

NSW Medical Practice Amendment Act 2008

Introduction

On 7 May 2008, the NSW Minister for Health introduced the Medical Practice Amendment Bill to the Legislative Assembly. The Bill was assented to without amendment on 4 June 2008 and some provisions came into effect on 1 August 2008, with the remainder of the Medical Practice Amendment Act coming into effect on 1 October 2008.

The stated aim of the Act is to improve public protection within the health system by providing the NSW Medical Board (the Board) and Health Care Complaints Commission with improved powers to deal quickly and effectively with complaints about medical practitioners. The Act is also intended to improve the transparency and accountability of investigative and disciplinary processes, and places mandatory reporting requirements on the medical profession to report colleagues whose conduct may constitute 'reportable misconduct'.

The Act raises a number of concerns in relation to its potential impact on the rights of medical practitioners and their ability to seek advice and support in a time of crisis from their treating doctors and their medical indemnity insurer.

Background To Act

In August 2006, the Minister for Health announced an urgent review to strengthen the powers of the NSW Medical Board, as a result of the case involving Dr Suman Sood¹. An expert panel was established in September 2006, with former Federal Court Judge Deidre O'Connor as chairperson of the panel. The panel conducted a review of the powers of the NSW Medical Board to take action in relation to medical practitioners to protect the public under Section 66 (emergency provisions) of the Medical Practice Act 1992, avenues of appeal and review in respect of such decisions, and powers and procedures for dealing with multiple complaints against a medical practitioner.

Arising from that review, a number of recommendations were made to the Minister for Health, which were incorporated in the Medical Practice Amendment Bill 2008. In February 2008, the Minister asked Ms O'Connor to re-visit the Bill in light of public concern over the manner in which the regulatory system had dealt with Dr Graeme Reeves² during the 1990s until his deregistration in 2004. The aim of the further review was to identify if additional amendments to the regulatory regime were required, further improving the way in which the system operated to protect the public. As part of this process, additional recommendations were made, including the introduction of mandatory reporting by medical practitioners of their colleagues.

Legislation

The Medical Practice Amendment Act 2008 makes amendments to both the Medical Practice Act 1992 and the Health Care Complaints Act 1993.

The major proposed amendments cover four main areas:

1. the powers of the Medical Board to take urgent action to protect the public under Section 66 of the Medical Practice Act 1992
 - a. the Board will be obliged to suspend or place conditions on a medical practitioner's registration, not only if it is appropriate to do so for the health or safety of the public, but if it is satisfied that the action is otherwise in the 'public interest'
 - b. Section 66 Inquiry must have at least one member who is not a medical practitioner
 - c. Section 66 Inquiry to be recorded
 - d. medical practitioners must appeal to the Medical

Tribunal in the first instance, rather than have the right of appeal directly to the Supreme Court of NSW for a judicial review of a decision made by a Section 66 Inquiry

- e. Board will have powers to compel a person to provide information, produce documents or give evidence to the Board.

2. changes to the conduct and composition of Professional Standards Committees (PSCs)

- a. to be conducted in public, unless ordered to the contrary. PSC decisions to be made public
- b. fourth member who will be legally qualified and chair of the PSC
- c. ability to make 'critical compliance orders or conditions'. If breached, the Medical Tribunal must order the deregistration of the medical practitioner (the Medical Tribunal can also make critical compliance orders or conditions).

3. mandatory reporting obligations on medical practitioners to report 'reportable misconduct' by their colleagues

A registered medical practitioner commits reportable misconduct in the following circumstances:

- a. if he or she practises medicine while intoxicated by drugs (whether lawfully or unlawfully administered) or alcohol,
- b. if he or she practises medicine in a manner that constitutes a flagrant departure from accepted standards of professional practice or competence and risks harm to some other person,
- c. if he or she engages in sexual misconduct in connection with the practice of medicine.

A medical practitioner who fails to report 'reportable misconduct' commits unsatisfactory professional conduct or professional misconduct.

4. the ability of the Health Care Complaints Commission and the Medical Board to have regard to any previous complaints and adverse findings against the practitioner

- a. the Health Care Complaints Commission can consider an 'associated complaint' (defined as another complaint

concerning the practitioner) including discontinued and terminated complaints, during the assessment and investigation stage, to the extent it considers the associated complaint relevant

- b. when determining whether to prosecute a complaint, the Director of Proceedings is to consider making a determination with respect to any associated complaints so that complaints are prosecuted concurrently.

