GP**Update 2014**

Overview

***GP Update* is produced annually and written specifically for General Practitioners as a companion to *Defence Update*. The aim of the publication is to highlight emerging and perennial medico-legal issues in general practice today, to provoke thought, and support quality medical practice .**

By its very nature, General Practice is broad and this is reflected in the breadth and depth of the range of issues covered in this bumper edition which include:

- opioid prescribing legislation and regulations
- how to deal with patients who refuse follow up
- risks associated with the newer combined oral contraceptive pill
- allied health access to private practice computer records
- tips on setting up practice websites
- computer systems and breaches of privacy
- best practice in skin care medicine
- Medicare compliance for removal of skin lesions.

Please contact our MDA National Medico-legal Advisory Service about any specific cases or concerns on 1800 011 255 or email advice@mdanational.com.au.

We welcome your feedback on any specific issues you'd like covered in future editions by emailing us at specialtyupdates@mdanational.com.au.

By Dr Julian Walter
MBBS (Sydney Uni) LLB Hon (Macquarie)

Opioid Prescribing
Legislation and Regulation

Despite the introduction of a National Registration Scheme on 1 July 2010, drug prescribing regulation has remained fragmented and is based on inconsistent individual state/territory legislation. There have been many concerns expressed, by coroners as well as others, about the inappropriate prescribing of drugs capable of inducing dependence – particularly benzodiazepines and opioids. These highlight the need for doctors to be aware of and understand the requirements imposed on them by the respective state/territory laws.

The purpose of this article is to demonstrate common themes and pitfalls across the various state/territory regulatory requirements.

Drug scheduling

A Therapeutic Goods Administration committee[1] categorises drugs into one of eight schedules as part of the Poisons Standard (SUSMP) [1,2] which is amended several times per year. They then pass these recommendations over to each state/territory to incorporate into their legislation.

Schedule 8 [S8] controlled drugs are considered to have a high potential for abuse and addiction. They include a broad range of drugs – e.g. amphetamines, barbiturates, opioids, and benzodiazepines – although not all of the drugs in these classes are Schedule 8 drugs. Note that flunitrazepam and alprazolam are S8 drugs.

This article does not discuss S8 stimulant regulation (e.g. dexamphetamine and methylphenidate) which are subject to differing requirements.

Commonwealth requirements

To prescribe under the Pharmaceutical Benefits Scheme (PBS), a doctor may need to obtain federal government authority from Medicare Australia to satisfy certain conditions. Commonwealth PBS authority is different to and **does not** address state/territory legislative and regulatory requirements, which are separate (and generally more restrictive).

State/territory requirements[1]

The definitions, terms, relevant drugs and requirements vary between states/territories *(see table on page 2)*.

In general terms, before prescribing you need to consider:

1. Is the patient drug dependent?
(Note the varying terms used.)
If a patient presents and requires the prescription of S8 drugs and your assessment is that the patient is drug dependent, then you will need to consider the additional and stringent requirements about obtaining an authority (or equivalent) **before you prescribe**. Note that in some states (QLD, VIC, TAS), drug addicted patients seeking S4 drugs of dependency (particularly benzodiazepines) may also require consideration.

2. Does the patient need to be reported as drug dependent to the authorities?
Some states (WA, VIC, TAS) separately require that a drug dependent patient be reported under certain conditions.

3. Does the length of anticipated treatment of a non-drug dependent patient with S8 drugs require approval?
If the patient is not deemed to be drug dependent, then there are strict time limits that S8 drugs can be prescribed before approval is required, likely including the time other doctors have been prescribing the same medication(s).

Note that in NSW an authority is required for only a very limited list of S8 drugs if the patient is not drug dependent.

In NT and TAS, out of state prescribers are not able to prescribe S8 drugs.

Given the complex and varying requirements, if you deal with S8 prescribing, it is imperative that you familiarise yourself with the relevant regulations.

References:

1. National Drugs and Poisons Scheduling Committee
2. Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)
3. Poisons Standard 2013 (SUSMP No 4) comlaw.gov.au/Details/F2013L01607 and the most recent amendment (SUSMP no 4 revision 1 of 2014) comlaw.gov.au/Details/F2014L00044
4. Due to the disparity of terms and definitions between the various jurisdictions, the following abbreviations have been used (the table uses the specific legislative terms):
   - Drug addicted / dependent / seeking patients are collectively referred to in this article as *drug dependent* patients
   - Authority / Permit / Approval are collectively referred to as an *Approval*

State and Territory Opioid Prescribing Legislation and Requirements

State / territory	Definitions	Length of treatment before authority required if not drug dependent
ACT	**Drug dependent** – a person with a condition who, as a result of the administration of a controlled medicine [S8 drugs] or prohibited substance, demonstrates, in relation to the person's use of the medicine or substance, impaired control or drug-seeking behaviour that suggests impaired control and who, as a result of the cessation of the administration of the medicine or substance, is likely to experience symptoms of mental or physical distress or disorder.	**Approval:** treatment >2 months (includes treatment by other prescriber)
NSW	**Drug dependent person** – means a person who has acquired an overpowering desire for the continued administration of such a drug, as a result of repeated administration of: (a) a drug of addiction [Schedule 8], or (b) a prohibited drug within the meaning of the Drug Misuse and Trafficking Act 1985 [contains illicit drugs and many others].	**Authority:** continuous therapeutic use >2 months
NT	**Addiction** – means a state of physiological or psychological dependence on or increased tolerance to the habitual and excessive use of a substance and includes pain and other symptomatic indications arising specifically from withdrawal of that substance.	**Notification:** treatment >8 weeks in the aggregate in preceding 12 months; specific initial and maximal dosing limits also apply; >30% dosing increases or dosing increases within 2 weeks **Authority:** if prescribing S8 drug for >15 patients
QLD	**Drug dependent person** – means a person: (a) who, as a result of repeated administration to the person of controlled or restricted drugs or poisons - demonstrates impaired control; or - exhibits drug-seeking behaviour that suggests impaired control over the person's continued use of controlled or restricted drugs or poisons; and (b) who, when the administration to the person of controlled or restricted drugs or poisons ceases, suffers or is likely to suffer mental or physical distress or disorder.	**Approval:** treatment >2 months (includes prior treatment)

