Health Legal Report – November 2011

Welcome to the November 2011 issue of the Health Legal Report.

In this issue we discuss the upcoming introduction of the national Personally Controlled Electronic Health Record, a recent case which considered the duty of care owed by specialists who are asked to perform diagnostic tests for other doctors and we remind our clients about the importance of properly structuring private practice arrangements in the public healthcare system.

The introduction of the PCEHR – it's coming!

by Teresa Pollock, Solicitor and Natalie Franks, Principal

The National E-Health Transition Authority Limited (known as **NEHTA**) was established by the Australian, State and Territory Governments to develop better ways of electronically collecting and securely exchanging health information.

EHealth is an integral part of the Australian Government's agenda for health reform. As such, the 2010/11 Federal Government budget included a $466.7 million investment over 2 years for a national Personally Controlled Electronic Health Record (**PCEHR**) system for all Australians who choose to register for one.

Australians can choose to register for a PCEHR from 1 July 2012.

The benefits of the PCEHR system for individuals include:

- *access:* individuals will be able to access key pieces of their health information
- *improved healthcare:* an availability of a wider source of health information will lead to opportunities for improved prevention, early intervention and treatment of chronic diseases, as well as improved diagnosis and treatment in emergencies
- *informed healthcare choices:* individuals will be able to access their own PCEHR, view their records and in time, may link to health literacy information relating specifically to their needs.

Draft eHealth legislation

The exposure draft *Personally Controlled Electronic Health Records Bill 2011* was released on 30 September 2011 for public consultation. To assist readers, a companion document written in plain English was also released in conjunction with the exposure draft. The companion document explains the provisions contained in the exposure draft and the reasons behind them and describes how the provisions are intended to operate.

The exposure draft and companion document are available to download from the http://www.yourhealth.gov.au website.

Draft regulations and rules are yet to be released.

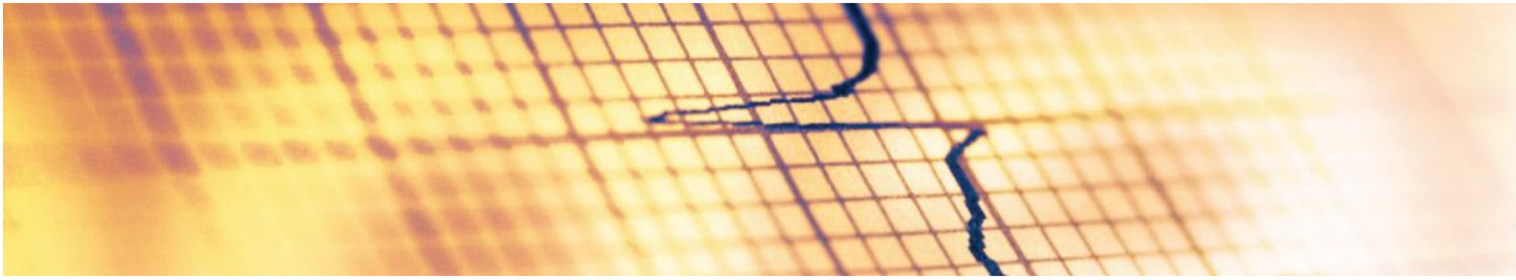
Key PCEHR concepts

The PCEHR system enables the secure sharing of health information between an individual's healthcare providers. Ultimately however, the access to the system is controlled by the individual, who is able to choose which healthcare providers access their PCEHR and what information can be seen by those providers. In short, it is a truly 'opt in' system.

Healthcare providers can also opt in to the PCEHR system.

An individual does not need to have a PCEHR in order to continue to receive medical treatment, however the PCEHR system will be an enhancement to the medical treatment provided by allowing the individual's health information to be shared when needed.

The PCEHR system will be broken down into a number of information sources, the first being the Shared Health Summary. The **Shared Health Summary** is the key clinical document in the PCEHR and is a clinically reviewed summary of the individual's healthcare status.



The Shared Health Summary will include information such as the individual's current medications, allergies, adverse reactions, immunisation history and general medical history.

