defenceupdate

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MDA National

Support Protect Promote

Editor's Note

If you're looking for a good holiday read, I highly recommend A/Prof Siddhartha Mukherjee's book, *The Gene: An Intimate History*. Beautifully written, the book traverses the past, present and future of genetic medicine. The future involving genetic manipulation is almost here, with the recent announcement that scientists have edited genes in embryos to remove DNA sequences that cause heritable diseases. The present, however, involves genetic testing which is a well-established part of medical practice.

In this edition of *Defence Update*, Prof Jan Dickinson and Dr Michael Gannon provide a thought-provoking discussion about non-invasive prenatal testing on pages 6-7, highlighting the ethical and medico-legal challenges posed by such testing. It's a must read for all clinicians who are involved in antenatal care.

On 22 February 2018, new legislation will introduce a mandatory Notifiable Data Breaches scheme across Australia. A quick guide about the new legal requirements can be found on page 12. The Privacy Know-How pull-out feature on pages 9–11 answers some common questions we receive from Members about privacy, including the use of email to communicate medical information and how to keep health information secure when using cloud storage.

And finally, to get us all in a festive mood, our Medico-legal Adviser Nerissa Ferrie gives us a light-hearted medico-legal rendition of the 12 Days of Christmas, on page 5.

This is our last edition of *Defence Update* for 2017. I would like to thank our many Members and colleagues who have contributed their knowledge and shared their experiences in *Defence Update* this year. I look forward to continuing the discussions in 2018.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

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In This Issue

Doctors for Doctors

"In the beginning I lived my life waiting to die.
Now I live to embrace everything life has to give."

I never planned on becoming a "statistic". Then, two years ago, I went from being a fit and active General Practitioner in my forties to being a patient – suddenly reliant on the gifted doctors around me to prolong my life.

On 11 December 2015, my life changed dramatically and irreversibly. After gnawing abdominal pain, I finally undertook the endoscopy/colonoscopy I had been putting off. During the preparation, I couldn't help but notice the black tarry water I was passing. I denied it was blood at first, but a urine dipstick confirmed my fears.

When my husband and I were called in after the procedure, I knew what was coming. I was afraid for him and my family who, until then, knew nothing of cancer. The lovely doctor tried to sugarcoat the news the best he could – "a gastrointestinal stromal tumour," he suggested – but the apple-sized mass in my stomach was fast and aggressive.

Next came surgery. I wanted to get the news myself about the biopsies. So, as I waited for my first operation, I rang the lab and asked for the histopathologist. Clearly the receptionist had not conveyed to the poor doctor in histology that I was both the doctor *and* the patient.

He rattled on about the horribly aggressive, metastatic melanomatous tumour, finishing by saying how unfortunate it was for the poor person this was, because it certainly wasn't good. At this point I fessed up.

This was the first time I cried, tears of fear – for my husband, my children, my family, my friends, and my patients.

There was, of course, more surgery, more time in hospital and more procedures, followed by a liquid diet for three very long months while we sought further oncology opinions. Immunotherapy trials were a possibility.

We did our sums and worked out that a year of therapy would be well over $500,000. My husband immediately wanted to sell everything, but it got me thinking. How much is a life worth? Do I want to cripple my family financially to gain only a few extra months?

I was lucky enough to start on the Nivolumab trial in early 2016. And to cut a long story short, after twelve months I returned to the work I love as a GP. My wonderful husband, George, supported me throughout, and my beautiful children grew up overnight and became capable young adults. My outlook on life has changed dramatically.

I don't put off until tomorrow like I used to, rather I embrace everything that life has to offer. I would certainly advise everyone who reads this to do the same.

Dr Natalie Sumich
General Practitioner
MDA National State Advisory Committee member

Notice Board

Education Facilitation Team – Seeking Expressions of Interest

Are you a doctor with a passion for teaching and learning, keen on helping to deliver practical, engaging, medico-legally informed education to fellow Members and the medical profession?

MDA National's face-to-face education sessions share knowledge from the experiences of Members and staff to support doctors in providing safe medical care. We use contracted Member facilitators to do this and, to better serve our Members, we are expanding the diversity of specialties and career stages in our facilitator team.

Expressions of interest are invited from Members who are enthusiastic about delivering high quality face-to-face education and who will thoughtfully fulfil this paid role's key performance indicators. Ongoing support and comprehensive topic training are provided to our facilitators.

If you are interested in becoming an MDA National education facilitator, please contact **peaceofmind@mdanational.com.au** for more information.

Re-scheduling of Codeine

Medicines containing codeine will no longer be available without a prescription from 1 February 2018. Codeine is an opioid drug closely related to morphine. It can cause opioid tolerance, dependence, addiction, poisoning and, in high doses, death. Codeine is increasingly a drug of abuse in Australia and the overall rate of codeine-related deaths more than doubled between 2000 and 2009.

More information is available on the TGA website: **tga.gov.au/codeine-info-hub#education**.

Privacy Legislation Update

On Thursday 22 February 2018, mandatory privacy breach notification obligations will commence for all medical organisations covered by the *Privacy Act 1988* (Cth). This applies to most doctors working in private practice. Privacy breaches may include patient health and financial information, contact details and identifiers. Importantly, not all privacy breaches are "eligible" for reporting.

For more information, read our article on page 12 of this edition of *Defence Update* or visit the Office of the Australian Information Commissioner website: **oaic.gov.au**.

Developing a Workplace Mental Health Strategy

At a working dinner for health service leaders on 30 August, *beyondblue*'s Chair, the Hon Julia Gillard and Victoria's Minister for Health and Ambulance Services, the Hon Jill Hennessy MP launched a world-first guide on how to develop a workplace mental health and wellbeing strategy specifically for health services.