State / territory	Definitions	Length of treatment before authority required if not drug dependent
SA	**Dependent on drugs** – means the person has: (a) acquired, as a result of the repeated administration of prescription drugs or controlled drugs, an overpowering desire for the continued administration of such drugs; and - is likely to suffer mental or physical distress or disorder on cessation of the administration of such drugs; or (b) a history of consuming or using prescription drugs or controlled drugs in a quantity or manner that: - in the case of drugs lawfully supplied to the person – is contrary to the prescribing practitioner's instructions relating to consumption or use of the drug; and, - in any case – presents a risk to the person's health.	**Authority:** treatment >2 months (includes prior treatment)
TAS	**Drug seeking behaviour** – means a person is taken to exhibit drug-seeking behaviour in respect of a drug of dependence if there is reason to believe that: (a) he or she is seeking to obtain a drug of dependence for the purpose of selling or supplying it to another person; or (b) he or she is seeking to obtain a drug of dependence for a non-medical purpose; or (c) as a result of the administration to him or her of the drug, he or she exhibits: (i) impaired ability to manage properly the use of any such drug; or (ii) behaviour which suggests such impaired ability; or (d) failure to obtain drugs of dependence for a non-medical purpose is likely to cause the person to exhibit signs of mental or physical distress or disorder. **Drug dependent person** – means a person who: - has acquired, as a result of the repeated administration of drugs of dependence, an overpowering desire for their continued administration; or - has a condition such that the cessation of the administration of a drug of dependence, or on inability to obtain such a drug, is likely to cause them to exhibit signs of mental or physical distress or disorder; or - exhibits drug-seeking behaviour that suggests impaired control as a result of the person's continued use of drugs of dependence; or - consumes or uses a drug of dependence contrary to the prescribing practitioner's instructions.	**Authority:** treatment >60 days
VIC	**Drug dependence** – NO CURRENT DEFINITION Drugs and Poisons Regulation (DPR) suggests intention is clinical drug dependence (drug seeking, addiction, escalating doses) rather than pharmacological tolerance. **Drug-dependent person** – (repealed definition) means a person who habitually uses drugs of addiction to such an extent that he has lost the power of self-control with respect to the use of drugs of addiction.	**Permit** treatment >8 continuous weeks, includes treatment by other doctors
WA	**Drug addict (or addicted to drugs)** – means a person who: - is under a state of periodic or chronic intoxication produced by consumption of a drug of addiction or any substitute; or - is under a desire or craving to take a drug of addiction or any substitute until he or she has so satisfied that desire or craving; or - is under a psychic or physical dependence to take a drug of addiction or any substitute; or - is listed in the register of information kept under the *Drugs of Addiction Notification Regulations 1980*.	**Authority:** treatment in aggregate >60 days in preceding 12 month period

Managing Patients Who Refuse Medical Advice

By Dr Natalie Sumich
MDA National Member and WA PMLC Member

It is a common misperception among doctors that medico-legally there is a duty for the doctor to ensure compliance with recommended investigations when the outcome is potentially significantly serious.

In medical practice, we anticipate that our patients will actively engage with our recommendations and follow through with investigations and treatments considered appropriate to their presenting complaints.

What happens when patients do not follow through? What onus is there on the medical practitioner to encourage completion of investigations and follow up treatment? And how do we manage patients who simply refuse to comply?

Elderly Mrs V presents with a history of two syncopal episodes in the past four weeks, one while walking and the other while seated as a passenger in a car. Additionally she describes two attacks of classic vertigo, having suffered from BPV for some years. She insists that it's just the normal vertigo she has had for years. The doctor probes, "But have you ever collapsed with these attacks?" "No," she concedes, "but I have been a bit stressed lately". The doctor suggests that further investigation is warranted, but Mrs V cannot be shaken from her firm belief that these episodes are nothing more than a bit of stress. "Please can I have my Stemetil prescription as usual?" she asks with some exasperation.

The dilemma for the doctor is whether to provide the script as requested, knowing that Mrs V could have a potentially serious condition that could cause her to collapse again, harming herself or others, or refuse to provide the script and further try to convince her to accept some investigations. In this case, Dr H employed the assistance of the patient's husband, who was fortunately present at the consultation, and Mrs V subsequently underwent a CT scan that afternoon which revealed a brain tumour.

Effective communication with the patient is essential, such that the patient can be considered adequately informed of the risks and benefits of proceeding, or not proceeding, with recommended investigations and treatments. Fear of the results may cause patients to hesitate at the investigations, and acknowledging and empathising with the patient may be sufficient for them to proceed.

Involving the patient in the decision making process and exploring their concerns can assist with this understanding. At times it can be useful to enlist the support of family members, something which can only be done with the patient's consent.

But how do we manage when a patient refuses to accept our recommendations? Careful documentation of proposed investigations is a must, something which has certainly been simplified by the introduction of computer records. If the investigation is likely to reveal or confirm significant pathological findings we have an ethical responsibility to assist even the most reticent patient to proceed.