The Shared Health Summary is authored by the individual's Nominated Provider. The **Nominated Provider** is an indentified healthcare provider who is involved in the ongoing care of the individual and has agreed to create and manage the Shared Health Summary. The exposure draft has preliminarily defined a Nominated Provider to be either a medical practitioner, registered nurse or Aboriginal healthcare worker, however it is expected that these categories will be expanded to include other groups over time.

Behind the Shared Health Summary lie the **Event Summaries**, which capture significant healthcare events that are relevant to the ongoing care of the individual. Any participating healthcare provider can submit an Event Summary to an individual's PCEHR, such as an emergency department or an allied health practitioner.

In front of the Shared Health Summary and Event Summaries is the **Consolidated View**. The consolidated view is a technical construct which provides an up-to-date snapshot of the individual's healthcare drawing on the latest information from the Shared Health Summary and recent Event Summaries.

Individuals will also have access via their consumer portal to enter notes on their healthcare. The consumer-entered notes are the first step in strengthening individual's involvement in their healthcare. These consumer-entered notes however, will not be visible to healthcare providers and are only intended to be a memory aid for individuals.

Importantly, the PCEHR system is an *information* system and not a *communication* system between healthcare provider and individual. Nominated Providers will not be expected to review new clinical information added to the PCEHR between consultations with the individual. Updates to the PCEHR in between consultations are intended to be a starting point or an aide memoir for individuals when they next see their Nominated Provider.

Further, the PCEHR system is not a communication system between various healthcare providers. Normal channels of communications between healthcare providers are expected to continue, for example referrals between GPs and specialists and hospital discharge summaries.

Health Legal's involvement

Health Legal has been working with NEHTA as a strategic advisor in relation to the medico-legal issues arising out of this national project.

Legislative compliance

Our legislative compliance services continue to expand.

We have developed a legislative compliance register which specifically meets the needs of aged care providers in Victoria, Western Australia, New South Wales and Queensland.

We have also recently released legislative compliance products which meet the needs of the public and private health care sector in New South Wales.

For further information, contact Megan Balakumar on (03) 9865 1334 or megan.balakumar@healthlegal.com.au

Duty of care when performing diagnostic tests

Mazza v Webb **[2011] QSC 163**

by Christopher Sykes, Solicitor

Introduction

This case demonstrates the duty of care owed by specialists who are asked to perform diagnostic tests on behalf of other medical practitioners.

In particular, the case highlights the need for specialists to consider (and report to the referring practitioner) whether the findings of a test adequately explain a patient's symptoms or whether additional tests or examinations are required.

Background

The plaintiff, Ms Raquel Mazza, had been diagnosed with Coeliac disease when she was 17 or 18 years old. The plaintiff's Coeliac disease was managed with diet; however there was some suggestion that the plaintiff did not strictly adhere to this diet.

In February 2004, when she was 25 years old, the plaintiff presented to her general practitioner, Dr Fitzsimon, with vomiting, abdominal pain, diarrhoea and 4kg of recent weight loss. Consequently, Dr Fitzsimon ordered an "upper endoscopy" – otherwise known as an "open endoscopy" or "open access" endoscopy.

The hallmark of an "open-endoscopy" is that the service provided is limited to the endoscopy itself. A report of what was *seen* is provided to the referring doctor, but no comment is provided by the specialist gastroenterologist who performs the procedure about what the findings mean, whether the findings provide a satisfactory explanation of the patient's symptoms or whether further tests are warranted.

In his report of the endoscopy, the defendant wrote to Dr Fitzsimon, stating that the pharynx, oesophagus and stomach appeared to be normal, but the "duodenum still appears abnormal consistent with ongoing villous atrophy". He advised that small bowel and entral biopsies had been taken and sent to a laboratory. Against the word "summary", he wrote "persisting villous atrophy".

Villous atrophy was an indication that the plaintiff had not been adhering to the gluten free diet which, as someone with Coeliac disease, she was required to do.

Had that been the only thing causing her then symptoms, her health could have been restored within a matter of months by resuming a proper diet. However, the patient remained significantly unwell. In addition, she gave birth in January 2005 and suffered severe symptoms throughout her pregnancy.