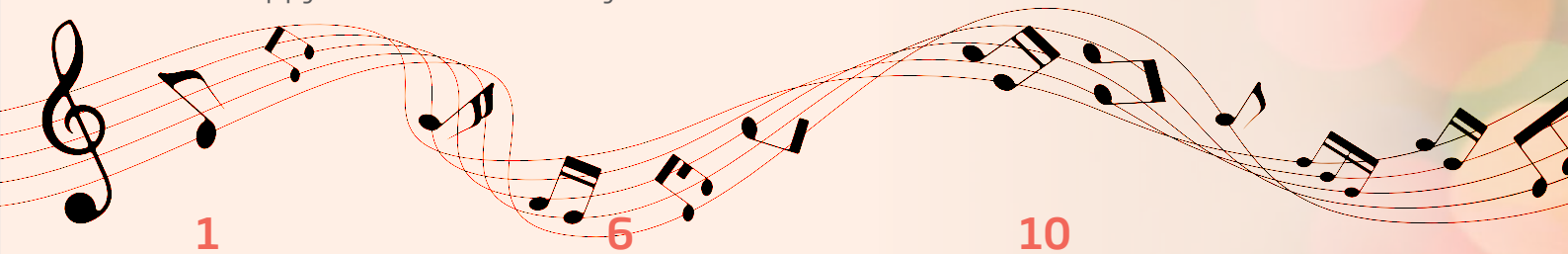
The guide provides health services with step-by-step guidance on how to create environments that support the mental health and wellbeing of their staff and help reduce their risk of depression, anxiety and suicide.

You can download *beyondblue*'s guide at **das.bluestaronline.com.au/api/prism/document?token=BL/1728**.

Order your free copy from the Heads Up website at **headsup.org.au/healthy-workplaces/information-for-health-services**.

12 Days of Medico-legal Christmas

A happy festive season to you all!



1
On the first day of Christmas my patient came to me with

a claim form and a sore knee.

2
On the second day of Christmas my patient came to me with

a last-minute subpoena;
and a claim form and a sore knee.

3
On the third day of Christmas my patient came to me for

a backdated sick note...
a last-minute subpoena;
and a claim form and a sore knee.

4
On the fourth day of Christmas my patient came to me for

an early S8 script...
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

5
On the fifth day of Christmas my patient came to me for

a Centrelink certificate...
an early S8 script,
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

6
On the sixth day of Christmas my patient came to me for

a letter of support...
a Centrelink certificate,
an early S8 script,
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

7
On the seventh day of Christmas my patient came to me with

a delay in diagnosis...
a letter of support,
a Centrelink certificate,
an early S8 script,
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

8
On the eighth day of Christmas my patient came to me with

alcoholic poisoning...
a delay in diagnosis,
a letter of support,
a Centrelink certificate,
an early S8 script,
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

9
On the ninth day of Christmas my patient came to me for

an urgent mini-mental...
alcoholic poisoning,
a delay in diagnosis,
a letter of support,
a Centrelink certificate,
an early S8 script,
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

10
On the tenth day of Christmas my patient came to me to

complain about my colleague...
an urgent mini-mental,
alcoholic poisoning,
a delay in diagnosis,
a letter of support,
a Centrelink certificate,
an early S8 script,
a backdated sick note,
a last-minute subpoena;
and a claim form and a sore knee.

11
On the eleventh day of Christmas my patient came to me to

whine about the gap fee...
a complaint about my colleague,
an urgent mini-mental,
alcoholic poisoning,
a delay in diagnosis,
a letter of support,
a Centrelink certificate,
an early S8 script,
a backdated sick note,
a last minute subpoena;
and a claim form and a sore knee.

12
On the twelfth day of Christmas no patients came to me...

so I called MDA National,
detailed all my problems,
got some good advice,
organised a locum, and...
took a break with my grateful family.

Nerissa Ferrie
Medico-legal Adviser
MDA National

Non-Invasive Prenatal Testing
Ethical & Medico-legal Issues

Often, the possibilities presented by medical science march well ahead of ethics and the law. This is a problem with aneuploidy screening. Increasingly the tests being performed reflect a push by industry, rather than a careful, scientific and ethical analysis of the potential implications of newly available testing.

Previously, pregnant women were offered invasive diagnostic testing for Down syndrome, the most common genetic cause of intellectual handicap, on the basis of advanced maternal age. Women aged 35-37 and above were counselled that the risk of pregnancy loss was roughly comparable to their age-related risk of Trisomy 21, and offered amniocentesis or chorionic villus sampling (CVS).

Over the past 40 years, there have been significant changes in the prenatal aneuploidy screening options available, coupled with substantial improvements in the performance of available screening tests. This has led to the current universal, rather than selective, offering of aneuploidy screening in pregnancy.

We have moved closer to the "perfect" test – one with detection rates of 100% and risk of 0%. But the old "Triple test" also allowed for early diagnosis of neural tube defects. First trimester screening, involving biochemical testing and nuchal translucency measurement from 11-14 weeks, offered higher rates of Trisomy 21 diagnosis and other useful information, including early detection of major anatomical anomalies, and insight into possible third trimester complications like intra-uterine growth restriction and pre-eclampsia.

Non-invasive prenatal testing (NIPT)

Recent Australian publications have demonstrated an increase in the prenatal detection of Trisomy 21 at the same time as a decline in invasive testing.[1,2] This trend was occurring prior to the 2012 introduction of NIPT. However, it has accelerated with MBS data showing a 53.7% reduction in amniocentesis and CVS over the past five years.[2]

NIPT for maternal plasma cell-free DNA is a high-level screening test for Trisomy 21 (sensitivity 99.3%), Trisomy 18 (97.4%) and Trisomy 13 (97.4%).[3] The positive predictive value (PPV) – the probability that those who have a positive test actually have the condition – is highest in high risk populations.

Virtually all new medical innovations exhibit an initial enthusiasm, followed by tempering of the optimism, and then a plateau into realism as the true benefits and concerns become evident. NIPT is no exception to this. It is the most sensitive and specific test available for Trisomy 21 in both high and low risk populations. However, it remains a screening test, meaning there is an imperative for confirmatory diagnostic testing. Of huge concern is that women are proceeding directly to termination of pregnancy following an abnormal NIPT result without confirmatory karyotyping.[4]

NIPT has been marketed as providing increased safety, accuracy, and availability at an early gestation. However, its performance characteristics vary substantially with the prevalence of the condition studied. NIPT has also been introduced into Australia with no government subsidy, creating a dichotomy in test provision, based on means to pay rather than clinical need.