It is a common misperception among doctors that medico-legally there is a duty for the doctor to ensure compliance with recommended investigations when the outcome is potentially significantly serious. For example, the case of the 50-year-old man who presents with a 10 day history of chest pain on exertion, particularly going up hills, in the presence of marked cardiovascular risk factors. An urgent exercise stress test appointment would be indicated for such a high risk patient and clear follow up instructions should be provided for the patient to re-attend in a timely manner for results. The patient should be appropriately informed of the seriousness of the potential diagnosis, and the possible consequences if appropriate treatment is not initiated. It is advisable to follow up with phone calls or a letter, clearly outlining to the patient the potential seriousness of the situation. Good documentation of information and efforts to ensure appropriate follow up is essential; however it remains the patient's responsibility to follow through with recommendations when appropriately advised of the risks.

The Combined Oral Contraceptive Pill

By Dr Marianna Dare
MDA National Member and VIC PMLC Member

Sandy is a 23 year old long term patient of your practice. She attends your clinic today in response to recent media reports warning that her contraceptive pill, Yasmin, has caused blood clots in a number of women who now intend to sue Bayer. Sandy is generally fit and well, does not smoke, has no relevant family history and commenced Yasmin six years ago as recommended by her dermatologist for treatment of acne.

Yasmin belongs to a group of contraceptive pills that contain drospirenone, a newer synthetic progesterone. For many years it has been known that the combined oral contraceptive pill (COCP) increases the risk of deep vein thrombosis (DVT) and pulmonary embolus (PE), however more recent evidence suggests that the risk of DVT and PE may be greater for some COCPs than others.[1] More recent studies show that the newer progesterones (desogestrel, gestodene, drospirenone and cyproterone acetate) have approximately double the risk of DVT or PE when compared to levenorgestrel containing pills.[1,3,4] The highest rate for DVT or PE is in the first 12 months of use and appears to decline with time, however will remain higher than the risk for women who are not on the COCP and increases as the woman gets older.[1,3]

With the overall risk of DVT/PE being low for a woman like Sandy, a reasonable approach would be to discuss that the increased risk of DVT and PE is a reality with any of the COCPs, but that there is some evidence of increased risk with the COCPs containing the newer progesterones. Some women will have tried other pills and found side effects to be unacceptable. In these women, providing their baseline risk of clots is low, after discussing the potential increased risk of clots, they may decide to stay on their current COCP and revisit the issue in 12 months.[3]

Three days later Sandy's sister Caroline attends your practice. She is aged 35 years, smokes, has a BMI of 40 and long history of migraines with aura. Caroline has been prescribed Yasmin. After hearing of your conversation with Sandy, Caroline has decided to see you for review of her combined contraceptive pill use.

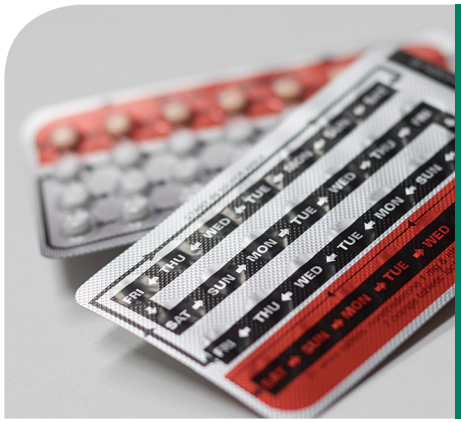
Caroline has multiple risk factors for venous thrombosis which you discuss with her. You consider that the risks of continuing with Yasmin are too great and you urge her to cease this medication and consider other options. You advise her that you are not prepared to provide her with further scripts for this medication.

As with all medications, clinical needs should be weighed against potential side effects. Combined oral contraceptives are contraindicated in women with severe or multiple risk factor(s) for venous or arterial thrombosis. Risk factors include, for example, age over 35 years, smoking and prolonged immobilisation.[1,2] The clinical needs of patients should be weighed against the possible slight increase in the risk of venous thromboembolism (VTE), and patients should be educated to recognise the signs and symptoms of VTE.[1]

Current advice from the Therapeutic Goods Association recommends that patients not stop taking these medications, but discuss their concerns with their doctor.