Implications For Medical Practitioners

The mandatory reporting provisions may discourage medical practitioners from disclosing incidents and seeking advice from their colleagues and other medical practitioners because of a concern that they may be reported to the NSW Medical Board. This is likely to undermine the Open Disclosure initiatives. Regardless of the specific wording of the legislation, there may be a perception amongst the profession that medical practitioners should not seek advice from a medically trained spouse, a medical colleague, a treating doctor and other services, such as medical indemnity insurers or the Doctors' Health Advisory Service. There is no evidence that mandatory reporting by medical practitioners would have prevented the Drs Sood and Reeves cases from occurring.

Deregistration is a significant penalty for any medical practitioner. The 'critical compliance orders and conditions' remove the right of medical practitioners to provide a 'reasonable explanation' for any contravention.

The changes to the Professional Standards Committees (PSCs), whereby:

- such hearings will now be held in public and
- the PSC must be chaired by a person with legal qualifications,

will result in medical practitioners facing a public and legally driven inquiry without the opportunity of having legal representation.

Implications For Medical Indemnity Insurers

The mandatory reporting obligations of medical practitioners will impact upon the ability of medical practitioner members of the Council, Board and other committees of the medical indemnity insurer, as well as the medical indemnity insurer's employees who are medical practitioners, to undertake their work within the organisation.

The mandatory reporting obligations of medical practitioners

may also impact upon medical practitioners who provide expert reports for medical indemnity insurers.

A committee of the MIAA has been working on issues surrounding the Act, and members continue to be concerned regarding the implications of aspects of the legislation. The MIAA welcomes input from other organisations or individuals concerned about the legislation.

Dr Sara Bird – MDA National Insurance and Helen Turnbull – Avant

1. Dr Suman Sood ran an abortion clinic in Western Sydney. She had been the subject of a number of disciplinary proceedings by the Board over the years, including suspension of her registration under Section 66. Dr Sood had her suspension stayed after an appeal to the Supreme Court. In October 2005, the Medical Tribunal found that Dr Sood had engaged in professional misconduct and was dishonest. The Medical Tribunal ordered that Dr Sood be deregistered and that she not apply for re-registration as a medical practitioner for ten years. By this time, Dr Sood had been charged with manslaughter and the performance of an illegal abortion in 2002. In October 2006, Dr Sood was found guilty of performing an illegal abortion, but not guilty of manslaughter.

2. Dr Graeme Reeves was an obstetrician and gynaecologist who had conditions placed on his medical registration following consideration of complaints about his practice before a Professional Standards Committee (PSC) in June 1997. One of the PSC conditions was that he no longer practise obstetrics. Dr Reeves was subsequently appointed as an obstetrician and gynaecologist by Southern Area Health Service in April 2002. The Medical Board held a Section 66 Inquiry on 26 February 2003 after becoming aware that Dr Reeves had been practising as an obstetrician in breach of the conditions on his registration. The Board did not suspend his registration at this time but re-imposed the existing conditions. Dr Reeves was ultimately deregistered by the Medical Tribunal in 2004 for contravention of the conditions on his registration. Multiple complaints about Dr Reeves' conduct throughout his medical career have come to light and received widespread media coverage in early 2008.

2008 Medical Indemnity Forum

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Ms Beth Wilson – Health Services Commissioner of Victoria

Dr Beres Wenck – RACGP

Ms Maureen Willson – Victorian Managed Insurance Authority

Ms Kathryn Booth – Maurice Blackburn

Dr Heather Wellington – DLA Phillips Fox

Prof Julian Rait

For a copy of the brochure either visit www.miaa.com.au or call the MIAA office on 08 8113 5312.

The 2008 SA Medical Indemnity Report

The most recent update of Australian medical malpractice insurance statistics was published by Insurance Statistics Australia (ISA) on 7 July 2008. The addition of another year's statistics to their previous reports provides a continued insight into premium and claim trends in Australia. The report will be welcomed by both the medical indemnity insurers and medical profession alike as it provides further support to the feeling that the industry is in good shape. A copy of the report can be obtained from the MIAA website www.miaa.com.au.

It is pleasing to note that when compared to the 1995/98 triennium, the report shows a marked reduction in claims for most specialties over the last triennium. Significant examples include a reduction of 54% for neurosurgery, 50% in orthopaedics, 39% for physicians, 36% for anaesthetics and 19% for non-procedural general practitioners (GPs). Procedural GPs on the other hand experienced a small increase of 5% over this period. The report excludes 'incidents' and 'notifications' except those that are expected to become claims in the future and also does not address disciplinary hearings and coronial matters. Of further interest is the expected slight increase in claims frequency ultimately predicted for the 2006/07 year but this is offset by an expected slight reduction in the average claim cost per policy.