The biotechnology companies who have invested billions of dollars into research and development have driven the market, not doctors. The companies have elected what genetic conditions to test for, raising significant concerns about the "expanded NIPT panel" and testing for sex chromosome abnormalities (SCA) by several professional societies and individual doctors.

The impact on human life

Human life is the core business of medical practitioners. We exist to prevent, ameliorate or cure disease. A core function of antenatal care is the timely detection of significant fetal malformations to provide parents with options for ongoing care, which may include termination for severe fetal conditions. While some women would never consider it, many others elect to interrupt their pregnancy following the diagnosis of a severe fetal condition. There is evidence that the earlier an abnormal fetal condition is diagnosed, the higher the termination rate.

The emergence of NIPT raises several ethical issues for doctors, patients and society. It has been marketed commercially, with practitioners concerned that failing to recommend the test may be perceived as sub-optimal care, opening up medico-legal or reputational risk. It has been marketed as a universally positive development in antenatal care, with little discussion about an alternative view.

Many women and healthcare providers now view NIPT as a routine component of obstetric care, and this may result in women feeling pressured to have testing. Some have made the analogy of NIPT as a screening test with that of prenatal ultrasound, a testing modality for which informed consent is usually conspicuously absent and is now in almost universal use with no general perception of performance characteristics or risk.[5]

Indeed, some doctors view informed consent for NIPT as unimportant, perceiving it as having no direct risk to the fetus.[6] Recent data has suggested that women value the perceived safety of NIPT more than the information it provides.[7] It is very clear that pre-test counselling for NIPT, including test performance characteristics, limitations, risks, and the potential for unanticipated information is required, but this adds a significant time burden.

Medico-legal pressures may influence the use of NIPT. Fear of a complaint or claim for failing to recommend NIPT may increase its use, a phenomenon well recognised in modern medicine where litigation concerns alter practice, especially in regards to use of laboratory and imaging modalities.

However, there are concerns by some doctors that the benefits of NIPT have been overstated and the disadvantages largely suppressed. As the use of NIPT increases, the potential harms are emerging. Test failure, typically secondary to a low fetal fraction, is more common than initially believed, and may lead to long delays in obtaining results.

Ethical issues such as early sex determination and detection of SCAs are controversial. Most companies now routinely offer sex chromosome testing as a component of NIPT. Concerns have been raised that determination of fetal gender at early gestations may lead to termination if the gender is not to the parents' liking.

SCA such as Monosomy X, 47,XXY, 47,XYY and 47,XXX have typically been detected previously as a result of amniocentesis or CVS for other reasons (e.g. advanced maternal age). The SCA phenotypes are highly variable, and prior to NIPT there had been a decreasing trend of termination for these conditions. The most common reasons for termination are parental fear of abnormal child development and directive counselling.

It is important that doctors requesting NIPT carefully discuss with the patient the potential for detection of a SCA when fetal gender is being ascertained and the limitations of this aspect of the test. The patient can elect to include or not include testing for SCAs. NIPT performance for SCAs is much poorer than for Trisomy 21, typically with a sensitivity of 90%.[8] In a recent publication from the USA that reviewed 2,851 pregnancies having NIPT by massively parallel sequencing techniques, the false positive rate of NIPT for Monosomy X was 91% (10/11 cases), i.e. a genuinely dismal PPV of 9% with no true positive cases in the presence of a normal nuchal translucency.[9] With such a high false positive rate, routine screening for Monosomy X should be critically reviewed.

A medico-legal and ethical dilemma

New technology drives a tendency to test for an increasing number of abnormalities, but as a society we have yet to determine the conditions of offering prenatal screening. Industry is framing the testing agenda, rather than medical need or societal values. It is easy to fall into the data trap of prenatal testing, rather than considering the values of human life in its many forms.

Currently, prenatal screening and diagnosis focuses on clinically significant disorders with well recognised phenotypes for which early diagnosis offers benefits. NIPT is potentially a powerful tool in fetal genetic diagnosis – and the range of recognisable conditions needs to be carefully evaluated to ensure there is merit in their detection; that the performance characteristics are robust and accurate; and that the testing modalities operate within ethical principles.

It is essential for GPs, Obstetricians and other clinicians to provide accurate pre-test and post-test counselling. Explaining the possibilities and limitations of prenatal testing is complex and time consuming. It is incumbent to delve past "I want that new test where I can find out whether it's a girl". If poorly targeted, the new test can cause great angst and heartache for patients. It is also an area of emerging risk for doctors and the society they serve.

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The views expressed in this article belong solely to the authors, and do not represent the views and opinions of MDA National.

View the list of references at **defenceupdate.mdanational.com.au/articles/nipt-ethical-issues**.

Good Samaritan Acts
– Responding to the App

One of our Members recently contacted us about "community first responder" apps. These apps notify a registered first responder if there is a nearby emergency, e.g. a notification may occur if you are within 500m of a 000 call. The first responder can attend to provide assistance until the ambulance arrives. Our Member wanted to know if he was legally or professionally obliged to attend if notified about an emergency by the app.

Is a doctor obliged to offer Good Samaritan assistance?

Under common law, there is no legal duty on any individual, regardless of whether he or she is a doctor, to rescue where there is no prior relationship. However, there are some exceptions to the general presumption that there is no legal obligation to provide emergency aid as a Good Samaritan.

In the Northern Territory, Section 155 of the Criminal Code states:

"Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously fails to do so is guilty of an offence and is liable to imprisonment for seven years."

In 1996, the NSW case of *Woods v Lowns* found that a General Practitioner (GP) had breached his duty of care and was negligent for failing to attend and provide assistance to a 10-year-old boy who was suffering from status epilepticus – despite the fact that the boy was not a patient of the GP. However, this judgment has been criticised by a number of commentators for imposing a legal duty to rescue on doctors.

The conduct of doctors in Australia is regulated by the National Law. While the definitions of "unprofessional conduct" and "professional misconduct" in the National Law do not refer to emergency assistance, the definition of "unsatisfactory professional conduct" applicable to doctors in NSW includes:

Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a medical practitioner if the practitioner has reasonable cause to believe the person is in need of urgent attention by a medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another medical practitioner attends instead within a reasonable time.

The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* states:

Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.