In May 2005, the plaintiff's weight had dropped to 33kg. She was referred by Dr Fitzsimon to the eating disorder unit at Royal Brisbane Hospital where she underwent 5 days of psychiatric assessment. Eventually, the plaintiff was reviewed by a gastroenterology registrar who recommended and arranged an endoscopy.

The endoscopy was performed by Dr Bryant who located a tumour. The tumour was removed and determined by the surgeon to be located in the jejunum – the part of the small bowel that joins onto the duodenum.

The plaintiff underwent chemotherapy but was given a poor prognosis. At the time of the trial however, the plaintiff's prognosis had improved and she had returned to part-time work.

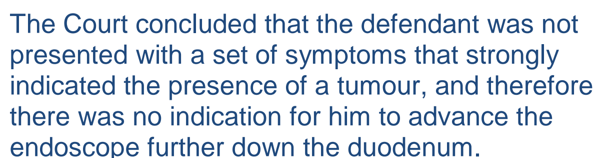
Colonoscopy not negligently performed

The Court was asked to consider whether the defendant had performed the endoscopy negligently by not examining all parts of the duodenum.

The Court heard that the duodenum (the part of bowel that connects with the stomach) is divided into 4 anatomical parts. Part D1 is the start of the duodenum that connects to the stomach. Part D4 is the part that connects to the jejunum.

Evidence before the Court was that the defendant had only examined the first half of the duodenum (parts D1 and D2). The key issue was whether the defendant should have extended the endoscopy and examined parts D3 and D4 – particularly as the tumour was ultimately found in the region of D4.

The Court accepted evidence from Dr Bryant (who performed the endoscopy in 2005) and the expert called by the defendant (Dr Sandford). The Court found that accepted medical practice during an "open-endoscopy" was to only pass the endoscope to the level D2 unless there were particular symptoms or signs that warranted further passage of the endoscope.



The Court concluded that the defendant was not presented with a set of symptoms that strongly indicated the presence of a tumour, and therefore there was no indication for him to advance the endoscope further down the duodenum.

Based on peer professional opinion, the Court held that the defendant did not perform the endoscopy negligently by only examining the duodenum as far as D2. The Court held that the peer professional opinion relied upon was not “irrational or contrary to a written law” for the purpose of the *Civil Liability Act 2003* (Qld).

Breach of duty of care

Having found the defendant was not negligent in performing what was effectively a limited examination, the attention of the Court then turned to the content of the report given to Dr Fitzsimon.

The Court noted that the defendant’s report indicated that all the plaintiff’s symptoms were explained by villous atrophy. There was no suggestion in the report that further investigation may be required - for example another diagnostic test to examine those parts of the duodenum and small bowel not examined in the limited “open-endoscopy”.

The Court asked the following:

> *Should Dr Webb have done more, either in the procedure or in his report? Undoubtedly Dr Webb owed a duty of care to the plaintiff. The duty which the law imposes on a medical practitioner is a “single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment”. In Rogers v Whitaker, it was said that this duty “extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case”. But the content of the duty here, it must be accepted, was affected by the limits of the task which Dr Webb had been asked to perform.*

The Court concluded that:

> *There was a foreseeable risk that a serious condition ... existed in the case of this patient with the symptoms which were recorded, and that this would go untreated if undetected. Notwithstanding the “open access” basis for the procedure, Dr Webb was obliged to exercise reasonable skill and care to avoid that risk. If he was not to pass the endoscope as far as possible, to try to identify the cause of all of her symptoms, reasonable care demanded that he at least alert the treating doctor and the patient that his investigation had been limited and that it had not yielded a satisfactory explanation for her symptoms. He failed to do that. Instead he wrote a report which represented that he had found such an explanation.*
>
> *Although he was not the doctor responsible for the plaintiff’s treatment, it must be remembered that he was the specialist. As Dr Sandford said, gastroenterologists “are dealing more commonly with these relatively uncommon conditions than GPs and we see a wider spectrum of the complications resulting from those diseases and therefore are far more aware of them as possibilities”. The specialist should not have left it to the GP to assess whether the symptoms had been satisfactorily explained by the presence of villous atrophy. And as I have found, in this case the report was not only uninformative but also misleading.*

The Court held that the defendant’s reporting of the endoscopy findings caused a delay in diagnosing the plaintiff’s cancer – the effect of which was to subject the plaintiff to 15 months of unnecessary pain and suffering.