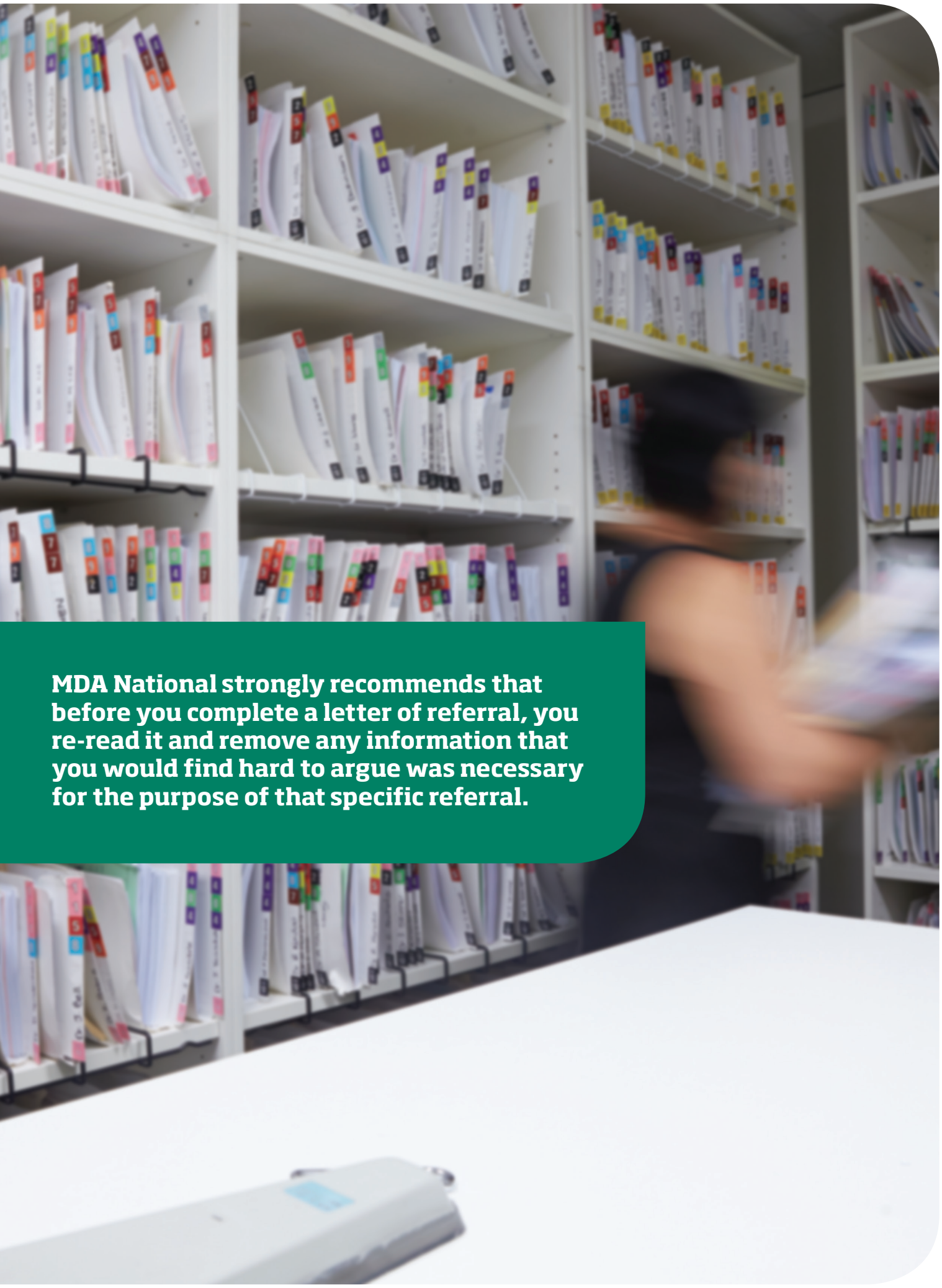
References:

1. Increased risk of thromboembolism in newer oral contraceptives. *NPS Medicinewise - Health News and Evidence*, 14 February 2013. Available at: nps.org.au/health-professionals/health-news-evidence/2013/combined-oral-contraceptives.
2. Dinger J, Bardenheuer, Heinemann. Cardiovascular and general safety of a 24-day regimen of drospirenone-containing combined oral contraceptives: final results from the International Active Surveillance Study of Women Taking Oral Contraceptives. *Contraception* 2014;89(4):253-63.
3. Lidegaard O, Nielsen L, Skovlund C, Skjeldestad F, Lokkegaard E. Risk of venous thromboembolism from use of oral contraceptives containing different progestoens and oestrogen doses: Danish cohort study, 2001-9. *BMJ* 2011;343:d6423.
4. Wu C, Grandi S, Filion K, Abenhaim H, Joseph L, Eisenberg M. Drospirenone-containing oral contraceptive pills and the risk of venous and arterial thrombosis: a systematic review. *BJOG* 2013;120:801-811.



Useful links:

- tga.gov.au/safety/alerts-medicine-oral-contraceptives-110706.htm#.UthkrU_xuUk.
- tga.gov.au/hp/msu-2011-05.htm#.UthlfU_xuUk.
- Parkin L, Sharples K, Hernandez RK, Jick SS. Risk of venous thromboembolism in users of oral contraceptives containing drospirenone or levonorgestrel: nested case-control study based on UK General Practice Research Database. *BMJ* 2011; 342:d2139.
- Jick SS, Hernandez RK. Risk of non-fatal venous thromboembolism in women using oral contraceptives containing drospirenone compared with women using oral contraceptives containing levonorgestrel: case-control study using United States claims data. *BMJ* 2011; 340:d2151.



MDA National strongly recommends that before you complete a letter of referral, you re-read it and remove any information that you would find hard to argue was necessary for the purpose of that specific referral.

How Much Clinical Information Can You Give to an Allied Health Practitioner?

By Dr Paul Nisselle
MDA National Member and VIC PMLC Member

The *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth) has thirteen Australian Privacy Principles (APPs). A medical practice is considered an "APP entity" under this law. APP6 relates to the use or disclosure of personal information and states, in part:

6.1 If an APP entity holds personal information about an individual that was collected for a particular purpose (the primary purpose), the entity must not use or disclose the information for another purpose (the secondary purpose).

The exceptions include where:

- the individual has consented to a secondary use or disclosure
- the individual would reasonably expect the APP entity to use or disclose their personal information for the secondary purpose, and that purpose is related to the primary purpose of collection, or, in the case of sensitive information, directly related to the primary purpose.

(Note: APP8 sets out requirements for the disclosure of personal information to a person who is not in Australia or an external territory.)