Therefore, in certain circumstances, doctors may be subject to disciplinary action for failing to respond to requests for emergency assistance. However, in the case of Good Samaritan apps, an ambulance has already been called – so other options for emergency care have already been activated.

Protection for Good Samaritans

Every Australian state and territory has legislation which protects Good Samaritans who act in good faith, honestly, without recklessness and/or with reasonable care and skill.

In addition, your Professional Indemnity Insurance Policy with MDA National provides worldwide cover for claims that arise out of Good Samaritan acts.

Dr Sara Bird
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MDA National

Privacy Know-How

Privacy law has implications for many areas of medical practice. Here are some common issues we have identified from our interaction with MDA National Members.

Privacy Know-How

Privacy law has implications for many areas of medical practice. Here are some common issues we have identified from our interaction with MDA National Members.

Your practice must have a privacy policy

Your privacy policy must include particular topics as specified in the legislation.[1] Your privacy policy is out of date if it was written before 2014 and refers to "National Privacy Principles" (rather than "Australian Privacy Principles"). Privacy policy templates are available from the RACGP[2] and the AMA,[3] and the OAIC[4] has a guide to developing a privacy policy. We recommend including in your policy how you contact patients, especially if using less traditional methods such as SMS.

Practices are expected to make their privacy policy available

Display your privacy policy in your practice and publish it on your website. New patient registration forms can include a statement such as, "I can ask to see the practice privacy policy, a copy of which is available to me, explaining how my personal information is dealt with".

Using email to communicate with patients or colleagues

- Include your use of email in your privacy policy.
- Have policy and procedures controlling your use of email.
- Patients should give consent to be contacted by email, preferably in writing.
- Encryption or secure messaging options provide greater email security, but this is not currently a legal requirement for medical practices. You must have robust IT systems and appropriate procedures to protect the security of emails.
- Consider carefully what information you include in emails.
- Confirm the patient's identity and contact details before hitting "send".

The RACGP has resources to help practices decide whether to use email.[5]

Taking photos of patients on mobile phones

- If the patient is identifiable in the image, it is considered personal information under the Privacy Act. De-identifying an image may require removal of distinctive features like a rare visible medical condition, physical marking or tattoo.
- You must get consent from the patient to take the photo, and to use or disclose it. Limited exceptions to the need to obtain consent include where there is a serious threat to life or health. When seeking consent, provide enough information for the patient to make an informed decision, for example, whether the photo will be placed on the internet. The OAIC advises that even if a patient is not identifiable, it would be good practice to obtain consent.
- You must take reasonable steps to keep the photo secure. With a mobile phone, this would involve security settings and passwords for the phone and any computer or cloud to which it is backed up.
- If using a photo sharing app, carefully consider whether you are able to maintain control of the images. If the photo is disclosed to an overseas location (directly, or via an app or cloud server) you will need to consider whether the overseas recipient complies with Australian privacy law.[6]

Providing copies of medical records to patients

Copies of medical records should be provided to patients in the format they request – for example, by email, phone, in person, hard or soft copy – if it is reasonable and practicable to do so. What is practicable will be influenced by:

- the volume of information (e.g. phone may not be practicable for a large volume)
- the nature of the information (e.g. you may not want to send very sensitive information by unencrypted email)
- any special needs of the individual requesting the information (e.g. a USB may not be useful to an elderly patient without a computer).

Cloud storage

To keep health information secure when using cloud storage, consider the recommendations[7] from the Defence Department, which include:

- using an accredited cloud service (the international standard for cloud privacy is ISO27018)
- encrypting data sent to the cloud
- choosing a service with multi-factor authentication
- storing encrypted backup offline or with another cloud provider
- having a contract with the provider which specifies who has access to your data and what security measures are used to protect your data.

Providers with servers located in Australia are recommended. If the servers are overseas, there are specific steps you must take, under the privacy law, to ensure that the overseas recipient complies with the Australian Privacy Principles.[6]

Transcription services

If health information is disclosed overseas, you will need to consider whether the overseas recipient complies with Australian privacy law.[6]

Direct marketing

A practice can only use or disclose personal information for direct marketing purposes if:

- the practice collected the information from the individual
- the individual would reasonably expect the practice to use the information for direct marketing (e.g. they have been told about it and consented to it)
- the practice provides a simple way to "opt out" from receiving direct marketing communications
- the individual has not made such a request to the organisation.

Disclosing information overseas

Before personal information is disclosed overseas, a practice must take reasonable steps to ensure that the overseas recipient does not breach the Australian Privacy Principles.

If you believe the recipient country has similar privacy laws to Australia, obtain documentation such as independent legal advice to support this.

If you do not believe the recipient country has similar privacy laws to Australia, do one of the following:

- Avoid disclosing the information.
- Enter into a contract with the overseas recipient requiring them not to breach the APPs.
- Obtain the patient's consent to disclose their information to the overseas recipient.

Privacy breaches in the media

- More than a dozen unauthorised medical staff were caught accessing the confidential records of a man after he was arrested over the murder of his father, a well known football coach (Feb 2016).
- Gold Coast Health apologised unreservedly to a patient and planned to re-educate staff after a surgical report and personal information ended up lying in the street (April 2016).
- Medical files belonging to at least a dozen patients were allegedly stolen from a Melbourne GP clinic and dumped in a park (April 2016).
- Australian Red Cross Blood Service staff contacted more than 550,000 blood donors whose personal information was contained in a file accidentally placed on an unsecured, public-facing part of their website (October 2016).
- Hundreds of specialist letters to GPs were found in the bin of a Sydney apartment block, having been left there by a sub-contractor from a transcription firm (April 2017).
- A cosmetic surgery clinic's website made public the details of hundreds of patients – names, home addresses, Medicare numbers, medical history, and before-and-after photos of breast enhancements (June 2017).
- A Guardian Australia journalist was able to buy their own Medicare details from a darknet trader who was illegally selling the information by "exploiting a vulnerability" in a government system (July 2017).

Karen Stephens
Risk Adviser
MDA National

View the list of references at **defenceupdate.mdanational.com.au/articles/privacy-know-how**.