At this time one can only speculate as to the reasons behind the continuing reduction in claims frequency but it is likely to be due to a combination of factors including the tort law reforms introduced approximately 5 years ago, the active application of risk management activities within the medical profession and perhaps a reduction in the community's appetite for seeking recompense for any imperfect experience, amongst others. More important, at this time, is to question why the procedural GPs have experienced a slight increase in claims frequency. There is no obvious answer to this observation but it may reflect increases in the volume and complexity of their workload, changes in types of procedures performed or even changes in the actuarial methodology in predicting the future for this craft group.

The inclusion of cause of loss, bodily function and structure affected and the venue to which claims were attributed for the first time is refreshing and important step forward. These figures

provide, for the first time, a more detailed insight into the underlying generic issues at the heart of the claims experiences of the insurers. Such information is important as identification of common problems leading claims allows for remedial action to be taken by the profession at large in concert with their insurance providers. In this regard, it is gratifying to note that the Australian Medical Association, the learned Colleges, the Divisions of General Practice and other professional organisations are actively supportive. There is a vast amount of further work to be done in this area and as further information comes to hand it is important to ensure that it is used to alert doctors so that a sick person's experience of the health care system is a happy one, at least as much as it ever can be!

Dr. Jonathan Burdon
MIIAA Chairman



Medical Practitioners And Access To Their Medical Records

An issue that often arises in a medical practice is who has legal rights to medical records, including a doctor's notes. For example, a doctor often compiles notes in connection with treating a patient with the expectation that they will not be revealed to third parties and even to the patient. The doctor may then be confronted with a subpoena for the notes, or a demand by the patient for access to the notes.

This article sets out recent legal developments with the object of providing practical guidance for medical practitioners. The most important topic addressed is the impact of the federal Privacy Act. However, the article is for general guidance only. Particular matters should be the subject of specialist advice. Privacy law can be complicated and may depend on different State and Territory legislation.

The General Rule

As a general rule in Australia, medical records are the property of the medical practitioner who created them. The purpose of creating the records is likely to determine who owns the records. Medical records are ordinarily created by the medical practitioner for their own professional purposes in order to provide health care services to the patient, including diagnosis, treatment and advice.

Where a treating medical practitioner, through the exercise of intellectual skills, applies professional knowledge to health information chosen from the patient's history to document results of the consultation, the medical practitioner becomes the owner of the 'new' information.

Unless there is a specific provision in the contract between the medical practitioner and the patient to the effect that intellectual property in medical records will belong to the patient (normally, there isn't), any records including notes will remain the property and copyright of the medical practitioner. The medical practitioner does not compile records as agent for the patient.

Also, there is no distinction between property rights to the physical records and property rights to the information contained in the records. The information, once imparted to the patient, belongs equally to the medical practitioner and the patient. The physical records are the doctor's alone.

Exceptions

X-rays, photographs, pathology reports and the like obtained by a medical practitioner on behalf of the patient and paid for

by the patient (or the patient's health fund) are likely to belong to the patient. Further:

- if a medical practitioner is not a treating doctor but prepares a medical report at the request of an insurance company (for example), the purpose of compiling the report might mean that the requesting party will own the report; and
- once legal proceedings have commenced in any particular case, a right of access to medical records normally exists pursuant to compulsory court process (normally, a subpoena to produce the records).

As discussed below, the question of ownership of medical records and the issue of privacy or confidentiality concerning those records, are two distinct matters.

The Impact Of The Federal Privacy Act

Before the federal Privacy Act applied to all medical practitioners in the private health sector on 21 December 2001 (regardless of the size of their business), a patient had no legal right of access to his or her medical records. This was subject to the contract between the medical practitioner and the patient providing the patient with such a right (normally, it doesn't). This common law position is now overridden to a large extent by the federal Privacy Act and some State/Territory privacy laws.

Freedom of information (FOI) legislation may also allow access by patients to their medical records held by public institutions or government agencies, but the private sector is not subject to FOI.

The federal Privacy Act applies to the Australian public and private health sectors. It regulates the management of health information by medical practitioners. "Health information" as a subset of personal information is:

- about an individual's health or disability, past present or future;
- about an individual's expressed wishes regarding future health services;
- about health services provided, or to be provided to the individual; or
- collected whilst providing a health service.