Information in letters of referral

Patients would generally reasonably expect that, if they are referred by their GP to a specialist or allied health practitioner, some of their health information would be conveyed to the referee. The important caveat is that ***the implied consent to disclosure applies only to information which is necessary for the purpose of the referral***. Many medical records software programs in general practice automatically copy to letters of referral, the patient's past history, family history, medication list, allergies, smoking and alcohol history, etc – that is, **all** the summarised information in that patient's medical notes. MDA National strongly recommends that before you complete a letter of referral, you re-read it and remove any information that you would find hard to argue was necessary for the purpose of that specific referral.

To take some extreme examples (which have occurred and had medico-legal consequences):

- Is a past history of two terminations of pregnancy decades earlier relevant to a referral for bunion surgery in middle age?
- Is the patient's HIV antibody status always necessary for the purpose of the referral? You may feel concerned for the referee's safety to let them know that the patient is HIV positive, but unless that information is directly relevant to the care required by the referral, the patient's specific consent to disclosure of their HIV status must be obtained.

Access to private practice medical records files

In the not so distant past, the patient's entire clinical file was kept on an open shelf in a lockable room or in a lockable cabinet – or, in a hospital, at the end of the patient's bed. If a staff member, nurse, doctor or allied health practitioner had a legitimate reason for access to part of the record, the only way they could see what they needed to see was to have access to the whole file.

APP11 requires a general practice to take active measures to ensure the security of personal information it holds, stating, in part:

If an APP entity holds personal information, the entity must take such steps as are reasonable in the circumstances to protect the information:

(a) from misuse, interference and loss; and

(b) from unauthorised access, modification or disclosure.

In a computerised general practice, unauthorised access may be prevented by an IT system with password-protected layered access such that, for example, administrative staff have access to the appointment system, basic patient data (name, address, Medicare details, etc) and other administrative databases, whereas professional staff (nurses, allied health practitioners) have deeper access – into clinical information – but still based on "need to know". Professional staff have their own ethical duty, independent of their duty not to breach the privacy/confidentiality clauses in their employment contracts, to respect and protect a patient's right to privacy – and may face disciplinary or civil consequences if there is a breach.

An "important" member of a small rural community presented to the GP with a condition that was embarrassing, both socially and medically. The receptionist in the practice mentioned it in passing to her husband that evening. The next afternoon, the husband mentioned it "in confidence" to a few of his friends. The news quickly spread around the town. The patient successfully sued both the receptionist **and her employing doctor**.

Practice Websites

By Karen Stephens
BA, BApplSc(Phty), Grad Cert Bus Admin, Risk Adviser, MDA National

There are legal, professional and ethical considerations for general practices' websites. Websites must comply with the Medical Board's *Guidelines for Advertising Regulated Health Services*.[1] Here are some tips to help set up and manage your practice's website.

Things to avoid

✘ Testimonials

Testimonials must not be used to advertise your practice – they are in breach of the Health Practitioner Regulation National Law.[2] Penalties are up to $5,000 for an individual and $10,000 for a body corporate.

✘ Naming prescription drugs

Prescription-only drugs such as the Schedule 4 drugs botox and restylane must not be named.

Under the *Therapeutic Goods Act*[3] this offence attracts a maximum penalty of $10,200 for an individual and $51,000 for a body corporate. It is, however, acceptable to use general terms and phrases such as cosmetic injections, anti-wrinkle injections, lip enhancement, or treatment for lines and folds.

✘ Unwanted incoming emails

Control the amount and type of communication the practice receives.

If you allow incoming emails from website users, ensure:

- regular monitoring of incoming emails and timely responses
- the website outlines how emails are monitored and when to expect a response
- the website explains what content is appropriate for emails, e.g. NOT for requesting a diagnosis, medical emergencies, or sensitive health information; whether repeat prescriptions, referrals or appointments can be requested.

Things to consider

✔ Purpose

Many practices do not need a website to increase business, but to:

- create a professional image, build a relationship with patients and build trust in the practice
- provide information – this can improve patients' experience, create realistic patent expectations, and free up front desk staff from answering phone requests for information.

✔ Content

Like a traditional practice information brochure, website content can include:

- location
- transport and parking
- hours of opening
- after hours contact details
- how phone calls to doctors are handled
- practice privacy policy
- billing and payment
- availability of home visits
- practitioners' special skills and interests
- process for suggestions or complaints
- requirements for repeat prescriptions, referrals and giving results.

The website can also allow patients to download:

- information such as post-procedural instructions or health information
- forms such as a new patient registration form, or a request to transfer medical records.

Consider carefully what personal details are given in staff profiles, so as not to detract from the professional nature of the relationship between practice and patients. Some staff may not want to have their named photo on the internet.

✔ Function

"Real-time" online appointments require reliable secure software so there are no double-ups or confusion between available appointments seen online and those seen by front-desk staff. Some websites allow patients to request appointments by email – the email would need to be checked frequently.

The practice policy for responding to online requests for prescriptions or referrals should be detailed on the website and all practitioners and staff should be aware of the criteria. The criteria should be guided by clinical and patient safety considerations.

Regularly update the site, check for spelling and grammatical errors, and only have a "news" section if you are sure you can regularly provide content for it.

Getting technical

Domain name and web hosting

For people to be able to see your website on the internet, you need to "host" it on a web server. You will also need to register a domain name. The two most popular ways are to:

- buy one from a domain name registrar
- get one included with your web hosting.