Privacy Breaches – New Obligations

From 22 February 2018, if a breach of personal information (data) occurs in your practice, you must notify the individuals involved and the Office of the Australian Information Commissioner (OAIC). This is known as the Notifiable Data Breaches scheme. Here is a quick guide based on the resources published by the OAIC.[1]

Making notifications

You must notify the individuals involved and the OAIC if:

- personal information is:
  - lost (e.g. a laptop containing medical records is stolen)
  - accessed by an unauthorised person (e.g. hackers take control of your medical records)
  - disclosed to an unauthorised person (e.g. a fax containing medical information is sent to the wrong person); and
- this is likely to result in serious harm to someone; and
- you can't take steps to prevent the risk of serious harm.

Addressing the likelihood of serious harm may mean the breach is no longer "eligible" for reporting to the OAIC.

In order to assess whether serious harm is likely, consider the following:

- Whose personal information? Certain people, such as young persons and vulnerable individuals, may be at more risk.
- How many individuals were involved?
- Is the personal information encrypted, anonymised, or otherwise not easily accessible?
- What parties have gained, or may gain access to, the personal information?

Notifying the OAIC

If such a breach occurs, you must promptly prepare a statement for the Australian Information Commissioner (the Commissioner). The OAIC's website includes an online form to lodge notification statements and provide additional supporting information.

Your statement must include:

- your organisation's identity and contact details
- a description of the data breach
- a description of the personal information involved
- recommendations to individuals about the steps they should take to minimise the impact of the breach.

Notifying individuals

After notifying the Commissioner, depending on what is practicable, you must notify individuals in one of three ways:

1. Notify all individuals whose personal information was part of the data breach.
2. Notify only those individuals at risk of serious harm.
3. If neither option 1 or 2 above is practicable, you must publish a notification on your website (if you have one) and take reasonable steps to publicise the contents of the statement.

When notifying individuals, you can use any method (e.g. a telephone call, SMS, physical mail, social media post, or in-person conversation), as long as the method is reasonable. You must provide the same information as provided in the statement to the Commissioner.

Online notifications

When publishing an online notification:

- ensure the webpage on which it is placed can be located and indexed by search engines
- publish an announcement on your social media channels
- take out a print or online advertisement in a publication or on a website reasonably likely to reach individuals at risk of serious harm.

1 Office of the Australian Information Commissioner. Notifiable Data Breaches. Available at: oaic.gov.au/engage-with-us/consultations/notifiable-data-breaches

Cultivating a Positive Team Culture

Creating a cohesive and harmonious team is one of the hardest things to do as a team leader. While each medical team faces unique challenges, inherited traditions that have normalised unprofessional behaviour are a barrier for many.[1] We outline some strategies for overcoming these obstacles by creating positive teams.

Staff engagement is a distinguishing feature of organisations that deliver safe and efficient health care, and having systems in place can encourage positive contributions and commitment.[2] Consider whether the following suggestions would work in your team.

1. Strengthen team relationships

- Establish a corporate social responsibility program and give back to the community.
- Plan an annual or quarterly social event outside of work hours.
- Incorporate fun into team meetings by starting with an appropriate joke or story, offering door prizes, or facilitating icebreaker exercises.[3]

2. Lead by example

- Model desired behaviour, especially during challenging situations. People are more likely to treat others with respect if they are treated with respect.[4]
- Work with your team and help them complete tasks, especially at busy times.[3]
- Empower employees to fix problems themselves and respond to difficult situations. Be readily available and supportive when necessary and do not interfere when you are not required.[5]
- Openly share information.[5]
- Embrace a non-hierarchical leadership style.[6]

3. Show appreciation

- Ask staff to complete a questionnaire about their favourite things, e.g. flower, sweet treat, magazine, colour. Use this information to reward individuals.[3]
- Set up a gratitude wall.
- Share small wins in team meetings.
- Provide healthy snacks such as nuts and fruit in common areas.

4. Encourage suggestions for improvement

- Schedule a regular and non-judgemental continuous improvement meeting for questions, suggestions and concerns to be discussed.
- Directly ask individuals what you can do to improve things and act on these ideas.

5. Put things in perspective

- Highlight individual accomplishments and share stories that show the value of what they do.
- Actively promote (and role model) healthy work–life balance. Morale suffers when personal, social and family obligations cannot be met.[3]

6. Help team members develop and grow

- Invite individuals to share their knowledge at a monthly meeting, e.g. discuss articles or teach a skill that is not necessarily directly applicable to the workplace. This also creates an opportunity for team members to get to know one another better.[3]
- Provide opportunities for staff to reach their professional goals through education and training, e.g. organise a facilitator to run a workshop in the workplace, send team members to conferences, enrol them in a webinar.[3]
- Conduct regular structured or "on the fly" coaching sessions.

MDA National Education Services

Effective change takes time and requires sustained commitment by everyone involved.

If you are interested in exploring this topic further and collaborating with peers to improve your team's culture, check out MDA National's face-to-face workshop commencing in November 2017: *Engaging Teams through Positive Culture and Effective Feedback*.

Use your Member login at **mdanational.com.au** and select *My Education* to find out more about this education opportunity and upcoming events. You can also request a session if one is not scheduled in your area or is not at a convenient time for you.

View the list of references at **defenceupdate.mdanational.com.au/articles/positive-team-culture**.

Expert Witness Testimony

At times, our Members provide expert opinion in medico-legal matters. They often ask us whether they can be sued in relation to the opinion that is provided.

Relevant court decisions

The traditional position in Australia has been that expert witnesses are immune from civil suit in relation to evidence they give in the course of legal proceedings.[1] The idea that expert witness immunity could extend to out-of-court work was then confirmed in the decision of *Young v Hones*[2] (Young).

The court in Young determined that expert witness immunity would apply to work done by an expert who is intimately connected with work in court.[3] In that case, the court held that there was a sufficient connection between the alleged negligent conduct of the experts (engineers who provided advice in earlier proceedings) and the settlement of the proceedings to bring the conduct within the scope of expert witness immunity.

However, two recent decisions of the High Court, *Attwells v Jackson Lalic Lawyers Ptd Ltd*[4] (Attwells) and *Kendirjiran v Lepore*[5] (Kendirjiran) concerning advocates' immunity may have implications for expert witness immunity in general.