The national privacy principles (NPPs) in the Privacy Act represent the minimum privacy standards for handling health information. The NPPs apply to health information in any form, including paper, electronic, visual (x-rays, CT scans, videos and photos) and audio records. Higher privacy standards apply to the handling of health information compared to mere personal information.

Collection, Use And Disclosure Of Health Information

Medical practitioners may only collect health information with consent, except in the circumstances specified in the Privacy Act including emergencies and as required by law. A patient's consent can be express or implied. A conventional consultation can normally be regarded as implied consent. Consent is only valid if the patient has been adequately informed. There are a limited number of situations where the Privacy Act allows health information to be collected without consent.

A medical practitioner must not use or disclose health information for a purpose other than the purpose of collection unless an exception specified in the Privacy Act applies, including:

- the patient has consented to the use or disclosure;
- the medical practitioner reasonably believes that the use or disclosure is necessary to lessen or prevent a serious and imminent threat to a patient's life, health or safety or a serious threat to public health; or
- the use or disclosure is required or authorised by or under law.

However, just because a patient provides a written consent to producing medical records (for example, to the patient's lawyer), does not mean that the medical practitioner must produce the records when they belong to the practitioner. The practitioner may properly insist on a subpoena, or that the access requirements in the Privacy Act be complied with (discussed below).

A subpoena to produce is a classic example of the "required or authorised by law" exception. Unlike legal professional privilege, there is no medical professional privilege at common law to resist a subpoena. There may be a statutory medical professional privilege in some States or Territories which could overcome a subpoena.

Also, in all States and Territories medical practitioners are required by legislation proactively to report certain contagious and infectious diseases, and child abuse is normally reportable.

Quality, Security And Openness Of Health Information

A medical practitioner must take reasonable steps to ensure that health information is accurate, complete and up-to-date, and protected from misuse, loss and unauthorised access, modification or disclosure.

A medical practitioner is also required by the Privacy Act to have a policy document with respect to management of health information, and must disseminate the document appropriately

(for example, having it displayed in a surgery waiting room).

Access to health information

This is an important change brought about by the Privacy Act. A medical practitioner must provide a patient with access to health information held by the practitioner on request, except to the extent that:

- providing access to the information would pose a serious threat to the life or health of any individual (an imminent threat to life or health is not necessary);
- providing access would have an unreasonable impact on the privacy of other individuals, or the request for access is frivolous or vexatious; or
- providing access would be unlawful, or denying access is required or authorised by or under law.

Also, there may be an exception for therapeutic privilege, where there is reasonable concern about possible adverse effects on the patient's physical or mental health as a result of granting access. There is also a limited exception in relation to commercially-sensitive information.

Generally, a medical practitioner must provide reasons for denial or access. In the case of most exceptions (not commercially-sensitive information), the medical practitioner must, if reasonable, consider whether the use of a mutually agreed intermediary would allow sufficient access.

A medical practitioner may charge for providing lawful access to health information (provided charges are not excessive), and may refuse access until payment is made.

Identifiers, Anonymity And Health Information

A medical practitioner must not adopt as his or her own identifier of a patient an identifier assigned by a government agency, such as a Medicare number.

Wherever it is lawful and practical, patients must have the option of not identifying themselves when dealing with a medical practitioner.

Sanctions Under The Privacy Act

Generally, of course, medical practitioners in Australia owe their patients legal and ethical duties not to use or disclose personal health information without their patient's consent unless a legal obligation or recognised exception exists.

Apart from the usual sanctions for a breach of these duties, the Privacy Act can be enforced against medical practitioners, which may involve performing an act or payment of compensation or costs.

Legal Risk Management

The relationship between medical practitioners and their patients is traditionally contractual in nature. Even when the contract is non-written (verbal), it will normally contain an implied condition imposing a duty to act at all times in the best interests of the patient and a duty of confidentiality.

Medical practitioners may consider having a written contract that unequivocally deals with ownership of medical records and access rights, which is consistent with the Privacy Act. The mandatory policy statement (mentioned above) an competent legal advice are also risk control measures.

Stephen Thompson

Sparke Helmore Lawyers

PIAA International Section Conference

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The MIAA is delighted to have been awarded the hosting rights for the Physician Insurers Association of America's International Section Conference in 2011. The Conference will be held in Melbourne from 6 October 2011. We look forward to welcoming the world wide medical indemnity community to Australia.