Research and seek advice about what factors to consider in choosing a web host. The web host's server may be physically located in Australia or overseas, or it may be located in "the cloud". If an overseas based-web host or cloud computing is used, privacy legislation regarding cross-border data transfer will apply.[4]

Website design

A professional website designer can help design a website that is easy to navigate, has relevant concise information and looks professional. The designer can also assist with promoting your site in search engines and getting links to your website. It may be an advantage for authorised practice staff to be able to update the site rather than having to do this via the site designer. Consider the capability of the site to be upgraded in the future, for example for online appointments or a mobile optimised site. Also consider data security, for example security question technology for online contact forms.

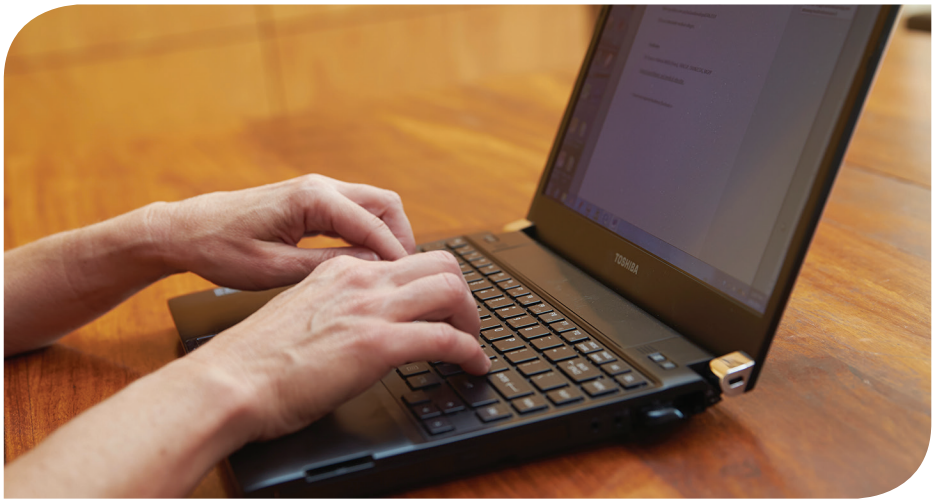
References:

1. Medical Board of Australia Guidelines for Advertising Regulated Health Services. Available at: medicalboard.gov.au/Codes-Guidelines-Policies.
2. Section 133 of the Health Practitioner Regulation National Law (the National Law) states:
   (1) A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that –
   (c) Uses testimonials or purported testimonials about the service or business
3. Section 42DL(1)(f) of the *Therapeutic Goods Act 1989* specifically mentions substances or preparations containing goods, included in Schedules 3, 4 or 8 of the Standard for the Uniform Scheduling of Medicines and Poisons (the Poisons Standard).
4. If the website is used for transfer of personal health information, and an overseas based-web host or cloud computing is used, privacy legislation *Privacy Amendment (Enhancing Privacy Protection) Act 2012* (Cth), which amends the *Privacy Act 1988* (Cth) requires a medical practice to:
   - obtain specific consent of patients for cross-border data transfer
   - advise patients what countries will be recipients of the data
   - advise patients of the complaint handling procedures in the recipient countries for breach of privacy
   - advise that that the patient waives the right to make a claim/ complaint under Australian law for a breach of privacy.

Security Risk – Is Your Computer Security Good Enough for the New Privacy Laws?

By Karen Stephens
BA, BApplSc(Phty), Grad Cert Bus Admin, Risk Adviser, MDA National

The spectre of new fines of up to $1.7million for breaches of the new privacy laws which came into effect on 12 March 2014 has raised concerns among GPs. One area of concern is the inadvertent breach of privacy caused by inadequate computer security.



What does the law require?

Australian Privacy Principle 11 – security of personal information requires a general practice to take such steps as are reasonable in the circumstances to protect the personal information it holds:

a) from misuse, interference and loss, and

b) from unauthorised access, modification or disclosure.

This is similar to the previous legal requirements, with the addition of the term "interference". (Under the previous National Privacy Principle 4 – *Data security* a general practice was required to take reasonable steps to protect the personal information it holds from misuse and loss and from unauthorised access, modification or disclosure. The Office of the Australian Information Commissioner has previously found, after investigation, that organisations were in breach of the *Privacy Act 1988* by not taking reasonable steps to prevent a data breach involving a cyber-attack (oaic.gov.au/news-and-events/statements/privacy-statements/cyber-attacks-do-not-mean-businesses-are-off-the-hook/cyber-attacks-do-not-mean-businesses-are-off-the-hook).

Remember that the law states "reasonable in the circumstances", not 100% invincible.

What could go wrong?

- ✘ A laptop with no password security could be stolen from the back seat of a car and patient records could subsequently appear on the internet.
- ✘ Medical records software could be hacked into and the practice held to ransom (this has happened to a number of practices, most famously to a Gold Coast practice in 2012 – abc.net.au/news/2012-12-10/hackers-target-gold-coast-medical-centre/4418676 and medicalobserver.com.au/news/hacking-into-health-files).
- ✘ An employee could access the records of a friend's teenage child to report back what the teenager has been seeing the doctor about.
- ✘ A disgruntled ex-employee could access the records and sabotage them.
- ✘ A computer virus could cause widespread damage to the records.

Such events would not only breach privacy law, but could

- upset or harm your patients
- damage your practice's reputation
- affect the practice's ability to function.

What can you do about it?

- Assign responsibility for computer security to an individual.
- Have an IT expert assess the risks and identify strategies to minimise them.
- User authentication, appropriate staff access levels, password management, remote access controls.
- Backup procedures – do not leave the backup connected to the computer.
- Protection from viruses and malware, regularly updated.
- Network perimeter controls (firewall).
- Only use authorised, encrypted USBs.
- Safe and proper use of internet and email which may include email encryption and spam filtering.
- Procedures for maintenance of hardware and software.
- Secure disposal of old computers.
- Staff training.
- Staff sign confidentiality agreements.
- Building security and alarms.
- Disaster recovery plan.
- Regularly monitor the effectiveness of IT security strategies.