In Attwells and Kendirjiran, the High Court adopted a narrower approach in determining the scope of advocates' immunity – and concluded that advocates' immunity would not extend to negligent advice which leads to the settlement of a case by agreement between the parties (out-of-court work), but that it only covers advice that affects the conduct of the case in court and resolution of the case by that court.

What does this mean for doctors providing expert opinion?

Whether immunity extends to work done by expert witnesses out of court is particularly relevant in the area of medico-legal expert opinion, as the majority of medico-legal matters resolve before hearing, and the expert opinion will often be provided in the pre-trial phase.

Given the narrower approach adopted by the High Court in relation to advocates' immunity, it may be that this approach is also used when considering the scope of general expert witness immunity. The result would be that expert witness immunity would only extend to cover expert opinion given in evidence during a court hearing which leads to a judgment. This might mean expert witness immunity may not extend to expert opinion:

- given in evidence during a court hearing, leading to a settlement
- given before a court hearing, leading to a settlement
- provided in the pre-litigation phase.

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Summary points

- MDA National will continue to monitor any further developments in this area. In the meantime, it is important that you carefully consider any request to provide an expert opinion.
- For tips and more information, see the article Providing Expert Evidence in our *Defence Update* Autumn 2015 edition, page 18. Available at: **defenceupdate.mdanational.com.au/articles/expert-evidence**
- If you have any questions or concerns, please contact our Medico-legal Advisory Services team on **1800 011 255**.

1 *Cabassi v Villa* [1940] HCA 41; 64 CLR 130.
2 *Young v Hones* [2014] NSWCA 337.
3 *Young v Hones* [2014] NSWCA 337 at 35.
4 *Atwells v Jackson Lalic Lawyers Pty Ltd* [2016] HCA 16.
5 *Kendirjian v Lepore* [2017] HCA 13.

CaseBook

Consensual Underage Sex: What Are Your Obligations?

Case history

Your 15-year-old patient, Grace, attends a consultation with her mother. Grace is seeking contraception, having recently entered into a sexual relationship with her 20-year-old boyfriend. Grace's mother is supportive of the relationship and the request for contraception. You are not sure if you are obliged to notify relevant authorities about Grace's relationship.

Medico-legal issues

Your obligations to Grace include maintaining confidentiality, considering Gillick competence,[1] acting in her best interests and considering whether mandatory child abuse reporting legislation applies.

Child abuse reporting

Mandatory child abuse reporting legislation relates to the risk of harm/abuse, not age of consent laws, and is designed to protect young people from sexual exploitation and abuse. This requires the exercise of professional judgement and careful consideration to establish whether the young person is being physically or psychologically coerced into sexual activity. If a sexual relationship involving a young person is unequal, non-consensual or coercive, it is abusive and mandatory notification is required.

Age of consent

Each state and territory has legislation providing that any person who engages in sexual behaviour with a child under the age of consent is guilty of an offence and liable to be prosecuted, because the child is deemed not to have decision-making capacity to consent. The age of consent is 16 in all jurisdictions, with the exception of Tasmania and SA where it is 17 years of age. Tasmania, Victoria, ACT and WA provide a legal defence when the sexual interaction is between two young people of a similar age.

However, doctors have no obligation to report underage sexual activity that is not abusive.

Discussion

Given the substantial age difference between Grace and her boyfriend, you rightly consider whether a power imbalance exists in the relationship. However, based on your consultation with Grace, including her mother's approval, you form the view that Grace is not being coerced into sexual activity and the sexual relationship is not abusive.

Although it is clear that Grace's boyfriend is committing an offence because she is under the age of consent, there is no obligation to report this to the police (although you could discuss the law with Grace and her mum). As there is no concern that Grace is being abused or in need of protection, the requirements of mandatory reporting of child sexual abuse are not triggered.

Tips for assessing underage developmentally appropriate sexual behaviour

Is there:

- **consent** – includes transparency, that both parties possess a similar cultural knowledge about standards of behaviour, are aware of possible consequences, have respect for agreement or disagreement without consequence, and have decision-making capacity (e.g. are unaffected by intoxication)
- **equality** – relates to the balance of power and control between those involved
- **coercion** – could be anything from implied authority and manipulation to physical force or threats of harm.[2]

If you are uncertain how to proceed in a particular case, please contact our Medico-legal Advisory Services team on **1800 011 255**.

Gayle Peres da Costa
Claims Manager (Solicitor)
MDA National

1 Bird S. Consent to Medical Treatment: The Mature Minor. *Australian Family Physician*. March 2011. Available at: racgp.org.au/afp/2011/march/consent-to-medical-treatment-the-mature-minor

2 Child Family Community Australia. Age of Consent Laws. Available at: aifs.gov.au/cfca/publications/age-consent-laws

CaseBook

Confidentiality vs Risk of Harm

A key element to the doctor–patient relationship is the patient's expectation that the doctor will hold their information in confidence.

But there are times when doctors are not required to maintain patient confidentiality, and these exceptions are set out in both state and federal privacy legislation. However, under privacy legislation, there is no mandatory duty for doctors to disclose confidential information to third parties. Against this background, a recent finding by a Victorian Coroner suggests there are those who consider that doctors should make disclosures when exceptions apply.[1]

Case history

Ms Adriana Donato was murdered by her ex-boyfriend, James Stoneham, on 23 August 2012 in Essendon, Victoria. The focus of the inquest into Ms Donato's death centred on the extent of Mr Stoneham's disclosure to his case manager, Clinical Psychologist Dr Caroline Gregory, of any threat to Ms Donato's safety, either implied or explicit.

Ms Donato ended her relationship with Mr Stoneham for the second time in December 2011. By early to mid-February 2012, there was a change in Mr Stoneham who struggled to deal with the breakup. From this time, Mr Stoneham was drinking excessively and taking illicit drugs. He was attending Dr Gregory for treatment. Dr Gregory last saw Mr Stoneham on 22 August 2012, the day before Ms Donato's death.

Medico-legal issues

The Victorian Coroner explored Dr Gregory's obligations of confidentiality in the therapeutic relationship and the exemption to that confidentiality as set out in the Health Privacy Principles contained in the *Health Records Act 2001* (Vic). The Coroner also examined whether the threshold for breaching confidentiality under the Health Privacy Principles – that the patient must present a "*serious and imminent threat to an individual*"[2] – was too high.

