Clinical Data, the Basic Staple of Health Learning

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Overview

MDA National understands that you have specific medico-legal needs and interests as a Physician.

The publication provides a “snapshot” of relevant medico-legal issues with the aim of keeping you informed and helping you to minimise your medico-legal risk. That way you can concentrate on what you do best and continue to provide quality medical care.

In this edition:
- clinical data, international trends and core privacy principles
- data – how this is used for judging doses and also colleagues
- sample articles for Physicians from the Medico-legal Blog.

Medico-legal questions

Our Medico-legal Advisers are here to support you by addressing any specific questions you have on 1800 011 255 or advice@mdanational.com.au.

Your feedback

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Clinical Data, the Basic Staple of Health Learning

Measuring, evaluating and managing health care is dependent upon the acquisition and availability of healthcare data. The major sources for this data are people (patients) within the healthcare system. This data reflects the quality and costs in the health system, resource utilisation, and also provides the tools to manage health care. It can be used for direct patient care, the assessment of government spending, research, epidemiology and to help determine the overuse, underuse and inappropriate of health care resources.

With the proliferation of health data there is an inherent seduction and danger that current health technologies alone will provide the answers we need. On this point Bellazzi noted, “We are currently witnessing examples of ‘technology push’ driven by the combination of pervasive computing, and big data storage and retrieval solutions.”

Privacy

Data management and integration associated with data silos, standardisation and interoperability still exist, but hopefully these problems will be resolved over time. The more serious problems relate to the privacy of the data. So how can we make sure our data will be appropriately - and not inappropriately – accessed and used?
Examples

Three recent examples, national and international, highlight some of the major issues related to data access and use.

In 2016 a research analysis of government released healthcare data within the Australian health system demonstrated that it was possible to decrypt and re-identify some of the service provider ID numbers and doctors, which was clearly not an intended outcome.²

In Canada, Physicians have expressed concerns about their government’s use of healthcare data for non-clinical activities.³

For example, Physicians “are particularly concerned to read in media reports that the government may be seeking to monetize this data-gathering ability for profit,” and stated there is an urgent need for “safeguards” to protect patients. The same article claims that “the blunt reality is that we do not currently have a functional eHealth system that benefits patient care and it is unclear to us currently how the mandate from the Minister will help encourage or support this”.⁴

The United Kingdom care.data project confirms that problems related to governments being the sole or main repository of healthcare data are universal. The care.data program was designed to automatically extract data sets from UK GP systems to be used for monitoring and performance management for the National Health Service. Healthcare community feedback and two independent reviews have led to the suspension of this project.⁵

Legal requirements in the practice

Handling electronic patient data in a medical practice requires adherence to privacy law and the 13 Australian Privacy Principles,⁶ including:

- having a privacy policy available to patients which explains what information is collected, how it is used, and who it is disclosed to
- getting consent from patients to collect their information
- taking reasonable steps to protect the security of the information
- providing appropriate access (and only appropriate access) to the information.

Participants in the My Health record system have specific legislative requirements⁷ relating to patient consent and privacy of data. Patients need to understand what information is included in their My Health Record and how they can control who can see their information. There are specific obligations with regard to:

- computer security
- software functionality and secure messaging capability
- data quality in the medical records
- training staff and appointing specific responsible staff
- written policies and procedures.

Privacy management

There are many implications for privacy management. Health data may be used for a purpose different from the reason they have been collected. For example, in the case of population-based analyses, there is the need for a secure and reliable system for anonymising data that reduces the potential for patients to be re-identified. Current systems do not have the ability to feed back immediately to the people at the point of care – a critical element for measuring and improving the quality of care.

Conclusions

- Australia has high-quality healthcare data in digital form which exists in fragmented, non-standardised and non-interoperable formats. This data fragmentation relates to the models of healthcare delivery. Health services are delivered across a myriad of primary, secondary, hospital and allied healthcare settings, by a combination of private, public and NGO providers. Poor coordination, independent functioning and different information needs and use exist.
- Change is required and an entire new model for governing research studies is vital.
- The My Health Record project has faced a number of obstacles and is yet to be fully implemented.
- Healthcare data is unable to support real-time personalised health care – thus consumers continue to be the biggest losers from this situation.
- A significant lack of involvement of Australian-based eHealth experts (e.g. CHI Macquarie University, ACHI, HIMAA, etc) in the development of a national healthcare database model contributes to the current situation and will persist until this deficiency is addressed.
- Major issues to be resolved that relate to the generation and use of healthcare data are consent for the use of clinical data, privacy, security, and the management of expectations and current meaningless false correlations from existing data.

References


5. Privacy Amendment (Enhancing Privacy Protection) Act 2012 (Cth) - which amends the Privacy Act 1988 (Cth)


Further information

Patient Privacy Rights. Available at: patientprivacyrights.org/

“All things are poison and nothing is without poison; only the dose makes a thing not a poison” Paracelsus 1493-1541

As with best clinical practice, when clinicians judge one another, it is prudent for their assessments to remain evidence-based. When analysed, many “complaints” about colleagues are often little more than anecdotal hearsay and opinion. Worryingly, a range of conflicts of interest in the workplace appear to influence such reports. Robust discussion to share and advance knowledge is sometimes replaced by conservative and judgemental behaviour that does not match the professionalism and respect we afford patients. Matters of disagreement are sometimes discussed “around” rather than “with” colleagues, which does not foster resolution.