Detailed guides to these steps and more are available:

Office of the Australian Information Commissioner. *Guide to Information Security – April 2013*. Available at: oaic.gov.au/privacy/privacy-resources/privacy-guides/guide-to-information-security

RACGP. *Computer and Information Security Standards*. Available at: racgp.org.au/your-practice/standards/computer-and-information-security-standards/.

Best Practice in Skin Cancer Medicine

Dr Damien Foong
President, Skin Cancer College Australasia
and MDA National Member

Skin cancer medicine has evolved to the degree where some GPs devote their entire working career to this area.

Minor surgical skills

A variety of biopsy techniques are often required, e.g. punch biopsy, shave biopsy, incisional biopsy, curettage biopsy and excisional biopsy. Lesions from general areas, e.g. trunk, chest, arms, forearms and thighs are usually excised as simple ellipse lesions. Other areas – face, scalp, dorsum hands and distal to knee – are more difficult and require a higher level of surgical competency to manage. The most difficult areas – nose, lips, ears, eyelids and digits – require a much higher level of skill and should only be attempted after appropriate levels of demonstrated experience.

Patients

Proper patient selection is vital. "Lesion triage" requires both assessing the possible clinical need for referral if the subset of surgical skills required is beyond that of the first practitioner and also assessing whether the patient would prefer referral – for example, to a plastic surgeon if the lesion is on a cosmetically sensitive area.

Medicare

It is essential to understand Medicare, its billing descriptors, and how to properly submit billing to Medicare. Common areas of concern are upcoding of skin lesion excision items and flap repairs. Visit medicareaustralia.gov.au for more information. A GP working full time in skin cancer may have gross billings well above those of a full-time GP. As a result, these practitioners tend to come under the review of Medicare and are sometimes subjected to an audit. Among other things, clear and accurate contemporaneous notes are essential. Ensure the size and site of the lesions is documented before excision and that your billing is substantiated by histopathology results, if required by the item descriptor.

Practice management

We live and work in an environment where we might not have great control of the administrative matters of the practice. Get involved. Be knowledgeable.

Medical indemnity

We need medical indemnity insurance to practice – this is articulated in the Medical Board of Australia's Professional Indemnity Insurance Registration Standard. However, please check and ensure that your level of medical indemnity cover is adequate, especially if you are engaged in a lot of skin surgical procedures, e.g. flaps. Policy wordings can change, year on year. Ensure your safety by reviewing your indemnity and the policy document schedule (PDS) at each renewal.

GPs should enjoy this fulfilling and rewarding area of medicine.

For more information, visit skincancercollege.org.

Skin Cancer Categorisation Table

It's important to make sure you're indemnified for any skin graft and flap procedures you're undertaking. Please review the summary table provided below for the categorisation so you can check you have the appropriate cover with MDA National. The procedures are also outlined under the relevant General Practitioner categories in our Risk Category Guide for the 2014/15 policy period.

Category	Procedure
General Practice Non Procedural -Level 1	Single stage local flaps for the removal of lesions – does not include defect repairs on the central face (eyelids, nose and lips), ear, thumb, fingers, lower leg (anterior shin) or genitals and flaps for male pattern baldness
General Practice – Limited Procedures – Level 2	Flaps – defect repairs on central face (eyelids, nose and lips), ear, thumb, fingers, lower leg (anterior shin) and genitals
	Full thickness skin grafts up to 3cm excluding the face
General Practice – Procedural – Level 3	Free grafting (split skin) of granulating area on the face and full thickness grafts above 3cm including the face
General Practice – Cosmetic – Level 6A	Flaps for male pattern baldness

Medicare Compliance For Removal of Skin Lesions

By Alice Cran
MDA National Claims Manager (Solicitor)

There are more than 50 items under the Medicare Benefits Schedule (MBS) relating to the removal of skin lesions. Choosing the wrong item number and/or failing to appropriately document the excision can expose practitioners to financial penalties and, in more serious cases, the imposition of sanctions[1] where the conduct constitutes inappropriate practice. For those GPs who practise in skin cancer medicine, it is therefore important to ensure you are able to substantiate that a specific treatment was performed for a skin procedure item.

Since 9 April 2011, the Department of Human Services has had the power to undertake audits into Medicare services provided on or after that date. The Increased Medicare Compliance Audits Initiative (IMCA) enables the department to issue a notice to a health professional, or a person in charge of the professional's records, if there is a reasonable concern that a Medicare benefit has been paid that exceeds the amount that should have been paid. In the case of audits concerning the removal of skin cancer lesions, the department seeks confirmation that practitioners have met the histopathological requirements and that the lesion size and location correlate strictly with the item descriptor. Adequate and contemporaneous records are therefore vital.

When rendering a service under Medicare that involves the removal of a skin lesion, it is good practice to keep in mind the following when it comes to documenting the excision:

- Measure and record the size and location of the lesion before removal. This is because the descriptor for many item numbers refers to the size of the lesion, not the size of the excised specimen. If the lesion is elliptical, the relevant size is determined by its average surface diameter.
- Ensure that histological confirmation is received before a skin malignancy item is claimed.
- Where multiple lesions are removed from a single anatomical region, ensure that there is histopathological evidence of malignancy within a lesion from that anatomical region.
- Retain a copy of the pathology report.

