stage procedure to discuss the situation – the Anaesthetist informed Dr A it must be due to "dead space" and not a problem with ventilation.

21:15 – The exhaled carbon dioxide expired waveform had diminished (30 to 25 mmHg). The CVP was 37 and Dr A was concerned that the patient's right ventricle was failing.

21:25 – The patient suffered an episode of profound cardiovascular collapse. Dr A administered adrenaline and directed the Surgeon to stop the procedure. The Surgeon quickly closed the wound and the patient was turned supine with immediate improvement in his condition.

Post-operatively, the patient was paraplegic. The cause of the paraplegia was an ischaemic injury to his spinal cord.

The patient's spinal fusion was successfully completed on 11 December 2009, without further complication.

It was not for Dr A (the Anaesthetist) to assess the urgency of the operation and decide that it justified a serious and immediate intra-operative risk to Mr Hobson being ignored, at least not without consulting Dr S who, as the principal Surgeon, was head of the surgical team.

Medico-legal issues

Supreme Court Judgment[1]

The patient commenced negligence proceedings against the Surgeons, Anaesthetist, Physician who performed the spinal monitoring and the hospital. The claim proceeded to a Supreme Court hearing in November 2016 and judgment was handed down on 17 May 2017.

Ultimately, the patient only pursued the proceedings against the principal Surgeon (Dr S) and the Anaesthetist (Dr A). The judge found them both negligent:

- Dr A - for not advising that surgery should have been abandoned no later than approximately 21:00
- Dr S - for not ceasing surgery at that time.

Damages of $3,828,075 plus legal costs were awarded against the Surgeon and the Anaesthetist.

Court of Appeal Judgment[2]

Both doctors appealed the decision. The matter was heard on 6 and 7 November 2017 and the Court of Appeal handed down its decision on 1 March 2018. By majority, the Court dismissed the Anaesthetist's appeal but unanimously allowed the Surgeon's appeal. This left the Anaesthetist liable for the full award of damages.

The judgment confirmed that Dr A's decision to allow the procedure to continue for 30 minutes after he had sought help from two experienced colleagues, without success, was a breach of his duty of care:

> *It was not for Dr A (the Anaesthetist) to assess the urgency of the operation and decide that it justified a serious and immediate intra-operative risk to Mr Hobson being ignored, at least not without consulting Dr S who, as the principal Surgeon, was head of the surgical team.*

The judge who dissented and upheld Dr A's appeal stated that the onus was on the patient's solicitors to establish that Dr A's decision not to direct the termination of surgery earlier represented a departure from the standard of care and skill required of a specialist Anaesthetist. She found the medical evidence fell "well short of permitting a conclusion to that effect".

In relation to the Surgeon's successful appeal, the Court stated:

> *Dr S was entitled to rely on Dr A to inform him of any matter of concern without Dr S making any enquiry. There is no evidence that Dr A did so in the period 20:50 to 21:20, and the evidence did not indicate that any matter came to Dr S's notice during that time that should have caused him to make an inquiry as to Mr Hobson's carbon dioxide levels. Without such information, Dr S was not negligent in failing to direct termination of the operation during that period. When Dr A did advise termination of the operation at around 21:25, Dr S promptly did so. Dr S's appeal on liability therefore succeeds.*

Summary

This decision highlights the importance of teamwork and communication between a Surgeon and Anaesthetist. The Court noted that Dr S was the principal Surgeon leading a team of specialist medical staff. Although as head of that team he had ultimate authority to make significant decisions regarding the operation, he was entitled to rely on the other team members to perform their duties.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

View the list of references at **defenceupdate.mdanational.com.au/articles/anaesthetist-negligence-costly-consequence**

CaseBook

The Lovelorn Patient

There is no rhyme or reason to the romantic feelings some patients develop for their doctor. It may be a physical attraction, the result of an exaggerated deference to authority, or a reflection of the patient's personal situation.

A sympathetic ear, or simply being heard, can often trigger an emotional response from a patient. Whatever the reason, the potential blurring of the doctor–patient relationship can lead to significant professional consequences if not managed promptly and appropriately.

Case study

A female patient in an abusive relationship always saw a female doctor in the practice. She was booked with a male doctor at short notice after her usual doctor left to deal with an emergency. The male doctor was sympathetic towards the patient who had been verbally abused by her partner the previous night.

The patient's usual doctor returned from leave, but the patient continued to book with the male doctor. The frequency of the visits increased and the patient asked the doctor for his mobile number in case of emergency. He provided it, concerned about the patient's previous history of domestic violence.

The patient didn't use the number until late one night when he received a text:

> My life sux - my time with you is all that keeps me going. Wanna meet 4 coffee?

The doctor was very concerned, and he was unsure what to do. His wife, also a doctor, urged him to contact MDA National for advice.

Discussion

In hindsight, the doctor was able to recall the warning signs. The patient didn't need to attend so often. She always booked his last appointment for the day and spent much of the consultation engaging him in conversation. The doctor was aware she was vulnerable and didn't know how to raise the issue without causing her distress. Once he received the text, he realised the doctor–patient relationship was unhealthy and that he would need to end the therapeutic relationship.

A medico-legal adviser assisted the Member to write to the patient, stating it was in her best interests to find a new doctor or practice.

Due to the risk of repercussions if the letter was opened by the patient's partner, it was agreed that the doctor would explain the situation and provide the letter to her in person. The patient was embarrassed and she opted to move to another practice.

Things to remember

- Doctors may feel responsible for the patient developing feelings towards them, but this is not usually the case. Over time, boundaries can blur gradually and subtly.
- It may seem easy to continue to see the patient rather than address the issue – but if warning bells are sounding, seek advice about ending the therapeutic relationship.
- The lovelorn patient is often vulnerable and should be managed sensitively. 'Firm but kind' is usually the best approach, as the patient may feel hurt and embarrassed when their advances are rejected.
- Embarrassment or naivety in these circumstances is understandable, but will carry little weight with AHPRA if it becomes clear professional boundaries have been breached and the doctor has not dealt with the matter in a professional and timely manner.
- Keep your professional and personal life separate, e.g. don't accept friend requests from patients on Facebook and avoid discussing your personal life during consultations.
- Doctors sometimes continue the therapeutic relationship, fearing that the patient will make a complaint if they end the relationship. In our experience, we find that the risk of a complaint increases the longer you continue to see the patient.
- Return any gifts, but keep a record of text messages (as screenshots), emails, letters or cards in a separate medico-legal file.

If the therapeutic relationship is causing you concern or no longer healthy, please contact our Medico-legal Advisory Services team for advice on how to manage the situation.

Nerissa Ferrie
Medico-legal Adviser, MDA National

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