The Court awarded the plaintiff $81,373.00 - the major components being loss of earnings ($23,370.00) general damages ($33,200.00) and past care ($20,000.00).

Conclusion

This case highlights that medical practitioners have a “single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment “. In situations where a practitioner has been asked to perform a test, the duty may extend beyond mere performance of the requested test.

In this case, a specialist competently performed a requested procedure, but negligently failed to adequately report his findings to the requesting practitioner.

Specialists who are asked to perform diagnostic tests should consider the significance of their findings with reference the patient’s symptoms and whether the test was limited in such a way that additional tests, examinations or follow-up is indicated. This information should be passed onto the referring practitioner.

Precedents/Standard Form Agreements and Policies

Due to client demand, we have developed a range of standard form Agreements and Policies which are commonly used by health and aged care service providers. The documents have been prepared in a template form so they can be completed by your staff and include service contracts for the provision of pathology and radiology services, requests for tenders, leases and supply of goods contracts.

Precedents added to our range recently include an interpreter services agreement, a corporate guarantee, and Executive management contracts.

For further information about these products contact Natalie Franks on (03) 9865 1324 or natalie.franks@healthlegal.com.au

Private Practice Arrangements

by Natalie Franks, Principal

The investigation last year by Medicare Australia of the private practice arrangements in place at 2 Victorian public health services is a timely reminder that care needs to be taken when re-structuring or introducing new arrangements.

In both those cases Medicare found no issues worth pursuing. However, it was clear from the questioning which both Health Services faced that the Medicare investigators were extremely well informed about ‘double dipping’ issues and the circumstances in which patient services can be billed to the Commonwealth.

General

In our experience, the 2 most common types of private practice arrangements in use in Victorian public hospitals are the ‘facility fee’ model and the ‘100% assignment model’.

The 100% assignment model can only be used where the doctors are employed (and are given a right of private practice) and it is a term of their employment that they must assign over 100% of their private practice earnings to the Health Service.

The facility fee model can be used in all other circumstances.

Why is the *Health Insurance Act* relevant?

In order for these agreements to be appropriately structured (and not breach the *Health Insurance Act*), providers must ensure the private patient professional services are not provided “by, or on behalf of or under an arrangement with” the public health service/public hospital.

Key features of the Facility Fee model

The Facility Fee model is documented using a Private Practice Agreement. In essence, under this Private Practice Agreement the Health Service grants a doctor the right to use specified facilities, support services and consumables in order to allow the doctor to see and treat private patients. In return for granting these rights and facilities to the doctor, the doctor pays the Health Service a ‘facility fee’.

The Private Practice Agreement is a record of the arms length commercial arrangement reached by both the Health Service and the relevant doctor.

Depending on the structure adopted, the doctor will be entitled to indemnity under the Health Service’s medical malpractice policy.

Key features of the 100% assignment model

In 2005, acting on behalf of the (then) Department of Human Services, PWC developed the following 3 related documents to be used in establishing 100% assignment private practice arrangements:

1. a private practice agreement between the practitioner and the Health Service
2. a special purpose fund agreement between the practitioner and the Health Service, and
3. a sample letter of appointment including provisions specifically relating to private practice.

These documents formed part of Tax Class Ruling issued by the ATO in 2005. In order to gain the protection of the Tax Ruling these documents cannot be materially altered.

Why the concern?

As pressure is placed on the public health system, providers will naturally look for other revenue streams. Private practice arrangements are legitimate and can be lawfully established.

If the arrangements are incorrectly set up, however, providers risk the repayment of all Medicare monies billed under the arrangements, plus the payment of interest and potentially administrative penalties under the *Health Insurance Act*.

Where the relevant intent is proven imprisonment terms can be imposed.