Dr Gregory was shocked to learn about Ms Donato's death. She stated that while Mr Stoneham had discussed feelings of anger, there was a vast difference between those feelings and what had happened. In her assessment of Mr Stoneham on 22 August 2012, Dr Gregory saw no risk of harm to anyone. At a consultation on 13 August 2012, Mr Stoneham had expressed aggression towards an unnamed individual and had thoughts of violence, but refused to disclose any details. There were earlier consultations where Mr Stoneham had expressed anger towards Ms Donato.

As a result of expert evidence, the Coroner concluded that Dr Gregory should have questioned Mr Stoneham on 13 August 2012 about his thoughts of violence and she should have made specific reference to Ms Donato. The Coroner considered that if this had occurred, it *may* have led to a notification by Dr Gregory to the police.

The Coroner commented that while the reporting of such matters is not mandatory, the spirit of the Health Privacy Principles demands that such matters must be addressed and that the reporting of above threshold cases should occur. In arriving at this view, the Coroner considered that the threshold under the Health Privacy Principles was too high and acknowledged that, at a federal level, there is no requirement that the threat needs to be "*imminent*". The Coroner recommended that the Department of Health and Human Services give consideration to the removal of the requirement that a "*serious risk of harm*" be also one which is "*imminent*".

Medico-legal advice

Under the Australian Privacy Principles (APPs), health information can be disclosed if it is a "permitted general situation" – this includes if you reasonably believe that the disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual.

Medico-legal Advisory Services
MDA National

Want to know more about your obligations under state and federal privacy legislation? Contact our Medico-legal Advisory Services team on **1800 011 255** for further information.

1 Inquest into the Death of Adriana Donato. Available at: coronerscourt.vic.gov.au/home/coroners+written+findings/findings+-+inquest+into+the+death+of+adriana+donato

2 *Health Records Act 2001* (Vic). Health Privacy Principle 2.2(h).

CaseBook

When is it Okay to Breach Patient Confidentiality?

Doctors approach the doctor–patient relationship with diligence, and are usually reluctant to breach patient confidentiality. Situations can arise where doctors feel ethically and morally bound to release patient information to protect the welfare of others, as detailed in the case below.

A patient booked a follow-up appointment with Dr Johns, a part-time GP working in a small rural practice. The patient, Peter Jackson, was returning for the results of a CT scan.

When Mr Jackson arrived for the last appointment of the day, he was told that Dr Johns was running behind time. Mr Jackson wasn't happy about the delay, but said he would rather wait than reschedule as he needed to see the doctor that day.

After ten minutes, Mr Jackson advised the junior receptionist that he had been out of town for a while and wanted to check that his details were up to date. The receptionist, feeling slightly intimidated by the patient, agreed to check his details and opened the patient database. She was surprised when she heard a noise behind her and realised Mr Jackson was now standing directly behind her. The receptionist was alone in the practice except for the doctor. Although she was uncomfortable with Mr Jackson's request, she was reluctant to ask him to return to the waiting room.

Keen to get the patient away from her desk, the receptionist typed in "Jackson" into the computer. A list of patient names appeared on the screen and the patient pointed to an entry for Peter Jackson, saying, "That's me". The receptionist brought up the record – but before she realised it couldn't be correct because the date of birth only made him 12 years of age, the patient grabbed a post-it note and wrote down the address on the screen.

Mr Jackson smiled at the receptionist and said, "I don't need that appointment after all – but my ex might need a doctor now that I have her address".

The receptionist called for Dr Johns who came out of his consulting room immediately. The receptionist was distraught, realising she had inadvertently disclosed the current address of Mr Jackson's ex-wife and son. Dr Johns had not initially recognised Mr Jackson, but was familiar with the family and aware of a long history of domestic violence which had resulted in the patient being jailed for three years.

Even though Dr Johns had only seen Mr Jackson once, there was still a doctor–patient relationship to consider, so he turned his mind to the issue of privacy and patient confidentiality. He was aware that confidentiality can be breached under certain circumstances, and he formed the view that Mrs Jackson and her son were at serious risk of harm. Dr Johns called both the local police and Mrs Jackson to warn them of the breach and the potential danger to the family, and he provided the police with Mr Jackson's current address.

Mrs Jackson was picking her son up from after-school sports when she received the call from Dr Johns, and she drove straight to the local police station. Mr Jackson was arrested outside the family home and was returned to jail for breaching his bail conditions.

Mrs Jackson was grateful to Dr Johns for raising the alarm, but was equally concerned about her son's personal details being released by the practice. The practice responded with an unreserved apology, and Mrs Jackson moved to another town for her own safety.

Nerissa Ferrie
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MDA National

CaseBook

A Coroner's Cautionary Christmas Tale

A recent coronial inquest highlighted communication issues between a Cardiologist and a General Practitioner (GP) which resulted in a patient's death.[1]

Case history

Mrs Aston, aged 86 years, consulted a Cardiologist regarding her atrial fibrillation on 19 December 2012. He advised her that she should be anticoagulated and commenced her on warfarin 5mg daily. The Cardiologist impressed upon Mrs Aston the need for monitoring of the warfarin level and asked her to have a blood test two days later on 21 December. He also advised her to see her GP that day.

The Cardiologist did not arrange for a copy of the INR result of 21 December to be sent to Mrs Aston's GP. The Cardiologist provided Mrs Aston with a note which stated: Atrial fibrillation – warfarin rat poison. Mrs Aston's INR result on 21 December was 1.9 and the Cardiologist did not take any particular action with regards to this result.

The Cardiologist dictated a letter to Mrs Aston's GP advising him that Mrs Aston had been commenced on warfarin. The letter went on to be typed and did not reach the GP until 9 January 2013.

For reasons which are not clear, Mrs Aston did not contact her GP on or around 21 December. It was not until 3 January 2013 (15 days after commencing warfarin) that she contacted her GP because she was not feeling well, and there was blood in her urine.

Mrs Aston's GP visited her at home on the evening of Thursday 3 January. He was surprised to learn that she had been commenced on warfarin. He advised her to cease taking warfarin for the moment, and he also prescribed antibiotics as he suspected she may have a urinary tract infection. He wanted to test her INR, but decided to return the following day to do this.