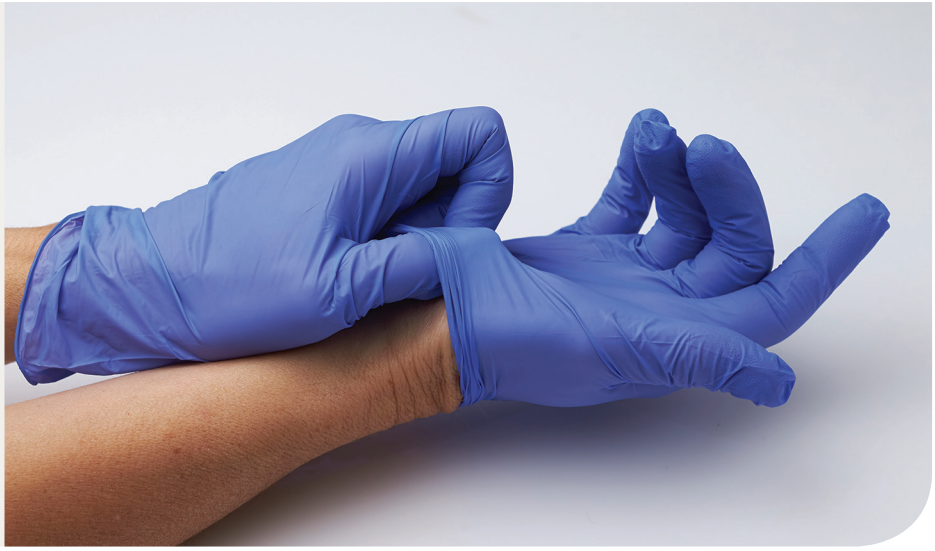
Further information regarding substantiating proof of malignancy can be obtained from the department's website.[2]

In cases where Members think they may have received an incorrect Medicare benefit, or they have received a notice to produce documents from Medicare, they should seek assistance immediately from MDA National.

References:

1. One of more of the following sanctions may be imposed. You may:
   - be reprimanded
   - be ordered to repay the Medicare benefit that has been paid by the Commonwealth
   - cease to be eligible for Medicare benefits
   - cease to have authority to participate in the Pharmaceutical Benefits Scheme, or
   - be disqualified from providing specified services for not more than three years.
2. Visit humanservices.gov.au/healthprofessionals.

Since 9 April 2011, the Department of Human Services has had the power to undertake audits into Medicare services provided on or after that date.



GP Resources

Education Resources for General Practitioners

We believe our education is unrivalled in Australian medical indemnity today. Most of our education is delivered to small groups to help fulfil personal learning needs and aid interaction.

You can choose from online resources to face to face workshops or interactive presentations, so there is something to suit everyone.

Face to face events include:

- The Challenging Emotions of Difficult News
- Online Communication for Medical Professionals
- Practical Solutions to Patient Boundaries.

Please refer to our Events Calendar at **mdanational.com.au**, log on to our Member Online Services, or call our Member Services team on **1800 011 255** for more details. **Places are limited so register soon.**

Publications, factsheets and handbooks

- Practice Self-assessment Checklist and Handbook are available at **mdanational.com.au/support-in-practice/practice-self-assessment.aspx**.
- Booklets and information sheets on medical records, retirement from medical practice, telehealth and other topics are available at **mdanational.com.au** via the Member Online Service.

Gain CPD Points!

Reading *Defence Update* and completing the online education activity is an easy way of gaining CPD points for the RACGP and ACCRM professional development programs. Take advantage of this by visiting **mdanational.com.au/publications/defence-update.aspx**.

Conferences

MDA National will be at the following national conferences. See you there!

- 2014 GPET (General Practice Education and Training Ltd) Convention 6–13 July 2014
- GP14 (The RACGP Conference for General Practitioners) 9–11 October 2014.

Support Programs

MDA National Doctors for Doctors Program – 1800 011 255

A peer support program for Members during the course of a complaint, investigation or other issue, from a doctor who has experience in the medico-legal process. Doctors employed or engaged by MDA National are exempt from mandatory reporting requirements with respect to colleagues and so Members can freely share their concerns during this peer support process.

MDA National Professional Support Service – 1800 011 255

Provides Members with direct access to a psychiatrist who can provide professional support during the course of a medico-legal matter. The service is completely confidential and details of the discussion between the psychiatrist and Member are not disclosed to MDA National.

Practice Policy

MDA National's practice policy protects your practice entity and your employees.

For more information on obtaining a quote contact – **1800 011 255** or email **peaceofmind@mdanational.com.au**

Freecall: 1800 011 255
Member Services fax: 1300 011 244
Email: peaceofmind@mdanational.com.au
Web: mdanational.com.au

MDA National
Support Protect Promote

Adelaide
Unit 7
161 Ward Street
North Adelaide SA 5006
Ph: (08) 7129 4500
Fax: (08) 7129 4520

Brisbane
Level 8
87 Wickham Terrace
Spring Hill QLD 4000
Ph: (07) 3120 1800
Fax: (07) 3839 7822

Hobart
GPO Box 828
Hobart TAS 7001
Ph: 0438 923 597
Fax: (03) 6278 2159

Melbourne
Level 3
100 Dorcas Street
Southbank VIC 3006
Ph: (03) 9915 1700
Fax: (03) 9690 6272

Perth
Level 3
88 Colin Street
West Perth WA 6005
Ph: (08) 6461 3400
Fax: (08) 9415 1492

Sydney
Level 5, AMA House,
69 Christie Street
St Leonards NSW 2065
Ph: (02) 9023 3300
Fax: (02) 9460 8344