Recent Legislative Changes

The following Acts and Regulations which are relevant to health and aged care services (and captured by our legislative compliance products) have recently commenced:

Aged Care Amendment Act 2011 (Cth)	**Healthcare Insurance Amendment (Compliance) Act 2011 No 10 (Cth)**
Births, Deaths and Marriages Registration Regulation 2011 (NSW)	**Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Amendment Regulations (No. 2) 2011 (WA)**
Building Amendment (Bushfire Construction – Short-Term Requirements) Regulations 2010 (Vic)	**Human Services Legislation Amendment Act 2011 (Cth)**
Cannabis Law Reform Act 2010 (WA)	**Human Services Legislation Amendment Regulations 2011 (No. 1) (Cth)**
Children and Community Services Amendment Act 2010 (WA)	**Multicultural Victoria Act 2011 (Vic)**
Corporations Amendment (Improving Accountability on Director and Executive Remuneration) Act 2011 (Cth)	**National Greenhouse and Energy Reporting Amendment Regulations 2011 (no. 1) (Cth)**
Disability (Access to Premises – Buildings) Standards 2010 (Cth)	**Poisons and Therapeutic Goods Amendment (Miscellaneous) Regulation 2011 (NSW)**
Electricity (Licensing) Amendment Regulations (No.1) 2011 (WA)	**Public Sector Management (Breaches of Public Sector Standards) Amendment Regulations 2011 (WA)**
Equal Opportunity Act 2010 (Vic)	**Quality of Care Amendment Principles 2011 (No. 1) (Cth)**
Food Amendment (Regulation Reform) Act 2009 (Vic)	**Severe Substance Dependence Treatment Act 2010 (Vic)**
Local Government Electoral Act 2011 (Qld)	**Sex and Age Discrimination Legislation Amendment Act 2011 (Cth)**
Gene Technology Amendment Regulations 2011 (Cth)	**User Rights Amendment Principles 2011 (No. 1) (Cth)**
Health (Western Australia Cancer Register) Regulations 2011 (WA)	**Water Agencies (Water Use) Amendment By-laws 2011 (WA)**
Health Services (Conciliation and Review) Amendment Regulations 2011 (WA)	**Workers' Compensation and Injury Management Amendment Act 2011 (WA)**

If you would like details of these new Acts and Regulations please contact Samantha Pearce on (03) 9865 1377 or email: samantha.pearce@healthlegal.com.au. In most cases we will be able to email you a short and practical summary of the impact of the new legislation.

Frequently Asked Medico-Legal Questions

Health Legal in conjunction with Austin Health has developed a handbook covering all the medico-legal questions which are frequently asked by health service staff.

The handbook covers more than 100 pages and focuses on the needs of the Victorian public and private health sector. Specifically, the handbook covers a wide range of topics, including consent, refusal/withdrawal of treatment, patient privacy/confidentiality and dealing with adverse events and patient complaints.

The handbook and updates will be provided to customers on disk so that it can be placed on your organisation's intranet.

If you would like to purchase the FAQ Medico-Legal Handbook or would like any further information about this publication, please do not hesitate to contact Natalie Franks on (03) 9865 1324.

For more information please contact:

Natalie Franks	Claudia Hirst	Bridget Thom
Principal **P:** 03 9865 1324 **E:** natalie.franks@healthlegal.com.au	**Executive Counsel** **P:** 03 9865 1340 **E:** claudia.hirst@healthlegal.com.au	**Senior Consultant** **P:** 03 9865 1312 **E:** bridget.thom@healthlegal.com.au
David Ruschena	**Megan Balakumar**	**Katherine Stevens**
Senior Consultant **P:** 03 9865 1333 **E:** david.ruschena@healthlegal.com.au	**Senior Associate** **P:** 03 9865 1334 **E:** megan.balakumar@healthlegal.com.au	**Solicitor** **P:** 03 9865 1300 **E:** katherine.stevens@healthlegal.com.au
Christopher Sykes	**Teresa Pollock**	**Giovanni Marino**
Solicitor **P:** 03 9865 1329 **E:** christopher.sykes@healthlegal.com.au	**Solicitor** **P:** 03 9865 1337 **E:** teresa.pollock@healthlegal.com.au	**Law Student** **P:** 03 9865 1339 **E:** giovanni.marino@healthlegal.com.au

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