The blood sample taken the next day was deemed inadequate to be tested. The request form did not mark the sample as urgent and the GP did not follow up the missing result until Monday.

On Saturday 5 January, Mrs Aston's son found her slumped in a chair. She was taken to hospital but died a short time later. Cause of death was subdural haematoma, and her INR was 12.

Discussion

In this case, a robust and foolproof handover was needed to ensure monitoring of Ms Aston's INR. The Cardiologist agreed he was aware that the GP would not receive his letter for 10-14 days. Handover of care to her GP had been delegated almost entirely to Mrs Aston. For whatever reason, Mrs Aston did not understand the importance of the monitoring or seeing her GP within a few days.

It was the Coroner's view that Mrs Aston's death could have been prevented if her warfarin had been appropriately monitored between 19 December 2012 and 3 January 2013. He was critical of both the Cardiologist and the GP.

Medico-legal issues

The Cardiologist's handover was grossly inadequate, relying as it did on Mrs Aston alone. The Cardiologist should have taken other steps (phone call, fax, email) to inform Mrs Aston's GP that she had been started on warfarin and that he was responsible for monitoring. He did not copy the GP into the INR test of 21 December.

The GP's management was also criticised in that he failed to arrange an INR test as a matter of urgency when he became aware that Mrs Aston had not been having her INR monitored.

This case highlights that handover of care is a critical time for patients, especially with potential delays during the Christmas period.

Dr Jane Deacon
Medico-legal Adviser
MDA National

1 Inquest into the Death of Ms Marjorie Aston. Available at: courts.sa.gov.au/CoronersFindings/Lists/Coroners%20Findings/Attachments/620/ASTON%20Marjorie%20Irene.pdf

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24 Mar	Practical Solutions to Patient Boundaries **Sydney, NSW**
21 Apr	*Geelong Education Day* Win-Win Conflict Resolution Avoiding Misunderstandings around Physical Contact & Intimate Examinations **Geelong, VIC**
26 May	Avoiding Misunderstandings around Physical Contact & Intimate Examinations **Melbourne, VIC**

For more information or to register, visit **mdanational.com.au**, call us on **1800 011 255** or email **events@mdanational.com.au**.

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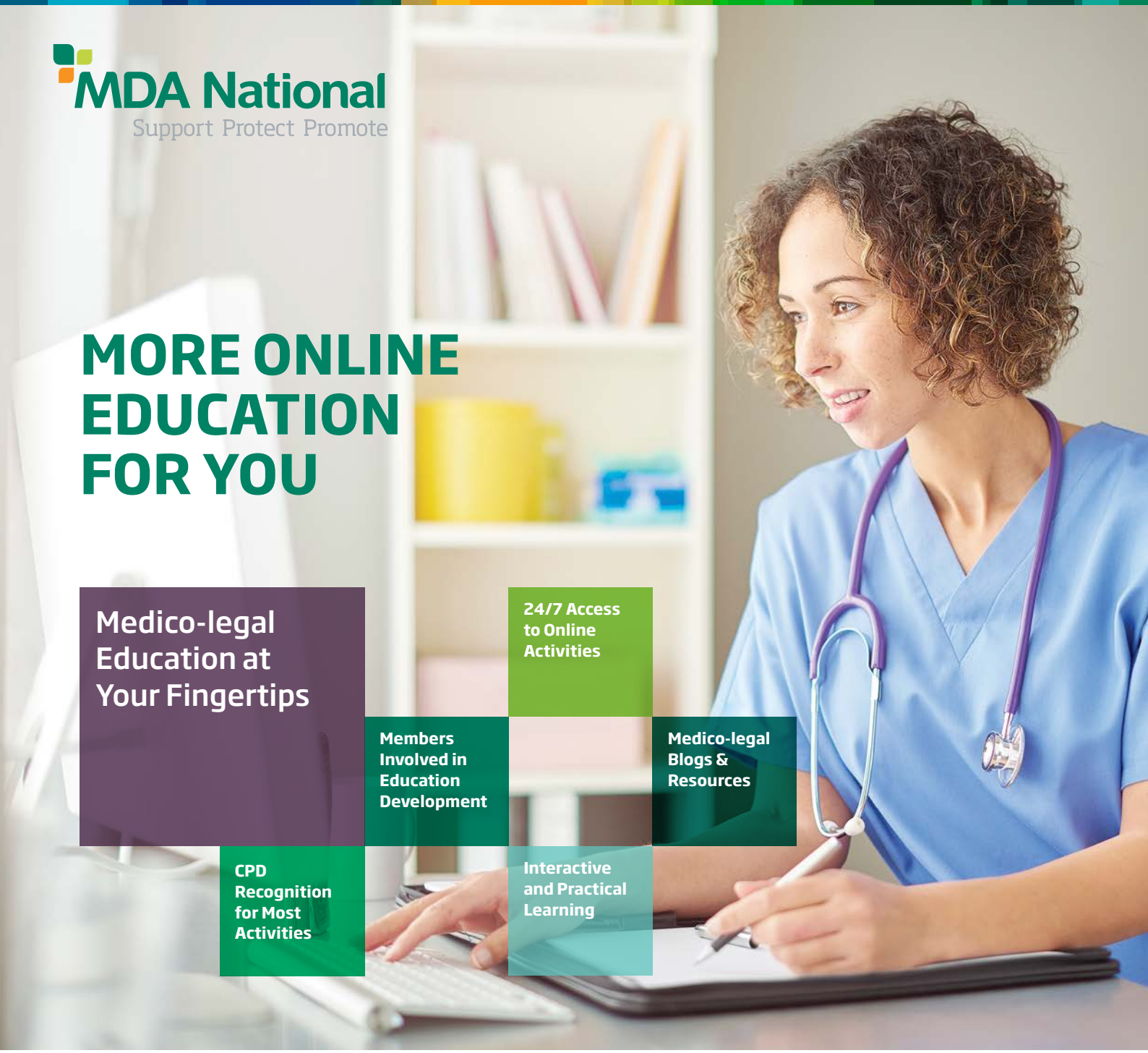

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