Professional risks
Medical practitioners live in challenging times with rapidly improving and expanding technologies. Our patients are better informed than before, and primary care provides comprehensive support and care of patients. This is complemented by deeper and more sophisticated specialist practice - all positive developments. This exposes clinicians to a range of professional risks, in particular, in relation to falling behind in knowledge of best practice outside one’s own interests. As clinicians, we should work together constructively and supportively to prevent patients or colleagues becoming disadvantaged.

Smaller doses
It was interesting in this context for me to observe the incredulity of colleagues when it became clear that many drugs are very effective at the smallest doses. Most drugs turn out to be useful and at their safest near the effective dose 50, ED50, the mean population dose of medication which delivers 50% of the maximum possible effect. This is in some ways analogous to pressing the accelerator only halfway to the “red” on the tachometer when driving! Efficacy substantially plateaus above ED50 but adverse effects continue to increase, some exponentially.

For example, adverse effects of excessive doses of statins (the ED50 of rosuvastatin is only around 1 mg) explains much of the reported less than 50% compliance. Doses around ED50 are sufficient and often better tolerated.

As has been settled with aspirin (ED50 of around 40 mg) in coronary disease and stroke, a small dose finds the appropriate balance of risks with benefit so a dose of 75 mg of aspirin is sufficient, but small when compared to doses of up to 650 mg used in the 1980s for these indications.

General Practitioners have discovered that many drugs are effective in smaller doses, nowhere more clearly than with analgesics and the earlier less well-tolerated antihypertensive and psychotropic drugs. However, small doses were often criticised by specialists, whose perspective is influenced by managing more severe diseases. Furthermore, there are conflicts of interest, as specialists and hospitals have increasingly become involved with manufacturer-sponsored teaching programs, professional meetings and clinical trials.

A positive compromise through sensible governance was the evidence-based decision to make lower dose statin (simvastatin 10 mg) available over the counter in the UK in 2004. The mean population ED50 of simvastatin is around 15 mg.

The desired clinical effect of a drug such as an anxiolytic may be relatively circumscribed – but the adverse effects are multiple which, with increasing dosage, can overtake the potential benefit. It would not be appropriate with any pharmaceutical to prescribe a higher dose than necessary.

Working with colleagues
Clinical governance is a complex issue, especially in teaching and training environments, and will advance both patients’ and clinicians’ interests as well as institutional and political goals. When documenting issues about colleagues, it is best to refrain from judgements which cannot be verified by evidence and data. Pharmacological science and published evidence will be increasingly embedded into clinical practice.

References
As clinicians, we should work together constructively and supportively to prevent patients or colleagues becoming disadvantaged.
Medico-legal Minutes

Stay on top of medico-legal issues, recent court cases and judgments involving the medical profession and legislative updates that could impact your practice. Here’s a taste of what’s recently been blogged:

Texting times

Dr A, a respiratory Physician, received a complaint relating to his care of an elderly patient, Mrs Brown. Mrs Brown had been admitted with pneumonia, and Dr A had reviewed her on the first day of admission. During Mrs Brown’s five-day stay, Dr A was updated daily on Mrs Brown’s care by his senior registrar by way of their usual arrangement – his registrar would send him a text message after conducting the morning ward round.

Mrs Brown’s family complained that Dr A had only reviewed Mrs Brown once, and had “washed his hands of her” after that. Dr A denied this, as he knew he had been updated regularly by his registrar. However, there was no record or reference to the text messages in the medical records. In the intervening months he had a new phone, and the registrar had moved overseas.

In this case, the text messages provided information about the patient’s care and were essential in assisting Dr A to respond to the complaint.

- Do you use text messaging when communicating about patient care with other doctors?
- Do you record anything in the medical records?
- How could text messages be included in the medical records?
- Any other comments about texting?

Euthanasia and Physician assisted suicide

The AMA has released a position statement on euthanasia and assisted suicide. While maintaining its belief that doctors should not be involved in interventions that have the primary aim of ending a person’s life, the AMA has acknowledged the divergent views on this issue. And there has been growing public debate, with a euthanasia bill in South Australia defeated by one vote on 17 November 2016. The Victorian parliament has been investigating options for the terminally ill, with a committee making 49 recommendations covering assisted suicide and amending the Crimes Act, to protect doctors who act within proposed assisted dying legislation.

The AMA clearly sees, and is advocating for, a role for the medical profession in the development of any laws that may allow euthanasia or physician assisted suicide.

Compassionate care for terminally ill patients

Providing compassionate health care - that is both ethically and legally sound – to a terminally ill patient is a sensitive and challenging situation for doctors.

End of Life Law in Australia (end-of-life.qut.edu.au/) is a new online resource providing practical information to assist doctors in navigating the challenging legal issues that can arise with end of life decision-making.

You may also be interested in our Defence Update article for tips on advance care planning and directives (defenceupdate.mdanational.com.au/articles/advance-care-planning).

For advice, please contact our Medico-legal Advisory Service on 1800 011 255.

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Members can access this activity any time from a tablet or desk computer, logging in and out as convenient to complete the 2.5-hour activity. Visit the online learning activities in the Resources section of our website to find out more.
If you prefer face-to-face education, we invite you to join us at an education session.

Our new workshop, Noteworthy: The How, What, Where and Why of Medical Documentation, uses case scenarios and quiz questions to explore areas of record-keeping identified as being problematic for doctors in recent court and Medical Board findings, and in Members’ queries to MDA National. It helps doctors use medical records effectively to support continuity of patient care, avoid pitfalls of electronic record keeping, and confidently manage storage of and access to records.
The medical documentation workshop will be offered in Perth, Melbourne, Toowoomba, Traralgon and Sydney in the coming months. Visit our Upcoming Events calendar at mdanational.com.au to find out more about this education session and others.

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